

PSC-CUNY Welfare Fund
Adjunct Basic Health Insurance Program



HIP Prime

Major Co-Payment Provisions

Primary Care Provider Office Visit	\$ 15 Co-Payment
Specialist Office Visit	\$ 15 Co-Payment
Hospital Admission	\$ 250 Co-Payment
Emergency Room Visit	\$ 35 Co-Payment
Prescription Drugs	\$5 Generic / \$15 Brand Formulary ¹ / \$35 Non-Formulary Up to 90-Day Supply with HIP Mail Order. Co-Payments at 50% Contraceptives Included

Inpatient Hospital Services

Hospital and Physican Services	Subject to Hospital Admission Co-payment
Semi-Private Room and Board	Included in Hospital Admission Co-payment
Operating Room / Recovery Room/ Intensive and Special Care	Included in Hospital Admission Co-payment
General Nursing Care, Prescribed Drugs, Anesthesia, X-Ray, Lab Tests	Included in Hospital Admission Co-payment
Short Term Physical/ Occupational/ Respiratory Therapy (as part of Acute Admission)	Included in Hospital Admission Co-payment [short-term only]
Short Term Physical/ Occupational/ Respiratory Therapy (as part of Rehabilitation Admission)	Subject to Hospital Admission Co-payment [90 Days per Calendar Year]
Radiation Therapy and Physical Therapy	Included in Hospital Admission Co-payment
Pre-Admission Testing	Included in Hospital Admission Co-payment
Human Organ Transplants	Included in Hospital Admission Co-payment

Outpatient Medical Care

Primary Care Provider Office Visit	\$ 15 Co-Payment
Specialist Office Visit	\$ 15 Co-Payment
Physical Exams, Eye/Ear Exams, PAP Smear, Mammography, Immunization	Included in Office Co-payment
Well-Child under 19	\$ 0 Co-Payment
Lab Tests EKG's and X-Ray / CAT / MRI	Included in Office Co-payment
Pre-Natal / Post-Natal Care in Physician Office	\$ 0 Co-Payment
Ambulatory Surgery	\$ 0 Co-Payment
Second Medical or Surgical Opinion	\$ 0 Co-Payment

Routine Foot Care	Not Covered
Chiropractic Service	\$ 15 Co-Payment

Mental Health and Substance Abuse
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Inpatient Mental Health	Subject to Hospital Co-Payment Limited to 30 Days per calendar year
Outpatient Mental Health	\$ 25 Co-Payment Limited to 20 Visits per calendar year
Inpatient Substance Abuse Detoxification	Subject to Hospital Co-Payment Limited to 7 Days per calendar year
Inpatient Substance Abuse Rehabilitation	Subject to Hospital Co-Payment Limited to 30 Days per calendar year
Outpatient Substance Abuse Rehabilitation	\$ 15 Co-Payment Limited to 60 Visits per calendar year

Special Kinds of Care

Urgent Care Facility	\$ 15 Co-Payment
Ambulance Service to Hospital	\$ 0 Co-Payment
Home Health Care	\$ 0 Co-Payment Limited to 200 Visits per calendar year
Hospice Care	\$ 0 Co-Payment Limited to 210 Days
Skilled Nursing Facility	\$ 0 Co-Payment
Renal Dialysis	\$ 15 Co-Payment
Diabetes Equipment / Supplies / Education	\$ 15 Co-Payment per Month
Outpatient Physical/ Speech/ Occupational/ Respiratory therapy	\$15 Co-Payment Limited to 30 Visits per calendar year
Family Planning	Covered
Infertility Diagnosis and Treatment	\$ 15 Co-Payment
Dental Care - General	Offered at Reduced Fee Schedule
Dental Care - Preventive Only	Oral Exam [1per 6 months] \$5 Co-Payment Cleaning [1per 6 months] \$10 Co-Payment Child (\leq 16) Flouride Treatment [1 per 6 months] \$5 Co-Payment
Durable Medical Equipment	No annual Deductible
Private Duty Nursing	Covered
Hearing Aids	Not Covered
Optical Care - Examination	\$ 0 Co-Payment
Optical Care - Eyeglasses	\$ 45 Co-Payment Limited to once every 24 months

1) Drugs are dispensed in accordance with the HIP Drug Formulary

- * Except for Emergency Care, HIP Benefits and Services or covered only when provided by or referred by a HIP Primary Care Physician or approved in advance by the HIP Care Management Program.
- * HIP Participating Physicians Have contracted with HIP To provide care and are not employees, agents or representatives of HIP.
- * This Summary is for information only and does not contain complete details of the HIP Prime program which are available only in the Contract or the Certificate of Coverage and Schedule of Benefits