

Feature	HIP VIP High Copay Option - Post-65
Provider	HIP Health Plan of NY Enrollment: 1-800-447-8632 Ongoing: 1-800-447-8255 www.hipusa.com
Cost Sharing	
Annual Deductible	\$0 Individual; \$0 Family
Out-of-pocket maximum	\$0 Individual; \$0 Family
Lifetime coverage limit	Limit does not apply
Policies/Requirements	
Need to file claims	No; except for covered urgent or emergency care received outside of the service area
Domestic partner benefits	Yes
Access	
Ability to self-refer to OB/GYN	Yes
Ability to self-refer to specialists	No
Out-of-area dependent coverage	No
Out-of-area participant coverage	No
Spending Account	
HRA -- You only	Not applicable
HRA -- You and spouse	Not applicable
HRA -- You and child	Not applicable
HRA -- You and family	Not applicable
Eligible expenses for reimbursement	Not applicable
Outpatient Services	
Primary doctor office visit	\$10 copay
Specialist doctor office visit	\$15 copay
Preventive Care	
Annual physical exam	\$10 copay
Well-woman exam (includes pap)	\$10 copay
Mammogram	100% covered
Pediatric exams	100% covered
Immunizations (child)	100% covered
Colorectal screening	100% covered
Cancer screenings	100% covered; included in office visit copay
Cardiovascular screenings	100% covered; included in office visit copay
Allergy tests and treatments	100% covered; included in office visit copay
Outpatient Care	
Outpatient surgery	\$50 copay
Outpatient laboratory services	100% covered; included in office visit copay
Outpatient physical therapy	\$10 copay
Outpatient X-ray	100% covered; included in office visit copay; \$50 copay for diagnostic and therapeutic services including MRI, PET, and CT scans at outpatient facility
Outpatient occupational therapy	\$10 copay
Outpatient speech therapy	\$10 copay

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Outpatient cardiac rehabilitation	\$10 copay
Family Planning/Maternity Care	
Office visit: pre/postnatal	\$10 copay; PCP; \$15 copay specialist
In-hospital delivery services	\$100 copay
Newborn nursery services	100% covered
Fertility services	Not covered
In vitro fertilization	Not covered
Artificial insemination	Not covered
Female tubal ligation	\$50 copay
Male vasectomy	\$50 copay
Hearing	
Hearing evaluations	\$20 copay; limited to one exam per benefit year
Hearing aids	One hearing aid at no cost or \$500 credit toward purchase of hearing aids; total hearing aid benefit once every 36 months
Vision	
Routine vision exams	\$15 copay; eye refraction exam
Regular lenses and frames	Limited to one set of eyeglasses every 12 months; limited to select group of frames
Contact lenses	Not covered
Dental	
Dental implants	Not covered
Accidental injury to teeth	Applicable copays apply; must be medically necessary; check with Plan for details
Surgical removal of tumors, cysts and impacted teeth	Applicable copays apply; must be medically necessary; check with Plan for details
Inpatient Services	
Hospital copay	\$100 copay
Hospital semi-private room	\$100 copay
Inpatient lab and X-ray	\$100 copay
Inpatient surgery	\$100 copay
Inpatient physician and surgeon services	\$100 copay
Emergency Care	
Emergency room (not followed by admission)	\$50 copay
Urgent care clinic visit	\$10 copay
Ambulance services	\$50 copay
Prescription Drug Coverage	
Annual prescription deductible	Not applicable
Prescription drug website	Same as medical plan
Prescription drug member services	Same as medical plan
Prescription drug vendor	Same as medical plan
Annual Rx out-of-pocket maximum	Not applicable
Retail	
Retail generic	\$10 copay; 30 day supply
Retail formulary brand	\$15 copay; 30 day supply
Retail nonformulary brand	50% covered; 30 day supply

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	Mail Order
Mail order generic	\$5 copay; 30 day supply; three times copay for up to 90 day supply
Mail order formulary brand	\$7.50 copay; 30 day supply; three times copay for up to 90 day supply
Mail order nonformulary brand	50% covered; 30 day supply; up to 90 day supply available
	Other
Oral contraceptives	Retail and mail order available; covered for medically necessary Medicare approved reasons
Fertility drugs	Not covered
Retail injectable drugs	Coverage based on place of service; applicable prescription drug copay or office visit copay applies; check with Plan for details
	Mental Health
Mental Health: Combined with substance abuse	No
Mental Health: Outpatient coverage	\$20 copay
Mental Health: Inpatient coverage	100% covered; limited to 190 days per lifetime at a psychiatric facility; no limit when admitted to a general hospital
	Substance Abuse
Detox: Outpatient coverage	Not covered
Detox: Inpatient coverage	\$100 copay per admission; must be medically necessary; limitations based on Medicare guidelines
Rehab: Outpatient coverage	\$15 copay
Rehab: Inpatient coverage	100% covered; must be medically necessary; limitations based on Medicare guidelines
	Alternative Care
Chiropractic	\$20 copay; must be medically necessary; no PCP referral required
Acupuncture	Not covered
	Care Management Programs
Heart disease care management	Yes; congestive heart failure
Hypertension care management	No
Diabetes care management	Yes
Asthma care management	Yes
Prenatal care management	Yes
Cancer care management	No
Smoking cessation program	Yes
Weight control program	No
	Other
Noncustodial home health care	100% covered
Hospice care	Covered under original Medicare program; contact Plan for details
Prescribed care in noncustodial skilled nursing facility	100% covered; days 1-20; \$25 copay per day for days 21-100; limited to 100 days per benefit period
Durable medical equipment	100% covered
Prosthetic devices	100% covered