

COVERAGE SUMMARY

MEDICAL PLAN DEDUCTIBLES AND MAXIMUMS

TYPE OF SERVICE	IMPORTANT PROVISIONS	IN-NETWORK PROVIDER	OUT-OF-NETWORK PROVIDER
		The Allowable Expense is limited to the Preferred Provider Reimbursement Schedule.	The Allowable Expense is limited to the Reasonable and Customary (R&C) amount. The Deductible applies to all services prior to benefit payment, except where noted.
DEDUCTIBLE	Per calendar year. (Carryover does not apply) Maximums are combined for In and Out-of-Network Providers, except where noted.	None	\$500 Individual
OUT-OF-POCKET MAXIMUM	Does not include deductible or Pre-Certification penalties. Maximums are combined for In and Out-of-Network Providers, except where noted.	None	\$3,500 Individual \$7,000 Family
LIFETIME MAXIMUM	Applies to non-Essential Health Benefits only. Maximums are combined for In and Out-of-Network Providers, except where noted.	\$1,000,000	\$1,000,000

MEDICAL COVERAGE SUMMARY
POINT OF SERVICE PLAN
EFFECTIVE JANUARY 1, 2011

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ACUPUNCTURE	Acupuncture is only covered when used in lieu of General Anesthesia.	See Anesthesia Benefit	See Anesthesia Benefit
ALLERGY CARE -Office Visit -Treatment (Injections) -Serum -Laboratory & Scratch Testing		\$20 Copay \$20 Copay Covered in full Covered in full	70% 70% 70% 70%
AMBULANCE		\$75 Copay	\$75 Copay, then payable at 100% of charges, not subject to deductible
ANESTHESIA -Inpatient -Outpatient -Office		Covered in full Covered in full Covered in full	70% 70% 70%
BIOFEEDBACK		Not covered	Not covered
BLOOD AND BLOOD PRODUCTS		Covered in full	70%
CARDIAC REHABILITATION -Outpatient Hospital -Any other place of service		\$20 Copay per visit \$20 Copay per visit	70% 70%
CHEMOTHERAPY -Outpatient Hospital -Any other place of service		\$20 Copay per visit \$20 Copay per visit	70% 70%
CHIROPRACTOR	Maximum of 25 visits per calendar year.	\$20 Copay per visit	70%
CONVALESCENT/SKILLED NURSING FACILITY	\$500 penalty if not Pre-Certified. Limited to 45 days per calendar year.	\$250 Copay per admission	70%

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DENTAL CARE COVERED UNDER MEDICAL PLAN -Accidental Injury to Teeth -Oral Surgery	Treatment must be rendered within 12 months of the date that the Injury occurred.	\$20 Copay Not covered	70% Not covered
DIABETIC TREATMENT -Education -Supplies and Equipment		Covered in full Covered through the Prescription Drug Plan	70% Covered through the Prescription Drug Plan
DIAGNOSTIC X-RAYS AND IMAGING TESTS -Independent Facility -Outpatient Hospital -Physician's Office		\$20 Copay per visit \$20 Copay per visit \$20 Copay per visit	70% 70% 70%
HIGH TECH IMAGING (SUCH AS MRI, MRA, PET AND CAT SCANS)	\$500 penalty if non-Emergency MRA and PET Scans are not Pre-Certified.	\$20 Copay	70%
DIALYSIS OR HEMODIALYSIS -Outpatient Hospital -Any other place of service		Covered in full Covered in full	70% 70%
DURABLE MEDICAL EQUIPMENT (DME) Including, but not limited to: -Durable Medical Equipment -Disposable Medical Supplies -Prosthetics (External) -Prosthetics (Internal) -Foot Orthotics -Orthotics (Braces) -Oxygen	\$500 penalty if DME over \$1,500 is not Pre-Certified. Covers only Medically Necessary supplies required for the proper functioning of Durable Medical Equipment.	50% 50% 50% Covered in full 50% 50% 50%	50% 50% 50% 50% 50% 50%

TYPE OF SERVICE	IMPORTANT PROVISIONS	IN-NETWORK PROVIDER	OUT-OF-NETWORK PROVIDER
ENTERAL FORMULA	Covered through Prescription Drug Plan at 50% Copay; limited to \$2,500 calendar year maximum.	Covered through Prescription Drug Plan	Covered through Prescription Drug Plan
FAMILY PLANNING SERVICES -Elective Sterilization Procedures -Voluntary Termination of Pregnancy -Infertility Treatment Guidelines apply – Refer to your Plan Document for more information on this benefit -Contraceptive Devices -Contraceptive Management Office Visit	Assisted reproductive procedures are not covered.	Covered as described under Surgery Covered as described under Surgery Covered as described under Type of Service rendered \$20 Copay \$20 Copay	Covered as described under Surgery Covered as described under Surgery Covered as described under Type of Service rendered 70% 70%
GENETIC TESTING	The Plan covers Genetic Testing, and associated counseling, when Medically Necessary or medically appropriate as determined by the Medical Services Team criteria and peer-reviewed literature.	Covered as described under Type of Service rendered	Covered as described under Type of Service rendered
HOME HEALTH CARE -Aide, Nurse, or any other Authorized Agency Employee -Home IV Therapy and Respiratory Care		\$20 Copay per visit Covered in full	70% 70%
HOSPICE CARE -Inpatient -Home	\$500 penalty if not Pre-Certified. Limited to 210 days per Lifetime.	Covered in full Covered in full	70% 70%

