



# HEALTH INSURANCE PLAN of GREATER NEW YORK HIP CLASSIC for SMALL GROUPS (2-50 Employees)

Group Name .....

## IN-NETWORK BENEFITS

### COPAYMENT OPTIONS (Select One from each category)

**PCP Office Visit**

- \$25
- \$20
- \$15
- Other \_\_\_\_\_

**Specialist Office Visit:**

- \$40
- \$35
- \$30
- \$25
- \$20
- \$15
- Other \_\_\_\_\_

**Inpatient Facility:**

- \$500
- \$250
- \$200
- \$100
- \$100/day, max 5 days
- \$50/day, max 5 days
- Other \_\_\_\_\_

**Ambulatory Surgery:**

- \$75
- \$50
- Other \_\_\_\_\_

**Emergency Room:**

- \$100
- \$75
- \$50
- Other \_\_\_\_\_

## OPTIONAL BENEFIT RIDERS

### PRESCRIPTION DRUG OPTIONS (select one)

**Deductible (if applicable) Generic/Brand/Non-Formulary Drug Copayments and Coinsurance:**

- |                                                        |                                             |                                                                       |
|--------------------------------------------------------|---------------------------------------------|-----------------------------------------------------------------------|
| <input type="checkbox"/> No Prescription Drug Coverage | <input type="checkbox"/> \$15 / \$25 / \$40 | <input type="checkbox"/> \$300 Deductible \$10 / \$20 / 50%           |
| <input type="checkbox"/> \$7 / \$30 / \$50             |                                             | <input type="checkbox"/> \$300 Deductible \$7 / \$30 / \$50           |
|                                                        |                                             | <input type="checkbox"/> \$100 Deductible \$10 / \$20 / 50%           |
|                                                        |                                             | <input type="checkbox"/> \$100 Deductible \$10 / \$20 / \$40          |
|                                                        |                                             | <input type="checkbox"/> \$100 Deductible \$10 / \$20 / \$35          |
|                                                        |                                             | <input type="checkbox"/> \$100 Deductible \$7 / \$30 / \$50           |
|                                                        |                                             | <input type="checkbox"/> \$100 Deductible \$10 Generic Only; No brand |
|                                                        |                                             | <input type="checkbox"/> \$50 Deductible \$7 / \$30 / \$50            |
|                                                        |                                             | <input type="checkbox"/> Other _____ / _____ / _____                  |

**All Prescription Drug Options Include Coverage for Oral Contraceptives**

### PRIVATE DUTY NURSING (select one)

- Not Covered
- 80% for hours 73 - 504
- 100% for hours 73- 504
- Covered in Full

### DURABLE MEDICAL EQUIPMENT (select one)

- Not Covered
- \$100 Deductible, then Covered In Full
- Covered In Full
- Other: \_\_\_\_\_

### SKILLED NURSING FACILITY (select one)

- 30 Days
- 60 Days
- 90 Days
- Other \_\_\_\_\_

### HOME HEALTH CARE (select one)

- 40 Visits
- 60 Visits
- 100 Visits
- 200 visits

### INPATIENT THERAPIES (select one)

- Not covered
- 30 Days
- 60 Days
- 90 Days

### OUTPATIENT THERAPIES (select one)

- 30 Visits
- 60 Visits
- 90 Visits

### INPATIENT MENTAL HEALTH (select one)

- 30 Days
- 60 Days
- Other \_\_\_\_\_

### OUTPATIENT MENTAL HEALTH (select one)

- Not Covered
- 20 Visits; \$40 Copayment
- 20 Visits; \$35 Copayment
- 20 Visits; \$25 Copayment
- Other: \_\_\_\_\_

### INPATIENT ALCOHOL/SUBSTANCE ABUSE REHABILITATION (select one)

- Not Covered
- 30 Days
- Other \_\_\_\_\_

### OUTPATIENT ALCOHOL/SUBSTANCE ABUSE REHABILITATION (select one)

- 60 Visits
- 120 Visits

**INPATIENT ALCOHOL/SUBSTANCE ABUSE DETOXIFICATION**

- Not Covered
- 7 Days
- Other \_\_\_\_\_

**REFRACTIVE EYE EXAM**

- \$15 Copayment
- \$0 Copayment

**OPTICAL**

- One pair eyeglasses every 24 months with \$45 copay;  
No contact lens option
- One pair eyeglasses every 24 months;  
\$25 contact lens copayment
- One pair eyeglasses every 12 months;  
\$25 contact lens copayment

**DEPENDENT COVERAGE**

- |                                         |                                          |
|-----------------------------------------|------------------------------------------|
| <b>Full-Time Students</b>               | <b>Dependent Children</b>                |
| <input type="checkbox"/> 23 End Of Year | <input type="checkbox"/> 19 End Of Month |
| <input type="checkbox"/> 25 End Of Year | <input type="checkbox"/> 23 End Of Year  |
|                                         | <input type="checkbox"/> 25 End Of Year  |

**MONTHLY RATES (to be completed by your broker or HIP)****4 TIER**

Individual	\$ _____
Employee & Child(ren)	\$ _____
Employee & Spouse	\$ _____
Family	\$ _____