



HIP INSURANCE COMPANY OF NEW YORK

# Prime EPO for LARGE GROUPS (51+Employees)

HIP PRIME NETWORK

VYTRA PREMIUM NETWORK

Group Name .....

### COPAYMENT OPTIONS (Select One from each category)

- |                         |                               |                                |                                |                                |   |                                |  |
|-------------------------|-------------------------------|--------------------------------|--------------------------------|--------------------------------|---|--------------------------------|--|
| PCP Office Visit        | <input type="checkbox"/> \$0  | <input type="checkbox"/> \$2   | <input type="checkbox"/> \$5   | <input type="checkbox"/> \$10  | <input type="checkbox"/> \$15   | <input type="checkbox"/> \$20  | <input type="checkbox"/> \$25                                |
| Specialist Office Visit | <input type="checkbox"/> \$0  | <input type="checkbox"/> \$2   | <input type="checkbox"/> \$5   | <input type="checkbox"/> \$10  | <input type="checkbox"/> \$15   | <input type="checkbox"/> \$20  | <input type="checkbox"/> \$25                                |
|                         | <input type="checkbox"/> \$30 | <input type="checkbox"/> \$35  | <input type="checkbox"/> \$40  |                                |   |                                |  |
| Inpatient Facility      | <input type="checkbox"/> \$0  | <input type="checkbox"/> \$100 | <input type="checkbox"/> \$150 | <input type="checkbox"/> \$200 | <input type="checkbox"/> \$250  | <input type="checkbox"/> \$500 |  |
|                         | <b>-Or-</b>                   |                                |                                |                                |   |                                |  |
|                         | <input type="checkbox"/> \$0  | <input type="checkbox"/> \$50  | <input type="checkbox"/> \$100 | <input type="checkbox"/> \$250 | each day of the first three <input type="checkbox"/> five <input type="checkbox"/> days of copayment per continuous confinement |                                |  |
| Ambulatory Surgery      | <input type="checkbox"/> \$0  | <input type="checkbox"/> \$50  | <input type="checkbox"/> \$75  | <input type="checkbox"/> \$100 |   |                                |  |
| Emergency Room          | <input type="checkbox"/> \$0  | <input type="checkbox"/> \$15  | <input type="checkbox"/> \$25  | <input type="checkbox"/> \$35  | <input type="checkbox"/> \$50   | <input type="checkbox"/> \$60  | <input type="checkbox"/> \$75 <input type="checkbox"/> \$100 |

## OPTIONAL BENEFIT RIDERS

### PRESCRIPTION DRUG OPTIONS

NO PRESCRIPTION DRUG COVERAGE

#### FORMULARY DRUG COPAYMENTS

##### Generic Copay

- \$0
- \$1
- \$2
- \$2.50
- \$5
- \$7
- \$10
- \$15
- \$20
- \$25

##### Brand Name Copay

- \$0
- \$1
- \$2
- \$2.50
- \$5
- \$7
- \$10
- \$12
- \$15
- \$20
- \$25
- \$30
- \$35
- No Brand

#### NON-FORMULARY DRUG COST SHARING

- \$1
- \$2.50
- \$5
- \$7
- \$10
- \$25
- \$30
- \$35
- \$40
- \$50
- 50%

### PRIVATE DUTY NURSING

- Covered In Full
- 80% for hours 73 - 504
- 100% for hours 73- 504
- Not Covered

### INPATIENT MENTAL HEALTH

- 30 Days (standard)
- 60 Days
- 90 Days

### PRE-HOSPITAL EMERGENCY SERVICES

- \$15
- \$35
- \$60
- \$100
- \$25
- \$50
- \$75
- No Copay

### DURABLE MEDICAL EQUIPMENT

- Covered In Full
- \$100 Deductible, then Covered In Full
- Not Covered
- Other: \_\_\_\_\_

### DIABETIC SUPPLIES

- \$2
- \$10
- \$20
- No Copay
- \$5
- \$15
- \$25

### HOME HEALTH CARE

- |   |                                     |                                     |
|---|-------------------------------------|-------------------------------------|
| <input type="checkbox"/> 40 visits (standard) | <input type="checkbox"/> \$1 Copay  | <input type="checkbox"/> \$20 Copay |
| <input type="checkbox"/> 60 visits            | <input type="checkbox"/> \$5 Copay  | <input type="checkbox"/> \$25 Copay |
| <input type="checkbox"/> 100 visits           | <input type="checkbox"/> \$10 Copay | <input type="checkbox"/> No Copay   |
| <input type="checkbox"/> 200 visits           | <input type="checkbox"/> \$15 Copay |                                     |

**SKILLED NURSING FACILITY**

- 30 Days (standard)     120 Days  
 45 Days                 \$0  
 60 Days                  Unlimited  
 90 Days

