



HEALTH INSURANCE PLAN of GREATER NEW YORK & HIP INSURANCE COMPANY OF NEW YORK
Prime POS 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 | <input type="checkbox"/> \$0 | <input type="checkbox"/> \$2 | <input type="checkbox"/> \$5 | <input type="checkbox"/> \$10 | <input type="checkbox"/> \$15 | <input type="checkbox"/> \$20 | <input type="checkbox"/> \$25 |
| Specialist Office Visit | <input type="checkbox"/> \$0 | <input type="checkbox"/> \$2 | <input type="checkbox"/> \$5 | <input type="checkbox"/> \$10 | <input type="checkbox"/> \$15 | <input type="checkbox"/> \$20 | <input type="checkbox"/> \$25 |
| | <input type="checkbox"/> \$30 | <input type="checkbox"/> \$35 | <input type="checkbox"/> \$40 | | | | |
| Inpatient Facility | <input type="checkbox"/> \$0 | <input type="checkbox"/> \$100 | <input type="checkbox"/> \$150 | <input type="checkbox"/> \$200 | <input type="checkbox"/> \$250 | <input type="checkbox"/> \$500 | |
| | -Or- | | | | | | |
| | <input type="checkbox"/> \$0 | <input type="checkbox"/> \$50 | <input type="checkbox"/> \$100 | <input type="checkbox"/> \$250 | each day for the first three <input type="checkbox"/> five <input type="checkbox"/> days of copayment per continuous confinement | | |
| Ambulatory Surgery | <input type="checkbox"/> \$0 | <input type="checkbox"/> \$50 | <input type="checkbox"/> \$75 | <input type="checkbox"/> \$100 | | | |
| Emergency Room | <input type="checkbox"/> \$0 | <input type="checkbox"/> \$15 | <input type="checkbox"/> \$25 | <input type="checkbox"/> \$35 | <input type="checkbox"/> \$50 | <input type="checkbox"/> \$60 | <input type="checkbox"/> \$75 <input type="checkbox"/> \$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 | <input type="checkbox"/> \$200 | <input type="checkbox"/> \$250 | <input type="checkbox"/> \$300 | <input type="checkbox"/> \$350 | <input type="checkbox"/> \$400 |
| Family | <input type="checkbox"/> \$400 | <input type="checkbox"/> \$500 | <input type="checkbox"/> \$600 | <input type="checkbox"/> \$700 | <input type="checkbox"/> \$800 |
| | <input type="checkbox"/> \$500 | <input type="checkbox"/> \$750 | <input type="checkbox"/> \$1,000 | <input type="checkbox"/> \$1,500 | <input type="checkbox"/> \$2,000 |
| | <input type="checkbox"/> \$1,000 | <input type="checkbox"/> \$1,500 | <input type="checkbox"/> \$2,000 | <input type="checkbox"/> \$3,000 | <input type="checkbox"/> \$4,000 |
| | <input type="checkbox"/> \$2,500 | <input type="checkbox"/> Other \$ _____ | | | |
| | <input type="checkbox"/> \$5,000 | \$ _____ | | | |
| | <input type="checkbox"/> \$300 | <input type="checkbox"/> \$500 | <input type="checkbox"/> \$1,500 | | |
| | <input type="checkbox"/> \$750 | <input type="checkbox"/> \$1,250 | <input type="checkbox"/> \$3,750 | | |

COINSURANCE MAXIMUM (Select One)

Maximum Coinsurance amount payable by member:

