HIP®

HEALTH INSURANCE PLAN OF GREATER NEW YORK

HIP PRIME for SMALL GROUPS (2-50 Employees)

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

Group Name .....

COPAYMENT OPTIONS (Select One from each category)

PCP Office Visit	☐ $5	☐ $10	☐ $15	☐ $20	
Specialist Office Visit	☐ $5	☐ $10	☐ $15	☐ $20	
Inpatient Hospital	☐ $0	☐ $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		
Emergency Room	☐ $35	☐ $50			

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 COINSURANCE

☐ $1 ☐ $2.50 ☐ $5 ☐ $7 ☐ $10 ☐ $25 ☐ $30
☐ $35 ☐ $40 ☐ $50

DEDUCTIBLE

☐ $0 ☐ $50 ☐ $100 ☐ $150 ☐ $200 ☐ $250 ☐ $300
☐ $400 ☐ $500

ANNUAL MAXIMUM

☐ $1,000 ☐ $2,000 ☐ $2,500 ☐ $3,000 ☐ $4,000 ☐ $5,000

DIALYSIS TREATMENT

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

INPATIENT ALCOHOL/SUBSTANCE ABUSE DETOXIFICATION

☐ 7 Days
☐ 21 Days
☐ 30 Days
☐ Unlimited Days
☐ Hospital Admission Copay

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	

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: _____

OUTPATIENT ALCOHOL/SUBSTANCE ABUSE REHABILITATION

☐ 60 Visits ☐ 120 Visits ☐ $0 Copay
☐ $2 Copay ☐ $5 Copay
☐ $10 Copay ☐ $15 Copay
☐ $20 Copay ☐ $25 Copay

OUTPATIENT THERAPIES

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

REFRACTIVE EYE EXAM

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

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 and contact lenses,
covered up to a maximum of $75 every 12 months

☐ No Rider

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

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