INSURANCE COMPANY OF NY

HIP INSURANCE COMPANY
HIPIC SELECT PPO for SMALL GROUPS

Group Name ....

IN-NETWORK BENEFITS

COPAYMENT OPTIONS (Select One from each category)

Office Visit PCP	☐ $0	☐ $5	☐ $10	☐ $15	☐ $20	☐ $25	☐ $30
Office Visit Specialist	☐ $0 ☐ $35	☐ $5 ☐ $40	☐ $10 ☐ $45	☐ $15 ☐ $50	☐ $20	☐ $25	☐ $30
Ambulatory Surgery	☐ $0	☐ $50	☐ $75	☐ $100	☐ **Subject to Deductible and Coinsurance**		
Hospital Admission Copayment	**Per Admission:** **Per Day (1-5):** ☐ **Subject to Deductible and Coinsurance**	☐ $0 ☐ $0	☐ $100 ☐ $50	☐ $200 ☐ $100	☐ $250	☐ $500	
Emergency Room	☐ $ 0 ☐ **Subject to Deductible and Coinsurance**	☐ $25	☐ $35	☐ $50	☐ $75	☐ $100	

COINSURANCE PERCENTAGE (Select One)

Percentage of covered charges payable by HIP Insurance Company:

☐ 80% ☐ 90% ☐ 100%

DEDUCTIBLE OPTIONS (Select One)

Annual Deductible payable by member:

Individual	☐ $0	☐ $500	☐ $1,000	☐ $1,500	☐ $2,000	☐ OTHER $ ________________
Family	$0	$1,000	$2,000	$3,000	$4,000	$ ________________

COINSURANCE MAXIMUM (Select One)

Maximum Coinsurance amount payable by member:

Individual	☐ $0	☐ $500	☐ $750	☐ $1,000	☐ $2,000	☐ OTHER $ ________________
Family	$0	$1,000	$1,500	$2,000	$4,000	$ ________________

OUT-OF-NETWORK BENEFITS

COINSURANCE PERCENTAGE (Select One)

Percentage of covered charges payable by HIP Insurance Company:

☐ 50% ☐ 60% ☐ 70% ☐ 80%

DEDUCTIBLE OPTIONS (Select One)

Annual Deductible payable by member:

Individual	☐ $250	☐ $500	☐ $750	☐ $1,000	☐ $3,000	☐ OTHER $ ________________
Family	$500	$1,000	$1,500	$2,000	$6,000	$ ________________

COINSURANCE MAXIMUM (Select One)

Maximum Coinsurance amount payable by member:

Individual	☐ $1,000	☐ $3,000	☐ $7,000	☐ $10,000	☐ $20,000	☐ OTHER $ ________________
Family	$2,000	$6,000	$14,000	$20,000	$40,000	$ ________________

OPTIONAL BENEFIT RIDERS

PRESCRIPTION DRUG OPTIONS

Generic/Brand Copayments for Formulary Drugs	Non-Formulary Cost Sharing	
☐ $5/$5 ☐ $5/$10 ☐ $7/$15 ☐ $10/$15 ☐ $10/$20 ☐ $100 Deductible, then $10/$20 ☐ $300 Deductible, then $10/$20 ☐ Other: $______ / _______ ☐ $50 deductible/$10 generic ☐ $100 deductible/$10 generic	☐ 50% Coinsurance ☐ $35 Copay ☐ $40 Copay ☐ Not Covered	☐ No Prescription Drug Coverage

CONTRACEPTIVES: ☐ Other

PRIVATE DUTY NURSING

☐ Covered In Full
☐ 80% for hours 73 - 504
☐ 100% for hours 73- 504
☐ Not Covered

SKILLED NURSING FACILITY

☐ 30 Days (standard)
☐ 60 Days
☐ 90 Days
☐ 120 Days
☐ Unlimited Days

☐ $0 Copay
☐ Deductible, then Coinsurance

INPATIENT THERAPIES

☐ 30 Days (standard)
☐ 60 Days
☐ 90 Days
☐ Not covered

☐ $ Hospital Admission Copay
☐ Deductible, then Coinsurance

INPATIENT MENTAL HEALTH

☐ 0 Days
☐ 30 Days (standard)
☐ 60 Days
☐ 90 Days

☐ $ Hospital Admission Copay
☐ Deductible, then Coinsurance

INPATIENT ALCOHOL/SUBSTANCE ABUSE REHABILITATION

☐ Not Covered (standard)
☐ 30 Days
☐ 60 Days
☐ 90 Days

☐ $ Hospital Admission Copay
☐ Deductible, then Coinsurance

INPATIENT ALCOHOL/SUBSTANCE ABUSE DETOXIFICATION

☐ 0 Days
☐ 7 Days (standard)
☐ 30 Days
☐ Unlimited Days

☐ $ Hospital Admission Copay
☐ Deductible, then Coinsurance

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 copay;
No contact lens option

☐ No Rider

OTHER

DURABLE MEDICAL EQUIPMENT

☐ Covered In Full
☐ $100 Deductible, then Covered In Full
☐ Not Covered
☐ Other: ________________________

HOME HEALTH CARE

☐ 40 Visits (standard)
☐ 60 Visits
☐ 100 Visits
☐ 200 visits

☐ $0 Copay
☐ Deductible, then Coinsurance

OUTPATIENT THERAPIES

☐ 30 Visits (standard)
☐ 60 Visits
☐ 90 Visits

☐ Not covered

OUTPATIENT MENTAL HEALTH

☐ 20 Visits; $25 Copayment (standard)
☐ Not Covered
☐ Other: ________________________

OUTPATIENT ALCOHOL/SUBSTANCE ABUSE REHABILITATION

☐ 60 Visits (standard)
☐ 120 Visits

REFRACTIVE EYE EXAM

☐ $0 Copayment (standard)
☐ $15 Copayment

DEPENDENT COVERAGE

Full-Time Students	Dependent Children
☐ 23 End Of Month	☐ 19 End Of Month
☐ 23 End Of Year	☐ 19 End Of Year
☐ Other (enter below)	
Age: ____________	____________
☐ End Of Year	☐ End Of Year
☐ End Of Month	☐ End Of Month

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

	4 TIER
Individual	$_______________
Two Persons	
Employee & Child(ren)	$_______________
Employee & Spouse	$_______________
Family	$_______________