

OBA \$1000, \$2500, OR \$7,500 DEDUCTIBLE PPO NETWORK PROGRAM

All eligible charges under the group policy are subject to applicable coinsurance, copays, calendar year deductible and per hospital confinement deductible unless otherwise specified. Some services are subject to Utilization Review as described in this brochure. Charges must be incurred while the covered person is insured under the policy and are subject to usual and prevailing charge criteria.

Deductibles (per person)

Calendar Year Deductible (2 person limit for family)	\$1,000, \$2,500 or \$7,500
Hospital Confinement Deductible (per hospital stay)	\$500 out-of-network
Prescription Drug Deductible: (2 person limit for family per calendar year)	\$1,000 deductible plan: \$100 \$2,500 deductible plan: \$250 \$7,500 deductible plan: \$750

Plan Coinsurance (unless otherwise noted)

In-Network	80%
Out-of-Network	50%

Out-of-Pocket Maximums per Calendar Year

In-Network Out-of-Pocket	\$1,500 Individual/\$3,000 Family
Out-of-Network Out-of-Pocket	\$3,750 Individual/\$7,500 Family

(Excludes all deductibles and penalties for non-compliance with Utilization Review.)

Calendar Year Benefit Maximums

Mental/Emotional Disorder and Chemical Dependency	40 Visits Outpatient
Mental/Emotional Disorder	30 Days Inpatient
Preventative Services (except immunizations)	1 Service
Skilled Nursing Facility (semi-private or 50% of room and board for prior hospital stay)	100 Days
Attention Deficit/Hyperactivity Disorder	\$2,500
Private Duty Nursing	\$10,000
Colonoscopy Screening	\$500

Overall Benefit Maximums (certain restrictions apply)

Plan Maximum	\$ 5,000,000
Attention Deficit/Hyperactivity Disorders	\$10,000
Mental/Emotional Disorder and/or Chemical Dependency (\$50,000 maximum is waived for mental disorders for firms with more than 50 employees)	\$50,000
Mental/Emotional Disorder	50 Days Inpatient
Chemical Dependency	60 Days Inpatient
Infertility Treatment	\$2,500
Temporomandibular Joint (TMJ) Syndrome	\$2,500

Incentive Benefit

Identification of Hospital Billing Errors	50% of Total Savings Up to \$1000 Maximum/Admission
-------------------------------------------	--------------------------------------------------------

Prescription Drugs:

Requires satisfaction of calendar year prescription deductible.

Prescriptions	Participating Pharmacy	Non-Participating Pharmacy
Drug Card Prescriptions	Generic: \$5 Non-Generic: \$50	Not Covered
Mail Order Prescriptions (90 day supply)	Generic: \$10 Non-Generic: \$100	Not Covered

Benefit Highlights

Benefit	In-Network	Out-of-Network	NOTE
Physician's Office Visit (includes adult physical exams, adult immunizations, blood work-up and stress test if performed in and billed by a physician's office)	80%	50%	Deductible Applies
Hospital Room & Board	80%	50%	Semi-Private
Pap Smear, Prostate Preventive Care	80%	50%	Deductible Waived; \$65 Maximum for Prostate Care
Mammogram	100%	100%	Up to \$115; Deductible Waived
Colonoscopy (beginning at age 50)	80%	50%	Once every 5 years
Immunizations (to age 18)	100%	100%	Deductible Waived
Mental Disorders & Chemical Dependency	80%	50%	Inpatient and Outpatient
Attention Deficit/Hyperactivity Disorder	80%	50%	\$600 max per initial visit \$50 max per outpatient visit
Home Health Care	80%	50%	Up to \$100 per visit
Private Duty Nursing	80%	50%	Outpatient up to one 8 hr shift per nurse per 24 hrs
Hospice Care (Inpatient)	100%	100%	Deductible Applies
Infertility	80%	50%	
Second Surgical Opinion	80%	50%	Required for eligible transplants
Ambulance	80%	50% (\$50 copay*)	*\$150 copay if other than local service

