

Plan Facts

HIP Prime NY High Co-Pay	
Web site	hipusa.com
Member services	1-800-447-8632; enrollment; 1-800-447-8255 ongoing
Find a network provider	Find a Doctor or Hospital
Binding arbitration	No

Cost

HIP Prime NY High Co-Pay	
Health Reimbursement Arrangement	
Eligible expenses for reimbursement	Not applicable
General Medical Expenses	
Deductible: Individual/Family	\$0 Individual; \$0 Family
Primary doctor office visit	\$10 copay
Specialist office visit	\$15 copay
Out-of-pocket maximum: Individual/Family	\$0 Individual; \$0 Family
Lifetime coverage limit	Limit does not apply
Inpatient Hospital Care	
Hospital copay	\$100 copay per admission
Hospital semi-private room	100% covered after inpatient hospital copay
Inpatient lab and X-ray	100% covered after inpatient hospital copay
Inpatient physician and surgeon services	100% covered after inpatient hospital copay
Outpatient Care	
Outpatient surgery	100% covered
Outpatient laboratory services	100% covered; included in office visit copay
Outpatient X-ray	100% covered; included in office visit copay
Emergency room (not followed by admission)	\$50 copay
Urgent care clinic visit	\$10 copay
Prescription Drug Expenses	
Prescription drug vendor	Same as medical plan
Prescription drug Web site	Same as medical plan
Prescription drug member services	Same as medical plan
Annual prescription deductible	Not applicable
Retail generic	\$10 copay; 30 day supply
Retail formulary brand	\$15 copay; 30 day supply
Retail nonformulary brand	\$40 copay; 30 day supply
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	\$40 copay; 30 day supply; three times copay for up to 90 day supply
Oral contraceptives	Retail and mail order available; applicable prescription drug copay applies

Coverage

	HIP Prime NY High Co-Pay
Adult Preventive Care	
Physical exam	\$10 copay
Well-woman exam (includes pap)	\$10 copay; PCP; \$15 copay specialist
Mammogram	100% covered
Cancer screenings	100% covered; included in office visit copay
Cardiovascular screenings	100% covered; included in office visit copay
Family Planning	
Fertility drugs	Covered under New York State mandates; check with Plan for details
Fertility services	Covered according to New York State guidelines; check with Plan for details
Artificial insemination	\$10 copay; PCP; \$15 copay specialist
In vitro fertilization	Not covered
Male vasectomy	\$10 copay; PCP; \$15 copay specialist
Maternity Care	
Office visit: Pre/postnatal	\$15 copay initial visit only
In-hospital delivery services	\$100 copay
Newborn nursery services	100% covered
Prenatal care management	Yes
Well-Baby/Well-Child Preventive Care	
Well-child exams	100% covered for Pediatric Well Care visits; copay may apply under certain circumstances; check with Plan for details
Immunizations (child)	100% covered
Mental Health Care	
Mental Health: Combined with substance abuse	No
Mental Health: Outpatient coverage	100% covered; limited to 60 visits per calendar year; no limit for biologically-based illnesses and children with serious emotional illnesses

Mental Health: Inpatient coverage	\$100 copay; limited to 30 days per calendar year; no limit for biologically-based illnesses and children with serious emotional illnesses
Substance Abuse Care	
Detox: Outpatient coverage	Not covered
Detox: Inpatient coverage	\$100 copay per admission; limited to seven days per calendar year
Rehab: Outpatient coverage	\$15 copay; limited to 60 visits per calendar year
Rehab: Inpatient coverage	Not covered
Dental Care	
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
Vision Care	
Routine vision exams	\$10 copay; PCP; \$15 copay specialist; limited to one screening per benefit plan year
Regular lenses and frames	Not covered
Contact lenses	Not covered
Other Services	
Ambulance services	100% covered
Allergy tests and treatments	100% covered; included in office visit copay
Durable medical equipment	100% covered
Hearing Care	
Hearing evaluations	\$15 copay
Hearing aids	Not covered
Medical Therapy	
Acupuncture	Covered at a discounted fee when utilizing HIP's network providers; acupuncture not covered
Chiropractic	\$15 copay
Outpatient physical therapy	\$15 copay; limited to 90 visits per calendar year for all therapies combined
Outpatient speech therapy	\$15 copay; limited to 90 visits per calendar year for all therapies combined
Outpatient occupational therapy	\$15 copay; limited to 90 visits per calendar year for all therapies combined
Care at Alternate Sites	

Noncustodial home health care	100% covered; limited to 40 visits per calendar year
Prescribed care in noncustodial skilled nursing facility	100% covered; limited to 90 days per calendar year
Hospice care	100% covered; limited to 210 days

Access

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Out-of-area dependent coverage	No
Out-of-area participant coverage	No

Ease of Use

	HIP Prime NY High Co-Pay
Need to file claims	No; except for covered urgent or emergency care received outside of the service area
Number of PCP changes allowed/year	365
Ability to self-refer to OB/GYN	Yes
Ability to self-refer to specialists	No

Care Management: Education and Assistance

	HIP Prime NY High Co-Pay
Asthma care management	Yes
Cancer care management	No
Diabetes care management	Yes
Heart disease care management	Yes; congestive heart failure
Hypertension care management	No
Smoking cessation program	Yes
Weight control program	Yes