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HOSPITAL FACILITY			
<u>Inpatient Hospital</u>	\$500 penalty if not Pre-Certified.	\$250 Copay per admission	70%
<u>Outpatient Hospital</u>			
-Emergency Room for a medical Emergency	Includes ER Physician.	\$150 Copay	\$150 Copay; 100% of charges, not subject to deductible
-Emergency Room used for a Non-Emergency	ER Physician services not covered.	Not covered	Not covered
-Outpatient Surgical Center		\$75 Copay	70%
-Clinic		\$20 Copay	70%
INFUSION THERAPY	Specialty drugs must be ordered through the Prescription Drug Plan.	\$20 Copay	70%
LABORATORY			
-Independent Facility		Covered in full	70%
-Outpatient Hospital		Covered in full	70%
-Physician's Office		Covered in full	70%
MASSAGE THERAPY (When rendered by a Licensed Massage Therapist)		Not covered	Not covered
MATERNITY CARE-MOTHER (Refer to Diagnostic Xrays, Imaging Tests and Laboratory for benefits related to maternity)			
-Inpatient Hospital	\$500 penalty if stay exceeds: 48 hours for Vaginal Delivery or 96 hours for Cesarean Section and the additional stay is not Post-Certified.	\$250 Copay per admission	70%
-Physician for Prenatal Care and Delivery		\$20 Copay for first visit, remaining visits covered in full	70%

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MENTAL ILLNESS SERVICES			
-Inpatient	\$500 penalty if not Pre-Certified. (Hospital or Behavioral Health Care Facility) Maximum of 30 days per calendar year. Partial Hospitalization is covered. Two partial days equal one inpatient day.	\$250 Copay per admission	70%
-Inpatient Physician	Maximum of 30 days per calendar year.	Covered in full	70%
-Outpatient/Office	Maximum of 20 visits per calendar year.	\$20 Copay	Covered at 50%
MODIFIED FOOD PRODUCTS		Not covered	Not covered
NEWBORN CARE (Prior to Discharge)		When Plan covers both Mother and Baby	
-Hospital		Covered in full	70%
-Physician		Covered in full	70%
-Newborn Circumcision		Covered in full	70%

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NEWBORN CARE (Prior to Discharge) -Hospital -Physician -Newborn Circumcision	When Plan covers the Baby but not the Mother \$500 penalty if stay exceeds: 48 hours for Vaginal Delivery or 96 hours for Cesarean Section and the additional stay is not Post-Certified.	Covered in full Covered in full Covered in full	70% 70% 70%
NUTRITIONAL COUNSELING	Covered as recommended by the US Preventive Task Force.	Covered in full	Not covered
OBESITY TREATMENT Guidelines apply – Refer to your Plan Document for more information on this benefit	The Plan covers treatment of clinically severe obesity as defined by the National Heart Lung Blood Institute. The Plan covers one course of treatment, including surgical intervention, per Lifetime per Covered Family Member. Anything not included or not approved in the written treatment plan is not covered.	Covered as described under Type of Service rendered	Covered as described under Type of Service rendered
OCCUPATIONAL THERAPY -Outpatient Hospital -Any other place of service	Limited to a maximum of 30 visits per calendar year combined with physical, respiratory and speech therapies.	\$20 Copay \$20 Copay	70% 70%
ORGAN TRANSPLANTS Guidelines apply – Refer to your Plan Document for more information on this benefit	\$500 penalty if not Pre-Certified.	Covered as described under type of service rendered	Covered as described under type of service rendered
PHYSICAL REHABILITATION FACILITY	\$500 penalty if not Pre-Certified.	\$250 Copay per admission	70%
PHYSICAL THERAPY -Outpatient Hospital -Any other place of service	Limited to a maximum of 30 visits per calendar year combined with occupational, respiratory and speech therapies.	\$20 Copay per visit \$20 Copay per visit	70% 70%

