PRODUCT	$1500/$3000 Platinum	$2500/$5000 Gold	$3500/$7000 Silver
BENEFIT PERIOD	06/01 - 5/31	06/01 - 5/31	06/01 - 5/31
MAXIUMUM ANNUAL BENEFIT AMOUNT	UNLIMITED	UNLIMITED	UNLIMITED
ALL BENEFITS PAYABLE UNDER THIS PLAN ARE SUBJECT TO THE APPLICABLE PLAN. EXCLUSIONS AND PROCEDURE BASED MAXIMUM EXPENSE			
PER COVERED PERSON (NETWORK)	$1,500	$2,500	$3,500
PER COVERED PERSON (NON-NETWORK)	$3,000	$5,000	$7,000
PER FAMILY UNIT (NETWORK)	$3,000	$5,000	$7,000
PER FAMILY UNIT (NON-NETWORK)	$6,000	$10,000	$14,000
NETWORK MAXIMUM OUT-OF-POCKET AMOUNT, PER PLAN YEAR (INCLUDES DEDUCTIBLE, COINSURANCE & COPAYMENTS)	PER COVERED PERSON $7350 PER FAMILY UNIT $14,700	PER COVERED PERSON $7350 PER FAMILY UNIT $14,700	PER COVERED PERSON $7350 PER FAMILY UNIT $14,700
NON-NETWORK MAXIMUM OUT-OF-POCKET AMOUNT, PER PLAN YEAR (INCLUDES DEDUCTIBLE, COINSURANCE & COPAYMENTS)	PER COVERED PERSON $20,000 PER FAMILY UNIT $40,000	PER COVERED PERSON $20,000 PER FAMILY UNIT $40,000	PER COVERED PERSON $20,000 PER FAMILY UNIT $40,000
COPAYMENTS			
Primary Care Physician office visits	$25 per visit	$25 per visit	$25 per visit
Specialist office visits	$40 per visit	$40 per visit	$45 per visit
Physical & Occupational Therapy	$40 per visit	$40 per visit	$45 per visit
Speech Therapy	$40 per visit	$40 per visit	$45 per visit
Cardiac Rehabilitation	$40 per visit	$40 per visit	$45 per visit
Outpatient Mental Health/Substance Abuse	$25 per visit	$25 per visit	$25 per visit
Prenatal/Postnatal Office Visits	$25 per visit	$25 per visit	$25 per visit
Spinal Manipulation Chiropractic	$40 per visit	$40 per visit	$45 per visit
Routine Vision Exam (One per year)	$40 Copay	$40 Copay	$45 Copay
Urgent Care	$60 per visit	$60 per visit	$60 per visit
PREVENTIVE SERVICES			
ANNUAL ADULT PHYSICAL	100% OF ALLOWABLE	100% OF ALLOWABLE	100% OF ALLOWABLE
ADULT IMMUNIZATIONS: FLU VACCINE, PNEUMONIA VACCINE, TETANUS/DIPTHERIA	100% OF ALLOWABLE	100% OF ALLOWABLE	100% OF ALLOWABLE
MAMMORGRAM	100% OF ALLOWABLE	100% OF ALLOWABLE	100% OF ALLOWABLE
GYNECOLOGICAL SERVICES	100% OF ALLOWABLE	100% OF ALLOWABLE	100% OF ALLOWABLE
ROUTINE COLONOSCOPY	100% OF ALLOWABLE	100% OF ALLOWABLE	100% OF ALLOWABLE
WELL CHILD CARE/NEWBORN CARE	100% OF ALLOWABLE	100% OF ALLOWABLE	100% OF ALLOWABLE
PHYSICIAN SERVICES: PERFORMED AND BILLED IN OFFICE			
NETWORK: Primary Care Physician Office visits (Includes: All services billed and performed by the physician except surgery, anesthesia, MRI/CT/PET/ SPECT/MRA) (Includes Family practice, General Practitioner, Internist, Pediatrician, OB/GYN, Physician Assistant, or Nurse Practitioner)	100%, AFTER COPAY, SUBJECT TO PLAN ALLOWABLE	100%, AFTER COPAY, SUBJECT TO PLAN ALLOWABLE	100%, AFTER COPAY, SUBJECT TO PLAN ALLOWABLE

PRODUCT	$1500/$3000 Platinum	$2500/$5000 Gold	$3500/$7000 Silver
