



**HIP INSURANCE COMPANY OF NEW YORK**  
**HIPIC SELECT EPO for LARGE GROUPS (51+Employees)**

**HIP PRIME NETWORK**

**VYTRA PREMIUM NETWORK**

**Group Name** .....

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

- Office Visit PCP**     \$0     \$2     \$5     \$10     \$15     \$20     \$25     \$30
- Office Visit Specialist**     \$0     \$2     \$5     \$10     \$15     \$20     \$25     \$30  
 \$35     \$40     \$45     \$50
- Ambulatory Surgery**     \$0     \$50     \$75     \$100     **Subject to Deductible and Coinsurance**
- Hospital Admission Copayment** **Per Admission:**     \$0     \$100     \$200     \$250     \$500  
**or**  
 \$0     \$50     \$100    each day for the first  three;  five days of copayment per continuous confinement  
 **Subject to Deductible and Coinsurance**
- Emergency Room**     \$ 0     \$25     \$35     \$50     \$75     \$100  
 **Subject to Deductible and Coinsurance**

**COINSURANCE PERCENTAGE (Select One)**

Percentage of covered charges payable by HIP Insurance Company:

- 80%**     **90%**     **100%**

**DEDUCTIBLE OPTIONS (Select One)**

Annual Deductible payable by member:

- Individual     **\$0**     **\$500**     **\$1,000**     **\$1,500**     **Other \$ \_\_\_\_\_**  
Family     **\$0**     **\$1,000**     **\$2,000**     **\$3,000**     **\$ \_\_\_\_\_**

**COINSURANCE MAXIMUM (Select One)**

Maximum Coinsurance amount payable by member:

- Individual     **\$0**     **\$2,000**     **\$2,500**     **\$3,000**     **Other \$ \_\_\_\_\_**  
Family     **\$0**     **\$4,000**     **\$5,000**     **\$6,000**     **\$ \_\_\_\_\_**

**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 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

**SKILLED NURSING FACILITY**

- 30 Days (standard)       \$0 Copay
- 60 Days                       Deductible, then Coinsurance
- 90 Days
- 120 Days
- Unlimited Days

**INPATIENT THERAPIES**

- 30 Days (standard)       Deductible, then Coinsurance
- 60 Days
- 90 Days
- Not covered

**INPATIENT MENTAL HEALTH**

- 30 Days (standard)       \$ Hospital Admission Copay
- 60 Days                       Deductible, then Coinsurance
- 90 Days
- Not covered

**PRE-HOSPITAL EMERGENCY SERVICES**

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

**INPATIENT ALCOHOL/SUBSTANCE ABUSE REHABILITATION**

- Not Covered
- 30 Days                       \$ Hospital Admission Copay
- 60 Days                       Deductible, then Coinsurance
- 90 Days

**INPATIENT ALCOHOL/SUBSTANCE ABUSE DETOXIFICATION**

- 7 Days                       \$ Hospital Admission Copay
- 21 Days                       Deductible, then Coinsurance
- 30 Days
- Unlimited Days
- Not covered

**DURABLE MEDICAL EQUIPMENT**

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

**HOME HEALTH CARE**

- 40 Visits (standard)       \$0 Copay
- 60 Visits                       Deductible, then Coinsurance
- 100 Visits
- 200 visits

**OUTPATIENT THERAPIES**

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

**OUTPATIENT MENTAL HEALTH**

- 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

**OR**

- | Visits 1-3                          | Visits 4-20                         |
|-------------------------------------|-------------------------------------|
| <input type="checkbox"/> No 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 |
|                                     | <input type="checkbox"/> \$25 Copay |

**OUTPATIENT ALCOHOL/SUBSTANCE ABUSE REHABILITATION**

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

**REFRACTIVE EYE EXAM**

- \$0 Copayment (standard)
- \$15 Copayment
- \$20 Copayment
- \$25 Copayment

**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 copay;  
No contact lens option
- No Rider

**DEPENDENT COVERAGE****Full-Time Students**

- 23 End Of Month
- 23 End Of Year
- Other (enter below)

**Dependent Children**

- 19 End Of Month
- 19 End Of Year

Age: \_\_\_\_\_

- End Of Year
- End Of Month

- End Of Year
- End Of Month

Domestic Partners: \_\_\_\_\_

- no  yes

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

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