HEALTH INSURANCE PLAN of GREATER NEW YORK & HIP INSURANCE COMPANY OF NEW YORK

HIP*access* II for SMALL GROUPS (2-50 Employees)

☐ HIP PRIME NETWORK ☐ VYTRA PREMIUM NETWORK

Group Name ....

IN-NETWORK BENEFITS

COPAYMENT OPTIONS (Select One from each category)

PCP Office Visit	☐ $0	☐ $2	☐ $5	☐ $10	☐ $15	☐ $20	☐ $25	
Specialist Office Visit	☐ $0	☐ $2	☐ $5	☐ $10	☐ $15	☐ $20	☐ $25	
	☐ $30	☐ $35	☐ $40					
Inpatient Facility	☐ $0	☐ $100	☐ $150	☐ $200	☐ $250	☐ $500		
	-Or-							
	☐ $0	☐ $50	☐ $100	☐ $250 each day for the first three ( ) five ( ) days of copayment per continuous confinement				
Ambulatory Surgery	☐ $0	☐ $50	☐ $75	☐ $100				
Emergency Room	☐ $0	☐ $15	☐ $25	☐ $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					
	☐ **$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**	☐ **$5,000 / $10,000**	☐ **$10,000 / $20,000**	☐ **No Deductible**	☐ **Other $ ________ / $ ________**
	☐ **$300 / $750**	☐ **$500 / $1,250**	☐ **$1,500 / $3,750**		

COINSURANCE MAXIMUM (Select One)

Maximum Coinsurance amount payable by member:

Individual / Family					
	☐ **$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		**Brand Name Copay**	
☐ $0	☐ $15	☐ $0	☐ $12
☐ $1	☐ $20	☐ $1	☐ $15
☐ $2	☐ $25	☐ $2	☐ $20
☐ $2.50		☐ $2.50	☐ $25
☐ $5		☐ $5	☐ $30
☐ $7		☐ $7	☐ $35
☐ $10		☐ $10	☐ No Brand

NON-FORMULARY DRUG COINSURANCE

☐ $1	☐ $2.50	☐ $5	☐ $7	☐ $10	☐ $25	☐ $30
☐ $35	☐ $40	☐ $50	☐ 50%			

DEDUCTIBLE

☐ $0	☐ $50	☐ $100	☐ $150	☐ $200	☐ $250	☐ $300
☐ $400	☐ $500	☐ $1,000	☐ $1,500	☐ $2,000		

ANNUAL MAXIMUM

☐ $1,000	☐ $2,000	☐ $2,500	☐ $3,000	☐ $4,000	☐ $5,000

PRIVATE DUTY NURSING (Select One)

☐ Covered In Full

☐ Excluded

DIALYSIS TREATMENT

☐ $0 Copay
☐ $10 Copay
☐ $15 Copay
☐ $20 Copay
☐ $25 Copay

INPATIENT ALCOHOL/SUBSTANCE ABUSE REHABILITATION

☐ Not Covered
☐ 7 Days
☐ 21 Days
☐ 30 Days
☐ Unlimited Days
☐ Hospital Admission Copay

INPATIENT ALCOHOL/SUBSTANCE ABUSE DETOXIFICATION

☐ Not Covered
☐ 7 Days
☐ 21 Days
☐ 30 Days
☐ Unlimited Days

OUTPATIENT THERAPIES

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

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

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 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 (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
☐ $2 Copay
☐ $5 Copay
☐ $10 Copay
☐ $15 Copay
☐ $20 Copay
☐ $25 Copay

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

☐ No Copay
☐ $2 Copay
☐ $5 Copay
☐ $10 Copay
☐ $15 Copay
☐ $20 Copay
☐ $25 Copay
☐ $30 Copay
☐ $35 Copay
☐ $40 Copay

Visits 4-20

☐ $25 Copay

OUTPATIENT ALCOHOL/SUBSTANCE ABUSE REHABILITATION

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

DEPENDENT COVERAGE (Select One from each column)

Full-Time Students	Dependent Children
☐ 23 End of year	☐ 19 End of Month
☐ 25 End of year	☐ 23 End of year
	☐ 25 End of year

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

4 TIER		
	Individual	$________________
	Employee & Child(ren)	$________________
	Employee & Spouse	$________________
	Family	$________________