

## SUMMARY OF MEDICAL BENEFITS Plan 551

Deductible Per Person Per Calendar Year Per Family Per Calendar Year Per Hospital Confinement	\$500 \$1,000 First Day Room and Board (not to exceed the semi-private room rate)*
Reimbursement Percentage	85% PPO and Out-of-Area 65% Non-PPO**
Annual Out-of-Pocket Maximum Per Family Per Calendar Year 90% 100%	\$2,600 including deductibles \$5,200 including deductibles
Prescription Drug Benefit Retail Maximum Amount Dispensed Generic Copay Brand Copay (generic not available) Brand Copay (generic available) Mail Order Maximum Quantity Dispensed Generic Copay Brand Copay (generic not available) Brand Copay (generic available) Out-of-Pocket Limit*** Per Person Per Calendar Year Per Family Per Calendar Year	30-day supply \$15 \$35 Not covered 90-day supply \$30 \$70 Not covered \$750 \$1,500
Lifetime Maximum Benefit	Unlimited
Home Health Care Limit Per Person Per Calendar Year	130 visits

\*The per confinement deductible will be reduced 50% if confined in a preferred provider facility.

\*\*For non-PPO services, a 20% reduction in reimbursement rates is applied to the first \$50,000 in covered charges. The reduction is not applied to the out-of-pocket limit. For the Anchorage hospital PPO, the covered charges will not exceed the contracted rate at the PPO facility.

\*\*\*Does not include brand-name prescriptions obtained when a generic is available. Does not include prescriptions obtained from a non-participating pharmacy.

Hospice Care Maximum Payable Per Day Lifetime Maximum Benefit	\$60 \$10,000 Per Person
Skilled Nursing Care	120 days per calendar year for confinement due to the same or related injury or illness
Physical Exam Maximum Benefit Per Calendar Year	\$500 Per Person
Treatment of Alcohol/Drug Abuse Reimbursement Percentage 1st Course of Care  2nd Course of Care  Subsequent Courses of Care Maximum Benefit Per Person Per 2 Consecutive Calendar Years Lifetime	85% PPO / 65% Non-PPO* provided the physician-recommended course of care is completed 50%** PPO / 30% Non-PPO* provided the physician-recommended course of care is completed No coverage  \$8,300  \$16,600
Mental/Nervous Treatment Inpatient Reimbursement Percentage Maximum Inpatient Days Covered Per Person Per Calendar Year Physician Charges Outpatient Reimbursement Percentage Maximum Visits Covered Per Person Per Calendar Year	85% PPO / 65% Non-PPO* 30  50%**  50%** 24

\*For non-PPO services, a 20% reduction in reimbursement rates is applied to the first \$50,000 in covered charges. The reduction is not applied to the out-of-pocket limit. For the Anchorage hospital PPO, the covered charges will not exceed the contracted rate at the PPO facility.

\*\*The reimbursement percentage remains at 50% after the out-of-pocket maximum has been reached.

Gastric Bypass Treatment Maximum allowable hospital charge for the gastric bypass procedure (effective 4/1/03) Lifetime Maximum Benefit* per Person	Facility rate at the Anchorage Preferred Provider  \$50,000
Spinal Therapy** Maximum Covered Visits Per Person Per Calendar Year Maximum Covered Charge Per Visit (effective 4/1/03) Maximum X-ray Exam Benefit Per Person Per Calendar Year	24 Visits  \$125  \$100
Mechanized Spinal Distraction Therapy Maximum Covered Charge Maximum Lifetime Benefit Per Person	 \$175 Per Session 20 Sessions
SAD Lights Lifetime Maximum Benefit	 \$200 Per Family
Infertility Treatment Lifetime Maximum Benefit	 \$12,000 Per Person
Hearing Aid Benefits Reimbursement Percentage Maximum Benefit Per Person	 80% \$500 every 3 calendar years

\*Includes the gastric bypass procedure and all related costs, as well as complications and future procedures, including but not limited to panniculectomies.

\*\*Limitations apply to all services, including chiropractic therapy and manipulations, physical therapy, occupational therapy and all x-rays and labs.

## HEARING AID BENEFITS

The Plan will pay for Covered Charges for a hearing evaluation examination and a hearing aid device according to the Summary of Medical Benefits.

In order to receive a hearing aid benefit, you must be examined by a Physician before obtaining a hearing aid and obtain a written certification from the examining Physician that you are suffering from a hearing loss that may be lessened by the use of a hearing aid. Benefits will not be provided without this certification.

Benefits will be provided for:

- an otologic examination by a Physician or surgeon; and
- an audiologic examination and hearing evaluation by a certified or licensed audiologist including a follow up consultation; and
- the hearing aid (monaural or binaural) prescribed as a result of such examination, which shall include:
  - (1) ear molds,
  - (2) the hearing aid instrument,
  - (3) initial batteries, cords and other necessary ancillary equipment,
  - (4) a warranty, and
  - (5) follow up consultation within thirty days following delivery of the hearing aids.

Benefits Payments will not be made for:

- the replacement of a hearing aid for any reason more than once in a period of three consecutive years; or
- batteries or other ancillary equipment other than that obtained upon purchase of the hearing aid; or
- repairs, servicing or alteration of hearing aid equipment; or
- a hearing aid which exceeds the specifications prescribed for correction of hearing loss; or
- Expenses incurred after termination of coverage under this program except expenses for a hearing aid which was ordered prior to termination and was delivered within 30 days after the date of termination.