NON-NETWORK: Primary Care Physician Office visits (Includes: All services billed and performed by the physician except surgery, anesthesia, MRI/CT/PET/ SPECT/MRA) (Includes Family practice, General Practitioner, Internist, Pediatrician, OB/GYN, Physician Assistant, or Nurse Practitioner)	60%, AFTER NON-NETWORK DEDUCTIBLE	60%, AFTER NON-NETWORK DEDUCTIBLE	60%, AFTER NON-NETWORK DEDUCTIBLE
NETWORK: Specialist office visits (Includes: All services billed and performed by the physician except surgery, anesthesia, MRI/CT/PET/ SPECT/MRA, chemotherapy, radiation, and dialysis)	100%, AFTER COPAY, SUBJECT TO PLAN ALLOWABLE	100%, AFTER COPAY, SUBJECT TO PLAN ALLOWABLE	100%, AFTER COPAY, SUBJECT TO PLAN ALLOWABLE
NON-NETWORK: Specialist office visits (Includes: All services billed and performed by the physician except surgery, anesthesia, MRI/CT/PET/ SPECT/MRA, chemotherapy, radiation, and dialysis)	60%, AFTER NON-NETWORK DEDUCTIBLE	60%, AFTER NON-NETWORK DEDUCTIBLE	60%, AFTER NON-NETWORK DEDUCTIBLE
TELEMEDICINE-GENERAL MED	$5 Copay	$5 Copay	$5 Copay
TELEMEDICINE-BEHAVIORAL HEALTH	$25 Copay	$25 Copay	$25 Copay
TELEMEDICINE-DERMATOLOGY	$40 Copay	$40 Copay	$45 Copay
OUTPATIENT SERVICES WHEN PERFORMED AND BILLED IN AN OUTPATIENT FACILITY			
DIAGNOSTIC TESTING (LAB, X-RAY)	80%, AFTER DEDUCTIBLE, SUBJECT TO PLAN ALLOWABLE	80%, AFTER DEDUCTIBLE, SUBJECT TO PLAN ALLOWABLE	80%, AFTER DEDUCTIBLE, SUBJECT TO PLAN ALLOWABLE
COMPLEX DIAGNOSTIC SERVICES (CT SCAN, MRI, ULTRA SOUND, PET & NUCLEAR MEDICINE)	80%, AFTER DEDUCTIBLE, SUBJECT TO PLAN ALLOWABLE	80%, AFTER DEDUCTIBLE, SUBJECT TO PLAN ALLOWABLE	80%, AFTER DEDUCTIBLE, SUBJECT TO PLAN ALLOWABLE
SURGICAL SERVICES (PROCEDURES & ANESTHESIA)	80%, AFTER DEDUCTIBLE, SUBJECT TO PLAN ALLOWABLE	80%, AFTER DEDUCTIBLE, SUBJECT TO PLAN ALLOWABLE	80%, AFTER DEDUCTIBLE, SUBJECT TO PLAN ALLOWABLE
EMERGENCY/URGENT CARE			
URGENT CARE IN A URGENT CARE FACILTIY	100%, AFTER COPAY, SUBJECT TO PLAN ALLOWABLE	100%, AFTER COPAY, SUBJECT TO PLAN ALLOWABLE	100%, AFTER COPAY, SUBJECT TO PLAN ALLOWABLE
EMERGENCY ROOM SERVICES	80%, AFTER DEDUCTIBLE, SUBJECT TO PLAN ALLOWABLE	80%, AFTER DEDUCTIBLE, SUBJECT TO PLAN ALLOWABLE	80%, AFTER DEDUCTIBLE, SUBJECT TO PLAN ALLOWABLE
EMERGENCY AMBULANCE SERVICES-GROUND/AIR AMBULANCE	80% AFTER DEDUCTIBLE, SUBJECT TO PLAN ALLOWABLE	80% AFTER DEDUCTIBLE, SUBJECT TO PLAN ALLOWABLE	80% AFTER DEDUCTIBLE, SUBJECT TO PLAN ALLOWABLE
INPATIENT HOSPITAL SERVICES			

PRODUCT	$1500/$3000 Platinum	$2500/$5000 Gold	$3500/$7000 Silver
ROOM AND BOARD Paid at the Facility's Semi-Private room rate	80% AFTER DEDUCTIBLE, SUBJECT TO PLAN ALLOWABLE	80% AFTER DEDUCTIBLE, SUBJECT TO PLAN ALLOWABLE	80% AFTER DEDUCTIBLE, SUBJECT TO PLAN ALLOWABLE
INTENSIVE CARE UNIT Paid at the facility's semi-private room rate	80% AFTER DEDUCTIBLE, SUBJECT TO PLAN ALLOWABLE	80% AFTER DEDUCTIBLE, SUBJECT TO PLAN ALLOWABLE	80% AFTER DEDUCTIBLE, SUBJECT TO PLAN ALLOWABLE
