Benefit Summary

for Musicians Association Tiered Plan

Effective Date 4/1/2008	**Health Plan** Group Health	**Ref** RQ-1755

This is a brief summary of benefits. THIS IS NOT A CONTRACT OR CERTIFICATE OF COVERAGE. All benefit descriptions, including alternative care, are for medically necessary services. The Member will be charged the lesser of the cost share for the covered service or the actual charge for that service. For full coverage provisions, including limitations, please contact our Sales or Customer Service Departments or refer to the plan contract.

Benefits	**Inside Network**
Plan deductible (PCY) - per calendar year	Individual deductible: $500 Family deductible: $1500
Plan coinsurance	Plan pays 80%, you pay 20%
Pre-existing condition (PEC) **waiting period**	3 Months
Out-of-pocket limit	Individual out-of-pocket limit: $2000 Family out-of-pocket limit: $6000
Lifetime Maximum	$2 million
Outpatient Services (Office visits - OV)	$30 copay, deductible and coinsurance apply
Hospital services	**Inpatient services:** Deductible and coinsurance apply **Outpatient surgery:** $30 copay, deductible and coinsurance apply
Prescription drugs	Formulary generic/formulary brand $20/$40 copay
Prescription mail order	2 x prescription cost share per 90 day supply
Acupuncture	Self-referred up to 8 visits per medical diagnosis PCY; additional visits when approved by plan $30 copay, deductible and coinsurance apply
Ambulance Services	Plan pays 80%, you pay 20%
Chemical Dependency	$14,000 per 24 months **Outpatient:** $30 copay, deductible and coinsurance apply **Inpatient:** Deductible and coinsurance apply
Devices, equipment and supplies (DME prosthetics)	DME-50% up to $5,000 ($2,500 max. benefit PCY); Prosthetics-50% up to $40,000 ($20,000 max. benefit PCY)
Diagnostic lab and X-ray Services (outpatient)	Deductible and coinsurance apply
Emergency Services (copay waived if admitted)	$100 ER copay at a designated facility $150 ER deductible at a non designated facility Deductible and coinsurance apply
Growth hormone	12 month wait, deductible and coinsurance apply
Hearing exams (Routine)	$30 copay, deductible and coinsurance apply
Hearing hardware	Not covered
Home health	Covered in full. No visit limit.
Infertility services	Not covered
Manipulative therapy	Self-referred up to 10 visits PCY; additional visits when approved by plan $30 copay, deductible and coinsurance apply
Maternity services	**Outpatient:** $30 copay, deductible and coinsurance apply **Inpatient:** Deductible and coinsurance apply
Mental Health	**Outpatient:** 20 visits PCY $30 copay, deductible and coinsurance apply **Inpatient:** 12 days PCY Deductible and coinsurance apply
Naturopathy	Self-referred up to 3 visits per medical diagnosis PCY; additional visits when approved by plan $30 copay, deductible and coinsurance apply
Obesity-related surgery (bariatric) When medically necessary and authorized lifetime max	Not covered

Organ transplants Donor search & harvest rolls to lifetime max	$250,000 lifetime max; includes donor search & harvest of $50,000; 6 month wait **Outpatient:** $30 copay, deductible and coinsurance apply **Inpatient:** Deductible and coinsurance apply
Preventive care Well-care physicals, immunizations, Pap smear exams, mammograms	$30 copay (deductible and coinsurance waived)
Rehabilitation services (Occupational, speech, physical-including massage) Rehab visits are a total of combined therapy visits PCY	**Outpatient:**60 visits PCY $30 copay, deductible and coinsurance apply **Inpatient:** 60 days PCY Deductible and coinsurance apply
Skilled nursing facility (PCY)	Up to 60 days, deductible and coinsurance apply
Sterilization (vasectomy, tubal ligation)	$30 copay, deductible and coinsurance apply
Temporomandibular Joint (TMJ) **Services**	$1,000 PCY; $5,000 lifetime max **Outpatient:** $30 copay, deductible and coinsurance apply **Inpatient:** Deductible and coinsurance apply
Tobacco Cessation See pharmacy benefit for associated drug coverage	Free & Clear Program - covered in full
Vision care Routine vision exam (1 visit PCY) No limit for medically necessary eye visits	$30 copay, deductible and coinsurance waived
Optical Hardware Lenses, including contact lenses, and frames	Not covered