



HIPaccess I for LARGE GROUPS (51+Employees)

HIP PRIME NETWORK

VYTRA PREMIUM NETWORK

Group Name

COPAYMENT OPTIONS (Select One from each category)

Table with 8 columns of copayment options for various services: PCP Office Visit, Specialist Office Visit, Hospital Admission Copayment, Ambulatory Surgery, and Emergency Room. Includes options for \$0, \$2, \$5, \$10, \$15, \$20, \$25, \$30, \$35, \$40, \$50, \$75, \$100, \$150, \$200, \$250, \$500, and \$1000.

OPTIONAL BENEFIT RIDERS

PRESCRIPTION DRUG OPTIONS

NO PRESCRIPTION DRUG COVERAGE

FORMULARY DRUG COPAYMENTS

Generic Copay

- Options for generic copay: \$0, \$1, \$2, \$2.50, \$5, \$7, \$10, \$15, \$20, \$25

Brand Name Copay

- Options for brand name copay: \$0, \$1, \$2, \$2.50, \$5, \$7, \$10, \$12, \$15, \$20, \$25, \$30, \$35, No Brand

NON-FORMULARY DRUG COST SHARING

- Options for non-formulary drug cost sharing: \$1, \$2.50, \$5, \$7, \$10, \$25, \$30, \$35, \$40, \$50, 50%

DEDUCTIBLE

- Options for deductible: \$0, \$400, \$50, \$100, \$150, \$200, \$250, \$300, \$500

ANNUAL MAXIMUM

- Options for annual maximum: \$1,000, \$2,000, \$2,500, \$3,000, \$4,000, \$5,000

DIALYSIS TREATMENT

- Options for dialysis treatment copay: \$0, \$10, \$15, \$20, \$25

OUTPATIENT MENTAL HEALTH (must choose a visit & copay)

- Options for outpatient mental health: 0, 20, 30, 40, 60 visits; \$5, \$10, \$15, \$20, \$25 copay; \$30, \$35, \$40 copay; No Copay

PRIVATE DUTY NURSING

- Options for private duty nursing: Covered In Full, 80% for hours 73-504, 100% for hours 73-504, Not Covered

OR

- Options for private duty nursing: Visits 1-3 (No Copay, \$2-\$15) and Visits 4-20 (\$25)

INPATIENT THERAPIES

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

INPATIENT MENTAL HEALTH

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

INPATIENT ALCOHOL/SUBSTANCE ABUSE REHABILITATION

- Not Covered
- 30 Days
- 60 Days
- 90 Days

INPATIENT ALCOHOL/SUBSTANCE ABUSE DETOXIFICATION

- 7 Days
- 21 Days
- 30 Days
- Unlimited Days
- Hospital Admission Copay

REFRACTIVE EYE EXAM

- \$0 Copay
- \$2 Copay
- \$5 Copay
- \$10 Copay
- \$15 Copay
- \$20 Copay
- \$25 Copay

OPTICAL (Select One)

- 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

PRE-HOSPITAL EMERGENCY SERVICES

- \$15 Copay
- \$20 Copay
- \$25 Copay
- \$35 Copay
- \$50 Copay
- \$60 Copay
- \$75 Copay
- \$100 Copay
- No Copay

SKILLED NURSING FACILITY

- 30 Days (standard)
- 60 Days
- 45 Days
- 90 Days
- 120 Days
- Unlimited Days

DURABLE MEDICAL EQUIPMENT

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

HOME HEALTH CARE

- 40 Visits (standard)
- 60 Visits
- 100 Visits
- 200 visits

OUTPATIENT THERAPIES

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

OUTPATIENT MENTAL HEALTH

- 20 Visits; \$25 Copayment (standard)
- Not Covered
- Other: _____

OUTPATIENT ALCOHOL/SUBSTANCE ABUSE REHABILITATION

- 60 Visits
- \$2 Copay
- \$10 Copay
- \$20 Copay
- 120 Visits
- \$5 Copay
- \$15 Copay
- \$25 Copay
- \$0 Copay

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

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