# HIPIC SELECT EPO FOR SMALL GROUPS
## (2-50 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 | ☐ $2 | ☐ $5 | ☐ $10 | ☐ $15 | ☐ $20 | ☐ $25 | ☐ $30 |
| Specialist office visit | ☐ $0 | ☐ $2 | ☐ $5 | ☐ $10 | ☐ $15 | ☐ $20 | ☐ $25 | ☐ $30 |
| | ☐ $35 | ☐ $40 | ☐ $45 | ☐ $50 | | | | |
| Ambulatory surgery | ☐ $0 | ☐ $50 | ☐ $75 | ☐ $100 | ☐ Subject to deductible and coinsurance | | | |
| Inpatient facility | ☐ $0 | ☐ $100 | ☐ $200 | ☐ $250 | ☐ $500 | ☐ $750 | | |
| | ***OR*** | | | | | | | |
| | ☐ $0 | ☐ $50 | ☐ $100 | each day of the first ☐ three ☐ five days of copayment per continuous confinement | | | | |
| Emergency room* | ☐ $0 | ☐ $25 | ☐ $35 | ☐ $50 | ☐ $75 | ☐ $100 | ☐ 125 | ☐ $150 |
| | ☐ Subject to deductible and coinsurance (*not to exceed the emergency room copayment) | | | | | | | |

**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 | ☐ $0 | ☐ $500 | ☐ $1,000 | ☐ $1,500 | ☐ Other | $_____ |
| Family | $0 | $1,000 | $2,000 | $3,000 | | $_____ |

**COINSURANCE MAXIMUM (select one)**

Maximum coinsurance amount payable by member:

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

## 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

## BENEFIT RIDERS

### 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
- ☐ $0 copay
- ☐ Deductible, then coinsurance

### INPATIENT THERAPIES
- ☐ 30 days (standard)
- ☐ 60 days
- ☐ 90 days
- ☐ Deductible, then coinsurance
- ☐ Not covered

### INPATIENT MENTAL HEALTH
- ☐ 30 days (standard)
- ☐ 60 days
- ☐ 90 days
- ☐ Unlimited days

### INPATIENT ALCOHOL/SUBSTANCE USE DISORDERS REHABILITATION
- ☐ 30 days
- ☐ 60 days
- ☐ 90 days
- ☐ Unlimited days

### INPATIENT ALCOHOL/SUBSTANCE USE DISORDERS DETOXIFICATION
- ☐ 7 days
- ☐ 21 days
- ☐ 30 days
- ☐ Unlimited days

### HOME HEALTH CARE
- ☐ 40 visits (standard)
- ☐ 60 visits
- ☐ 100 visits
- ☐ 200 visits
- ☐ $0 copay
- ☐ Deductible, then coinsurance

### OUTPATIENT THERAPIES
- ☐ 30 visits (standard)
- ☐ 60 visits
- ☐ 90 visits
- ☐ Not covered

### OUTPATIENT MENTAL HEALTH
- ☐ 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
- ☐ Biologically-based and children with serious emotional disorders (CSED)

### OUTPATIENT ALCOHOL/SUBSTANCE USE DISORDERS REHABILITATION
- ☐ 60 visits (standard)
- ☐ 120 visits
- ☐ $0 copay
- ☐ $2 copay
- ☐ $5 copay
- ☐ $10 copay
- ☐ $15 copay
- ☐ $20 copay
- ☐ $25 copay

### ALTERNATIVE MEDICINE (Nutrition/Accupuncture/Massage)
- ☐ $25 copay
- ☐ $20 copay

### 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 copayment
- ☐ Not covered

### REFRACTIVE EYE EXAM
- ☐ $0 copay (standard)
- ☐ $15 copay
- ☐ $20 copay
- ☐ $25 copay

## DEPENDENT COVERAGE

☐ 26 end of month ☐ 29 end of month
☐ 26 end of year ☐ 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 | $ _____ |
| Two persons | |
| Employee & child(ren) | $ _____ |
| Employee & spouse | $ _____ |
| Family | $ _____ |

Underwritten by Health Insurance Plan of Greater New York.

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