



Summary of Proposed Benefits ERISA Self-Funded Single Employer Trust

ADVANTAGE 80/50 PPO BENEFIT DESIGN

	In-Network	Out-of-Network
Deductible <i>(per calendar year)</i>	<ul style="list-style-type: none"> Family Deductible is 3X individual Deductible 	Individual Deductible Options ** \$500 \$1,000 \$2,500 \$5,000
Out-of-Pocket Maximum <i>(per calendar year)</i>	<ul style="list-style-type: none"> Family Out-of-Pocket is 3X individual Out-of-Pocket <i>(does not include deductibles or co-pays)</i> 	Individual Deductible Options \$1,000 \$2,000 \$5,000 \$10,000
Preventive Care	<ul style="list-style-type: none"> Routine physical exams, pap smears, mammograms, PSA/prostate, gynecological exams Routine well child care 	100% after \$25 Co-Pay* up to \$200 maximum per calendar year 80%* up to \$200 maximum per calendar year
Physician Services	<ul style="list-style-type: none"> Physician office visits <i>(co-pay does not apply to any other services rendered in the office)</i> Specialist office visits <i>(co-pay does not apply to any other services rendered in the office)</i> Other office services—diagnostic, lab, x-rays Chiropractic care Outpatient therapy – cardiac, physical, occupational, pulmonary and speech 	50% up to \$200 maximum per calendar year 50%* up to \$250 maximum per calendar year
Urgent Care	<ul style="list-style-type: none"> Urgent care facility <i>(co-pay does not apply to any other services rendered in the office)</i> Other urgent care facility services including diagnostic tests, lab, x-rays 	100% after \$25 Co-Pay* 100% after \$50 Co-Pay* 80% 80% after \$25 Co-Pay* up to \$1,000 maximum per calendar year 80% up to \$2,500 maximum per calendar year
Hospital Services	<ul style="list-style-type: none"> Per Confinement Deductible Inpatient care and physician services Surgery – physician services Surgery – inpatient & outpatient facility Diagnostic lab and x-ray – outpatient Emergency room <i>(co-pay waived if admitted to hospital)</i> 	50% up to \$200 maximum per calendar year 50%* up to \$250 maximum per calendar year
Other Medical Services	<ul style="list-style-type: none"> Skilled nursing facility, rehabilitation center and private duty nursing services Hospice care <i>(inpatient respite care limited to 10 days)</i> Durable Medical Equipment Transplant Related Services Home Health Care Ambulance Other Eligible Medical Expenses 	80% up to \$200 maximum per calendar year 80% up to \$250 maximum per calendar year
Mental Health and Substance Abuse	<ul style="list-style-type: none"> Outpatient and Inpatient Care 	50% up to \$200 maximum per calendar year 50%* up to \$250 maximum per calendar year
Lifetime Maximum	<ul style="list-style-type: none"> Combined Maximum In-Network and Out-of-Network benefits 	50% up to \$200 maximum per calendar year 50%* up to \$250 maximum per calendar year



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Prescription Drug Card Benefit

RETAIL DRUGS (Maximum 34 day supply per prescription)

- ◆ Generic 100% after \$15 Co-Pay
- ◆ Brand Name Average wholesale price less 12% or lower promotional price if available

MAIL ORDER DRUGS (Maximum 90 day supply per prescription)

- ◆ Generic 100% after \$30 Co-Pay
- ◆ Brand Name Average wholesale price less 16%

NOTE: A list of covered and excluded drugs is available from the Plan Sponsor. Coverage provided by an independent vendor-participating pharmacy

Life and AD&D

◆ \$15,000 Minimum **required** for all employees ◆ \$100,000 Maximum
Benefit available on a flat amount (all employees) or by class. AD&D is equal to life amount. Amount reduces beginning at age 65.

* Calendar year deductibles do not apply

** \$2,500 Deductible available to groups of 50 lives or more / \$5,000 Deductible available to groups of 100 lives or more

NOTE: Out-of-Pocket maximums exclude Deductibles or Co-Pays.

Once the Out-of-Pocket Maximum is reached, covered services are paid at 100% for remainder of the calendar year up to plan maximums.

IMPORTANT INFORMATION

- ◆ Pre-certification is required in advance of all scheduled hospital admissions, non-emergency surgical procedures and several outpatient services, or benefits will be reduced for that confinement.
- ◆ Emergency admissions must be certified within 48 hours of admission, or the next business day, or benefits will be reduced for that confinement.
- ◆ All claims are paid in accordance with Contract Administrator's Network Fee Schedules.
- ◆ Please contact Contract Administrator for information on any benefits not listed in this summary.
- ◆ The Pre-Certification List shown below is not an entirely exhaustive list. Please refer to the utilization management program found in the Summary Plan Description (SPD) for complete details. If you are in doubt as to whether or not pre-certification is required, you should contact the Contract Administrator immediately. Failure to obtain the necessary pre-certification for required procedures **will result in a reduction of benefits by \$500.**

Pre-Certification List

If your Physician recommends any of the listed procedures, diagnostic tests or services, you must contact Pre-Certification to obtain pre-authorization. Failure to obtain prior approval may result in a reduction of benefits.

Diagnostics: Bone Scans/CT Scans, MRA (brain), MRI, Open MRIs

Services: Chemotherapy, Dialysis, Free Standing Surgical Facility, Prenatal Genetic Services, Home Health Care, Hospital Admissions, Hospice Services, Infusion Services, Skilled Nursing Facilities, Physical, Speech, Occupational, Pulmonary and Cardiac Rehabilitation Therapies.

Pre-Existing Condition definition:

For Plan purposes, a "pre-existing condition" is an illness or injury for which medical advice, diagnosis, care or treatment was recommended or received during the six (6) months before an individual's enrollment date. A Pregnancy will not be considered a pre-existing condition, regardless of the date of conception, diagnosis, or first treatment. Genetic information is not a pre-existing condition in the absence of a diagnosis of a condition related to the genetic information. Except as noted below and/or outlined in the Plan Document, a pre-existing condition will not be covered until the twelve (12) month anniversary of an individual's enrollment date (12 months from the first day of plan coverage, or if there is a waiting period, 12 months from the first day of the waiting period for such coverage).

Allowance for Prior Creditable Coverages:

An individual (Employee or Dependent) who transfers to this Plan from another plan of "creditable coverage" within 63 days (i.e., with not more than 62 days of non-coverage, not counting any days applied toward waiting period requirements), has a right to demonstrate "creditable coverage" and to request a certificate of creditable coverage from the prior health plan(s). An individual also has the right to demonstrate creditable coverage through the presentation of documentation or other means where a certificate of creditable coverage cannot be obtained from the prior health plan(s). If the prior coverage is determined to be "creditable coverage", the Plan enrollee will be credited with time covered under such prior plan(s) toward the time limits of this Plan's pre-existing condition limitation or other time-covered requirements that may apply to Plan coverages.

KEY INFORMATION

Type of Administration – The SET Program is an alternative method of funding health benefits where you, the employer, sponsor a health and welfare benefit plan funded by contributions from you and your employees. The program retains some of the risk for medical expenses, but uses some of its funds to purchase Excess Loss Coverage, which covers the cost of medical expenses in excess of a predetermined limit. Employers who choose to self-fund an employee benefit plan must comply with the Employee Retirement Income Security Act of 1974 (ERISA), as amended. See Administrative Services Agreement and SET New Business Disclosure Form for additional details.

ERISA Self-Funded Single Employer Trust Marketed and Administered by:



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