

**RETIREE 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).

For more information, please contact the Claims Department at (800) 527-4613

**CHANGES EFFECTIVE JANUARY 1, 2003**

	Medicare Retirees & Dependents		Non-Medicare Retirees & Dependents	
	Contracting Provider	Non-Contracting Provider	Contracting Provider	Non-Contracting Provider
Calendar Year Ded.	\$250 per person \$750 per family	\$500 per person \$1500 per family	\$250 per person \$750 per family	\$500 per person \$1500 per family
Percentage Payable Inpatient Hospital	80% of contracted rate	60% of covered charges; additional \$500 deductible	80% of contract rate	60% of covered charges additional \$500 deductible
Outpatient Hospital	80% of contracted rate	60% of covered charges	80% of contract rate	60% of covered charges
Chiropractor & Acupuncture	80% of contract rate maximum payment of \$2000 per calendar year	60% of covered charges to a maximum payment of \$2000 per calendar year	80% of contract rate to a maximum payment of \$2000 per calendar year	60% of covered charges to a maximum payment of \$2000 per calendar year
Outpatient Therapy (Physical & Respiratory)	80% of contract rate to a maximum payment of \$2000 per calendar year	60% of covered charges to a maximum payment of \$2000 per calendar year	80% of contract rate to a maximum of \$2000 per calendar year	60% of covered charges to a maximum payment of \$2000 per calendar year
Routine Physical Care, Routine Female Care,	80% of contract rate; \$300 per calendar year " " " " "	60% of covered charges after satisfaction of the calendar year deductible	80% of contract rate \$300 per calendar year " " " " "	60% of covered charges \$300 per calendar year
Well Baby Care	80% of contract rate; \$600 per calendar year eff. 1/1/2000	60% of covered charges \$600 per calendar year eff. 1/1/2000	80% of contract rate \$600 per calendar year eff. 1/1/2000	60% of covered charges, \$600 per calendar year eff. 1/1/2000
Ambulance	No contract provider	80% of covered charges with \$500 deductible	No contract rate	80% of covered charges with \$500 deductible
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	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	40% 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	30% 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 (Prescription Solutions)				
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.	\$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.

	Medicare Retirees & Dependents			Non-Medicare Retirees & Dependents				
	Contracting Provider	Non-Contracting Provider			Contracting Provider	Non-Contracting Provider		
Preferred Brand (Refer to Formulary)	\$20 co-payment per prescription; 30-day supply maximum. <i>Generic Availability - \$30 if you elect to take the brand name or physician does not allow generic substitution</i>	All Prescriptions must be provided through a Prescription Solutions Retail Pharmacy or a Prescription Solutions Mail Order Pharmacy to be covered.			\$20 co-payment per prescription; 30-day supply maximum. <i>Generic Availability - \$30 if you elect to take the brand name or physician does not allow generic substitution</i>	All Prescriptions must be provided through a Prescription Solutions Retail Pharmacy or a Prescription Solutions Mail Order Pharmacy to be covered.		
Non-Preferred Brand (brand names drugs not included on formulary)	\$30 co-payment per prescription; 30-day supply maximum. <i>Generic Availability - \$40 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 supply maximum.	“	“	“	“	“	“	“
Preferred Brand Refer to Formulary	\$20 co-payment per prescription; 90-day supply maximum. <i>Generic Availability - \$30 if you elect to take the brand name or physician does not allow generic substitution</i>	“	“	“	“	“	“	“
Non-Preferred Brand	\$30 co-payment per prescription; 90-day supply maximum. <i>Generic Availability - \$40 if you elect to take the brand name or physician does not allow generic substitution</i>	“	“	“	“	“	“	“
Supplemental Accident Benefit	80% of contracted rate	100% of covered charges incurred within 90 days of an accident up to a maximum payment of \$400 per accident			80% of contracted rate	80% of covered charges incurred within 90 days of an accident up to a maximum payment of \$320 per accident		
HEARING CARE Exams	80% of contracted rate up to \$100	100% of covered charges; up to \$100 per calendar year			100% of covered charges; up to \$100 maximum per year	100% of covered charges; up to \$100 maximum per year		
Hearing Aid Benefit	100% of covered charges up to a maximum payment of \$2000 per device; 1 device per ear (once every 3 years to date)	100% of covered charges up to a maximum payment of \$2000 per device; 1 device per ear (once every 3 years to date)			100% of covered charges up to a maximum payment of \$2000 per device; 1 device per ear (once every 3 years to date)	100% of covered charges up to a maximum payment of \$2000 per device; 1 device per ear (once every 3 years to date)		
Mental & Nervous Disorders	Not Covered	Not Covered			Not Covered	Not Covered		
*Vision Benefit (VSP)	Vision exam once per year; Lenses: one pair every 12 months; Frames: once every 24 months (if needed)	Not Covered (must use a VSP Provider)			Vision exam once per year; Lenses: one pair every 12 months; Frames: once every 24 months (if needed)	Not Covered (must use a VSP Provider)		
*Spectera Vision	Vision exam once per year; Lenses: one pair every 12 months; Frames: once every 24 months	Not Covered (must use a Spectera Provider)			Vision exam once per year; Lenses: one pair every 12 months; Frames: once every 24 months	Not Covered (must use a Spectera Provider)		
*Must Elect at Time of Retirement								

\*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.