



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 | |
| | -Or- | | | | | | |
| | <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

- | | | |
|-------------------------------------|-------------------------------------|-------------------------------------|
| Visits 1-3 | | Visits 4-20 |
| <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

- | | |
|--|--|
| Full-Time Students | Dependent Children |
| <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	\$ _____	\$ _____	\$ _____