HIPIC SELECT PPO FOR SMALL GROUPS
(2-50 Employees)

☐ Prime Network ☐ Premium Network

Group Name

IN-NETWORK BENEFITS

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	☐ $150	☐ $200	☐ $250	☐ $500	☐ $750		
	OR								
	☐ $0	☐ $50	☐ $100	☐ $250	each day of the first ☐ three ☐ five days of copayment per continuous confinement				
	☐ Subject to deductible and coinsurance								
Emergency room	☐ $0	☐ $15	☐ $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	☐ $100	☐ $200	☐ $300	☐ $500	☐ $1,000	☐ $1,500	☐ $2,000
Family	$0	$200	$400	$600	$1,000	$2,000	$3,000	$4,000
	☐ Other	$______						
		$______						

COINSURANCE MAXIMUM (select one)

Maximum coinsurance amount payable by member:

Individual	☐ $0	☐ $500	☐ $750	☐ $1,000	☐ $2,000	☐ Other	$______
Family	$0	$1,000	$1,500	$2,000	$4,000		$______

OUT-OF-NETWORK BENEFITS

COINSURANCE PERCENTAGE (select one)

Percentage of covered charges payable by HIP Insurance Company:

☐ 50% ☐ 60% ☐ 70% ☐ 80% ☐ 90%

DEDUCTIBLE OPTIONS (select one)

Annual deductible payable by member:

Individual	☐ $250	☐ $500	☐ $750	☐ $1,000	☐ $3,000	☐ Other	$______
Family	$500	$1,000	$1,500	$2,000	$6,000		$______

COINSURANCE MAXIMUM (select one)

Maximum coinsurance amount payable by member:

Individual	☐ $1,000	☐ $3,000	☐ $7,000	☐ $10,000	☐ $20,000	☐ Other	$______
Family	$2,000	$6,000	$14,000	☐ $20,000	$40,000		$______

OUT-OF-NETWORK REIMBURSEMENT

FAIR Health ☐ 70th percentile ☐ 80th percentile ☐ 90th percentile

BENEFIT RIDERS

PRESCRIPTION DRUG OPTIONS

☐ **NO PRESCRIPTION DRUG COVERAGE**

FORMULARY DRUG COPAYMENTS

Generic copay
- ☐ $0
- ☐ $1
- ☐ $2
- ☐ $2.50
- ☐ $5
- ☐ $7
- ☐ $10
- ☐ $15
- ☐ $20
- ☐ $25

Brand-name copay
- ☐ $0
- ☐ $1
- ☐ $2
- ☐ $2.50
- ☐ $5
- ☐ $7
- ☐ $10
- ☐ $12
- ☐ $15
- ☐ $20
- ☐ $25
- ☐ $30
- ☐ $35
- ☐ No brand

NONFORMULARY DRUG COST SHARING
- ☐ $1
- ☐ $2.50
- ☐ $5
- ☐ $7
- ☐ $10
- ☐ $25
- ☐ $30
- ☐ $35
- ☐ $40
- ☐ $50

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
- ☐ $10 copay
- ☐ $15 copay
- ☐ $20 copay
- ☐ $25 copay

INPATIENT MENTAL HEALTH
- ☐ 30 days (standard)
- ☐ 60 days
- ☐ 90 days
- ☐ Include biological and CSED

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

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

OUTPATIENT MENTAL HEALTH (must choose a visit & copay)
- ☐ 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 SUBSTANCE USE DISORDERS REHABILITATION
- ☐ 60 visits
- ☐ 120 visits
- ☐ $0 copay
- ☐ $2 copay
- ☐ $10 copay
- ☐ $20 copay
- ☐ $5 copay
- ☐ $15 copay
- ☐ $25 copay

PRIVATE DUTY NURSING (select one)
- ☐ 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
- ☐ 20% coinsurance
- ☐ 25% coinsurance
- ☐ 30% coinsurance

INPATIENT THERAPIES
- ☐ 30 days (standard)
- ☐ 60 days
- ☐ 90 days
- ☐ Not covered
- ☐ Subject to inpatient facility copay
- ☐ Deductible, then coinsurance

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

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

ALTERNATIVE MEDICINE (Nutrition/Acupuncture/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
- ☐ 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	$ ____________
Two persons	
Employee & child(ren)	$ ____________
Employee & spouse	$ ____________
Family	$ ____________

Underwritten by HIP Insurance Company of New York.

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