Orthodox HealthPlans Medical Benefits
As of May 1, 2007

PPO Benefit Highlights	**In Network**	**Out of Network**
Deductible		
Individual	$300	$500
Family	$600	$1,000
Coinsurance Limit		
Individual	$3,000	$4,000
Family	$6,000	$8,000
Preventative Care		
Routine Physicals - adults 19 & older		
1 exam every 12 months	100% after $25 copay	70% after ded.
Well Baby Care/Immunizations	100% no ded or copay	70% after ded.
Routine Mammogram - 1 per yr.	90% no ded or copay	70% after ded.
Routine OB/GYN Exam - 1 per yr	100% after $35 copay	70% after ded.
Physician Services		
Office Visits, non-surgical	100% after $25 copay	70% after ded.
Allergy Test/Treat (by Phy.)	100% after $25 copay	70% after ded.
Allergy Injections (not by Phy.)	90% after ded.	70% after ded.
Specialist Office Visits	100% after $35 copay	70% after ded.
Surgical Services	90% after ded.	70% after ded.
Physician In-Hospital Services	90% after ded.	70% after ded.
Other Physician Services	90% after ded.	70% after ded.
Maternity Care	SAAOCE*	SAAOCE*
Hospital Services		
Inpatient Coverage	90% after $250 per confinement and ded	70% after $250 per confinement and ded
Outpatient Coverage	90% after ded.	70% after ded.
Emergency Room Visit	90% after $50 copay waived if admitted	70% after $50 copay waived if admitted
Non-emergency use of ER	50%	50% after ded.
Maternity Care	SAAOCE*	SAAOCE*
Prescription Drug Benefit		
Retail: 30 day supply		
Generic	$15 copay	Not covered
Formulary	$25 copay	Not covered
Non-formulary	$40 copay	Not covered
Mail order: 90 day supply		
Generic	$30 copay	Not covered
Formulary	$50 copay	Not covered
Non-formulary	$80 copay	Not covered

Orthodox HealthPlans Medical Benefits
As of May 1, 2007

PPO Benefit Highlights	**In Network**	**Out of Network**
Mental Health		
Inpatient-up to 30 days per calendar yr	90% after $250 per confinement fee & ded	70% after $250 per confinement fee and ded
Outpatient-up to 30 visits per calendar yr	90% after ded.	70% after ded.
Crisis Intervention-3 visits per calendar yr	90% after ded.	70% after ded.
Substance Abuse		
Inpatient-up to 30 days per calendar yr	90% after ded & $250 per confinement fee	70% after ded & $250 per confinement fee
Outpatient-up to 60 visits per calendar yr	90% after ded.	70% after ded.
Other Benefits		
Skilled Nursing Facility	90% after ded.up to 90 days per yr	70% after ded
(Other than at physician's office)	90% no ded or copay	70% / ded. Waived
Hospice care	same as skilled nursing	same as skilled nursing
Inpatient Coverage	80% after ded.up to 30 days per yr	Same as In Network
Outpatient Coverage	80% after ded. Max of $5000	Same as In Network
Ambulance	80%	Same as In Network
Durable Medical Equipment	80%	Same as In Network
Short Term Rehabilitation	80%	Same as In Network

*same as any other covered expense

NOTE:

This is a Summary of Plan Benefits Only. The Master Policy Contract holds more detailed information on coverage. In the event of discrepancies, the Master Contract shall be binding, subject to State Mandates.