**INPATIENT THERAPIES**

- 30 Days (standard)  
 60 Days  
 90 Days  
 Not covered

**INPATIENT ALCOHOL/SUBSTANCE ABUSE REHABILITATION**

- Not Covered  
 30 Days  
 60 Days  
 90 Days

**INPATIENT ALCOHOL/SUBSTANCE ABUSE DETOXIFICATION**

- Not Covered  
 7 Days  
 21 Days  
 30 Days  
 Unlimited Days

**DIALYSIS TREATMENT**

- \$10 Copay  
 \$15 Copay  
 \$20 Copay  
 \$25 Copay  
 No Copay

**OPTICAL**

- One pair eyeglasses every 12 months;  
           \$25 contact lens copayment  
 One pair eyeglasses every 24 months;  
           \$25 contact lens copayment  
 One pair eyeglasses every 12 months;  
           \$70 contact lens copayment  
 One pair eyeglasses every 24 months;  
           \$70 contact lens copayment  
 One pair eyeglasses every 24 months with \$45 copayment  
 One pair eyeglasses and contact lenses,  
           covered up to a maximum of \$75 every 12 months  
 No Rider

**OTHER****OUTPATIENT THERAPIES**

- 30 Visits (standard)  
 60 Visits  
 90 Visits  
 120 Visits

**OUTPATIENT MENTAL HEALTH (must choose a visit & copay)**

- |                                    |                                     |                                     |
|------------------------------------|-------------------------------------|-------------------------------------|
| <input type="checkbox"/> 0 Visits  | <input type="checkbox"/> \$5 Copay  | <input type="checkbox"/> \$30 Copay |
| <input type="checkbox"/> 20 Visits | <input type="checkbox"/> \$10 Copay | <input type="checkbox"/> \$35 Copay |
| <input type="checkbox"/> 30 Visits | <input type="checkbox"/> \$15 Copay | <input type="checkbox"/> \$40 Copay |
| <input type="checkbox"/> 40 Visits | <input type="checkbox"/> \$20 Copay | <input type="checkbox"/> No Copay   |
| <input type="checkbox"/> 60 Visits | <input type="checkbox"/> \$25 Copay |                                     |

**OR**

- |                                     |                                     |                                     |
|-------------------------------------|-------------------------------------|-------------------------------------|
| <b>Visits 1-3</b>                   |                                     | <b>Visits 4-20</b>                  |
| <input type="checkbox"/> No Copay   | <input type="checkbox"/> \$20 Copay | <input type="checkbox"/> \$25 Copay |
| <input type="checkbox"/> \$2 Copay  | <input type="checkbox"/> \$25 Copay |                                     |
| <input type="checkbox"/> \$5 Copay  | <input type="checkbox"/> \$30 Copay |                                     |
| <input type="checkbox"/> \$10 Copay | <input type="checkbox"/> \$35 Copay |                                     |
| <input type="checkbox"/> \$15 Copay | <input type="checkbox"/> \$40 Copay |                                     |

**OUTPATIENT ALCOHOL/SUBSTANCE ABUSE REHABILITATION**

- |   |                                     |                                     |
|---|-------------------------------------|-------------------------------------|
| <input type="checkbox"/> 60 Visits (standard) | <input type="checkbox"/> \$0 Copay  | <input type="checkbox"/> \$20 Copay |
| <input type="checkbox"/> 120 Visits           | <input type="checkbox"/> \$2 Copay  | <input type="checkbox"/> \$25 Copay |
|   | <input type="checkbox"/> \$5 Copay  |                                     |
|   | <input type="checkbox"/> \$10 Copay |                                     |
|   | <input type="checkbox"/> \$15 Copay |                                     |

**REFRACTIVE EYE EXAM**

- |   |                                     |
|---|-------------------------------------|
| <input type="checkbox"/> \$0 Copay (standard) | <input type="checkbox"/> \$20 Copay |
| <input type="checkbox"/> \$5 Copay            | <input type="checkbox"/> \$25 Copay |
| <input type="checkbox"/> \$10 Copay           |                                     |
| <input type="checkbox"/> \$15 Copay           |                                     |

**DEPENDENT COVERAGE**

- |  |  |
|--|--|
| <b>Full-Time Students</b>                    | <b>Dependent Children</b>                |
| <input type="checkbox"/> 23 End Of Month     | <input type="checkbox"/> 19 End Of Month |
| <input type="checkbox"/> 23 End Of Year      | <input type="checkbox"/> 19 End Of Year  |
| <input type="checkbox"/> Other (enter below) |  |
| Age: _____                                   | _____                                    |
| <input type="checkbox"/> End Of Year         | <input type="checkbox"/> End Of Year     |
| <input type="checkbox"/> End Of Month        | <input type="checkbox"/> End Of Month    |

Domestic Partners:     no     yes

**MONTHLY RATES (to be completed by your broker or HIP)**

	<u>2 TIER</u>	<u>3 TIER</u>	<u>4 TIER</u>
Individual	\$ _____	\$ _____	\$ _____
Two Persons		\$ _____	
Employee & Child(ren)			\$ _____
Employee & Spouse			\$ _____
Family	\$ _____	\$ _____	\$ _____