SCHEDULE OF MEDICAL BENEFITS

CIGNA

HDHP/HSA PLAN

PLAN IS EFFECTIVE AS OF JANUARY 1, 2011

	Annual Deductibles (Medical & Prescription Drugs)		Annual Coinsurance Maximums (Excludes Deductible)		Annual Out-of-Pocket Maximums	
Network	$2,700	Individual	$1,500	Individual	$4,200	Individual
	$5,450	Family	$3,000	Family	$8,450	Family
Out-of-Network	$3,000	Individual	$4,000	Individual	$7,000	Individual
	$6,000	Family	$7,000	Family	$13,000	Family

Lifetime Benefit Maximum

(Includes All Other Maximums)

None

The following schedule summarizes coinsurance amounts paid by the Plan, benefit maximums, and any additional explanation needed for your benefits. The Plan's coinsurance will be reduced if you do not follow the procedures outlined in the "Medical Management" section of this Handbook. Please refer to the text for additional Plan provisions that may affect your benefits.

Our Benefits: Although a specific service may be listed as a covered expense, it may not be covered unless it is medically necessary for the prevention, diagnosis or treatment of an illness or condition.

COVERED HEALTH SERVICE	YOUR COST SHARE	COPAY APPLY TO ANNUAL OOP MAX?	NEED TO MEET ANNUAL DEDUCTIBLE?	ADDITIONAL LIMITATIONS AND EXPLANATIONS
Acupuncture Services	**Network** 20%	Yes	Yes	Any combination of network and out-of-network benefits for pain therapy is limited to 12 visits per calendar year. Acupuncture services received on an inpatient basis are not covered.
	Out-of-Network 20%	Yes	Yes	
Allergy Testing (Injections)	**Network** 20%	Yes	Yes	
	Out-of-Network 45%	Yes	Yes	
Ambulance Services	**Network & Out-of-Network** 20%	Yes	Yes	
Diagnostic Tests/X-Ray and Laboratory Services	**Network** 20%	Yes	Yes	
	Out-of-Network 45%	Yes	Yes	
Durable Medical Equipment (DME)	**Network** 20%	Yes	Yes	
	Out-of-Network 45%	Yes	Yes	

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COVERED HEALTH SERVICE	YOUR COST SHARE	COPAY APPLY TO ANNUAL OOP MAX?	NEED TO MEET ANNUAL DEDUCTIBLE?	ADDITIONAL LIMITATIONS AND EXPLANATIONS
Emergency Room Services	**Network & Out-of-Network** 20%	Yes	Yes	Hospital admission must be precertified within 24 hours.
Home Health Care	**Network** 20%	Yes	Yes	Limited to 200 days per plan year; precertification is required.
	Out-of-Network 45%	Yes	Yes	
Hospice Care	**Network** 20%	Yes	Yes	Benefits include bereavement counseling. Precertification is required.
	Out-of-Network 45%	Yes	Yes	
Hospital Services (Inpatient)	**Network** 20%	Yes	Yes	The Plan's coinsurance for hospital expenses will be reduced to 50% if you do not follow the procedures required by the Medical Management Program. This penalty does not apply to the out-of-pocket maximum.
	Out-of-Network 45%	Yes	Yes	
Hospital Services (Outpatient)	**Network** 20%	Yes	Yes	
	Out-of-Network 45%	Yes	Yes	
Hypnosis	**Network** 20%	Yes	Yes	
	Out-of-Network 20%	Yes	Yes	
Maternity Services **Hospital Services**	**Network** 20%	Yes	Yes	The Plan's coinsurance for hospital expenses will be reduced to 50% if you do not follow the procedures required by the Medical Management Program. This penalty does not apply to the out-of-pocket maximum.
	Out-of-Network 45%	Yes	Yes	
Outpatient Services	**Network** 20%	Yes	Yes	Antepartum care only.
	Out-of-Network 45%	Yes	Yes	

