

HIP PRIME 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 \$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

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

PRESCRIPTION DRUG ANNUAL MAXIMUM

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

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
- \$2 copay
- \$10 copay
- \$20 copay
- 120 visits
- \$5 copay
- \$15 copay
- \$25 copay
- \$0 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 _____
- 20% coinsurance
- 25% coinsurance
- 30% coinsurance

INPATIENT THERAPIES

- 30 days
- 60 days
- 90 days
- Not covered

OUTPATIENT THERAPIES

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

SKILLED NURSING FACILITY

- 30 days
- 45 days
- 60 days
- 90 days
- 120 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 29 end of month
 26 end of year 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	\$ _____
Employee & child(ren)	\$ _____
Employee & spouse	\$ _____
Family	\$ _____

Underwritten by Health Insurance Plan of Greater New York.