- | | | | | | |
|------------|--|--|--|--|--|
| Individual | <input type="checkbox"/> \$1,000 | <input type="checkbox"/> \$1,500 | <input type="checkbox"/> \$2,000 | <input type="checkbox"/> \$3,000 | <input type="checkbox"/> \$4,000 |
| Family | <input type="checkbox"/> \$2,000 | <input type="checkbox"/> \$3,000 | <input type="checkbox"/> \$4,000 | <input type="checkbox"/> \$6,000 | <input type="checkbox"/> \$8,000 |
| | <input type="checkbox"/> \$5,000 | <input type="checkbox"/> \$7,000 | <input type="checkbox"/> \$7,500 | <input type="checkbox"/> \$10,000 | <input type="checkbox"/> \$20,000 |
| | <input type="checkbox"/> \$10,000 | <input type="checkbox"/> \$14,000 | <input type="checkbox"/> \$15,000 | <input type="checkbox"/> \$20,000 | <input type="checkbox"/> \$40,000 |
| | <input type="checkbox"/> 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 | Brand Name Copay |
| <input type="checkbox"/> \$0 <input type="checkbox"/> \$15 | <input type="checkbox"/> \$0 <input type="checkbox"/> \$12 |
| <input type="checkbox"/> \$1 <input type="checkbox"/> \$20 | <input type="checkbox"/> \$1 <input type="checkbox"/> \$15 |
| <input type="checkbox"/> \$2 <input type="checkbox"/> \$25 | <input type="checkbox"/> \$2 <input type="checkbox"/> \$20 |
| <input type="checkbox"/> \$2.50 <input type="checkbox"/> \$2.50 <input type="checkbox"/> \$25 | |
| <input type="checkbox"/> \$5 <input type="checkbox"/> \$5 | <input type="checkbox"/> \$30 |
| <input type="checkbox"/> \$7 <input type="checkbox"/> \$7 | <input type="checkbox"/> \$35 |
| <input type="checkbox"/> \$10 <input type="checkbox"/> \$10 | <input type="checkbox"/> No Brand |

NON-FORMULARY DRUG COINSURANCE

- | | | | |
|-------------------------------|---------------------------------|-------------------------------|-------------------------------|
| <input type="checkbox"/> \$1 | <input type="checkbox"/> \$2.50 | <input type="checkbox"/> \$5 | <input type="checkbox"/> \$7 |
| <input type="checkbox"/> \$10 | <input type="checkbox"/> \$25 | <input type="checkbox"/> \$30 | <input type="checkbox"/> \$35 |
| <input type="checkbox"/> \$40 | <input type="checkbox"/> \$50 | <input type="checkbox"/> 50% | |

PRE-HOSPITAL EMERGENCY SERVICES

- | | |
|--------------------------------|-----------------------------------|
| <input type="checkbox"/> \$15 | <input type="checkbox"/> \$25 |
| <input type="checkbox"/> \$35 | <input type="checkbox"/> \$50 |
| <input type="checkbox"/> \$60 | <input type="checkbox"/> \$75 |
| <input type="checkbox"/> \$100 | <input type="checkbox"/> No Copay |

DIABETIC SUPPLIES

- | | |
|-----------------------------------|-------------------------------|
| <input type="checkbox"/> \$2 | <input type="checkbox"/> \$5 |
| <input type="checkbox"/> \$10 | <input type="checkbox"/> \$15 |
| <input type="checkbox"/> \$20 | <input type="checkbox"/> \$25 |
| <input type="checkbox"/> No Copay | |

DIALYSIS TREATMENT

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

PRIVATE DUTY NURSING

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

SKILLED NURSING FACILITY

- 30 Days (standard)
- 45 Days
- 60 Days
- 90 Days
- 120 Days
- Unlimited
- \$0

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

- Not Covered
- 7 Days
- 21 Days
- 30 Days
- Unlimited Days

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 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: _____

HOME HEALTH CARE

- 40 visits (standard)
- 60 visits
- 100 visits
- 200 visits
- \$1 Copay
- \$5 Copay
- \$10 Copay
- \$15 Copay
- \$20 Copay
- \$25 Copay
- No Copay

OUTPATIENT THERAPIES

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

OUTPATIENT MENTAL HEALTH (must choose a visit & copay)

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

REFRACTIVE EYE EXAM

- \$0 Copay (standard)
- \$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)**

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