## MAJOR COPAYMENT PROVISIONS

<table>
<thead>
<tr>
<th>Service</th>
<th>HIP PRIME™</th>
</tr>
</thead>
<tbody>
<tr>
<td>PCP Office visits</td>
<td>$10 copay per visit</td>
</tr>
<tr>
<td>Specialist Office visits</td>
<td>$10 copay per visit</td>
</tr>
<tr>
<td>Hospital admission</td>
<td>No copay</td>
</tr>
<tr>
<td>Emergency room copay (waived if admitted)</td>
<td>No copay</td>
</tr>
<tr>
<td>Prescription drugs</td>
<td>$25 generic / $35 brand; Unlimited Brand Maximum (Subject to Drug Formulary)</td>
</tr>
<tr>
<td></td>
<td>Contraceptives Included</td>
</tr>
<tr>
<td></td>
<td>(Formulary copays are reduced by 50% when utilizing the HIP Mail Order Pharmacy Service. Up to a 90 day supply may be obtained.)</td>
</tr>
</tbody>
</table>

## INPATIENT HOSPITAL SERVICES

<table>
<thead>
<tr>
<th>Service</th>
<th>HIP PRIME™</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital and Physician Services</td>
<td>No copay</td>
</tr>
<tr>
<td>Semi-private Room and Board</td>
<td>No copay</td>
</tr>
<tr>
<td>Operating and recovery room, intensive and special care units, general nursing care, prescribed drugs, anesthesia, X-rays and lab tests</td>
<td>No copay</td>
</tr>
<tr>
<td>Short-term speech, physical, occupational and respiratory therapy (when part of an acute admission)</td>
<td>Short-term only</td>
</tr>
<tr>
<td>Speech, physical, occupational and respiratory therapy (when part of a rehabilitation admission)</td>
<td>60 days per plan year</td>
</tr>
<tr>
<td>Radiation therapy and chemotherapy</td>
<td>No copay</td>
</tr>
<tr>
<td>Pre-admission testing</td>
<td>No copay</td>
</tr>
<tr>
<td>Human organ transplants</td>
<td>No copay</td>
</tr>
</tbody>
</table>

## OUTPATIENT MEDICAL CARE

<table>
<thead>
<tr>
<th>Service</th>
<th>HIP PRIME™</th>
</tr>
</thead>
<tbody>
<tr>
<td>PCP office visits</td>
<td>Subject to PCP office visit copay</td>
</tr>
<tr>
<td>Specialist office visits</td>
<td>Subject to Specialist office visit copay</td>
</tr>
<tr>
<td>Preventive care, including physical exams, ear exams, health education and counseling, pap smear, mammography and immunizations</td>
<td>$0 Copay</td>
</tr>
<tr>
<td>Well-child care</td>
<td>No copay</td>
</tr>
<tr>
<td>Diagnostic services including X-ray, lab tests, EKG’s</td>
<td>Included in PCP office visit copay</td>
</tr>
<tr>
<td>Prenatal, postnatal care in physician’s office</td>
<td>No copay</td>
</tr>
<tr>
<td>Ambulatory surgery</td>
<td>No copay</td>
</tr>
<tr>
<td>Second medical and surgical opinion</td>
<td>No copay</td>
</tr>
<tr>
<td>Routine foot care</td>
<td>Not covered</td>
</tr>
<tr>
<td>Chiropractic services</td>
<td>Subject to Specialist office visit copay</td>
</tr>
</tbody>
</table>

