

**Summary of Benefits
Medical Plan 1**

	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
MAXIMUM LIFETIME BENEFIT AMOUNT	\$1,000,000	
<p>Note: The maximums listed below are the total for Network and Non-Network expenses. For example, if a maximum of 60 days is listed twice under a service, the Benefit Period maximum is 60 days total which may be split between Network and Non-Network providers.</p>		
COPAYMENTS		
Physician visits	\$15	N/A
Urgent Care visits	\$30	N/A
Emergency Room visits	\$100	\$100
DEDUCTIBLE, PER BENEFIT PERIOD		
Per Covered Person	\$500	\$500
Per Family Unit	\$1,000	\$1,000
MAXIMUM OUT-OF-POCKET AMOUNT, PER BENEFIT PERIOD		
Per Covered Person	\$750	\$1,750
Per Family Unit	\$1,500	\$3,500
<p>The Plan will pay the designated percentage of Covered Charges until out-of-pocket amounts are reached, at which time the Plan will pay 100% of the remainder of Covered Charges for the rest of the Benefit Period unless stated otherwise.</p>		
<p>The following charges do not apply toward the out-of-pocket maximum and are never paid at 100%. Outpatient substance abuse treatment charges Inpatient substance abuse treatment charges Cost containment penalties Spinal manipulation/chiropractic charges Copayments Outpatient mental health charges Inpatient mental health charges</p>		
COVERED CHARGES		
Hospital Services		
Room and Board	90% after deductible the semiprivate room rate	70% after deductible the semiprivate room rate
Intensive Care Unit	90% after deductible Hospital's ICU Charge	70% after deductible Hospital's ICU Charge
Skilled Nursing Facility	90% after deductible the facility's semiprivate room rate within 14 days of a 3 day stay 60 days benefit period days Benefit Period maximum	70% after deductible the facility's semiprivate room rate within 14 days of a 3 day stay 60 days benefit period days Benefit Period maximum
Physician Services		
Inpatient visits	90% after deductible	70% after deductible
Office visits	100% after copayment	70% after deductible
Surgery	90% after deductible	70% after deductible
Allergy testing	90% after deductible	70% after deductible

	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
Allergy serum and injections	100% after copayment, or cost of serum, whichever is less	70% after deductible
Emergency Services		
Emergency Room	After copay plan pays 90% after deductible	After copay plan pays 70% after deductible
Urgent Care Facility	100% after copay	70% after deductible
Home Health Care	90% after deductible \$3,500 Benefit Period maximum	70% after deductible \$3,500 Benefit Period maximum
Outpatient Private Duty Nursing	90% after deductible \$5,000 Benefit Period maximum	70% after deductible \$5,000 Benefit Period maximum
Hospice Care	90% after deductible \$10,000 inpatient and outpatient Lifetime maximum	70% after deductible \$10,000 inpatient and outpatient Lifetime maximum
Bereavement Counseling	90% after deductible \$500 Lifetime maximum	70% after deductible \$500 Lifetime maximum
Ambulance Service (ground or air)	90% after deductible	70% after deductible
Occupational Therapy	90% after deductible	70% after deductible
Speech Therapy	90% after deductible	70% after deductible
Physical Therapy	90% after deductible	70% after deductible
Durable Medical Equipment	90% after deductible	70% after deductible
Prosthetics	90% after deductible	70% after deductible
Orthotics	90% after deductible	70% after deductible
Spinal Manipulation Chiropractic	90% after deductible \$20 per visit; 30 visits Benefit Period maximum	70% after deductible \$20 per visit; 30 visits Benefit Period maximum
Mental Disorders		
2 days of partial hospitalization will count as 1 inpatient day		
Inpatient	90% after deductible 30 days Benefit Period maximum 90 days Lifetime maximum	70% after deductible 30 days Benefit Period maximum 90 days Lifetime maximum
Outpatient	90% after deductible 30 visits Benefit Period maximum	70% after deductible 30 visits Benefit Period maximum
Substance Abuse		
Inpatient	90% after deductible 30 days Benefit Period maximum 90 days Lifetime maximum	70% after deductible 30 days Benefit Period maximum 90 days Lifetime maximum
Outpatient	90% after deductible; \$25 per visit limit 30 visits Benefit Period maximum	70% after deductible; \$25 per visit limit 30 visits Benefit Period maximum

Preventive Care		
Routine Well Adult Care	90% (deductible waived) \$300 Benefit Period maximum	70% after deductible \$300 Benefit Period maximum
Includes: office visits, pap smear, mammogram, prostate screening, gynecological exam, routine physical examination, x-rays and laboratory blood tests.		
Routine Mamograms	50% after deductible	50% after deductible
Frequency limits for mammogram Ages 35 to 39 1 baseline Ages 40 to 49 1 every 2 years Ages 50 and over annually		
Routine Colonoscopy	50% after deductible	50% after deductible
Routine Well Newborn Care	90% after deductible	70% after deductible
Routine Well Child Care	90% (deductible waived) \$300 Benefit Period maximum	70% after deductible \$300 Benefit Period maximum
Includes: office visits, routine physical examination, laboratory blood tests, x-rays and immunizations through age 18.		
Organ Transplants	90% after deductible \$5,000 Donor Lifetime maximum	70% after deductible \$5,000 Donor Lifetime maximum
Pregnancy	90% after deductible	70% after deductible
Dependent daughters not covered.		

PRESCRIPTION DRUG BENEFIT

Pharmacy Option

Generic Drugs

Copayment \$10

Brand Name Drugs with No Generic Alternative

Percentage payable..... 25%

Minimum..... \$20

Maximum \$40

Brand Name Drugs with Generic Alternatives

Percentage payable..... 25% plus difference between generic and brand

Mail Order Prescription Drug Option

Generic drugs

Copayment \$20

Brand Name drugs

Percentage payable..... 25%

Minimum..... \$40

Maximum \$80

CuraScript Specialty Pharmacy Program

Specialty drugs MUST be obtained directly from the CuraScript Specialty Pharmacy Program, operated by Express Scripts.

Generic Drugs

Copayment \$10

Brand Name Drugs with No Generic Alternative

Copayment \$65

Brand Name Drugs with Generic Alternatives

Copayment \$90