

DATED: 8/6/07

Please read Insurer Descriptions and Focus Provider Directories before making benefit plan selections.

BENEFIT CHOICES	IN NETWORK
<b>FINANCIAL</b>	
Network Copay	\$25 co-payment(PCP) \$40 co-payment(specialist)
<b>Annual Deductible Out of Network (Individual/Family)</b>	N/A
Out of Network Coinsurance/Coinsurance Max	N/A
Out of Pocket Maximum	N/A
<b>Annual Deductible In-Network (Individual/Family)</b>	N/A
In-Network Coinsurance/Coinsurance Max	N/A
Out of Pocket Maximum	N/A
Lifetime Maximum Benefit	N/A
Max.Age for Dependent Children/Full-time Students	25
<b>PRESCRIPTION DRUG CARD BENEFITS</b>	
Generic/Name Brand/Non-formulary	\$20/30/40
<b>ADULT &amp; CHILDREN'S PREVENTIVE CARE</b>	
Preventative: Well Baby, Well Child, Immunizations, Mammograms, Pap Tests, Annual Physical Exam	\$0 co-payment \$25 co-payment
<b>Care Rendered Outside a Hospital Setting</b>	
Primary Physician Office Visits	\$25 co-payment
Specialist Office Visits	\$40 co-payment
Laboratory Services	\$25 co-payment
Radiology	\$25 co-payment
<b>HOSPITAL CARE</b>	
Inpatient Facility Services	\$500 co-payment per continuous confinement
Out Patient Facility Service (Ambulatory Surgery)	\$75 co-payment
In-Patient Physician and Surgeon Services	No-copayment
Out-Patient Physician and Surgeon Services	N/A
Semi-Private Room and Board	N/A
All Drugs and Medications	\$20/30/40
<b>EMERGENCY CARE</b>	
Emergency Room Copay	\$50 co-payment
Emergency Room Professional Services	\$50 co-payment
Ambulance Services when necessary	\$50 co-payment
<b>MATERNITY CARE</b>	
Prenatal and Post-Natal Care	\$25 co-payment
Hospital Service	\$500 co-payment per continuous confinement
<b>MENTAL HEALTH CARE</b>	
Outpatient Visits (20 visits per calendar year)	\$40 co-payment
Inpatient Care (30 days per calendar year)	\$500 co-payment for continuous confinement
<b>SUBSTANCE ABUSE</b>	
Inpatient Detox. (7 days per calendar year)	\$500 co-payment for continuous confinement
Inpatient Rehab. (Rider)	Rider Available
Outpatient Rehab. (60 visits per calendar year)	\$40 co-payment
<b>ALTERNATIVE CARE SERVICES</b>	
Skilled Nursing Facility (30 days per calendar year)	\$500 co-payment per continuous confinement
Home Health Care (60 visits)	\$25 co-payment
Hospice (210 days combined with outpatient)	No co-payment
<b>SHORT-TERM THERAPY (Outpatient)</b>	
*Physical Therapy, Occupational, Speech Therapy	\$40 co-payment \$25 co-payment (only following an in-patient stay)
<b>CHIROPRACTIC CARE</b>	\$40 co-payment
<b>DURABLE MED. EQUIPMENT/PROSTHETICS</b>	20% coinsurance
<b>VISION</b>	N/A
<b>DENTAL</b>	N/A

NOTE: This is a brief summary of benefits and should only be used as a guide. You must refer to the selected insurer's subscriber agreement for a complete description of requirements for coverage, covered services, limitations and exclusions.

\* Inpatient 30 days per diagnosis per calendar year/ Outpatient 20 visits per diagnosis per calendar year (only after hospitalization)