HIP INSURANCE COMPANY OF NY

HIP INSURANCE COMPANY OF NEW YORK

HIPIC SELECT PPO for SMALL GROUPS (2-50 Employees)

☐ **HIP PRIME NETWORK** ☐ **VYTRA PREMIUM NETWORK**

Group Name .....

IN-NETWORK BENEFITS

COPAYMENT OPTIONS (Select One from each category)

Office Visit PCP
☐ $0 ☐ $2 ☐ $5 ☐ $10 ☐ $15 ☐ $20 ☐ $25 ☐ $30

Office Visit Specialist
☐ $0 ☐ $2 ☐ $5 ☐ $10 ☐ $15 ☐ $20 ☐ $25 ☐ $30
☐ $35 ☐ $40 ☐ $45 ☐ $50

Ambulatory Surgery
☐ $0 ☐ $50 ☐ $75 ☐ $100 ☐ **Subject to Deductible and Coinsurance**

Hospital Admission Copayment
Per Admission: ☐ $0 ☐ $100 ☐ $150 ☐ $200 ☐ $250 ☐ $500
or
☐ $0 ☐ $50 ☐ $100 ☐ $250 each day for the first ☐ three; ☐ five days of copayment per continuous confinement
☐ **Subject to Deductible and Coinsurance**

Emergency Room
☐ $ 0 ☐ $15 ☐ $25 ☐ $35 ☐ $50 ☐ $75 ☐ $100
☐ **Subject to Deductible and Coinsurance**

COINSURANCE PERCENTAGE (Select One)

Percentage of covered charges payable by HIP Insurance Company:

☐ 80% ☐ 90% ☐ 100%

DEDUCTIBLE OPTIONS (Select One)

Annual Deductible payable by member:

Individual	$0	$100	$200	$300	$500	$1,000	$1,500
Family	$0	$200	$400	$600	$1,000	$2,000	$3,000

☐ $2,000 / $4,000 ☐ OTHER $ _____
$ _____

COINSURANCE MAXIMUM (Select One)

Maximum Coinsurance amount payable by member:

Individual	$0	$500	$750	$1,000	$2,000	☐ OTHER $ _____
Family	$0	$1,000	$1,500	$2,000	$4,000	$ _____

OUT-OF-NETWORK BENEFITS

COINSURANCE PERCENTAGE (Select One)

Percentage of covered charges payable by HIP Insurance Company:

☐ 50% ☐ 60% ☐ 70% ☐ 80% ☐ 90%

DEDUCTIBLE OPTIONS (Select One)

Annual Deductible payable by member:

Individual	$250	$500	$750	$1,000	$3,000	☐ OTHER $ _____
Family	$500	$1,000	$1,500	$2,000	$6,000	$ _____

COINSURANCE MAXIMUM (Select One)

Maximum Coinsurance amount payable by member:

Individual	$1,000	$3,000	$7,000	$10,000	$20,000	☐ OTHER $ _____
Family	$2,000	$6,000	$14,000	$20,000	$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		**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 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

DURABLE MEDICAL EQUIPMENT

☐ Covered In Full
☐ $100 Deductible, then Covered In Full
☐ Not Covered
☐ Other: _____

☐ 20% Coinsurance
☐ 25% Coinsurance
☐ 30% Coinsurance

SKILLED NURSING FACILITY

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

☐ $0 Copay
☐ Deductible, then Coinsurance

HOME HEALTH CARE

☐ 40 Visits (standard)
☐ 60 Visits
☐ 100 Visits
☐ 200 visits

☐ $0 Copay
☐ Deductible, then Coinsurance

INPATIENT THERAPIES

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

☐ $ Hospital Admission Copay
☐ Deductible, then Coinsurance

OUTPATIENT THERAPIES

☐ 30 Visits (standard)
☐ 60 Visits
☐ 90 Visits

☐ Not covered

INPATIENT MENTAL HEALTH

☐ 0 Days
☐ 30 Days (standard)
☐ 60 Days
☐ 90 Days

☐ $ Hospital Admission Copay
☐ Deductible, then Coinsurance

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		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	

PRE-HOSPITAL EMERGENCY SERVICES

☐ $15 Copay
☐ $20 Copay
☐ $25 Copay
☐ $35 Copay

☐ $50 Copay
☐ $75 Copay
☐ $100 Copay

☐ No Copay

INPATIENT ALCOHOL/SUBSTANCE ABUSE REHABILITATION

☐ Not Covered
☐ 30 Days
☐ 60 Days
☐ 90 Days

☐ $ Hospital Admission Copay
☐ Deductible, then Coinsurance

OUTPATIENT ALCOHOL/SUBSTANCE ABUSE REHABILITATION

☐ 60 Visits (standard)
☐ 120 Visits

☐ $0 Copay
☐ $2 Copay
☐ $5 Copay

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

INPATIENT ALCOHOL/SUBSTANCE ABUSE DETOXIFICATION

☐ 0 Days
☐ 7 Days
☐ 21 Days
☐ 30 Days
☐ Unlimited Days

☐ $ Hospital Admission Copay
☐ Deductible, then Coinsurance

ALTERNATIVE MEDICINE (Nutrition/Accupuncture/Massage)

☐ $25 Copay
☐ $20 Copay

REFRACTIVE EYE EXAM

☐ $0 Copayment (standard)
☐ $15 Copayment
☐ $20 Copayment
☐ $25 Copayment

FITNESS CENTER (Membership Reimbursement)

☐ $200

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 every 24 months with $45 copay; No contact lens option

☐ No Rider

DEPENDENT COVERAGE

Full-Time Students	Dependent Children
☐ 23 End Of Month	☐ 19 End Of Month
☐ 23 End Of Year	☐ 19 End Of Year
☐ Other (enter below)	
Age: _____	_____
☐ End Of Year	☐ End Of Year
☐ End Of Month	☐ End Of Month

OTHER

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

	4 TIER
Individual	$_____
Two Persons	
Employee & Child(ren)	$_____
Employee & Spouse	$_____
Family	$_____