

SUMMARY OF BENEFITS

➤ MAJOR COPAYMENT PROVISIONS	HIP PRIME™
PCP Office visits	No copay
Specialist Office visits	No copay
Hospital admission	No copay
Emergency Room copay	No copay
Prescription drugs	\$0 generic/\$0 brand (Subject to Drug Formulary ¹) Contraceptives Included

➤ INPATIENT HOSPITAL SERVICES	HIP PRIME™
• Hospital and physician services	No copay
• Semi-private room and board	No copay
• Operating and recovery room, intensive and special care units, general nursing care, prescribed drugs, anesthesia, X-rays and lab tests	No copay
• Short-term speech, physical, occupational and respiratory therapy (when part of an acute admission)	No copay Short-term only
• Speech, physical, occupational and respiratory therapy (when part of a rehabilitation admission)	No copay 90 days per calendar year
• Radiation therapy and chemotherapy	No copay
• Pre-admission testing	No copay
• Human organ transplants	No copay

➤ OUTPATIENT MEDICAL CARE	HIP PRIME™
• PCP office visits	No copay
• Specialists office visits	No copay
• Preventive care, including physical exams, eye and eye exams, health education and counseling, pap smear, mammography and immunizations	No copay
• Well-child care to age 19 including immunizations	No copay
• Diagnostic services including X-ray, lab tests, EKG's, MRI's and CAT scans	No copay
• Prenatal, postnatal care in physician's office	No copay
• Ambulatory surgery	No copay
• Second medical and surgical opinion	No copay
• Wheelchairs	Covered under DME rider
• Routine foot care	Not covered
• Chiropractic services	No copay

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SUMMARY OF BENEFITS

➤ MENTAL HEALTH AND ALCOHOL AND SUBSTANCE ABUSE CARE	HIP PRIME™
Mental Health Care	
• Inpatient	No copay; 30 days per calendar year
• Outpatient	No copay; 60 visits per calendar year
Alcohol and Substance Abuse Care	
• Inpatient Detoxification	No copay; 7 days per calendar year
• Inpatient Rehabilitation Treatment	No copay; 60 days per calendar year
• Outpatient Rehabilitation Treatment	No copay; 120 visits per calendar year

➤ SPECIAL KINDS OF CARE	HIP PRIME™
Emergency and urgent care	
• In hospital emergency room	No copay
• In urgent care facility	No copay
• In physicians office	No copay
• Ambulance service to hospital	No copay
Home health care	No copay; 200 visits per calendar year
Hospice care	No copay; 210 days
Skilled Nursing Facility care	No copay; Unlimited days
Dialysis treatment	\$10 copay per visit
Diabetes equipment, supplies and education	No copay
Outpatient physical, speech, occupational and respiratory therapy.	No copay; 90 visits per calendar year
Family Planning Services	Covered
Dental Care	
• General Dental Care	Covered at reduced member fee schedule
• Preventive Dental	Oral exam (One every six months - \$5 copay per visit) Cleaning (One every six months - \$10 copay per visit), Topical application of fluoride for children age 16 and under (One every six months - \$5 copay per visit)
Durable Medical Equipment	\$0 annual deductible
Private Duty Nursing	100%
Hearing Aids	Not Covered, Cochlear implants covered
Optical Care	
• Refractive Eye Exams	No copay
• Eyeglasses	\$45 for a complete pair every 24 months

FOOTNOTES

¹ Drugs are dispensed in accordance with HIP's Drug Formulary. Please refer to your Prescription Drug Rider for details.

Except for emergency care, the above benefits and services are covered only when provided or referred by a HIP Primary Care Physician and /or approved in advance by HIP Care Management Program. HIP Participating Physicians and Providers have contracted with HIP to provide care to our members; they are not employees, agents, servants or representatives of HIP. This summary is provided for information only; it does not contain complete details of the Plan which are available only in the Contract or Certificate of Coverage Schedule of Benefits, and it does not constitute an Agreement.