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COVERED HEALTH SERVICE	YOUR COST SHARE	COPAY APPLY TO ANNUAL OOP MAX?	NEED TO MEET ANNUAL DEDUCTIBLE?	ADDITIONAL LIMITATIONS AND EXPLANATIONS
Mental Health/ Substance Abuse Services - Inpatient	**Network** 20%	Yes	Yes	Must be preauthorized. The Plan's coinsurance for hospital expenses will be reduced by 50% if you do not follow the procedures required by the Medical Management Program. This penalty does not apply to the out-of-pocket maximum.
	Out-of-Network 45%	Yes	Yes	
Mental Health/ Substance Abuse Services - Outpatient	**Network** 20%	Yes	Yes	
	Out-of-Network 45%	Yes	Yes	
Nutritional Counseling	**Network** 20%	Yes	Yes	Limited to 6 visits per calendar year.
	Out-of-Network 45%	Yes	Yes	
Outpatient Therapy Services	**Network** 20%	Yes	Yes	Limited to 120 days for physical/pulminary therapy; 120 days for speech/cognitive therapy; 60 days for occupational therapy; unlimited cardiac therapy
	Out-of-Network 45%	Yes	Yes	
Physician's Office Services	**Network** 20%	Yes	Yes	
	Out-of-Network 45%	Yes	Yes	
Routine & Preventive Services **Routine Exams** **Routine Exam X-Rays & Laboratory Services** **Well-Child Checkups** **Routine Colonoscopy** **Routine Sigmoidoscopy** **Other Routine Services**	**Network** 0%	n/a	No	Benefits include routine physicals, including gynecological exams; hearing exams performed by your physician during a routine physical; and vaccinations, inoculations, and immunizations. Pap tests; mammograms; PSA screenings, and all related routine x-rays and laboratory services. Well-child checkups, including the office visit, vaccinations, inoculations, immunizations, and all related x-ray and laboratory services. Routine sigmoidoscopy and routine colonoscopy. All services provided at the age and frequency recommended by American Medical Association guidelines.
	Out-of-Network 45%	Yes	Yes	
Skilled Nursing Facility/ Inpatient Rehabilitation Facility Services	**Network** 20%	Yes	Yes	Limited to 60 days per year.
	Out-of-Network 45%	Yes	Yes	

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COVERED HEALTH SERVICE	YOUR COST SHARE	COPAY APPLY TO ANNUAL OOP MAX?	NEED TO MEET ANNUAL DEDUCTIBLE?	ADDITIONAL LIMITATIONS AND EXPLANATIONS
Spinal Treatment	**Network** 20%	Yes	Yes	Limited to 20 days per year.
	Out-of-Network 45%	Yes	Yes	
Surgical Treatment of Morbid Obesity	**Network** 20%	Yes	Yes	$15,000 maximum per lifetime.
	Out-of-Network 45%	Yes	Yes	
Urgent Care Services	**Network & Out-of-Network** 20%	Yes	Yes	

Additional Benefits

COVERED HEALTH SERVICE	YOUR COST SHARE	COPAY APPLY TO ANNUAL OOP MAX?	NEED TO MEET ANNUAL DEDUCTIBLE?	ADDITIONAL LIMITATIONS AND EXPLANATIONS
Anesthesiology Services				
Professional	**Network** 20%	Yes	Yes	
	Out-of-Network 45%	Yes	Yes	
Facility	**Network** 20%	Yes	Yes	
	Out-of-Network 45%	Yes	Yes	
Organ Transplants	**Network** 20%	Yes	Yes	Precertification required. There is a $10,000 travel and lodging limit when utilizing LifeSource transplant services.
	Out-of-Network 45%	Yes	Yes	

CIGNA Member Services toll-free number: (800) CIGNA-24 (800-244-6224)
CIGNA Pre-Enrollment: (800) 401-4041

NOTES: The word “lifetime” refers to the period of time you or your eligible dependents participate in this plan or any other plan sponsored by the Medical Trust.

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MEDCO

HDHP/HSA PLAN

PLAN IS EFFECTIVE AS OF JANUARY 1, 2011

	RETAIL PRESCRIPTION DRUGS	MAIL-ORDER PRESCRIPTION DRUGS
Annual Prescription Deductible	Combined With Medical	
Tier 1: Generic	15% (after deductible)	
Tier 2: Formulary Brand-Name	25% (after deductible)	
Tier 3: Non-Formulary Brand-Name and Brand Non-Sedating Antihistamines	50% (after deductible)	
Paper Claims Reimbursement	You must pay the full price at the pharmacy and file a claim for reimbursement, as outlined in the "Pharmacy Benefits" section of this Handbook. You will be reimbursed according to what the Plan would have paid at a participating pharmacy, less your applicable copayment.	
Dispensing Limits Per Copayment	Up to a 30-day supply.	Up to a 90-day supply

Coverage of Non-Sedating Antihistamines

Brand non-sedating antihistamine drugs are paid as Tier 3, regardless of the drug's formulary status of preferred or non-preferred drug. For example, if you prefer to take the medication Clarinex rather than buying Claritin over the counter, you will pay the Tier 3 copayment.

Retail Refill Limit

The Prescription Drug Program will maintain a Retail Refill Limit policy. The retail refill limit requires that you use the mail-order pharmacy if you are prescribed a maintenance medication, rather than refilling multiple prescriptions for the same drug at a retail pharmacy. If you or a covered dependent receives a prescription for a maintenance medication and you do not use the mail-order pharmacy, your prescriptions may not be covered.

