

BENEFIT RIDERS

PRESCRIPTION DRUG OPTIONS

NO PRESCRIPTION DRUG COVERAGE

FORMULARY DRUG COPAYMENTS

Generic copay

- \$0
- \$1
- \$2
- \$2.50
- \$5
- \$7
- \$10

Brand-name copay

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

NONFORMULARY DRUG COST SHARING

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

PRESCRIPTION DRUG DEDUCTIBLE

- \$0
- \$200
- \$500
- \$50
- \$250
- \$1,000
- \$100
- \$300
- \$1,500
- \$150
- \$400
- \$2,000

PRESCRIPTION DRUG ANNUAL MAXIMUM

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

PRIVATE DUTY NURSING

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

DIALYSIS TREATMENT

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

HOME HEALTH CARE

- 40 visits (standard)
- 60 visits
- 100 visits
- 200 visits
- \$1 copay
- \$5 copay
- \$10 copay
- \$15 copay
- \$20 copay
- \$25 copay
- No copay

SKILLED NURSING FACILITY

- 30 days (standard)
- 45 days
- 60 days
- 90 days
- 120 days
- Unlimited
- \$0

INPATIENT THERAPIES

- 30 days (standard)
- 60 days
- 90 days
- Included in inpatient facility copayment
- Not covered

INPATIENT MENTAL HEALTH

- Unlimited days
- Subject to inpatient facility copayment

INPATIENT SUBSTANCE USE

DISORDERS REHABILITATION

- Unlimited days
- Subject to inpatient facility copayment

INPATIENT SUBSTANCE USE

DISORDERS DETOXIFICATION

- Unlimited days
- Subject to inpatient facility copayment

DURABLE MEDICAL EQUIPMENT

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

OUTPATIENT THERAPIES

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

OUTPATIENT MENTAL HEALTH

- Unlimited visits
- \$5 copay
- \$10 copay
- \$15 copay
- \$20 copay
- \$25 copay
- \$30 copay
- \$35 copay
- \$40 copay
- \$50 copay
- No copay

OUTPATIENT SUBSTANCE USE

DISORDERS REHABILITATION

- Unlimited visits
- \$0 copay
- \$5 copay
- \$10 copay
- \$15 copay
- \$20 copay
- \$25 copay

DIABETIC SUPPLIES

- \$2
- \$10
- \$20
- No copay
- \$5
- \$15
- \$25

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 and contact lenses, covered up to a maximum of \$75 every 12 months.
- Not covered

REFRACTIVE EYE EXAM

- \$0 copay (standard)
- \$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	\$ _____	\$ _____	\$ _____