HIP*ACCESS* II FOR SMALL GROUPS
(2-50 Employees)

EmblemHealth®
GHI and HIP are EmblemHealth companies

☐ Prime Network ☐ Premium Network

Group Name

IN-NETWORK BENEFITS

COPAYMENT OPTIONS (Select one from each category)

PCP office visit	☐ $0	☐ $5	☐ $10	☐ $15	☐ $20	☐ $25	☐ $30			
Specialist office visit	☐ $0	☐ $5	☐ $15	☐ $20	☐ $25	☐ $30	☐ $35	☐ $40	☐ $45	☐ $50
Inpatient facility	☐ $0	☐ $250	☐ $500	☐ $750						
	OR									
	☐ $0	☐ $50	☐ $100	☐ $250	each day of the first ☐ three ☐ five days of copayment per continuous confinement					
Ambulatory surgery	☐ $0	☐ $50	☐ $75	☐ $100	☐ $125	☐ $150				
Emergency room	☐ $0	☐ $15	☐ $25	☐ $35	☐ $50	☐ $60	☐ $75	☐ $100	☐ $125	☐ $150
Ambulance*	☐ $0	☐ $15	☐ $25	☐ $35	☐ $50	☐ $60	☐ $75	☐ $100		

(*not to exceed the emergency room copayment)

OUT-OF-NETWORK BENEFITS

COINSURANCE PERCENTAGE (select one)

Percentage of covered charges payable by HIP Insurance Company:

☐ 100% ☐ 80% ☐ 75% ☐ 70% ☐ 50%

DEDUCTIBLE OPTIONS (select one)

Annual deductible payable by member:

Individual	☐ $200	☐ $250	☐ $300	☐ $300	☐ $350	☐ $400	☐ $500	☐ $500
Family	$400	$500	$600	$750	$700	$800	$1,000	$1,250
	☐ $750	☐ $1,000	☐ $1,500	☐ $1,500	☐ $2,000	☐ $2,500	☐ $5,000	☐ $10,000
	$1,500	$2,000	$3,000	$3,750	$4,000	$5,000	$10,000	$20,000

☐ No deductible ☐ Other : $_____

$_____

COINSURANCE MAXIMUM (select one)

Maximum coinsurance amount payable by member:

Individual	☐ $1,000	☐ $1,500	☐ $2,000	☐ $3,000	☐ $4,000	☐ $5,000	☐ $7,000	☐ $7,500
Family	$2,000	$3,000	$4,000	$6,000	$8,000	$10,000	$14,000	$15,000
	☐ $10,000	☐ $20,000	☐ Other :	$_____				
	$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		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	
☐ $7	☐ $35	

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

INPATIENT MENTAL HEALTH

☐ 30 days (standard)	☐ 90 days
☐ 60 days	☐ Include biological and CSED

INPATIENT SUBSTANCE USE DISORDERS REHABILITATION

☐ 30 days	☐ 90 days
☐ 60 days	☐ Unlimited

INPATIENT SUBSTANCE USE DISORDERS DETOXIFICATION

☐ 7 days	☐ Unlimited
☐ 21 days	
☐ 30 days	

OUTPATIENT MENTAL HEALTH (must choose a visit & copay)

☐ 20 visits	☐ $5 copay	☐ $30 copay
☐ 30 visits	☐ $10 copay	☐ $35 copay
☐ 40 visits	☐ $15 copay	☐ $40 copay
☐ 60 visits	☐ $20 copay	☐ No copay
	☐ $25 copay	

☐ Biologically-Based and Children with Serious Emotional Disorders (CSED)

OUTPATIENT SUBSTANCE USE DISORDERS REHABILITATION

☐ 60 visits	☐ 120 visits	☐ $0 copay
☐ $2 copay	☐ $5 copay	
☐ $10 copay	☐ $15 copay	
☐ $20 copay	☐ $25 copay	

PRIVATE DUTY NURSING (select one)

☐ Covered in full
☐ Not covered

DURABLE MEDICAL EQUIPMENT

☐ Covered in full
☐ $100 deductible, then covered in full
☐ Not covered
☐ Other _____

INPATIENT THERAPIES

☐ 30 days	☐ 90 days
☐ 60 days	☐ Not covered

OUTPATIENT THERAPIES

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

SKILLED NURSING FACILITY

☐ 30 days	☐ 90 days
☐ 45 days	☐ 120 days
☐ 60 days	☐ Unlimited

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 Health Insurance Plan of Greater New York and HIP Insurance Company of New York.

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