PRODUCT	$5000/$10,000 Bronze	$7,350/$14,700 Copper	$5,000/$10,000 HSA'
CLASS	VALUE	VALUE	VALUE
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)	$5,000	$7,350	$5,000
PER COVERED PERSON (NON-NETWORK)	$10,000	$20,000	$10,000
PER FAMILY UNIT (NETWORK)	$10,000	$14,700	$10,000
PER FAMILY UNIT (NON-NETWORK)	$20,000	$40,000	$20,000
NETWORK MAXIMUM OUT-OF-POCKET AMOUNT, PER CALENDAR 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 $6,550 PER FAMILY UNIT $13,100
NON-NETWORK MAXIMUM OUT-OF-POCKET AMOUNT, PER CALENDAR 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 (Family and General Practioner, and Internist)	$25 per visit	$25 per visit	80% After Deductible
Specialist office visits	$45 per visit	$45 per visit	80% After Deductible
Physical & Occupational Therapy	$45 per visit	$50 per visit	80% After Deductible
Speech Therapy	$45 per visit	$50 per visit	80% After Deductible
Cardiac Rehabilitation	$45 per visit	$50 per visit	80% After Deductible
Outpatient Mental Health/Substance Abuse	$25 per visit	$25 per visit	80% After Deductible
Prenatal/Postnatal Office Visits	$45 per visit	$50 per visit	80% After Deductible
Spinal Manipulation Chiropractic	$45 per visit	$50 per visit	80% After Deductible
Routine Vision Exam (One per year)	100% after Deductible, Subject to plan allowable	100% after Deductible, Subject to plan allowable	80% After Deductible
Urgent Care	$60 per visit	$60 per visit	80% After Deductible
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)	80%, AFTER DEDUCTIBLE, SUBJECT TO PLAN ALLOWABLE	100% AFTER COPAYMENT	80% After Deductible, Subject to Plan Allowable
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% of allowable fee after non-network deductible.	60% of allowable fee after non-network deductible.	60% After Deductible, Subject to Plan Allowable
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)	80%, AFTER DEDUCTIBLE, SUBJECT TO PLAN ALLOWABLE	100% AFTER COPAYMENT	80% After Deductible, 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% of allowable fee after non-network deductible.	60% of allowable fee after non-network deductible.	60% After Deductible, Subject to Plan Allowable
TELEMEDICINE-TELEDOC	100%	100%	100%

OUTPATIENT SERVICES WHEN PERFORMED AND BILLED IN AN OUTPATIENT FACILITY			
DIAGNOSTIC TESTING (LAB, X-RAY)	80%, AFTER DEDUCTIBLE, SUBJECT TO PLAN ALLOWABLE	100%, 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	100%, AFTER DEDUCTIBLE, SUBJECT TO PLAN ALLOWABLE	80% After Deductible, Subject to Plan Allowable
SURGICAL SERVICES (PROCEDURES & ANESTHESIA)	80%, AFTER DEDUCTIBLE, SUBJECT TO PLAN ALLOWABLE	100%, AFTER DEDUCTIBLE, SUBJECT TO PLAN ALLOWABLE	80% After Deductible, Subject to Plan Allowable
EMERGENCY/URGENT CARE			
URGENT CARE IN A URGENT CARE FACILTIY	80%, AFTER DEDUCTIBLE, SUBJECT TO PLAN ALLOWABLE	100% AFTER COPAYMENT, SUBJECT TO PLAN ALLOWABLE	80% AFTER COPAYMENT, SUBJECT TO PLAN ALLOWABLE
EMERGENCY ROOM SERVICES	80%, AFTER DEDUCTIBLE, SUBJECT TO PLAN ALLOWABLE PROFESSIONAL FEES: 80% AFTER DEDUCTIBLE, SUBJECT TO PLAN ALLOWABLE.	100% OF PLAN ALLOWABLE, DEDUCTIBLE DOES NOT APPLY. PROFESSIONAL FEES: 100% AFTER DEDUCTIBLE, SUBJECT TO PLAN ALLOWABLE.	80% AFTER COPAYMENT, SUBJECT TO PLAN ALLOWABLE
EMERGENCY AMBULANCE SERVICES-GROUND/AIR AMBULANCE	80% AFTER DEDUCTIBLE, SUBJECT TO PLAN ALLOWABLE	100% AFTER DEDUCTIBLE, SUBJECT TO PLAN ALLOWABLE	80% AFTER COPAYMENT, SUBJECT TO PLAN ALLOWABLE
INPATIENT HOSPITAL SERVICES			
ROOM AND BOARD	Facility: 80% of plan allowable, deductible does not apply Professional Fees: 80% after deductible, subject to plan allowable.	Facility: 100% of plan allowable, deductible does not apply Professional Fees: 100% after deductible, subject to plan allowable.	80% After Deductible, Subject to Plan Allowable Paid at the Facility's Semi-Private room rate
INTENSIVE CARE UNIT	Facility: 80% of plan allowable, deductible does not apply Professional Fees: 80% after deductible, subject to plan allowable.	Facility: 100% of plan allowable, deductible does not apply Professional Fees: 100% after deductible, subject to plan allowable.	80% After Deductible, Subject to Plan Allowable Paid at Hospital ICU Charge
MATERNITY SERVICES:			
(Room and Board charges limited to semi-private room rate) (Dependent daughter pregnancy is not covered)	Facility: 80% of plan allowable, deductible does not apply Professional Fees: 80% after deductible, subject to plan allowable.	Facility: 100% of plan allowable, deductible does not apply Professional Fees: 100% 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	80% After Deductible, 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	80% After Deductible, 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	80% After Deductible, 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	80% After Deductible, Subject to Plan Allowable

