2019 HIP Prime HMO Plan Benefit Highlights for NYSHIP

SERVICE CATEGORY	COVERAGE	COPAY
Physician Services	**Primary Care Physician (PCP) Office Visits**	
	Adults	$5
	Sick child visits (age 0-25)	$5
	Laboratory services	Included in PCP office visit
	Specialist Office Visits	
	Office visits	$10
	Refractive eye exams	$0
	X-ray services	$0
	Inpatient Hospital Services	$0
	Anesthesiology	$0
	Radiology visits/consultations	$0
Preventive and Wellness Care Services	Well-baby, child care, and immunizations	Covered in full
	Adult physical	Covered in full
	Mammography and prostate cancer screening	Covered in full
	Annual Pap test and OB/GYN exam	Covered in full
	Immunizations for adults	Covered in full
	Colonoscopy and sigmoidoscopy screening for adults	Covered in full
	Bone density tests	Covered in full
Hospital	Hospital inpatient	$0 per continuous stay
	Hospital outpatient surgery	$0
	Hospital outpatient x-ray	Covered in full
	Hospital outpatient laboratory	Covered in full
Maternity	Physician services	$0
	Hospital services	$0
	Nursery care	Covered in full
Emergency Room (ER) Visit		$75 per visit
Ambulance		$0
Chiropractic Benefit		$10 per visit
Durable Medical Equipment		Covered in full
Mental Health	Inpatient	$0
	Outpatient	$0
Substance Use Diagnosis and Treatment	Inpatient	$0
	Rehabilitation outpatient	
	• PCP office	$5 per visit
	• Specialist office	$10 per visit
Physical/Occupational/Speech Therapy	Outpatient	Combined 90 visits/year; $10 per visit
Home Health Care		200 visits per calendar year; Covered in full
Prescription Coverage[1]	Retail 30-day supply	$5 generic / $20 brand
	Mail-order 90-day supply	$7.50 generic / $30 brand
Lifetime Maximum Coverage		No maximum

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SERVICE CATEGORY	COVERAGE	COPAY
ADDITIONAL BENEFITS:		
Autism Spectrum Disorder	Inpatient	$0
	Outpatient: • PCP office • Specialist office Assistive communication devices	 $5 $10 $10
Diabetes Supplies		$5 per 34-day supply
Dialysis Treatment		$10 per visit
Hospice Care		210 days; Covered in full
Annual Out-of-Pocket Maximum (The highest amount you have to pay for in-network services in a calendar year.)		$6,850 per individual $13,700 per family
Skilled Nursing Facility Care		$0
Urgent Care		$5 per visit

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 our 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, and it does not constitute an Agreement.

Full details of the plan are set forth in the Certificate of Coverage. Please refer to HIP certificate form number 155-23-HMOCERT (3/99).