

HIP INSURANCE COMPANY OF NEW YORK HIPIC SELECT PPO for SMALL GROUPS (2-50 Employees) RANCE COMPANY OF NY HIP PRIME NETWORK **□ VYTRA PREMIUM NETWORK**

	Group N	ame								
			IN-NETWO	ORK BEN	IEFITS					
COPAYMENT OPTIONS (Select One from each category)										
Office Visit PCP	□ \$0	□ \$2	□ \$5	□ \$10	□ \$15	□ \$20	□ \$25	□ \$30		
Office Visit Specialist	□ \$0 □ \$35	□ \$2 □ \$40	□ \$5 □ \$45	□ \$10 □ \$50	□ \$15	□ \$20	□ \$25	□ \$30		
Ambulatory Surgery	□ \$0	□ \$50	□ \$75	□ \$100	□ Subject to	Deductible and	d Coinsurance			
Hospital Admission Copayment	Per Admission	on:	□ \$0	□ \$100	□ \$150	□ \$200	□ \$250	□ \$500		
	□ \$0	□ \$50	□ \$100	□ \$250	each day for the fi per continuous co	rst \square three; \square nfinement	five days of co	payment		
_	-	Deductible an			•					
Emergency Room	□ \$ 0 □ Subject to	□ \$15 Deductible an	□ \$25 d Coinsurance	□ \$35	□ \$50	□ \$75	□ \$100			
COINSURANCE PERCENTAGE (Select One)										
Percentage of covered charges payable by HIP Insurance Company:										
DEDUCTIBLE OPTIONS (Select One)										
Annual Deductible paya Individual S0 \$0 \$0 \$1 \$4,000	□ \$ \$ □ □ OTHE	100 200	\$200 \$400	\$300 \$600	□ \$500 \$1,000	□ \$1,00 \$2,00		,500 ,000		
COINSURANCE MAX	IMUM (Selec	ct One)								
Maximum Coinsur Individual □ Family	ance amount p \$0		nber: \$750 \$1,500	□ \$1,0 \$2,0			ER \$ \$			
		0	UT-OF-NET	WORK E	ENEFITS					
COINSURANCE PERCENTAGE (Select One)										
Percentage of cover	— <u> </u>	yable by HIP In: 60% □	surance Compa 70%	ny: □ 80%	□ 90%					
DEDUCTIBLE OPTIONS (Select One)										
Annual Deductible payd Individual □ \$250 Family \$500	□ □ [\$	er: 500 ,000	\$750 \$1,500	\$1,000 \$2,000	□ \$3,000 \$6,000	☐ OTHER	\$ \$			
COINSURANCE MAXIMUM (Select One)										
Maximum Coinsurance Individual \$1,000 Family \$2,000	D □ \$3	3,000 □	: \$7,000 \$14,000 □	\$10,000 \$20,000	□ \$20,000 \$40,000	☐ OTHER	\$ \$			
HIAA REIMBURSEMENT (Select One)										
□ 70th P	ercentile	□ 80th Pei	rcentile	90th Per	centile					
OPTIONAL BENEFIT RIDERS										
PRESCRIPTION DRUG OPTIONS										
□ NO PRESCRIPTION DRUG COVERAGE FORMULARY DRUG COPAYMENTS Generic Copay Brand Name Copay										
□ \$0 □] \$15	□ \$0	□ \$12							
] \$20] \$25	□ \$1 □ \$2 □ \$2.50 □ \$5 □ \$7 □ \$10	☐ \$15 ☐ \$20 ☐ \$25 ☐ \$30 ☐ \$35 ☐ No Brar	nd						
NON-FORMULARY			50 □ ტı	<u> </u>	□ ¢7	□ 610	□ ¢0	<u> </u>		
	□ \$1 □ \$35	□ \$2.5 □ \$40	·		□ \$7 □ 50%	□ \$10	□ \$25	□ \$30		