MENTAL HEALTH CARE SERVICES (SUBJECT TO GROUP SIZE AND REGULATRORY REQUIREMENTS (SEE PLAN DOCUMENT)			
INPATIENT/PARTIAL HOSPITALIZATION MENTAL HEALTHCARE SERVICES	Facility: 80% of plan allowable, deductible does not apply Professional Fees: 80% after deductible, subject to plan allowable. Paid at the facility's semi-private room rate.	Facility: 100% of plan allowable, deductible does not apply Professional Fees: 100% after deductible, subject to plan allowable. Paid at the facility's semi-private room rate.	80% After Deductible, Subject to Plan Allowable Paid at facility's semi-private room rate
OUTPATIENT MENTAL HEALTHCARE SERVICES	100% after copayment, subject to plan allowable.	100% after copayment, 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	Facility: 80% of plan allowable, deductible does not apply Professional Fees: 80% after deductible, subject to plan allowable. Paid at the facility's semi-private room rate.	Facility: 100% of plan allowable, deductible does not apply Professional Fees: 100% after deductible, subject to plan allowable. Paid at the facility's semi-private room rate.	80% After Deductible, Subject to Plan Allowable Paid at the facility's semi-private room rate.
SUBSTANCE ABUSE REHABILITATION-OUTPATIENT	100% after copayment, subject to plan allowable.	100% after copayment, subject to plan allowable.	80% After Deductible, Subject to Plan Allowable
OTHER SERVICES			
HOME HEALTH CARE (60 VISITS PER BENEFIT PERIOD)	80%, AFTER DEDUCTIBLE, SUBJECT TO PLAN ALLOWABLE	100%, AFTER DEDUCTIBLE, SUBJECT TO PLAN ALLOWABLE	80% After Deductible, Subject to Plan Allowable
HOSPICE CARE-RESIDENTIAL/FACILITY	80%, AFTER DEDUCTIBLE, SUBJECT TO PLAN ALLOWABLE	100%, AFTER DEDUCTIBLE, SUBJECT TO PLAN ALLOWABLE	80% After Deductible, Subject to Plan Allowable
SKILLED NURSING CARE (PAID AT FACILITY'S SEMI-PRIVATE ROOM RATE AND LIMITED TO 60 DAYS PER BENEFIT PERIOD MAXIMUM)	Facility: 80% of plan allowable, deductible does not apply Professional Fees: 80% after deductible, subject to plan allowable.	Facility: 100% of plan allowable, deductible does not apply Professional Fees: 100% 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	100%, AFTER DEDUCTIBLE, SUBJECT TO PLAN ALLOWABLE	80% After Deductible, Subject to Plan Allowable
PROSTHETICS AND ORTHOTIC DEVICES	80%, AFTER DEDUCTIBLE, SUBJECT TO PLAN ALLOWABLE	100%, AFTER DEDUCTIBLE, SUBJECT TO PLAN ALLOWABLE	80% After Deductible, Subject to Plan Allowable
ALL OTHER COVERED CHARGES	Facility: 80% of plan allowable, deductible does not apply Professional Fees: 80% after deductible, subject to plan allowable.	Facility: 100% of plan allowable, deductible does not apply Professional Fees: 100% after deductible, subject to plan allowable.	80% After Deductible, Subject to Plan Allowable

PLAN FEATURES

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 TREATMENT TO MEET THEIR INDIVIDUAL NEEDS.PLEASE SEE PLAN DOCUMENT FOR A COMPLETE LIST OF ALL SERVICES THAT REQUIRE PRECERTIFICATION UNDER YOUR PLAN. A PENALTY MAY APPLY FOR NOT OBTAINING PRECERTIFICATION**

**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
Sleep Studies
Dialysis
Prosthetics

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-80% coinsurance after deductible	GENERIC-80% coinsurance after deductible
	BRAND NAME FORMULARY -$45 COPAYMENT	BRAND NAME FORMULARY -80% coinsurance after deductible	BRAND NAME FORMULARY -80% coinsurance after deductible
	NON-PREFERRED BRAND COPAYMENT -$100	BRAND NAME NON FORMULARY-80% coinsurance after deductible	BRAND NAME NON FORMULARY-80% coinsurance after deductible
MAIL ORDER OR RETAIL PHARMACY COPAYMENTS (90 DAY SUPPLY)	GENERIC-$30 COPAYMENT	GENERIC-80% coinsurance after deductible	GENERIC-80% coinsurance after deductible
	BRAND NAME FORMULARY -$90 COPAYMENT	BRAND NAME FORMULARY -80% coinsurance after deductible	BRAND NAME FORMULARY -80% coinsurance after deductible
	NON-PREFERRED BRAND COPAYMENT -$150	BRAND NAME NON FORMULARY-80% coinsurance after deductible	BRAND NAME NON FORMULARY-80% coinsurance after deductible

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

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