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PHYSICIAN			
-Inpatient		Covered in full	70%
-PCP Office Visit		\$20 Copay	70%
-Diagnostic Office Visits		\$20 Copay	70%
-Home		\$20 Copay	70%
<u>Consultation (Specialist)</u>			
-Inpatient		Covered in full	70%
-Outpatient		\$20 Copay	70%
-Office		\$20 Copay	70%
<u>Second Medical Opinion</u>		\$20 Copay	70%
PREADMISSION TESTING		Covered in full	70%
PREVENTATIVE/WELL CARE	Preventative/Well Care is covered as recommended by the US Preventive Task Force.		
-Bone Density Testing		Covered in full	70%
-Colonoscopy/Sigmoidoscopy		Covered in full	70%
-GYN Office Visit		Covered in full	70%
-PAP Smear		Covered in full	70%
-Mammogram		Covered in full	70%
-Prostate Cancer Screening (PSA)		\$20 Copay	70%
-Routine Vision Exam	Covered once every 24 months.	Covered in full	70%
-Routine Hearing Exam	Covered once per calendar year.	Covered in full	70%
-Routine Adult Physical	(Includes appropriate labs, x-rays and immunizations)	Covered in full	70%
-Well Child Care	Covered up to age 19. (Includes appropriate labs, x-rays and immunizations)	Covered in full	100%, not subject to deductible

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PRIVATE DUTY NURSING		Not covered	Not covered
RADIATION THERAPY			
-Outpatient Hospital		\$20 Copay	70%
-Any other place of service		\$20 Copay	70%
RESPIRATORY THERAPY	Limited to a maximum of 30 visits per calendar year combined with occupational, speech and physical therapies.		
-Outpatient Hospital		\$20 Copay	70%
-Any other place of service		\$20 Copay	70%
SMOKING CESSATION PROGRAMS	Covered as recommended by the US Preventive Task Force.	Covered in full	Not covered
SPEECH THERAPY	Limited to a maximum of 30 visits per calendar year combined with occupational, respiratory and physical therapies.		
-Outpatient Hospital		\$20 Copay	70%
-Any other place of service		\$20 Copay	70%
SUBSTANCE ABUSE TREATMENT			
-Detoxification	\$500 penalty if not Pre-Certified. Maximum of seven days per calendar year.	\$250 Copay per admission	70%
-Inpatient Rehabilitation		Not covered	Not covered
-Inpatient Physician	Maximum of seven days per calendar year for detoxification only.	Covered in full	70%
-Outpatient/Office	Maximum of 60 visits per calendar year.	\$20 Copay	70%

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SURGERY (Refer to Hospital Facility, Surgery Center or Anesthesia for benefits related to surgery) <u>Surgeon</u> -Inpatient -Outpatient -Office <u>Assistant Surgeon</u> <u>Second Surgical Opinion</u> -Voluntary -Mandatory		Covered in full Covered in full \$20 Copay Covered in full \$20 Copay Not Required	70% 70% 70% 70% 70% Not Required
SURGERY CENTER (Freestanding Surgical Facility)		\$75 Copay	70%
TEMPOROMANDIBULAR JOINT DISORDER (TMJ)		Covered as described under Type of Service rendered	Covered as described under Type of Service rendered
URGENT CARE FACILITY		\$40 Copay	70%

PRESCRIPTION DRUG PLAN

TYPE OF PROGRAM	IMPORTANT PROVISIONS	BENEFIT
RETAIL DRUGS	Up to a 30-day supply	\$ 5 Copay – Generic Drug \$20 Copay – Preferred Brand Name Drug \$45 Copay – Non-Preferred Brand Name Drug
MAIL ORDER MAINTENANCE DRUGS	Up to a 90-day supply	\$10 Copay – Generic Drug \$40 Copay – Preferred Brand Name Drug \$90 Copay – Non-Preferred Brand Name Drug
DIABETIC SUPPLIES AND INSULIN		See Benefit for Retail and Mail Order Maintenance Drugs
SPECIALTY DRUGS		See Benefit for Retail and Mail Order Maintenance Drugs
Copays under the Prescription Drug Plan do not count toward the Medical Out-of-Pocket Maximum.		
Contact your Pharmacy Benefit Manager for prescription drug coverage inquiries. Your Pharmacy Benefit Manager's contact information is located on your Benefit Identification Card.		

Note: This Coverage Summary is intended to be a general description of benefits only. Some limitations, conditions, or exclusions may apply. The benefits listed above are subject to change at any time. If there is a discrepancy between this overview and the Plan Document, the Plan Document will prevail. Services must be Medically Necessary treatment of Sickness or Injury, unless otherwise stated. The fact that a physician may prescribe, order, recommend or approve a service or supply does not, of itself, make it Medically Necessary even though it is not specifically listed as an exclusion. All of the facts and circumstances surrounding the claim must be considered.