

HIP HMO 20 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
FINANCIAL	
Network Copay	\$20 copay
Annual Deductible Out of Network (Individual/Family)	
Out of Network Coinsurance/Coinsurance Max	NA
Out of Pocket Maximum	NA
Annual Deductible In-Network (Individual/Family)	
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
PRESCRIPTION DRUG CARD BENEFITS	
Generic/Name Brand/Non-formulary	\$7/\$30/\$50 w/\$50 Deductible
ADULT & CHILDREN'S PREVENTIVE CARE	
Preventative: Well Baby, Well Child, Immunizations Mammograms, Pap Tests, Annual Physical Exam	Covered in full Included in PCP copay
Care Rendered Outside a Hospital Setting	
Primary Physician Office Visits	\$20 copay
Specialist Office Visits	\$20 copay
Laboratory Services	Included in PCP copay
Radiology	Included in PCP copay
HOSPITAL CARE	
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	
EMERGENCY CARE	
Emergency Room Copay	\$50 copay per visit
Emergency Room Professional Services	NA
Ambulance Services when necessary	No copay
MATERNITY CARE	
Prenatal and Post-Natal Care	Covered in full (in physician's office)
Hospital Service	\$500 copay
MENTAL HEALTH CARE	
Outpatient Visits	\$35 copay; 20 visits per calendar year
Inpatient Care	\$500 copay; 30 days per calendar year
SUBSTANCE ABUSE	
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
ALTERNATIVE CARE SERVICES	
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
SHORT-TERM THERAPY	
Physical Therapy, Occupational	Outpatient: \$20 copay; 30 visits per calendar year
Speech Therapy	Inpatient: \$500 copay (when part of an acute admission)
CHIROPRACTIC CARE	\$20 copay
DURABLE MED. EQUIPMENT/PROSTHETICS	Not covered
VISION	Eye Exam: \$15 copay Eyeglasses; \$45 for complete pair/24 months
DENTAL	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.