MATERNITY SERVICES:			
Room and Board charges limited to semi-private room rate Dependent daughter pregnancy is not covered	80% AFTER DEDUCTIBLE, SUBJECT TO PLAN ALLOWABLE	80% AFTER DEDUCTIBLE, SUBJECT TO PLAN ALLOWABLE	80% AFTER DEDUCTIBLE, SUBJECT TO PLAN ALLOWABLE
THERAPIES			
PHYSCIAL & OCCUPATIONAL THERAPIES LIMITED TO 20 VISITS COMBINED PER BENEFIT PERIOD	100% AFTER COPAYMENT, SUBJECT TO PLAN ALLOWABLE	100% AFTER COPAYMENT, SUBJECT TO PLAN ALLOWABLE	100% AFTER COPAYMENT, SUBJECT TO PLAN ALLOWABLE
SPEECH THERAPY (LIMITED TO 20 VISITS PER BENEFIT PERIOD)	100% AFTER COPAYMENT, SUBJECT TO PLAN ALLOWABLE	100% AFTER COPAYMENT, SUBJECT TO PLAN ALLOWABLE	100% AFTER COPAYMENT, SUBJECT TO PLAN ALLOWABLE
CARDIAC REHABILITATION THERAPY (LIMITED TO 36 VISITS PER THERAPY , PER BENEFIT PERIOD	100% AFTER COPAYMENT, SUBJECT TO PLAN ALLOWABLE	100% AFTER COPAYMENT, SUBJECT TO PLAN ALLOWABLE	100% AFTER COPAYMENT, SUBJECT TO PLAN ALLOWABLE
CHIROPRACTIC SERVICES/SPINAL MANIPULATION (LIMITED TO 20 VISITS PER BENEFIT PERIOD)	100% AFTER COPAYMENT, SUBJECT TO PLAN ALLOWABLE	100% AFTER COPAYMENT, SUBJECT TO PLAN ALLOWABLE	100% AFTER COPAYMENT, SUBJECT TO PLAN ALLOWABLE
MENTAL HEALTH CARE SERVICES (SUBJECT TO GROUP SIZE AND REGULATRORY REQUIREMENTS (SEE PLAN DOCUMENT)			
INPATIENT/PARTIAL HOSPITALIZATION MENTAL HEALTHCARE SERVICES Paid at the facility's semi-private room rate.	80% AFTER DEDUCTIBLE, SUBJECT TO PLAN ALLOWABLE	80% AFTER DEDUCTIBLE, SUBJECT TO PLAN ALLOWABLE	80% AFTER DEDUCTIBLE, SUBJECT TO PLAN ALLOWABLE
OUTPATIENT MENTAL HEALTHCARE SERVICES	80% AFTER DEDUCTIBLE, SUBJECT TO PLAN ALLOWABLE	80% AFTER DEDUCTIBLE, SUBJECT TO PLAN ALLOWABLE	80% AFTER DEDUCTIBLE, SUBJECT TO PLAN ALLOWABLE
SUBSTANCE ABUSE SERVICES: SUBJECT TO GROUP SIZE AND REGULATORY REQUIREMENTS (SEE PLAN DOCUMENT FOR DETAILS)			
SUBSTANCE ABUSE REHABILITATION-INPATIENT Paid at the facility's semi-private room rate.	80% AFTER DEDUCTIBLE, SUBJECT TO PLAN ALLOWABLE	80% AFTER DEDUCTIBLE, SUBJECT TO PLAN ALLOWABLE	80% AFTER DEDUCTIBLE, SUBJECT TO PLAN ALLOWABLE
SUBSTANCE ABUSE REHABILITATION-OUTPATIENT	100% AFTER COPAY, SUBJECT TO PLAN ALLOWABLE	100% AFTER COPAY, SUBJECT TO PLAN ALLOWABLE	100% AFTER COPAY, SUBJECT TO PLAN ALLOWABLE
OTHER SERVICES			
HOME HEALTH CARE (60 VISITS PER BENEFIT PERIOD)	80%, AFTER DEDUCTIBLE, SUBJECT TO PLAN ALLOWABLE	80%, AFTER DEDUCTIBLE, SUBJECT TO PLAN ALLOWABLE	80%, AFTER DEDUCTIBLE, SUBJECT TO PLAN ALLOWABLE
HOSPICE CARE-RESIDENTIAL/FACILITY	80%, AFTER DEDUCTIBLE, SUBJECT TO PLAN ALLOWABLE	80%, AFTER DEDUCTIBLE, SUBJECT TO PLAN ALLOWABLE	80%, AFTER DEDUCTIBLE, SUBJECT TO PLAN ALLOWABLE

PRODUCT	$1500/$3000 Platinum	$2500/$5000 Gold	$3500/$7000 Silver
