

HIP HMO 25/40A 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	\$25 PCP/\$40 Specialist
Annual Deductible Out of Network (Individual/Family) Out of Network Coinsurance/Coinsurance Max Out of Pocket Maximum	NA NA
Annual Deductible In-Network (Individual/Family) In-Network Coinsurance/Coinsurance Max Out of Pocket Maximum	NA NA NA
Lifetime Maximum Benefit Max.Age for Dependent Children/Full-time Students	NA 19/25
PRESCRIPTION DRUG CARD BENEFITS	
Generic/Name Brand	\$20/\$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 Specialist Office Visits Laboratory Services Radiology	\$25 copay \$40 copay Included in PCP copay Included in PCP copay
HOSPITAL CARE	
Inpatient Facility Services Out Patient Facility Service (Ambulatory Surgery) In-Patient Physician and Surgeon Services Out-Patient Physician and Surgeon Services Semi-Private Room and Board All Drugs and Medications	Inpatient: \$500 copay per admission Ambulatory Surgery: \$75 copay per visit
EMERGENCY CARE	
Emergency Room Copay Emergency Room Professional Services Ambulance Services when necessary	\$100 copay per visit NA No copay
MATERNITY CARE	
Prenatal and Post-Natal Care Hospital Service	Covered in full (in physician's office) \$500 copay
MENTAL HEALTH CARE	
Outpatient Visits Inpatient Care	\$40 copay; 20 visits per calendar year \$500 copay; 30 days per calendar year
SUBSTANCE ABUSE	
Inpatient Detox. Inpatient Rehab. Outpatient Visits	\$500 copay; 7 days per calendar year Not covered \$25 copay per visit; 60 visit limit per calendar year
ALTERNATIVE CARE SERVICES	
Skilled Nursing Facility Home Health Care Hospice	\$0 copay; 30 days per calendar year No copay; 40 visits per calendar year No copay; 210 days
SHORT-TERM THERAPY	
Physical Therapy, Occupational Speech Therapy	Outpatient: \$40 copay; 30 visits per calendar year Inpatient: \$500 copay (when part of an acute admission)
CHIROPRACTIC CARE	
DURABLE MED. EQUIPMENT/PROSTHETICS	
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.