Other Covered Expenses

Medical Services and supplies furnished by a hospital
Anesthetics and administration
Medical treatment and surgical procedures by a doctor
X-ray, lab tests and other diagnostic services
X-ray and radiation therapy
Medical supplies, blood, surgical dressings, oxygen
Rental of durable medical equipment
Artificial limbs and eyes for the initial replacement of a limb or eye lost while insured
Casts, splints, trusses, braces (non-dental), crutches
Sterilization
Child Health Supervision Services (from birth through age 18)
Newborn Circumcisions
Maternity
Occupational Therapy
Physical Therapy
Organ and Tissue Transplants
Foot Care, Vision Care, Hearing Impairments, Speech Therapy, Dental Care and Cosmetic Surgery: Benefits are limited as described in the Group Policy

Limitations and Exclusions

No benefits or limited benefits are payable for charges:
Which are not specifically provided for
Resulting from losses due to war or any action of war whether declared or undeclared
Incurred unless the insured is under the direct care of a legally qualified physician
For services or supplies for which the insured is not legally obligated to pay
In excess of the usual and prevailing charges
For services provided by volunteers or persons who do not normally charge for their services
Treatment for corns, calluses or nails of the feet, except removal of nail roots
For corrective shoe, orthotics or other corrective devices
For the reversal of male or female sterilizations
For artificial insemination; actual or attempted impregnation or fertilization which involves either an insured person or surrogate as donor or recipient
For hypnosis, except when used in lieu of anesthesia
For the donor of a transplanted organ unless not covered by donee's insurance
Which are not medically necessary for the care or treatment of an illness or injury
For dental treatment, except when required due to (1) an accidental injury if the accident occurs and treatment is rendered while the patient is insured under the plan and the treatment is begun within 90 days after the accident and the charges for such treatment are incurred within 1 year after such accident; (2) removal of cyst, leukoplakia or malignant tissue; (3) freeing of a muscle attachment or; (4) correction of a harelip, cleft palate or protruding mandible
For the purchase or fitting of eyeglasses, unless such charge is for treatment of an eye injured in an accident which occurs and treatment is rendered, while insured under this plan and the treatment is begun within 90 days of the accident and charges for such treatment are incurred within 2 years after such accident, or contact lenses, except in connection with cataract surgery
For the purchase or fitting of hearing aids.

For services or supplies furnished by the U.S. or a foreign government agency, unless otherwise prohibited by law
For voluntary abortions
For charges incurred before a person becomes insured under this plan or after the insurance has ended
For a nursing home other than a skilled nursing facility
Related to a sex change
For care, treatment, services or supplies which are experimental or investigational in nature or which are mainly provided for research or education
For inappropriate, unapproved or unnecessary care or treatment
For non-prescription or unapproved drugs or medicines except for equipment and supplies used in the treatment of diabetes
For custodial care
For the treatment of obesity
For charges which would result in benefits in excess of the \$5,000,000 plan maximum or any other overall or calendar year benefit maximum
For any limited benefits as described in this brochure or in the group policy
For cosmetic treatment or surgery** except payment will be made for cosmetic surgery or treatment due to an accident or a birth defect
Incurred as a result of any injury or sickness for which the insured would be eligible for Worker's Compensation
For a pre-existing condition for up to 12 months after the effective date if the insured did not have satisfactory proof of prior coverage
For Speech Therapy unless the charge is for (a) restoring speech loss or the correction of an impairment due to an injury or sickness if speech was normal before such injury and if such injury or sickness is not a functional disorder or (b) congenital malformation for which corrective surgery has been performed

**The group policy describes specific benefits which comply with the Omnibus Budget Bill ERISA Amendment regarding reconstructive surgery, cosmetic surgery, and prosthesis prescribed for covered mastectomy.