



POS SUMMARY OF BENEFITS

➤ DEDUCTIBLES	➤ COINSURANCE	➤ COINSURANCE MAXIMUM	➤ ANNUAL MAXIMUM BENEFIT
In-Network: \$0 Out-of-Network: \$250 individual; \$500 family	In-Network: Member pays 0% Out-of-Network: Member pays 20%	In-Network: Not applicable Out-of-Network: \$1,500 individual; \$3,000 family	In-Network: Unlimited Out-of-Network: \$5,000,000 per member
➤ MAJOR COPAYMENT PROVISIONS (IN-NETWORK)		COPAYMENT	
PCP Office visits		\$10 copay	
Specialist Office visits		\$10 copay	
Hospital admission		\$200 copay	
Emergency Room copay		\$35 copay	
Prescription drugs		\$5 generic/\$10 brand (Subject to Drug Formulary ¹) (Copays are reduced by 50% when utilizing the HIP Mail Order Pharmacy Service. Up to a 90 day supply may be obtained.)	
➤ INPATIENT HOSPITAL SERVICES	IN-NETWORK	OUT-OF-NETWORK	
<ul style="list-style-type: none"> • Semi-private room and board 	Included in Hospital Admission copay	Covered 80% after Deductible	
<ul style="list-style-type: none"> • Operating and recovery room, intensive and special care units, general nursing care, staff physician services, prescribed drugs, anesthesia, x-rays and lab tests 	Included in Hospital Admission copay	Covered 80% after Deductible	
<ul style="list-style-type: none"> • Short-term speech, physical, occupational and respiratory therapy (when part of an acute admission) 	Included in Hospital Admission copay Short-term only	Covered 80% after Deductible	
<ul style="list-style-type: none"> • Speech, physical, occupational and respiratory therapy (when part of a rehabilitation admission) 	Included in Hospital Admission copay 90 days per calendar year	Covered 80% after Deductible	
<ul style="list-style-type: none"> • Radiation therapy and chemotherapy 	Included in Hospital Admission copay	Covered 80% after Deductible	
<ul style="list-style-type: none"> • Pre-admission testing 	Included in Hospital Admission copay	Covered 80% after Deductible	
<ul style="list-style-type: none"> • Surgeon & Specialist services 	Included in Hospital Admission copay	Covered 80% after Deductible	
<ul style="list-style-type: none"> • Human organ transplants 	Included in Hospital Admission copay	Covered 80% after Deductible	
➤ OUTPATIENT MEDICAL CARE	IN-NETWORK	OUT-OF-NETWORK	
<ul style="list-style-type: none"> • PCP office visits 	\$10 copay	Covered 80% after Deductible	
<ul style="list-style-type: none"> • Specialists office visits 	\$10 copay	Covered 80% after Deductible	
<ul style="list-style-type: none"> • Preventive care, including physical exams, health education and counseling, immunizations and associated diagnostic services 	\$10 copay	Not covered Out-of-Network	
<ul style="list-style-type: none"> • Well-woman care, including pap smears and mammography 	\$10 copay	Covered 80% after Deductible	
<ul style="list-style-type: none"> • Well-child care to age 19 including immunizations 	\$0 copay	Covered 80% after Deductible	
<ul style="list-style-type: none"> • Diagnostic services including X-ray, lab tests, EKG's, MRI's and CAT scans 	\$0 copay	Covered 80% after deductible when related to illness or injury	
<ul style="list-style-type: none"> • Prenatal, postnatal care in physician's office 	\$0 copay	Covered 80% after Deductible	
<ul style="list-style-type: none"> • Outpatient hospital services and ambulatory surgery including physician and facility services 	\$0 copay	Covered 80% after Deductible	
<ul style="list-style-type: none"> • Second medical and surgical opinion 	\$0 copay	Covered 80% after Deductible	
<ul style="list-style-type: none"> • Disposable Medical supplies 	\$0 copay	Covered 80% after Deductible	
<ul style="list-style-type: none"> • Wheelchairs 	Covered under DME rider	Not covered Out-of-Network	
<ul style="list-style-type: none"> • Routine Foot Care 	Not covered	Not covered	
<ul style="list-style-type: none"> • Chiropractic Services 	\$10 copay	Covered 80% after Deductible	



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➤ MENTAL HEALTH AND ALCOHOL AND SUBSTANCE ABUSE CARE	IN-NETWORK	OUT-OF-NETWORK
Mental Health Care		
• Inpatient	Included in Hospital Admission copay 30 days per calendar year	Covered 80% after Deductible
• Outpatient	\$25 copay 20 visits per calendar year	Covered 50 % after Deductible & Coinsurance
Alcohol and Substance Abuse Care		
• Inpatient Detoxification	Included in Hospital Admission copay 7 days per calendar year	Covered 80% after Deductible
• Inpatient Rehabilitation Treatment	Not covered	Not covered
• Outpatient Rehabilitation Treatment	\$10 copay 60 visits per calendar year	Covered 80% after Deductible
➤ SPECIAL KINDS OF CARE	IN-NETWORK	OUT-OF-NETWORK
Emergency and urgent care		
• In hospital emergency room	\$35 copay	Same as In-Network Coverage
• In urgent care facility	\$10 copay	Covered 80% after Deductible
• In physicians office	\$10 copay	Covered 80% after Deductible
• Ambulance service to hospital	\$0 copay	Covered 80% after Deductible
Home health care	\$0 copay; 200 visits	Covered 80% after Deductible
Hospice care	\$0 copay; 210 days	Not covered Out-of-Network
Skilled Nursing Facility care	\$0 copay; Unlimited days	Not covered Out-of-Network;
Dialysis treatment	\$10 copay per visit	Covered 80% after Deductible
Diabetes equipment, supplies and education	\$10 copay	Covered 80% after Deductible
Outpatient physical, speech, occupational and respiratory therapy.	\$10 copay; 90 visits per calendar year	Covered 80% after Deductible
Family Planning Services	Covered	Not covered Out-of-Network
Dental Care		
• General Dental Care	Covered at reduced member fee schedule	Not covered Out-of-Network
• Preventive Dental	Oral exam (One every six months - \$5 copay per visit) Cleaning, including one application of fluoride for children age 16 and under (One every six months - \$10 copay per visit)	Not covered Out-of-Network
Durable Medical Equipment	\$100 annual deductible	Not covered Out-of-Network
Private Duty Nursing	Not covered	Not covered
Hearing Aids	Not Covered, Cochlear implants covered	Not covered
Optical Care		
• Refractive Eye Exams	\$0 copay	Covered 80% after Deductible
• Eyeglasses	\$45 for a complete pair	Not covered Out-of-Network

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 the HIP Member Advocacy 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 and Schedule of Benefits, and it does not constitute an Agreement.