SKILLED NURSING CARE (PAID AT FACILITY'S SEMI-PRIVATE ROOM RATE AND LIMITED TO 60 DAYS PER BENEFIT PERIOD MAXIMUM)	80%, AFTER DEDUCTIBLE, SUBJECT TO PLAN ALLOWABLE	80%, AFTER DEDUCTIBLE, SUBJECT TO PLAN ALLOWABLE	80%, AFTER DEDUCTIBLE, SUBJECT TO PLAN ALLOWABLE
DURABLE MEDICAL EQUIPMENT (DME): (Limited to 12 month rental or purchase price,whichever is less)	80%, AFTER DEDUCTIBLE, SUBJECT TO PLAN ALLOWABLE	80%, AFTER DEDUCTIBLE, SUBJECT TO PLAN ALLOWABLE	80%, AFTER DEDUCTIBLE, SUBJECT TO PLAN ALLOWABLE
PROSTHETICS AND ORTHOTIC DEVICES Max amount of $6500 per member/per plan year	80%, AFTER DEDUCTIBLE, SUBJECT TO PLAN ALLOWABLE	80%, AFTER DEDUCTIBLE, SUBJECT TO PLAN ALLOWABLE	80%, AFTER DEDUCTIBLE, SUBJECT TO PLAN ALLOWABLE
ALL OTHER COVERED CHARGES	80%, AFTER DEDUCTIBLE, SUBJECT TO PLAN ALLOWABLE	80%, AFTER DEDUCTIBLE, SUBJECT TO PLAN ALLOWABLE	80%, AFTER DEDUCTIBLE, SUBJECT TO PLAN ALLOWABLE
PLAN FEATURES			
PRECERTIFICATION	PREAUTHORIZATION IS A CLINICAL PROGRAM IN WHICH OUR NURSES WORK WITH PHYSICIANS TO APPROVE AND MONITOR CERTAIN HEALTH CARE SERVICES. THE PURPOSE OF PREAUTHORIZATION IS TO ENSURE ALL MEMBERS RECEIVE MEDICALLY APPROPRIATE **PRECERTIFICATION IS REQUIRED FOR: Hospitalizations Inpatient Substance Abuse/Mental Disorder treatments Skilled Nursing Facility stays Home Health Care Hospice Care Durable Medical Equipment >$500 Physical, speech and/or occupational therapy Cardiac rehabilitation therapy Outpatient surgical procedures (other than the physician's office) MRI/MRA/CAT/PET scans Observation > 23 hours Chemotherapy / Radiation therapy Organ transplant		
RX BENEFIT HIGHLIGHTS			
RX COMPANY	Medalist RX		
PHONE#	855-633-2579		
WEBSITE	www.medalistrx.com		
RX COPAYMENTS			
RETAIL PHARMACY COPAYMENTS (30 DAY SUPPLY)	GENERIC-$10 COPAYMENT	GENERIC-$10 COPAYMENT	GENERIC-$10 COPAYMENT
	BRAND NAME FORMULARY -$45 COPAYMENT	BRAND NAME FORMULARY -$45 COPAYMENT	BRAND NAME FORMULARY -$45 COPAYMENT
	NON-PREFERRED BRAND COPAYMENT - $85	NON-PREFERRED BRAND COPAYMENT - $85	NON-PREFERRED BRAND COPAYMENT - $100
MAIL ORDER OR RETAIL PHARMACY COPAYMENTS (90 DAY SUPPLY)	GENERIC-$30 COPAYMENT	GENERIC-$30 COPAYMENT	GENERIC-$30 COPAYMENT
	BRAND NAME FORMULARY -$90 COPAYMENT	BRAND NAME FORMULARY -$90 COPAYMENT	BRAND NAME FORMULARY -$90 COPAYMENT
	NON-PREFERRED BRAND COPAYMENT - $150	NON-PREFERRED BRAND COPAYMENT - $150	NON-PREFERRED BRAND COPAYMENT - $150

**NON-PARTICIPATING PHARMACIES ARE NOT COVERED. ALL SPECIALITY MEDS MUST GO THROUGH FOUNDATIONAL ASSISTANCE AND INTERNATIONAL

THIS ILLUSTRATION DESCRIBES THE PLAN IN AN EASILY UNDERSTOOD MANNER AND IS PRESENTED AS A MATTER OF GENERAL INFORMATION ONLY. THE CONTENTS ARE NOT TO BE ACCEPTED OR CONSTRUED AS A SUBSTITUTE FOR THE PROVISIONS OF THE PLAN DOCUMENT OR SUMMARY PLAN DESCRIPTION, WHICH CONTAINS MORE EXACT TERMS AND DETAILED PROVISIONSOF THE PLAN; AND IT, IS NOT TO BE CONSIDERED A POLICY OF INSURANCE