Copyred In Full Copyred Copyre	Covered In Full 20%, Coinsurance 200		I				
S00 body S00 Copay S00 C	B00% for hours 73 - 504		DURABLE MEDICAL EQUIPMENT				
O Days (standard) \$0 Copay Deductible, then Coinsurance 100 Visits 1200 Visi	30 Days (standard) 30 Copay Deductible, then Coinsurance 10 Visits 100 Vi	□ 80% for hours 73 - 504□ 100% for hours 73- 504	□ \$100 Deductible, then Covered In Full □ 25% Coinsurance □ Not Covered □ 30% Coinsurance				
Go Days Go Copay Go Uninited Days Go Days Go Uninited Days Go Days	60 Days 90 Days 90 Days 90 Deductible, then Coinsurance 100 Visits 1200 Vi	SKILLED NURSING FACILITY	HOME HEALTH CARE				
30 Days (standard) S Hospital Admission Copay 90 Visits 90	30 Days (standard) S Hospital Admission Copay 90 Usits 90	 ☐ 60 Days ☐ 90 Days ☐ Deductible, then Coinsurance ☐ 120 Days 	☐ 60 Visits ☐ Deductible, then Coinsurance ☐ 100 Visits				
Go Days S Hospital Admission Copay Go Visits Go Days Go	O Days	INPATIENT THERAPIES	OUTPATIENT THERAPIES				
O Days 30 Days (standard) \$ Hospital Admission Copay 30 Days (standard) \$ Hospital Admission Copay 30 Opay \$30 Copay \$30 C	O Days 30 Days (standard) \$ Hospital Admission Copay 20 Visits \$10 Copay \$30 Copay \$30 Copay \$30 Days \$30 Visits \$30 Days \$30 Copay \$30 Copay \$30 Copay \$30 Visits \$30 Days \$30 Copay \$30 Copay \$30 Copay \$30 Visits \$30 Copay \$35 Cop	☐ 60 Days☐ \$ Hospital Admission Copay☐ 90 Days☐ Deductible, then Coinsurance	☐ 60 Visits				
30 Days (standard) S Hospital Admission Copay 90 Days 90 Copay 940 Copay	30 Days (standard) \$ Hospital Admission Copay 30 Visits \$15 Copay \$40 Copay \$4	INPATIENT MENTAL HEALTH	OUTPATIENT MENTAL HEALTH				
S15 Copay \$50 Copay \$75 Copay \$20 Copay \$25	St Copay \$20 Copay \$25 C	□ 30 Days (standard)□ \$ Hospital Admission Copay□ Deductible, then Coinsurance	□ 20 Visits □ \$10 Copay □ \$35 Copay □ 30 Visits □ \$15 Copay □ \$40 Copay □ 40 Visits □ \$20 Copay □ No Copay □ 60 Visits □ \$25 Copay				
\$20 Copay \$75 Copay \$35 Copay \$35 Copay \$30 Copay \$35	\$20 Copay \$75 Copay \$100 Copay \$25 Copay \$20 Copay \$25 Copay \$30 Copay \$35	PRE-HOSPITAL EMERGENCY SERVICES	OR Visits 1-3 Visits 4-20				
Not Covered \$ Hospital Admission Copay \$ 10 Copay \$ 10 Copay \$ 20 Copay \$ 15 Copay \$ 20 Copay	Not Covered 30 Days Shospital Admission Copay 60 Days 90 Days Deductible, then Coinsurance 60 Visits (standard) \$2 Copay \$15 Copay \$2 Copay \$25 Copay	□ \$20 Copay □ \$75 Copay □ \$25 Copay □ \$100 Copay	□ \$2 Copay □ \$25 Copay □ \$5 Copay □ \$30 Copay □ \$10 Copay □ \$35 Copay				
30 Days	30 Days Shospital Admission Copay 90 Days Deductible, then Coinsurance 120 Visits \$2 Copay \$15 Copay \$20 Copay \$25 Copay	INPATIENT ALCOHOL/SUBSTANCE ABUSE REHABILITATION	OUTPATIENT ALCOHOL/SUBSTANCE ABUSE REHABILITATION				
O Days	O Days S Hospital Admission Copay \$20 Copay \$2	□ 30 Days□ \$ Hospital Admission Copay□ 60 Days□ Deductible, then Coinsurance	☐ 120 Visits ☐ \$2 Copay ☐ \$15 Copay ☐ \$5 Copay ☐ \$20 Copay				
7 Days	7 Days	INPATIENT ALCOHOL/SUBSTANCE ABUSE DETOXIFICATION	ALTERNATIVE MEDICINE (Nutrition/Accupuncture/Massage)				
\$0 Copayment (standard) \$15 Copayment \$20 Copayment \$20 Copayment \$20 Copayment \$25 Contact lens copayment \$25 Contact lens copayment \$25 Contact lens copayment \$25 Contact lens copayment \$23 End Of Month \$23 End Of Year \$19 End Of Ye	\$0 Copayment (standard) \$15 Copayment \$20 Copayment \$20 Copayment \$20 Copayment \$25 Contact lens copayment \$	☐ 7 Days ☐ \$ Hospital Admission Copay ☐ 21 Days ☐ Deductible, then Coinsurance ☐ 30 Days					
