HMO Medical Plan - Group Health
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	**008700**
	In-Network
HMO Network	**Group Health Providers**
Deductible	**N/A**
Coinsurance	**N/A**
Out-of-Pocket Limit	**$2,000 Individual/$4,000 Family**
Maximum Benefit	**Unlimited**
Office Visits	**$20 copay**
Preventive Care	**$20 copay**
Lab Work	**100%**
Ambulance	**80%**
Hospital Inpatient	**100%**
Emergency Room	**$75 copay at Group Health Facility (waived if admitted)** **$125 copay at Non-Group Health Facility (Not waived)**
Maternity	**Hospital: 100%** **Physician: $20 copay per visit**
Chiropractic - 10 visits/yr	**$20 copay**
Rehabilitative Therapy	
Inpatient - 60 days/condition/yr	**100%**
Outpatient - 60 visits/condition/yr	**$20 copay**
Mental Health:	
Inpatient - 12 days/yr	**80%**
Outpatient - 20 visits/yr	**$20 copay per individual/family/couple visit; $10 copay per group visit**
Chemical Dependency:	**$11,285 max in 24 months**
Inpatient	**100%**
Outpatient	**$20 copay**
Retail Prescriptions (Participating Pharmacies)	**Generic: $15 copay** **Brand Name: $30 copay**
Supply Limit per Copay	**30-day supply**
Mail Order Prescriptions	**Generic: $15 copay** **Brand Name: $30 copay**
Supply Limit per Copay	**30-day supply**
Vision Benefit - one exam/yr	**$20 copay** **See the self-funded NBN Vision Plan Summary offered by SSD.**
Hearing/Audio Benefit	**$20 copay for exam once every 12 months; No hardware benefit**
Notes	***No benefits are payable for services outside of the Group Health 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.**