(continued on next page)
### SUMMARY OF BENEFITS

**HIP Prime Network**

**EQUITY LEAGUE HEALTH TRUST FUND**

<table>
<thead>
<tr>
<th><strong>MENTAL HEALTH AND SUBSTANCE USE DISORDER</strong></th>
<th><strong>HIP PRIME™</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Health Care</td>
<td></td>
</tr>
<tr>
<td>• Inpatient</td>
<td></td>
</tr>
<tr>
<td>- Treatment of Mental Illness</td>
<td>No copay; Unlimited days per plan year</td>
</tr>
<tr>
<td>• Outpatient</td>
<td></td>
</tr>
<tr>
<td>- Treatment of Mental Illness</td>
<td>$10 copay Unlimited Visits per plan year</td>
</tr>
<tr>
<td>Substance Use Disorder</td>
<td>No copay</td>
</tr>
<tr>
<td>• Inpatient Detoxification</td>
<td>No limit on days per plan year</td>
</tr>
<tr>
<td>• Inpatient Rehabilitation Treatment</td>
<td>No copay</td>
</tr>
<tr>
<td></td>
<td>Unlimited days per plan year</td>
</tr>
<tr>
<td>• Outpatient Rehabilitation Treatment</td>
<td>$10 Copay per visit, Unlimited Visit - per plan year</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>SPECIAL KINDS OF CARE</strong></th>
<th><strong>HIP PRIME™</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency and urgent Care</td>
<td></td>
</tr>
<tr>
<td>- In hospital emergency room</td>
<td>Subject to Emergency room copay</td>
</tr>
<tr>
<td>- In urgent care facility</td>
<td>Subject to PCP office visit copay</td>
</tr>
<tr>
<td>- In physician’s office</td>
<td>No copay</td>
</tr>
<tr>
<td>- Ambulance service to the hospital</td>
<td>No copay</td>
</tr>
<tr>
<td>Home Health Care</td>
<td>No copay; 200 visits per plan year</td>
</tr>
<tr>
<td>Hospice Care</td>
<td>No copay; 210 days</td>
</tr>
<tr>
<td>Skilled Nursing Facility care</td>
<td>$0 copay; 60 days per plan year</td>
</tr>
<tr>
<td>Dialysis treatment</td>
<td>$10 copay per visit</td>
</tr>
<tr>
<td>Diabetes equipment, supplies and education</td>
<td>$10 copay per month</td>
</tr>
<tr>
<td>Outpatient physical, speech, occupational and respiratory therapy.</td>
<td>Subject to Specialist office visit copay; 60 visits per plan year</td>
</tr>
<tr>
<td>Family Planning Services</td>
<td>Covered</td>
</tr>
<tr>
<td>Infertility Diagnosis and Treatment</td>
<td>Subject to applicable copays</td>
</tr>
<tr>
<td>In-vitro Fertilization</td>
<td>IVF 3 Cycle limit per lifetime, subject to applicable copay</td>
</tr>
<tr>
<td>Dental Care</td>
<td>Covered at reduced member fee schedule</td>
</tr>
</tbody>
</table>

• General dental care

(continued on next page)
# SUMMARY OF BENEFITS

## HIP Prime Network

**EQUITY LEAGUE HEALTH TRUST FUND**

<table>
<thead>
<tr>
<th>Benefits</th>
<th>Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventive dental care</td>
<td></td>
</tr>
<tr>
<td>- Oral exam (One every six months)</td>
<td>$5 copay per visit</td>
</tr>
<tr>
<td>- Cleaning (One every six months)</td>
<td>$10 copay per visit</td>
</tr>
<tr>
<td>- Topical application of fluoride for</td>
<td></td>
</tr>
<tr>
<td>children age 16 and under</td>
<td></td>
</tr>
<tr>
<td>(One every six months)</td>
<td></td>
</tr>
<tr>
<td>- Fluoride applications age 17 and over</td>
<td>Copay to be determined by zip code</td>
</tr>
<tr>
<td>(One every six months)</td>
<td></td>
</tr>
<tr>
<td>Durable Medical Equipment</td>
<td>$500 annual deductible</td>
</tr>
<tr>
<td>Private Duty Nursing</td>
<td>After the first 72 hours, covered 80% up to 504 hours</td>
</tr>
<tr>
<td>Hearing aids</td>
<td>Not covered; Cochlear implants covered</td>
</tr>
<tr>
<td>Optical care</td>
<td>$10 copay</td>
</tr>
<tr>
<td>- Refractive Eye Exams</td>
<td></td>
</tr>
<tr>
<td>- Eyeglasses</td>
<td>Every 24 months: $80 frame allowance; $35 co-pay for lenses</td>
</tr>
</tbody>
</table>

## ADDITIONAL BENEFITS

<table>
<thead>
<tr>
<th>Benefits</th>
<th>Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurse Advice Line</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Wellness Rider</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Maximum Out of Pocket (MOOP)</td>
<td>Individual $6,600/Family $13,200</td>
</tr>
<tr>
<td>Telemmedicine</td>
<td>Not Covered</td>
</tr>
</tbody>
</table>

## FOOTNOTES

* 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 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 Schedule of Benefits, and it does not constitute an Agreement. HIP Health Plan of New York (HIP) is an EmblemHealth company.