

ACTIVE FEE-FOR-SERVICE BENEFIT SUMMARY

The following comparison is only a summary of the major features of the Plan. Not all exclusions and limitations have been included.

Important! You must pre-certify your hospital confinements.

If you do not pre-certify your hospital stay, the hospital benefits that would usually be payable will be reduced by 10%.

COMPREHENSIVE MAJOR MEDICAL BENEFITS

Maximum Lifetime Benefit: **\$1,000,000 per person**

Co-Payment Limit: **If you use a Contracting Provider, your out-of-pocket maximum expense will be \$1000.00 per person per calendar year. If you use a Non-Contracting Provider, your out-of-pocket maximum expense will be \$3,000 per person per calendar year. When your applicable co-payment limit is reached, benefits will be paid at 100% for the balance of the calendar year (50% for extended care facility).**

**CHANGES EFFECTIVE
JANUARY 1, 2006**

ACTIVE PARTICIPANTS & DEPENDENTS

Fee-For-Service Plan (Benefits paid by the Plan)	Contracting Provider	Non-Contracting Provider
Calendar Year Deductible	\$250 per person / \$750 per family Deductible applies unless otherwise specified	\$500 per person, \$750 per family *Calendar year deductible is never waived on non-contracting provider benefits
Percentage Payable Inpatient Hospital	80% of contract rate	60% of covered charges; additional
Outpatient Hospital	80% of contract rate	60% of covered charges *Facility Maximum of \$1,500.00
Chiropractor & Acupuncture	100% of contract rate after a \$20 co-payment; up to a maximum benefit of \$2,000 per calendar year Calendar Year Deductible Does Not Apply	60% of covered charges to a maximum payment of \$2,000 per calendar year
Outpatient Therapy (Physical & Respiratory)	100% of contract rate after a \$20 co-payment; up to a maximum benefit of \$2,000 per calendar year <i>*Additional benefit for Physical Therapy only after major accident or major surgery.</i> Calendar Year Deductible Does Not Apply	60% of covered charges to a maximum payment of \$2,000 per calendar year; <i>*Additional benefit for Physical Therapy only after major accident for major surgery.</i>
Routine Physical Care, Routine Female Care,	100% of contract rate after a \$20 co-payment; up to a maximum benefit of \$300 per calendar year Calendar Year Deductible Does Not Apply	60% of covered charges after satisfaction of the calendar year deductible; \$300 per calendar year
Well Baby Care	100% of contract rate after a \$20 co-payment; up to a maximum benefit of \$600 per calendar year Calendar Year Deductible Does Not Apply	60% of covered charges after satisfaction of the calendar year deductible; \$600 per calendar year effective 1/1/2000
Ambulance	No contract provider (See non-contracting benefit)	80% of covered charges with \$500 deductible - Deductible is never waived
Anesthesia, Home Health Care, Hospital Visits, Medical Supplies, Office Visits, Orthopedic Braces, Prosthetic Appliances, Surgery, X-ray & Lab	80% of contract rate	60% of covered charges
Extended Care Facility	45% of covered charges; 55 days per period of disability; minimum 5-day inpatient hospital stay required prior to admission; must be readmitted within 7 days of discharge	35% of covered charges; 55 days per period of disability; minimum 5-day inpatient hospital stay required prior to admission; must be readmitted within 7 days of discharge
*Prescription Drug Benefit Retail Network Walk-in Generic	\$5 co-payment per prescription; 30-day supply maximum	All prescriptions must be provided through a Prescription Solutions Retail Pharmacy or a Prescription Solutions Mail Order Pharmacy to be covered.
Preferred Brand Refer to Formulary	\$20 co-payment per prescription; 30-day supply maximum. <i>Generic Availability - \$30.00 if you elect to take the brand name or physician does not allow generic substitution.</i>	
Non-Preferred Brand	\$30.00 co-payment per prescription, 30-day	

	supply maximum. <i>Generic Availability - \$40.00 if you elect to take the brand name or physician does not allow generic substitution.</i>	“ “ “ “ “ “
Mail Order Generic	\$10 co-payment per prescription; 90-day maximum.	

ACTIVE PARTICIPANTS & DEPENDENTS continued

Fee-For-Service Plan (Benefits paid by the Plan)	Contracting Provider	Non-Contracting Provider
Preferred Brand Refer to Formulary	\$20.00 co-payment per prescription; 90-day supply maximum. <i>Generic Availability - \$30.00 if you elect to take the brand name or physician does not allow generic substitution.</i>	“ “ “ “ “ “
Non-Preferred Brand (Brand name drugs not included on Formulary)	\$30.00 co-payment per prescription; 90-day supply maximum. <i>Generic Availability - \$40.00 if you elect to take the brand name or physician does not allow generic substitution.</i>	“ “ “ “ “ “
Supplemental Accident Benefit	80% of contract rate	100% of covered charges incurred within 90 days of an accident up to a maximum payment of \$400 per accident; includes \$300 Major Medical and \$100 X-ray and lab
Hearing Care (Exams)	100% of contract rate up to \$100 maximum per calendar year	100% of covered charges; up to \$100 per calendar year maximum
Hearing Aid Benefit	100% of covered charges up to a maximum payment of \$2,000 per device; 1 device per ear (once every 3 years to the date)	100% of covered charges up to a maximum payment of \$2,000 per device; 1 device per ear (once every 3 years to the date)
Mental & Nervous Disorders	Not Covered	Not Covered
Vision Benefit Vision Service Plan	\$25 deductible per 12 months; Vision exam once per 12 months; Lenses: once each 12 months; 2 nd pair glasses: for member only, \$10 deductible per 12 months	Not Covered (must use VSP or Spectera Vision Provider)
Frames	\$100 frame allowance plus lens extras; once every 24 months for member and dependents	“ “ “ “ “ “
Contact Lenses	\$90 allowance	“ “ “ “ “ “
Spectera Vision	\$10 exam and \$10 materials co-payment; Vision exam once per 12 months; Lenses: once each 12 months; 2 nd pair glasses: for member only, \$10 deductible per 12 months	“ “ “ “ “ “
Frames	\$50 frame allowance; once every 24 months for members and dependents	“ “ “ “ “ “
Contact Lenses	\$105 allowance	“ “ “ “ “ “
DENTAL BENEFIT	SEE DENTAL FEE SCHEDULE	SEE DENTAL FEE SCHEDULE

*If you are using maintenance medication and you obtain your prescriptions at a retail pharmacy instead of the mail – order program, you will be charged two times the retail co-payment on your fourth and subsequent presentations of that prescription at a retail pharmacy. If you use the mail-order program, you can receive a 90-day supply for two times the retail co-payment.

FOR ADDITIONAL INFORMATION, PLEASE CONTACT THE CLAIMS DEPARTMENT AT (800) 527-4613