



HIP Prime (HMO) 2026 Summary of Benefits

SERVICE CATEGORY	COVERAGE	COPAY
Physician Services	Primary Care Provider Office Visits	
	Adults	\$5 per visit
	Sick-child visits (age 0–25)	\$5 per visit
	Laboratory services	\$5 per visit
	X-ray services	\$5 per visit
	Specialist Office Visits	
	Office visits	\$10 per visit
	Laboratory services	\$10 per visit
	Refractive eye exams	\$0
	X-ray services	\$10
	Inpatient Hospital Services	
	Anesthesiology	\$0
	Radiology visits/consultations	\$0
Preventive and Wellness Care Services*	Well-baby, child care, and immunizations	\$0
	Adult physical	\$0
	Mammography and prostate cancer screening	\$0
	Annual Pap test and OB/GYN exam	\$0
	Immunizations for adults	\$0
	Colonoscopy and sigmoidoscopy screening for adults	\$0
	Bone density tests	\$0
Hospital	Hospital inpatient	\$0 per continuous stay
	Hospital outpatient surgery	\$0
	Hospital outpatient x-ray	\$0
	Hospital outpatient laboratory	\$0
Maternity	Physician services	\$0
	Hospital services	\$0
	Nursery care	\$0
Emergency Room (ER) Visit		\$75 per visit
Ambulance		\$0
Chiropractic Benefit		\$10 per visit
Durable Medical Equipment		\$0
Mental Health	Inpatient	\$0
	Outpatient	\$0
Substance Use Diagnosis and Treatment	Inpatient	\$0
	Rehabilitation outpatient:	
	• Primary care provider office	\$0 per visit
	• Specialist office	\$0 per visit
Physical/Occupational/Speech Therapy	Outpatient facility	\$0; Combined 90 visits per calendar year
	Primary care provider office	\$5 per visit

(continued)

*Preventive services are covered in full only when provided in accordance with the comprehensive guidelines supported by the Health Resources and Services Administration; if the items or services have an “A” or “B” rating from the United States Preventive Services Task Force; if the immunizations are recommended by the Advisory Committee on Immunization Practices; or when required by New York state law.

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SERVICE CATEGORY	COVERAGE	COPAY
Home Health Care		\$0 – 200 visits per calendar year
Lifetime Maximum Coverage		Not applicable
Additional Benefits		
Autism Spectrum Disorder	Inpatient	\$0
	Outpatient:	
	• Primary care provider office	\$0 per visit
	• Specialist office	\$0 per visit
	Assistive communication devices	\$0 per visit
Diabetic Supplies		\$5 per 34-day supply
Dialysis Treatment	Primary care provider office	\$5 per visit
	Freestanding center	\$0
	Outpatient hospital	\$0
Hospice Care		\$0 – 210 days per lifetime
Skilled Nursing Facility Care		\$0
Urgent Care		\$25 per visit
Out-of-Pocket Maximum (per calendar year): \$6,850 per individual and \$13,700 per family		

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 Utilization Management department. 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.