



HIPaccess II for LARGE GROUPS (51+Employees)

HIP PRIME NETWORK

VYTRA PREMIUM NETWORK

Group Name

IN-NETWORK BENEFITS

COPAYMENT OPTIONS (Select One from each category)

- PCP Office Visit, Specialist Office Visit, Inpatient Facility, Ambulatory Surgery, Emergency Room. Options include \$0, \$2, \$5, \$10, \$15, \$20, \$25, \$30, \$35, \$40, \$100, \$150, \$200, \$250, \$500, \$75, \$35, \$50, \$60, \$75, \$100.

OUT-OF-NETWORK BENEFITS

COINSURANCE PERCENTAGE (Select One)

Percentage of covered charges payable by HIP Insurance Company:

- 100%, 80%, 75%, 70%, 50%

DEDUCTIBLE OPTIONS (Select One)

Annual Deductible payable by member:

- Individual/Family deductible options: \$200/\$400, \$250/\$500, \$300/\$600, \$350/\$700, \$400/\$800, \$500/\$1,000, \$750/\$1,500, \$1,000/\$2,000, \$1,500/\$3,000, \$2,000/\$4,000, \$2,500/\$5,000, No Deductible, \$5,000/\$10,000, \$10,000/\$20,000, \$300/\$750, \$500/\$1,250, \$1,500/\$3,750, Other \$_____

COINSURANCE MAXIMUM (Select One)

Maximum Coinsurance amount payable by member:

- Individual/Family maximum options: \$1,000/\$2,000, \$1,500/\$3,000, \$2,000/\$4,000, \$3,000/\$6,000, \$4,000/\$8,000, \$5,000/\$10,000, \$7,000/\$14,000, \$7,500/\$15,000, \$10,000/\$20,000, \$20,000/\$40,000, Other \$_____

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, \$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 COINSURANCE

- \$1, \$2.50, \$5, \$7, \$10, \$25, \$30, \$35, \$40, \$50, 50%

DEDUCTIBLE

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

ANNUAL MAXIMUM

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

PRIVATE DUTY NURSING (Select One)

- Covered In Full
- 80% for hours 73 - 504
- 100% for hours 73- 504
- Not Covered

DIALYSIS TREATMENT

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

SKILLED NURSING FACILITY

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

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

OUTPATIENT THERAPIES

- 30 Visits (standard) 50% Coinsurance
- 60 Visits
- 90 Visits
- 120 Visits

HOME HEALTH CARE

- 40 visits (standard) \$1 Copay \$20 Copay
- 60 visits \$5 Copay \$25 Copay
- 100 visits \$10 Copay No Copay
- 200 visits \$15 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 and contact lenses, covered up to a maximum of \$75 every 12 months
- No Rider

OTHER

DURABLE MEDICAL EQUIPMENT (Select One)

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

REFRACTIVE EYE EXAM

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

INPATIENT THERAPIES

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

INPATIENT MENTAL HEALTH

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

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"/> \$20 Copay | <input type="checkbox"/> \$25 Copay |
| <input type="checkbox"/> \$2 Copay | <input type="checkbox"/> \$25 Copay | <input type="checkbox"/> \$30 Copay |
| <input type="checkbox"/> \$5 Copay | <input type="checkbox"/> \$30 Copay | <input type="checkbox"/> \$35 Copay |
| <input type="checkbox"/> \$10 Copay | <input type="checkbox"/> \$35 Copay | <input type="checkbox"/> \$40 Copay |
| <input type="checkbox"/> \$15 Copay | <input type="checkbox"/> \$40 Copay | |

OUTPATIENT ALCOHOL/SUBSTANCE ABUSE REHABILITATION

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

DEPENDENT COVERAGE (Select One from each column)

- | | |
|--|--|
| 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)

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