



HIP INSURANCE COMPANY OF NEW YORK

HIP PRIME 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)

- PCP Office Visit, Specialist Office Visit, Inpatient Facility, Ambulatory Surgery, Emergency Room. Options include \$0, \$2, \$5, \$10, \$15, \$20, \$25, \$30, \$35, \$40, \$100, \$150, \$200, \$250, \$500, \$75, \$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. Options include \$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, and Other \$_____.

COINSURANCE MAXIMUM (Select One)

Maximum Coinsurance amount payable by member:

- Individual Family. Options include \$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, and 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

- 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 COST SHARING

- \$1, \$2.50, \$5, \$7, \$10, \$25, \$30, \$35, \$40, \$50, 50%

DEDUCTIBLE

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

ANNUAL MAXIMUM

- \$1,000, \$2,000, \$2,500, \$3,000, \$4,000, \$5,000

PRIVATE DUTY NURSING (Select One)

- Covered In Full
- Excluded

DURABLE MEDICAL EQUIPMENT (Select One)

- Covered In Full
- \$100 Deductible, then Covered In Full
- Not Covered
- Other: _____
- 20% Coinsurance
- 25% Coinsurance
- 30% Coinsurance

DIALYSIS TREATMENT

- \$0 Copay
- \$10 Copay
- \$15 Copay
- \$20 Copay
- \$25 Copay

REFRACTIVE EYE EXAM

- \$0 Copay
- \$2 Copay
- \$5 Copay
- \$10 Copay
- \$15 Copay
- \$20 Copay
- \$25 Copay

INPATIENT ALCOHOL/SUBSTANCE ABUSE DETOXIFICATION

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

OUTPATIENT MENTAL HEALTH (must choose a visit & copay)

- 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

OUTPATIENT THERAPIES

- 30 Visits (standard)
- 60 Visits
- 90 Visits
- 120 Visits
- 50% Coinsurance (out-of-network)

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

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

OUTPATIENT ALCOHOL/SUBSTANCE ABUSE REHABILITATION

- 60 Visits (standard)
- \$2 Copay
- \$15 Copay
- 120 Visits
- \$5 Copay
- \$20 Copay
- \$0 Copay
- \$10 Copay
- \$25 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

DEPENDENT COVERAGE (Select One from each column)

- | Full-Time Students | Dependent Children |
|---|--|
| <input type="checkbox"/> 23 End of year | <input type="checkbox"/> 19 End of Month |
| <input type="checkbox"/> 25 End of year | <input type="checkbox"/> 23 End of year |
| | <input type="checkbox"/> 25 End of year |

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

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