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

# HIP PRIME POS 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 | | | | |
| Hospital Admission Copayment | ☐ $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:

☐ **80%** ☐ **75%** ☐ **70%** ☐ **50%**

### DEDUCTIBLE OPTIONS (Select One)

Annual Deductible payable by member:

| Individual / Family | | | | |
|---|---|---|---|---|
| ☐ **$200 / $400** | ☐ **$250 / $500** | ☐ **$300 / $600** | ☐ **$400 / $800** | ☐ **$1,000 / $2,000** |
| ☐ **$2,000 / $4,000** | ☐ **$5,000 / $10,000** | ☐ **$10,000 / $20,000** | ☐ Other $________ $________ | |

### 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**

☐ $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%

## PRIVATE DUTY NURSING (Select One)

☐ Covered In Full

☐ Excluded

## DIALYSIS TREATMENT

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

## OUTPATIENT THERAPIES

☐ 30 Visits (standard)    50% coinsurance (Out-of-Network)
☐ 60 Visits
☐ 90 Visits
☐ 100 Visits
☐ 120 Visits

## REFRACTIVE EYE EXAM

| | |
|---|---|
| ☐ $0 Copay | ☐ $15 Copay |
| ☐ $2 Copay | ☐ $20 Copay |
| ☐ $5 Copay | ☐ $25 Copay |
| ☐ $10 Copay | |

## INPATIENT ALCOHOL/SUBSTANCE ABUSE DETOXIFICATION

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

## 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: ____________________

## OUTPATIENT MENTAL HEALTH *(must choose a visit & copay)*

| | | |
|---|---|---|
| ☐ 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 |
|---|---|---|
| ☐ No Copay | ☐ $20 Copay | ☐ $25 Copay |
| ☐ $2 Copay | ☐ $25 Copay | |
| ☐ $5 Copay | ☐ $30 Copay | |
| ☐ $10 Copay | ☐ $35 Copay | |
| ☐ $15 Copay | ☐ $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 |
|---|---|
| ☐ 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 | $____________ |