

HIP PRIME HMO FOR LARGE GROUPS (51+ Employees)



Prime Network Premium Network

Group Name

COPAYMENT OPTIONS (Select one from each category)

PCP office visit	<input type="checkbox"/> \$0	<input type="checkbox"/> \$5	<input type="checkbox"/> \$10	<input type="checkbox"/> \$15	<input type="checkbox"/> \$20	<input type="checkbox"/> \$25	<input type="checkbox"/> \$30	
Specialist office visit	<input type="checkbox"/> \$0	<input type="checkbox"/> \$5	<input type="checkbox"/> \$10	<input type="checkbox"/> \$15	<input type="checkbox"/> \$20	<input type="checkbox"/> \$25	<input type="checkbox"/> \$30	<input type="checkbox"/> \$35
	<input type="checkbox"/> \$40	<input type="checkbox"/> \$45	<input type="checkbox"/> \$50					
Inpatient facility	<input type="checkbox"/> \$0	<input type="checkbox"/> \$100	<input type="checkbox"/> \$150	<input type="checkbox"/> \$200	<input type="checkbox"/> \$250	<input type="checkbox"/> \$500	<input type="checkbox"/> \$750	
	OR							
	<input type="checkbox"/> \$0	<input type="checkbox"/> \$50	<input type="checkbox"/> \$100	<input type="checkbox"/> \$250	each day of the first <input type="checkbox"/> three <input type="checkbox"/> five days of copayment per continuous confinement			
Ambulatory surgery	<input type="checkbox"/> \$0	<input type="checkbox"/> \$50	<input type="checkbox"/> \$75	<input type="checkbox"/> \$100	<input type="checkbox"/> \$125	<input type="checkbox"/> \$150		
Emergency room	<input type="checkbox"/> \$0	<input type="checkbox"/> \$15	<input type="checkbox"/> \$25	<input type="checkbox"/> \$35	<input type="checkbox"/> \$50	<input type="checkbox"/> \$60	<input type="checkbox"/> \$75	<input type="checkbox"/> \$100
	<input type="checkbox"/> \$125	<input type="checkbox"/> \$150						
Ambulance*	<input type="checkbox"/> \$0	<input type="checkbox"/> \$15	<input type="checkbox"/> \$25	<input type="checkbox"/> \$35	<input type="checkbox"/> \$50	<input type="checkbox"/> \$60	<input type="checkbox"/> \$75	<input type="checkbox"/> \$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 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 \$15 copay
- \$2 copay \$20 copay
- \$5 copay \$25 copay
- \$10 copay

OUTPATIENT THERAPIES

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

DIABETIC SUPPLIES

- \$0 copay \$15 copay
- \$2 copay \$20 copay
- \$5 copay \$25 copay
- \$10 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) 120 days
- 45 days Unlimited days
- 60 days \$0 copay
- 90 days

HOME HEALTH CARE

- 40 visits (standard) \$1 copay \$20 copay
- 60 visits \$5 copay \$25 copay
- 100 visits \$10 copay
- 200 visits \$15 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 \$15 copay
- \$2 copay \$20 copay
- \$5 copay \$25 copay
- \$10 copay

DEPENDENT COVERAGE

- 26 end of month 29 end of month
- 26 end of year 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	\$ _____	\$ _____	\$ _____