

SUMMARY OF MEDICAL BENEFITS Plan 553

Deductible Per Person Per Calendar Year Per Family Per Calendar Year Per Hospital Confinement	\$600 \$1,200 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%	\$2,700 including deductibles
100%	\$5,400 including deductibles
Prescription Drug Benefit	
Retail	
Maximum Amount Dispensed	30-day supply
Generic Copay	\$15
Brand Copay (generic not available)	\$35
Brand Copay (generic available)	Not covered
Mail Order	
Maximum Quantity Dispensed	90-day supply
Generic Copay	\$30
Brand Copay (generic not available)	\$70
Brand Copay (generic available)	Not covered
Out-of-Pocket Limit***	
Per Person Per Calendar Year	\$750
Per Family Per Calendar Year	\$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	Not Covered

*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

Plan 553 does not have hearing aid benefits.