



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

HIP PRIME NETWORK

VYTRA PREMIUM NETWORK

Group Name

IN-NETWORK BENEFITS

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 \$150 \$200 \$250 \$500
or
 \$0 \$50 \$100 \$250 each day for the first three; five days of copayment per continuous confinement
 Subject to Deductible and Coinsurance
- Emergency Room** \$0 \$15 \$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 \$100 \$200 \$300 \$500 \$1,000 \$1,500
Family \$0 \$200 \$400 \$600 \$1,000 \$2,000 \$3,000
 \$2,000 \$4,000 OTHER \$ _____
 \$ _____

COINSURANCE MAXIMUM (Select One)

Maximum Coinsurance amount payable by member:

- Individual \$0 \$500 \$750 \$1,000 \$1,500 OTHER \$ _____
Family \$0 \$1,000 \$1,500 \$2,000 \$3,000 \$ _____

OUT-OF-NETWORK BENEFITS

COINSURANCE PERCENTAGE (Select One)

Percentage of covered charges payable by HIP Insurance Company:

- 50% 60% 70% 80% 90%

DEDUCTIBLE OPTIONS (Select One)

Annual Deductible payable by member:

- Individual \$100 \$200 \$250 \$500 \$750 \$1,000 \$3,000
Family \$200 \$400 \$500 \$1,000 \$1,500 \$2,000 \$6,000
 OTHER \$ _____
 \$ _____

COINSURANCE MAXIMUM (Select One)

Maximum Coinsurance amount payable by member:

- Individual \$1,000 \$3,000 \$7,000 \$10,000 \$20,000 OTHER \$ _____
Family \$2,000 \$6,000 \$14,000 \$20,000 \$40,000 \$ _____

HIAA REIMBURSEMENT (Select One)

- 70th Percentile 80th Percentile 90th Percentile

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

INPATIENT THERAPIES

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

INPATIENT MENTAL HEALTH

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

PRE-HOSPITAL EMERGENCY SERVICES

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

INPATIENT ALCOHOL/SUBSTANCE ABUSE REHABILITATION

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

INPATIENT ALCOHOL/SUBSTANCE ABUSE DETOXIFICATION

- 0 Days
- 7 Days
- 21 Days
- 30 Days
- Unlimited Days
- \$ Hospital Admission Copay
- Deductible, then Coinsurance

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

DURABLE MEDICAL EQUIPMENT

- Covered In Full
- \$100 Deductible, then Covered In Full
- Not Covered
- Other: _____
- 20% Coinsurance
- 25% Coinsurance
- 30% Coinsurance

HOME HEALTH CARE

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

OUTPATIENT THERAPIES

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

OUTPATIENT MENTAL HEALTH

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

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

DEPENDENT COVERAGE

- | | |
|----------------------------------------------|------------------------------------------|
| <u>Full-Time Students</u> | <u>Dependent Children</u> |
| <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

OTHER**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	\$ _____	\$ _____	\$ _____