



Bankers Health Trust

Medical Benefits for Group 001N47 – Comprehensive Plan Effective 7/1/08

Calendar Year /Policy Deductible & Out-Of-Pocket (including deductible)

Annual Deductible Single:		\$750
	Family:	\$1,500
Annual Out-of-Pocket Single:		\$3,250
	Family:	\$6,500

Expenses eligible to accumulate towards a member's Out-Of-Pocket Maximum include Deductible and Co-Insurance only. Member copays (Prescriptions, Office Visits, In-Patient Hospital, etc.) and expenses resulting from Non-Pre-certification penalties or charges for ineligible benefit types are not counted towards the Out-Of-Pocket maximum.

The Family Deductible and Out-of-Pocket Maximum are satisfied by a combination of all covered family members.

Preventive Care

Routine Physical Exams including:	\$20 copay then *100% R & C
-Gynecological exam & Pap smear	
-Routine Mammogram	
-Routine Prostate Screening & Lab	
-Total Serum Cholesterol	
-Adult Immunizations	
Routine Pediatric Care & Immunizations	\$20 copay then *100% R & C

Doctor's Services

Office Visits	*80% R & C after deductible
Chiropractic Care & Manual Spinal Manipulation (36 visits/cy)	*80% R & C after deductible
Inpatient Physician Hospital Care including:	
-Surgery	*80% R & C after deductible
-Maternity	*80% R & C after deductible
-Chemo Therapy/Radiation	*80% R & C after deductible
Outpatient Physician Hospital Care including:	
-Surgery	*80% R & C after deductible
-Maternity	*80% R & C after deductible
-Chemo Therapy/Radiation	*80% R & C after deductible
Emergency Room Physician	*80% R & C after deductible

Hospital Services – Inpatient***

Room and Board	*80% R & C after deductible
Surgical Facility	*80% R & C after deductible
Maternity Services	*80% R & C after deductible
Newborn Care	*80% R & C after deductible
Miscellaneous Hospital Charges & Supplies	*80% R & C after deductible

An Inpatient co-pay of \$400 applies to any In-patient admission (hospital, psychiatric, substance abuse) one (1) per person per calendar year.

Hospital Services - Outpatient

Surgical Facility & Supplies**	*80% R & C after deductible
Clinic Service/Infirmary	*80% R & C after deductible
Emergency Room Facility Charges	*80% R & C after deductible

Mental Health
Inpatient **

Hospital/ Lic. Treatment Ctr./ Doctor's Services	*80% R & C after deductible
--	-----------------------------

(One (1) Inpatient Day= Two (2) day Treatment Sessions limited to 31 days/cy or Equivalent)

Outpatient (40 visits/cy)

Office Visits & Outpatient Mental Facility	*50% after deductible
--	-----------------------

Alcohol and Drug Abuse Care
Inpatient **

Hospital/Lic. Treatment Center/Doctor's Service	*80% R & C after deductible
---	-----------------------------

Outpatient

Outpatient Treatment Center/ Clinic Services/office	*80% R & C after deductible
Outpatient Physician Hospital Visit/Care	*80% R & C after deductible
Physician Office Visit	*80% R & C after deductible



Other Services

Ambulance	*80% R & C after deductible
Anesthesia	*80% R & C after deductible
Diagnostic Lab, X-Rays & Clinical Tests	*80% R & C after deductible
Asthma Education (\$200/cy)	*80% R & C after deductible
Diabetes Education & Training	*80% R & C after deductible
Durable Medical Equipment (\$3,000/cy)	*80% R & C after deductible
Private Duty Nursing	*80% R & C after deductible
Home Health Care (\$10,000/cy)	*80% R & C after deductible
Skilled Nursing Facility (100 days/cy)	*80% R & C after deductible
Hospice Services	*80% R & C after deductible
Inborn Errors in Metabolism (Special foods limit: \$3,000/cy)	*80% R & C after deductible
Nicotine Replacement Therapy	*80% R & C after deductible
Physical & Occupational Therapy (60 visits combined/cy)	*80% R & C after deductible
Speech Therapy (40 visits/cy)	*80% R & C after deductible
Prosthetics	*80% R & C after deductible
Hearing Aids (birth-age 5)	up to \$1,400 per ear every 36 months

Infertility Benefit

Infertility Treatment (<i>\$50,000/lifetime maximum \$45,000 for medical; \$5,000 for prescription drugs</i>)	
-Hospital Care**; Lab & X-Ray	*80% R & C no deductible
-Physicians Care	*50% R & C after deductible

Vision Care Benefit

Routine Vision Exam (1 exam every 2 calendar years)	\$20 copay then *100% R & C
--	-----------------------------

Prescription Drug Benefit through Caremark

Retail up to 30 day supply:	\$12.50 Generic/ \$30 Preferred Brand \$50 Non-Preferred Brand
Mail Order: 90 day supply	\$25 Generic/ \$60 Preferred Brand \$100 Non-Preferred Brand

*Plan participant is responsible for paying amounts above Reasonable & Customary allowance

**UTILIZATION REVIEW/HOSPITAL PRE-CERTIFICATION/LARGE CASE MANAGEMENT is provided by Care Management Services (CMS). The CMS toll-free number is located on your ID card. If you fail to follow the pre-admission certification requirements, you will be responsible for the first \$300 of otherwise covered charges of a hospital or other facility for each admission.

Individual Lifetime Maximum-\$3,000,000

NOTES:

a) This summary does not describe all terms, conditions and limitations. Refer to your Plan Document or contact your Benefits Manager for details.

b) Charges for the following and other mental health illnesses are excluded from this Plan's Mental Health benefit limitations: psychotic disorders (including schizophrenia), dissociative disorders, mood disorders, anxiety disorders, personality disorders, paraphilias, attention deficit and disruptive behavior disorders, pervasive developmental disorders, tic disorders, eating disorders (including bulimia & anorexia); & substance abuse-related disorders (including nicotine replacement therapy). Charges for these illnesses are paid the same as any other illness, in accordance to this Plan. Every one day of inpatient treatment will reduce the number of remaining day treatment days by two days. Conversely, every two days of day treatment will reduce the number of remaining inpatient treatment days by one day.

c) Covered expenses for outpatient diagnostic testing, lab and X-ray, prescription medicine, as well as services rendered for medical management of prescription medicines are excluded from the Mental Health maximum allowances defined above. They are inclusive with this Plan's Annual Out-Of-Pocket Maximum and the Maximum Lifetime Benefit, as defined herein. Covered expenses incurred as a result of inpatient and/or outpatient mental health (except for the mental health illness listed above) are excluded from the Out-Of-Pocket Maximum as defined herein.