



HIP INSURANCE COMPANY OF NEW YORK
PPO 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 | |
| | <input type="checkbox"/> \$0 | <input type="checkbox"/> \$50 | <input type="checkbox"/> \$100 | 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"/> \$400 | <input type="checkbox"/> \$500 | <input type="checkbox"/> \$750 | <input type="checkbox"/> \$1,000 |
| Family | <input type="checkbox"/> \$400 | <input type="checkbox"/> \$500 | <input type="checkbox"/> \$600 | <input type="checkbox"/> \$800 | <input type="checkbox"/> \$1,000 | <input type="checkbox"/> \$1,500 | <input type="checkbox"/> \$2,000 |
| | <input type="checkbox"/> \$1,500 | <input type="checkbox"/> \$2,000 | <input type="checkbox"/> \$2,500 | <input type="checkbox"/> \$5,000 | <input type="checkbox"/> \$10,000 | <input type="checkbox"/> No Deductible | <input type="checkbox"/> Other _____ |
| | <input type="checkbox"/> \$350 | <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 | <input type="checkbox"/> \$5,000 | <input type="checkbox"/> \$7,000 |
| 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"/> \$10,000 | <input type="checkbox"/> \$14,000 |
| | <input type="checkbox"/> \$7,500 | <input type="checkbox"/> \$10,000 | <input type="checkbox"/> \$20,000 | <input type="checkbox"/> Other _____ | | | |
| | <input type="checkbox"/> \$15,000 | <input type="checkbox"/> \$20,000 | <input type="checkbox"/> \$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

PRE-HOSPITAL EMERGENCY SERVICES

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

SKILLED NURSING FACILITY

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

INPATIENT THERAPIES

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

INPATIENT MENTAL HEALTH

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

DIALYSIS TREATMENT

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

INPATIENT ALCOHOL/SUBSTANCE ABUSE REHABILITATION

- Not Covered \$2 Copay
- 30 Days \$30 Copay
- 60 Days \$35 Copay
- 90 Days \$40 Copay

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

OTHER**DURABLE MEDICAL EQUIPMENT**

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

DIABETIC SUPPLIES

- \$2 \$5
- \$10 \$15
- \$20 \$25
- No Copay

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

OUTPATIENT THERAPIES

- 30 Visits (standard) 50% Coinsurance (out-of-network)
- 60 Visits
- 90 Visits
- 120 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"/> \$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 \$0 Copay \$20 Copay
- 120 Visits \$2 Copay \$25 Copay
- \$5 Copay
- \$10 Copay
- \$15 Copay

REFRACTIVE EYE EXAM

- \$0 Copayment (standard) \$20 Copay
- \$2 Copay \$25 Copay
- \$5 Copay
- \$10 Copay
- \$15 Copay

DEPENDENT COVERAGE

- | | |
|---|--|
| 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: <input type="checkbox"/> no <input type="checkbox"/> yes | |

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	\$ _____	\$ _____	\$ _____