Medical Plan - Aetna Health HMO
October 1, 2003 - September 30, 2004

Information provided is in summary format. Any difference between the summary provided and actual contract will be settled in favor of the contract.

Policy Number	**56659**
Network	**Aetna Providers***
Deductible	**None**
Coinsurance**	**90%**
Out-of-Pocket Max	**$1,500 Individual/$3,000 Family**
Maximum Benefit	**Unlimited**
Office Visits	**$15 Copay, then 100%**
Preventive Care	**$15 Copay, then 100%**
Lab Work	**$20 Copay**
Ambulance	**100%**
Hospital Inpatient***	**$100 Copay**
Emergency Room	**$50 Copay (waived if admitted)**
Chiropractic - 20 visits/yr	**$20 Copay**
Rehabilitation:	
Inpatient*- 120 days/yr**	**$50 Copay/day**
Outpatient	**$20 Copay**
Mental Nervous:	
Inpatient*- 30 days/yr**	**$100 Copay**
Outpatient - 30 visits/yr	**$25 Copay**
Chemical Dependency:	**$11,285 max in 24 month period**
Inpatient***	**$100 Copay**
Outpatient	**$20 Copay**
Vision - one exam/yr	**$20 Copay** **See the self-funded NBN Vision Plan Summary offered by SSD.**
Hearing - one exam/yr	**$20 Copay**
Retail Prescriptions (Par Pharmacies)	**Generic: $10 Copay** **Preferred Brand: $20 Copay** **Non-Preferred Brand: $35 Copay**
RX Supply - Retail	**30-day supply**
Mail Order Prescriptions	**Generic: $20 Copay** **Preferred Brand: $40 Copay** **Non-Preferred Brand: $70 Copay**
RX Supply - Mail Order	**90-day supply**
Notes	***No benefits are payable for services outside of the Aetna Managed Care Network unless it is a medical emergency. Also, referrals are generally required from your Primary Care Provider (PCP) for care outside your PCP.** ****Of allowable charges** *****Pre-authorization is required for inpatient hospitalizations outside plan service area.**