



HIP PRIME for SMALL GROUPS (2-50 Employees)

HIP PRIME NETWORK

VYTRA PREMIUM NETWORK

Group Name

COPAYMENT OPTIONS (Select One from each category)

- PCP Office Visit [] \$5 [] \$10 [] \$15 [] \$20
Specialist Office Visit [] \$5 [] \$10 [] \$15 [] \$20
Inpatient Hospital [] \$0 [] \$250 [] \$500
or
[] \$0 [] \$50 [] \$100 [] \$250 each day for the first [] three; [] five days of copayment per continuous confinement
Ambulatory Surgery [] \$0 [] \$50 [] \$75
Emergency Room [] \$35 [] \$50

OPTIONAL BENEFIT RIDERS

PRESCRIPTION DRUG OPTIONS

NO PRESCRIPTION DRUG COVERAGE

FORMULARY DRUG COPAYMENTS

Generic Copay

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

Brand Name Copay

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

NON-FORMULARY DRUG COINSURANCE

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

DEDUCTIBLE

- [] \$0 [] \$50 [] \$100 [] \$150 [] \$200 [] \$250 [] \$300
[] \$400 [] \$500

ANNUAL MAXIMUM

- [] \$1,000 [] \$2,000 [] \$2,500 [] \$3,000 [] \$4,000 [] \$5,000

DIALYSIS TREATMENT

- [] \$0 Copay
[] \$10 Copay
[] \$15 Copay
[] \$20 Copay
[] \$25 Copay

OUTPATIENT MENTAL HEALTH (must choose a visit & copay)

- [] 0 Visits [] \$5 Copay [] \$30 Copay
[] 20 Visits [] \$10 Copay [] \$35 Copay
[] 30 Visits [] \$15 Copay [] \$40 Copay
[] 40 Visits [] \$20 Copay [] No Copay
[] 60 Visits [] \$25 Copay

INPATIENT ALCOHOL/SUBSTANCE ABUSE DETOXIFICATION

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

OR

- Visits 1-3: [] No Copay [] \$20 Copay [] \$25 Copay [] \$30 Copay [] \$35 Copay [] \$40 Copay
Visits 4-20: [] \$25 Copay

PRIVATE DUTY NURSING (Select One)

- Covered In Full
- Excluded

DURABLE MEDICAL EQUIPMENT (Select One)

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

OUTPATIENT ALCOHOL/SUBSTANCE ABUSE REHABILITATION

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

OUTPATIENT THERAPIES

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

REFRACTIVE EYE EXAM

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

DEPENDENT COVERAGE (Select One from each column)**Full-Time Students**

- 23 End of year
- 25 End of year

Dependent Children

- 19 End of Month
- 23 End of year
- 25 End of year

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 and contact lenses,
covered up to a maximum of \$75 every 12 months
- No Rider

MONTHLY RATES (to be completed by your broker or HIP)**4 TIER**

Individual \$ _____

Employee & Child(ren) \$ _____

Employee & Spouse \$ _____

Family \$ _____