

HIP POS 20/1000 with Vytra Premium Network

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

BENEFIT CHOICES	IN NETWORK	OUT OF NETWORK
FINANCIAL		
Network Copay	\$20 copay	NA
Annual Deductible Out of Network (Individual/Family)	NA	\$1000/\$2000
Out of Network Coinsurance/Coinsurance Max	NA	70%/30% \$2000/\$4000
Out of Pocket Maximum	NA	NA
Annual Deductible In-Network (Individual/Family)	NA	NA
In-Network Coinsurance/Coinsurance Max	NA	NA
Out of Pocket Maximum	NA	NA
Lifetime Maximum Benefit	Unlimited	\$5,000,000 per member
Max.Age for Dependent Children/Full-time Students	19/25	19/25
PRESCRIPTION DRUG CARD BENEFITS		
Generic/Name Brand/Non-formulary	\$10/\$20/\$40	NA
ADULT & CHILDREN'S PREVENTIVE CARE		
Preventative: Well Baby, Well Child, Immunizations Mammograms, Pap Tests, Annual Physical Exam	\$0 copay Included in PCP copay	Covered 70% after deductible Covered 70% after deductible Annual Physical - not covered
Care Rendered Outside a Hospital Setting		
Primary Physician Office Visits	\$20 copay	Covered 70% after deductible
Specialist Office Visits	\$20 copay	Covered 70% after deductible
Laboratory Services	Included in PCP copay	(Covered 70% after deductible when related to illness or injury)
Radiology	Included in PCP copay	
HOSPITAL CARE		
Inpatient Facility Services	\$250 copay per admission	Covered 70% after deductible
Out Patient Facility Service (Ambulatory Surgery)	Ambulatory Surgery: No copay	Covered 70% after deductible
In-Patient Physician and Surgeon Services		
Out-Patient Physician and Surgeon Services		
Semi-Private Room and Board		
All Drugs and Medications		
EMERGENCY CARE		
Emergency Room Copay	\$50 copay per visit	NA
Emergency Room Professional Services	NA	NA
Ambulance Services when necessary	\$0 copay	Covered 70% after deductible
MATERNITY CARE		
Prenatal and Post-Natal Care	\$0 copay	Covered 70% after deductible
Hospital Service	\$250 copay	Covered 70% after deductible
MENTAL HEALTH CARE		
Outpatient Visits	\$35 copay; 20 visits per calendar year	Covered 50% after deductible
Inpatient Care	\$250 copay; 30 days per calendar year	Covered 70% after deductible
SUBSTANCE ABUSE		
Inpatient Detox.	\$250 copay; 7 days per calendar year	Covered 70% after deductible
Inpatient Rehab.	\$250 copay; 30 days per calendar year	Not covered
Outpatient Visits	\$20 copay 60 visits per calendar year	Covered 70% after deductible
ALTERNATIVE CARE SERVICES		
Skilled Nursing Facility	\$0 copay; 90 days per calendar year	Not covered Out-of-Network
Home Health Care	\$20 copay; 40 visits per calendar year	Covered 70% after deductible
Hospice	\$0 copay; 210 days	Not covered Out-of-Network
SHORT-TERM THERAPY		
Physical Therapy, Occupational Speech Therapy	Outpatient: \$20 copay; 120 visits per cal yr Inpatient: \$250 copay; 30 days per cal yr	Covered 70% after deductible Covered 70% after deductible
CHIROPRACTIC CARE	\$20 copay	Covered 70% after deductible
DURABLE MED. EQUIPMENT/PROSTHETICS	\$0 annual deductible	Not covered Out-of-Network
VISION	Eye Exam: \$20 copay; Eyeglasses: \$45 for a complete pair every 24 months	Covered 70% after deductible Eyeglasses: Not covered Out-of-Network
DENTAL	Reduced member fee schedule	Not covered Out-of-Network

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.