

HEALTH INSURANCE-
NETWORK ONLY PLAN (HMO)

Coverage	2004 Plan
Type plan- Network Coverage Only	Yes
Deductible	\$500/person per year, not to exceed \$1000/family per year
Annual Out of Pocket Max (in addition to deductible)	\$2000/person per year, not to exceed \$4000/family per year
Provider Office Visit	
Primary Physician	\$25 per visit
Specialist	\$25 per visit
Maternity care office visits	\$25 per pregnancy (first visit only)
Medical Inpatient Hospital & Related Services	
Medical room & board/other patient services & supplies	20% after deductible
Physician services while hospitalized	20% after deductible
Maternity inpatient services	20% after deductible
Hospital & related services for mastectomy & postmastectomy care	20% after deductible
Outpatient Services & Supplies	
Outpatient surgery	20% after deductible
Outpatient physician services	20% after deductible
Laboratory/diagnostic tests & procedures (except below)	100%, not subject to deductible
MRI's, CT Scan, PET Scan, Nuclear Medicine	20% after deductible
Emergency Services	
Emergency room services	\$150 per occurrence
Emergency room prescriptions	See prescriptions
Ambulance services	20% subject to deductible
Urgent care center	\$50 per visit
Outpatient Mental Health Svcs	
Individual therapy services	Limited to 20 visits per calendar year
Group therapy services	\$25 per visit
	\$20 per visit
Inpatient Mental Health	
Inpatient Services	Limited to 30 days per calendar year
Physician services while hospitalized	20% subject to deductible
Treatment of medical complications	20% subject to deductible
Outpatient Chemical Dependency Services	
Individual therapy services	\$25 per visit
Group therapy services	\$20 per visit
Intensive rehabilitation	20% after deductible
Miscellaneous Health Services	
Home health care	20% after deductible
Physical, occupational & speech therapy limited to 20 visits per therapeutic type, per calendar year	\$25 per visit
Skilled nursing facility & rehabilitative care limited to 90 days per calendar year	20% after deductible
Non-emergency ground transportation	20% after deductible
Durable medical equipment & prsthetics	20% after deductible
Diabetic supplies & medication	Use RX benefit
Diabetic outpatient education	20% after deductible
Ostomy medical supplies	20% after deductible
Cardiac rehabilitation services	\$25 per visit, 36 visits, no dollar maximum
Accident related dental services limited to \$1500 maximum benefit per calendar year	20% after deductible
Dental anesthesia and related hospital services	20% after deductible
Infertility testing & diagnosis limited to \$1500 lifetime max benefit	Not covered
Prescription Coverage	
Tier 1	\$10*
Tier 2	\$25*
Tier 3	\$40*
=call first for pre-authorization	
*Rates are less if ordered from Extended Supply Mail Pharmacy-This summary is an outline for general informational purposes only.	
Please refer to your Certificate of Coverage for specific coverage.	