

HIP ACCESS | FOR SMALL GROUPS (2-50 Employees)



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 \$15 \$20 \$25 \$30 \$35 \$40 \$45 \$50
- Inpatient facility \$0 \$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

- \$0 \$15
 \$1 \$20
 \$2 \$25
 \$2.50
 \$5
 \$7
 \$10

Brand-name copay

- \$0 \$12
 \$1 \$15
 \$2 \$20
 \$2.50 \$25
 \$5 \$30
 \$7 \$35
 \$10 No brand

NONFORMULARY DRUG COST SHARING

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

PRESCRIPTION DRUG DEDUCTIBLE

- \$0 \$50 \$100 \$150
 \$200 \$250 \$300 \$400
 \$500

PRESCRIPTION DRUG ANNUAL MAXIMUM

- \$1,000 \$2,000 \$2,500 \$3,000
 \$4,000 \$5,000
 50% coinsurance after annual maximum is reached

DIALYSIS TREATMENT

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

INPATIENT MENTAL HEALTH

- 30 days (standard) 90 days
 60 days Include biological and CSED

INPATIENT SUBSTANCE USE DISORDERS REHABILITATION

- 30 days 90 days
 60 days Unlimited

INPATIENT SUBSTANCE USE DISORDERS DETOXIFICATION

- 7 days Unlimited
 21 days
 30 days

OUTPATIENT MENTAL HEALTH (must choose a visit & copay)

- 20 visits \$5 copay \$30 copay
 30 visits \$10 copay \$35 copay
 40 visits \$15 copay \$40 copay
 60 visits \$20 copay No copay
 \$25 copay
 Biologically-Based and Children with Serious Emotional Disorders (CSED)

BENEFIT RIDERS

OUTPATIENT SUBSTANCE USE

DISORDERS REHABILITATION

- 60 visits
- \$2 copay
- \$10 copay
- \$20 copay
- 120 visits
- \$5 copay
- \$15 copay
- \$25 copay
- \$0 copay

PRIVATE DUTY NURSING (select one)

- Covered in full
- Not covered

DURABLE MEDICAL EQUIPMENT

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

INPATIENT THERAPIES

- 30 days
- 60 days
- 90 days
- Not covered

OUTPATIENT THERAPIES

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

SKILLED NURSING FACILITY

- 30 days
- 45 days
- 60 days
- 90 days
- 120 days
- Unlimited

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

For members 19 years of age and over, there will be a waiting period of up to 12 months for benefits for any condition for which medical advice, diagnosis, care or treatment was recommended or received during the six-month period ending on a member's enrollment date. This waiting period will be reduced to the extent that a member is entitled by law to a credit for prior continuous creditable coverage. The Certification of Insurance or Certificate of Coverage will contain more information about the pre-existing condition waiting period and the types of coverage that qualify as prior continuous creditable coverage.

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

4 TIER

Individual	\$ _____
Employee & child(ren)	\$ _____
Employee & spouse	\$ _____
Family	\$ _____

Underwritten by Health Insurance Plan of Greater New York.

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