HIP PRIME EPO FOR LARGE GROUPS

(51+ Employees)

EmblemHealth®
GHI and HIP are EmblemHealth companies

☐ Prime Network ☐ Premium Network

Group Name

COPAYMENT OPTIONS (Select one from each category)

PCP office visit	☐ $0	☐ $5	☐ $10	☐ $15	☐ $20	☐ $25	☐ $30	
Specialist office visit	☐ $0	☐ $5	☐ $10	☐ $15	☐ $20	☐ $25	☐ $30	☐ $35
	☐ $40	☐ $45	☐ $50					
Inpatient facility	☐ $0	☐ $100	☐ $150	☐ $200	☐ $250	☐ $500	☐ $750	
	OR							
	☐ $0	☐ $50	☐ $100	☐ $250	each day of the first ☐ three ☐ five days of copayment per continuous confinement			
Ambulatory surgery	☐ $0	☐ $50	☐ $75	☐ $100	☐ $125	☐ $150		
Emergency room	☐ $0	☐ $15	☐ $25	☐ $35	☐ $50	☐ $60	☐ $75	☐ $100
	☐ $125	☐ $150						
Ambulance*	☐ $0	☐ $15	☐ $25	☐ $35	☐ $50	☐ $60	☐ $75	☐ $100

(*not to exceed the emergency room copayment)

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

NONFORMULARY DRUG COST SHARING

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

PRESCRIPTION DRUG DEDUCTIBLE

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

PRESCRIPTION DRUG ANNUAL MAXIMUM

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

☐ 50% coinsurance after annual maximum is received

DIALYSIS TREATMENT

☐ $0 copay	☐ $20 copay
☐ $10 copay	☐ $25 copay
☐ $15 copay	

INPATIENT MENTAL HEALTH

☐ Unlimited days
☐ Subject to inpatient facility copay

INPATIENT SUBSTANCE USE DISORDERS REHABILITATION

☐ Unlimited days
☐ Subject to inpatient facility copay

INPATIENT SUBSTANCE USE DISORDERS DETOXIFICATION

☐ Unlimited days
☐ Subject to inpatient facility copay

INPATIENT THERAPIES

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

OUTPATIENT MENTAL HEALTH

☐ Unlimited visits

☐ $5 copay	☐ $30 copay
☐ $10 copay	☐ $35 copay
☐ $15 copay	☐ $40 copay
☐ $20 copay	☐ No copay
☐ $25 copay	

BENEFIT RIDERS

OUTPATIENT SUBSTANCE USE DISORDERS REHABILITATION

- ☐ Unlimited visits
- ☐ $0 copay
- ☐ $2 copay
- ☐ $5 copay
- ☐ $10 copay
- ☐ $15 copay
- ☐ $20 copay
- ☐ $25 copay

OUTPATIENT THERAPIES

- ☐ 30 visits (standard)
- ☐ 60 visits
- ☐ 90 visits
- ☐ 120 visits

DIABETIC SUPPLIES

- ☐ $0 copay
- ☐ $2 copay
- ☐ $5 copay
- ☐ $10 copay
- ☐ $15 copay
- ☐ $20 copay
- ☐ $25 copay

DURABLE MEDICAL EQUIPMENT

- ☐ Covered in full
- ☐ $100 deductible, then covered in full
- ☐ Not covered
- ☐ Other _____

PRIVATE DUTY NURSING (Select one)

- ☐ Covered in full
- ☐ 80% for hours 73-504
- ☐ 100% for hours 73-504
- ☐ Not covered

SKILLED NURSING FACILITY

- ☐ 30 days (standard)
- ☐ 45 days
- ☐ 60 days
- ☐ 90 days
- ☐ 120 days
- ☐ Unlimited days
- ☐ $0 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

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 copayment
- ☐ One pair eyeglasses and contact lenses, covered up to a maximum of $75 every 12 months.
- ☐ Not covered

REFRACTIVE EYE EXAM

- ☐ $0 copay
- ☐ $2 copay
- ☐ $5 copay
- ☐ $10 copay
- ☐ $15 copay
- ☐ $20 copay
- ☐ $25 copay

DEPENDENT COVERAGE

- ☐ 26 end of month
- ☐ 26 end of year
- ☐ 29 end of month
- ☐ 29 end of year

DOMESTIC PARTNERS

- ☐ No
- ☐ Yes

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

	2 TIER	3 TIER	4 TIER
Individual	$ _____	$ _____	$ _____
Two persons		$ _____	
Employee & child(ren)			$ _____
Employee & spouse			$ _____
Family	$ _____	$ _____	$ _____