

## HIP HMO 20 Super Value with Prime Network

DATED: 2/16/07

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

BENEFIT CHOICES	IN NETWORK
<b>FINANCIAL</b>	
Network Copay	\$20 copay
<b>Annual Deductible Out of Network (Individual/Family)</b>	
Out of Network Coinsurance/Coinsurance Max	NA
Out of Pocket Maximum	NA
<b>Annual Deductible In-Network (Individual/Family)</b>	
In-Network Coinsurance/Coinsurance Max	NA
Out of Pocket Maximum	NA
Lifetime Maximum Benefit	NA
Max.Age for Dependent Children/Full-time Students	19/25
<b>PRESCRIPTION DRUG CARD BENEFITS</b>	
Generic Only	\$10 Generic w/\$100 Deductible
<b>ADULT &amp; CHILDREN'S PREVENTIVE CARE</b>	
Preventative: Well Baby, Well Child, Immunizations Mammograms, Pap Tests, Annual Physical Exam	Covered in full Included in PCP copay
<b>Care Rendered Outside a Hospital Setting</b>	
Primary Physician Office Visits	\$20 copay
Specialist Office Visits	\$20 copay
Laboratory Services	Included in PCP copay
Radiology	Included in PCP copay
<b>HOSPITAL CARE</b>	
Inpatient Facility Services	Inpatient: \$500 copay per admission
Out Patient Facility Service (Ambulatory Surgery)	Ambulatory Surgery: \$75 copay per visit
In-Patient Physician and Surgeon Services	
Out-Patient Physician and Surgeon Services	
Semi-Private Room and Board	
All Drugs and Medications	
<b>EMERGENCY CARE</b>	
Emergency Room Copay	\$50 copay per visit
Emergency Room Professional Services	NA
Ambulance Services when necessary	No copay
<b>MATERNITY CARE</b>	
Prenatal and Post-Natal Care	Covered in full (in physician's office)
Hospital Service	\$500 copay
<b>MENTAL HEALTH CARE</b>	
Outpatient Visits	\$35 copay; 20 visits per calendar year
Inpatient Care	\$500 copay; 30 days per calendar year
<b>SUBSTANCE ABUSE</b>	
Inpatient Detox.	\$500 copay; 7 days per calendar year
Inpatient Rehab.	Not covered
Outpatient Visits	\$20 copay per visit; 60 visit limit per calendar year
<b>ALTERNATIVE CARE SERVICES</b>	
Skilled Nursing Facility	\$0 copay; 30 days per calendar year
Home Health Care	No copay; 40 visits per calendar year
Hospice	No copay; 210 days
<b>SHORT-TERM THERAPY</b>	
Physical Therapy, Occupational	Outpatient: \$20 copay; 30 visits per calendar year
Speech Therapy	Inpatient: not covered
<b>CHIROPRACTIC CARE</b>	
	\$20 copay
<b>DURABLE MED. EQUIPMENT/PROSTHETICS</b>	
	Not covered
<b>VISION</b>	
	Eye Exam: \$15 copay
	Eyeglasses; \$45 for complete pair/24 months
<b>DENTAL</b>	
	Reduced member fee schedule

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.