HIP PRIME PPO FOR LARGE GROUPS
(51+ 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	☐ 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	

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	☐ 20% coinsurance
☐ $100 deductible, then covered in full	☐ 25% coinsurance
	☐ 30% coinsurance
☐ 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
- ☐ $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	$ _____	$ _____	$ _____