

HIP HMO 5 with Prime Network

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

BENEFIT CHOICES	IN NETWORK
FINANCIAL	
Network Copay	\$5 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
ADULT & CHILDREN'S PREVENTIVE CARE	
Preventative: Well Baby, Well Child, Immunizations	Covered in full
Mammograms, Pap Tests, Annual Physical Exam	Included in PCP copay
Care Rendered Outside a Hospital Setting	
Primary Physician Office Visits	\$5 copay
Specialist Office Visits	\$5 copay
Laboratory Services	Included in PCP copay
Radiology	Included in PCP copay
HOSPITAL CARE	
Inpatient Facility Services	Inpatient: No copay
Out Patient Facility Service (Ambulatory Surgery)	Ambulatory Surgery: No copay
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	\$35 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	No copay
MENTAL HEALTH CARE	
Outpatient Visits	\$20 copay; 20 visits per calendar year
Inpatient Care	No copay; 30 days per calendar year
SUBSTANCE ABUSE	
Inpatient Detox.	No copay; 7 days per calendar year
Inpatient Rehab.	No copay; 30 days per calendar year
Outpatient Visits	\$5 copay per visit; 60 visit limit per calendar year
ALTERNATIVE CARE SERVICES	
Skilled Nursing Facility	\$0 copay; 60 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: \$5 copay; 30 visits per calendar year
Speech Therapy	Inpatient: no copay; 60 days per calendar year
CHIROPRACTIC CARE	
DURABLE MED. EQUIPMENT/PROSTHETICS	
VISION	
DENTAL	
	Eye Exam: no copay
	Eyeglasses; \$45 for complete pair/24 months
	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.