

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: \$5,000,000 per person

**BENEFITS
EFFECTIVE
JANUARY 1, 2009**

Out of Pocket Maximum:

If you use a Contracting Provider, your out-of-pocket maximum expense will be \$1000.00 per person or \$3,000 per family, per calendar year. If you use a Non-Contracting Provider, your out-of-pocket maximum expense will be \$3,000 per person or \$9,000 per family, 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).

ACTIVE PARTICIPANTS & DEPENDENTS

Fee-For-Service Plan (Benefits paid by the Plan)	Contracting Provider	Non-Contracting Provider
Calendar Year Deductible	None	\$500 per person, \$1,500 per family; NEVER WAIVED
Office Visit	\$20 co-payment	60% of covered charges
Emergency Room	100% of covered charges after a \$100 co-payment	60% of covered charges
Inpatient Hospital	100% of contract rate	60% of covered charges
Outpatient Surgery	100% of contract rate	60% of covered charges Facility Maximum Benefit of \$1,500 per calendar year
Chiropractor & Acupuncture	100% of contract rate after a \$20 co-payment; up to a maximum benefit of \$2,000 per calendar year	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>	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 and Routine Female Care,	100% of contract rate after a \$20 co-payment; up to a maximum benefit of \$300 per calendar year	60% of covered charges; \$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	60% of covered charges up to a maximum benefit of \$600 per calendar year
Infertility	Not covered	Not covered
Vasectomy, Tubal Ligation, Elective Abortions	80% of contract rate; deductible does not apply	60% of covered charges; deductible applies
Ground Ambulance	No contract provider (See non-contracting benefit)	\$50 co-payment per transport
Air Ambulance	No contract provider (See non-contracting benefit)	80% of contract rate; deductible applies
Home Health Care, Medical Supplies, Orthopedic Braces, Prosthetic Appliances	80% of contract rate	60% of covered charges
Lab and X-Ray	100% after a \$20 co-payment	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
Behavioral / Mental Health	Pre-authorization required by MHN (800) 977-7962 Member and Eligible Dependent Benefit	
Inpatient Treatment	No co-payment up to 30-days	30% co-payment up to 30-days
Outpatient Treatment	\$30 (individual) \$15 (group) Maximum 30 visits per calendar year	40% of total charges Maximum 30 visits per calendar year
Chemical Dependency	Pre-authorization required by MHN (800) 977-7962 / Member Benefit Only	
Outpatient	No co-payment / 2 Episodes per lifetime	No Benefit Available Out of Network

ACTIVE PARTICIPANTS & DEPENDENTS (continued)

Fee-For-Service Plan (Benefits paid by the Plan)	Contracting Provider	Non-Contracting Provider
Inpatient	No co-payment Maximum 30-days per calendar year	No Benefit Available Out of Network
Detoxification	No co-payment / 1 Episode per calendar year Maximum benefit is \$4000 per calendar year	No Benefit Available Out of Network
*Prescription Drug Benefit Prescription Solutions (800) 797-9791		All prescriptions must be provided through a Prescription Solutions Retail Pharmacy or a Prescription Solutions Mail Order Pharmacy to be covered.
Retail Network Walk-in Generic	\$5 co-payment per prescription; 30-day supply maximum	" " " " " "
Brand Name 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>	" " " " " "
Mail Order Generic	\$10 co-payment per prescription; 90-day maximum.	" " " " " "
Brand Name 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>	" " " " " "
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)
Vision Benefit Vision Service Plan (800) 877-7195	\$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 (800) 839-3242	\$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	" " " " " "
FFS Dental Benefits United Concordia (800) 332-0366	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