\$15 Copayment \$20 Copayment \$20 Copayment \$25 Copayment \$25 Copayment \$25 Copayment \$25 Copayment \$25 Copayment \$25 contact lens copayment \$26 contact lens copayment \$27 contact lens copayment \$28	\$15 Copayment \$20 Copayment \$20 Copayment \$25 Copayment \$25 Copayment \$25 Copayment \$25 Copayment \$25 Copayment \$25 Contact lens copayment \$	REFRACTIVE EYE EXAM	FITNESS CENTER (Membership Reimbursement)				
 □ 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 12 months; \$70 contact lens copayment □ One pair eyeglasses every 24 months; \$70 contact lens copayment □ One pair eyeglasses every 24 months; \$70 contact lens copayment □ One pair eyeglasses every 24 months with \$45 copay; No contact lens option □ No Rider 	 □ One pair eyeglasses every 12 months; \$25 contact lens copayment □ One pair eyeglasses every 24 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; \$70 contact lens copayment □ One pair eyeglasses every 24 months with \$45 copay; No contact lens option □ No Rider 	☐ \$15 Copayment ☐ \$20 Copayment	□ \$200				
\$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; \$70 contact lens copayment One pair eyeglasses every 24 months; \$70 contact lens copayment One pair eyeglasses every 24 months with \$45 copay; No contact lens option No Rider	\$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; \$70 contact lens copayment One pair eyeglasses every 24 months with \$45 copay; No contact lens option No Rider	OPTICAL	DEPENDENT COVERAGE				
\$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; \$70 contact lens copayment One pair eyeglasses every 24 months with \$45 copay; No contact lens option No Rider	\$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; \$70 contact lens copayment One pair eyeglasses every 24 months with \$45 copay; No contact lens option No Rider						
S70 contact lens copayment ☐ One pair eyeglasses every 24 months; \$70 contact lens copayment ☐ One pair eyeglasses every 24 months with \$45 copay; No contact lens option ☐ No Rider	\$70 contact lens copayment One pair eyeglasses every 24 months; \$70 contact lens copayment One pair eyeglasses every 24 months; \$70 contact lens copayment One pair eyeglasses every 24 months with \$45 copay; No contact lens option No Rider	\$25 contact lens copayment					
 □ One pair eyeglasses every 24 months; □ \$70 contact lens copayment □ One pair eyeglasses every 24 months with \$45 copay; No contact lens option □ No Rider □ End Of Year □ End Of Month □ End Of Month □ End Of Month □ End Of Month □ End Of Year □ End Of Year □ End Of Month □ End Of Month	 □ One pair eyeglasses every 24 months; □ S70 contact lens copayment □ One pair eyeglasses every 24 months with \$45 copay; No contact lens option □ No Rider □ End Of Year □ End Of Month □ End Of Month □ End Of Month □ End Of Month □ End Of Year □ End Of Month □ End Of Year □ End Of Month <li< td=""><td></td><td>Age:</td></li<>		Age:				
No contact lens option ☐ No Rider	No contact lens option ☐ No Rider	\$70 contact lens copayment	☐ End Of Year ☐ End Of Year				
		No contact lens option					
OTHED	OTHER	⊔ No Rider					
UINEN		OTHER					

MONTHLY RATES (to be completed by your broker or HIP) 4 TIER

Individual \$_______

Two Persons

Employee & Child(ren) \$______

Employee & Spouse \$______

Family \$______