HIP INSURANCE COMPANY OF NY

HIP INSURANCE COMPANY OF NEW YORK

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

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

Group Name .....

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 Coinsurance**			
Hospital Admission Copayment	**Per Admission:**		☐ $0	☐ $100	☐ $200	☐ $250	☐ $500	
	or							
	☐ $0	☐ $50	☐ $100	each day for the first ☐ three; ☐ five days of copayment per continuous confinement				
	☐ **Subject to Deductible and Coinsurance**							
Emergency Room	☐ $ 0	☐ $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 Family	☐ **$0** **$0**	☐ **$500** **$1,000**	☐ **$1,000** **$2,000**	☐ **$1,500** **$3,000**	☐ **Other**	**$** _____ **$** _____

COINSURANCE MAXIMUM (Select One)

Maximum Coinsurance amount payable by member:

Individual Family	☐ **$0** **$0**	☐ **$2,000** **$4,000**	☐ **$2,500** **$5,000**	☐ **$3,000** **$6,000**	☐ **Other**	**$** _____ **$** _____

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: _____

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

☐ Deductible, then Coinsurance

OUTPATIENT THERAPIES

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

☐ Not covered

INPATIENT MENTAL HEALTH

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

☐ $ 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

☐ 7 Days
☐ 21 Days
☐ 30 Days
☐ Unlimited Days
☐ Not covered

☐ $ 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	$_____