HIPIC SELECT EPO FOR LARGE GROUPS
(51 + Employees)

EmblemHealth®
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☐ 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			
Hospital admission per admission:	☐ $0	☐ $100	☐ $200	☐ $250	☐ $500	☐ $750		
copayment	***OR***							
	☐ $0	☐ $50	☐ $100 each day of the first ☐ three ☐ five days of copayment per continuous confinement					
	☐ Subject to deductible and coinsurance							
Emergency room	☐ $0	☐ $25	☐ $35	☐ $50	☐ $75	☐ $100	☐ $125	☐ $150
	☐ Subject to deductible and coinsurance							
Ambulance*	☐ $0	☐ $15	☐ $25	☐ $35	☐ $50	☐ $60	☐ $75	☐ $100
	(*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

DIALYSIS TREATMENT
- ☐ $20 copay
- ☐ Deductible, then coinsurance

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
- ☐ Deductible, then coinsurance

OUTPATIENT MENTAL HEALTH
- ☐ Unlimited visits
- ☐ $5 copay
- ☐ $10 copay
- ☐ $15 copay
- ☐ $20 copay
- ☐ $25 copay
- ☐ $30 copay
- ☐ $35 copay
- ☐ $40 copay
- ☐ No copay

OUTPATIENT SUBSTANCE USE DISORDERS REHABILITATION
- ☐ Unlimited visits
- ☐ $0 copay
- ☐ $2 copay
- ☐ $5 copay
- ☐ $15 copay
- ☐ $20 copay
- ☐ $25 copay

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

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

SKILLED NURSING FACILITY
- ☐ 30 days (standard)
- ☐ 60 days
- ☐ 90 days
- ☐ 120 days
- ☐ Unlimited days
- ☐ Deductible, then coinsurance
- ☐ $0 copay

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

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 copay; no contact lens option
- ☐ 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	$ _____	$ _____	$ _____