In some circumstances, you may not be required to use the mail-order pharmacy. For example, there are several categories of medications that are uniquely appropriate for multiple refills at your local pharmacy (and are therefore exempt from the mandatory mail-order provision, as outlined above). If you have a prescription for any of the following medications, the Prescription Drug Program allows you to receive multiple refills at your local retail pharmacy:

- Anti-infectives, including antibiotics (Amoxicillin, Biaxin), antivirals (Zovirax, Famvir), antifungals (Diflucan), and drops used in the eyes and ears (Polsporin Opth, Cipro Otic). Please note that drops must be prescribed specifically to treat infection. For example, glaucoma drops are not covered.
- Prescription cough medications, including Phenergan with Codeine, Tessalon, and Tussionex.
- Medications to treat acute pain, both narcotic (Vicodin, Percodan, etc.) and non-narcotic (Darvocet). Please note that long-term pain medications, such as NSAIDs, do not meet the necessary retail requirements.
- Medications that require a new written prescription each time you need them, as refills are prohibited by federal law (e.g., Percodan, Ritalin, and Nembutal).
- Medications used to treat both attention deficit disorder (Ritalin, Cylert) and narcolepsy (Dexedrine).

Keep in mind, the retail pharmacy program allows for a total of three fills of a maintenance medication at a retail pharmacy (one original fill and two refills). Additional fills will not be covered by the Plan. Each fill can be for no more than a 30-day supply. Note that you are allowed a total of three fills, even if each is for less than 30 days.

Generic Substitution Requirement

Generic medications and their brand-name counterparts have the same active ingredients and are manufactured according to the same strict federal regulations. Generic drugs may differ in color, size, or shape, but the U.S. Food and Drug Administration (FDA) requires that the active ingredients have the same strength, purity, and quality as their brand-name counterparts. **For this reason, the Plan will cover the cost of the generic equivalent if you purchase a brand-name medication when there is a generic available. You will be charged the generic copayment and the cost difference between the brand-name and the generic medication.** If you have questions or concerns about generic medication, speak to your physician or your pharmacist, and he or she will be able to help you.

Refilling Mail-Order Prescriptions

Since your medication can take 7 to 11 days to be delivered, you should have at least a 14-day supply of that medication on hand to hold you over. If you do not have enough medication, you may need to ask your doctor for another prescription for a 14-day supply that you can fill at your local retail network pharmacy.

Prescriptions Filled At A Nonparticipating Pharmacy

If you go to a retail pharmacy that is not part of the Medco network, you must pay the full cost of the prescription and then submit a direct reimbursement claim form to Medco. You will be reimbursed for the amount the medication would have cost your Plan at a participating pharmacy minus the copayment you would have paid.

Your Plan May Have Coverage Limits

Your plan may have certain coverage limits. For example, prescription drugs used for cosmetic purposes may not be covered, or a medication might be limited to a certain amount (such as the number of pills or total dosage) within a specific time period.

If you submit a prescription for a drug that has coverage limits, your pharmacist will tell you that approval is needed before the prescription can be filled. The pharmacist will give you or your doctor a toll-free number to call. If you use *Medco By Mail*, your doctor will be contacted directly.

When a coverage limit is triggered, more information is needed to determine whether your use of the medication meets your plan's coverage conditions. We will notify you and your doctor of the decision in writing. If coverage is approved, the letter will indicate the amount of time for which coverage is valid. If coverage is denied, an explanation will be provided, along with instructions on how to submit an appeal.

Medco toll-free number: (800) 841-3361

NOTES: Some prescriptions may require prior authorization. Please refer to the "Pharmacy Benefits" section of this Handbook for further information.

Prescription deductibles and copayments do not apply to the medical plan deductibles or out-of-pocket maximums.

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EyeMed Vision Care

Services	Copayments for Benefits
Exam	$0
Eye Glass Lenses	$10

Benefit Description	Network	Out-of-Network
Eye Examinations	You pay $0	Plan pays up to $30 for ophthalmologists or optometrists
Lenses*	You pay $10 for single, bifocal or trifocal	Plan pays up to: $32—single vision $46—bifocal $57—trifocal
Lens Options		You are responsible for the cost of any lens options that you elect from out-of-network providers
UV Coating	You pay up to $15	
Tint (Solid and Gradient)	You pay up to $15	
Standard Scratch Resistance	You pay up to $15	
Standard Polycarbonate	You pay $0	
Standard Anti-Reflective Coating	You pay up to $45	
Standard Progressive (Add-On to Bifocal)	You pay up to $65	
Other Add-Ons and Services	20% off retail price	
Frames*	$130 allowance, 20% off balance over $130	Plan pays up to $47
Contact Lenses*		
Conventional	$130 allowance, 15% off balance over $130	Plan pays up to $100
Disposable	$130 allowance, then you pay balance over $130	Plan pays up to $100

** You are eligible to receive lenses and frames* **or** *contact lenses once per calendar year.*

When you use EyeMed network providers, you will not need to submit a claim. Your EyeMed provider will submit claims on your behalf. You will pay the copayment and for any noncovered expenses at the time you receive services.

For More Information

For more information about EyeMed, and to see a list of EyeMed providers, please visit **www.eyemedvisioncare**, or call EyeMed toll-free at (866) 723-0513.

Services listed on this page are offered solely through EyeMed Vision Care, and are not available through, nor coordinated with, Kaiser Permanente.