SUMMARY OF MEDICAL
PPO PLAN BENEFITS
FOR 2005

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	For Services Obtained In the PPO Network	*For Services Obtained Outside the PPO Network*
CALENDAR YEAR DEDUCTIBLE		
	$150 (individual) / $250 (family)	
OUT-OF-NETWORK DEDUCTIBLE		
	N/A	$300 for each hospital admission (maximum 2 for a family each calendar year)
PLAN PAYMENTS		
(The plan pays the following percentages after you meet the calendar year deductible and the out-of-network hospital deductible, where it applies.)		
Doctor's Visits	90%	70%
Hospital Expenses Outpatient	90%	80%
Chiropractic Visits - 20 Per year max, three modalities per visit	90%	70%
Emergency Accident and Emergency Medical Care	90%	90% (the hospital admission deductible does not apply)
(ENCOMPASS certification required for the following services. Call 1-800-373-3727.)		
Inpatient Hospital Expenses	90%	60%
Outpatient Occupational and Speech Therapy	90%	70%
Prosthetic Devices and Durable Medical Equipment (DME)	90%	
Ambulance Transportation Between Hospitals	90%	
Infertility Treatment	90%	
Skilled Nursing Facility	90%	
Skilled Home Health Care and Hospice Care	90%	
MENTAL HEALTH AND SUBSTANCE ABUSE TREATMENT		
(ENCOMPASS certification required for the following services. Call 1-800-373-3727.)		
Inpatient Mental Health	90%	60%
Inpatient Substance Abuse* 1st course of treatment	90%	75%**
2nd course of treatment	80%**	60%**
Subsequent treatments	50%**	0%**
Outpatient Mental Health and Substance Abuse	80% of $100 maximum covered expense for a session; only 7 sessions will be covered if treatment is not certified; maximum covered expense is $5,000 a year	
MENTAL HEALTH AND SUBSTANCE ABUSE TREATMENT MAXIMUM COVERED EXPENSE		
Individual (annual)	$ 37,500	
Individual (lifetime)	$250,000	
Family (lifetime)	$500,000	

PRESCRIPTION DRUGS

Retail (short term medication)
Purchased at a participating pharmacy
34-Day Supply or 100 Units
(whichever is less)

Generic: $10.00 co-pay (effective 1/1/03)

*Brand Name (Formulary): $20 co-pay (effective 1/1/01)
*Brand Name (Non-Formulary): $35 (effective 1/1/03)
(*If the member chooses brand when a generic is available, member pays the cost difference between the brand and the generic drug **PLUS** the generic co-pay)

Mail Order
(Long-term medication for chronic conditions)
90 day supply

	Formulary	Non-Formulary
Generic	$5	$10
*Brand	$15	$20

(*If the member chooses brand when a generic is available, member pays the cost difference between the brand name and the generic drug **PLUS** the generic co-pay)

	For Services Obtained In the PPO Network	*For Services Obtained Outside the PPO Network*
OUT-OF-POCKET LIMIT		
(each calendar year; cannot be combined) (does not include prescription co-pays)	$1,000 (individual) $2,000 (family)	$3,500 (individual) $7,000 (family)
MAXIMUM LIFETIME		
(includes separate mental health and substance abuse treatment maximum benefits)	$1.5 million	

* A new course of treatment begins when 30 or more days have passed during which no treatment was received and is determined over the entire period of time you are covered by the plan.
** Your share of these expenses does NOT count toward the out-of-pocket limit.
This is a summary of material modifications. The terms of the plan document and any subsequent summary material modifications control.
Revised 01/05