

Plan C Schedule Of Benefits Effective January 1, 2006

<i>Comprehensive Medical Benefits¹</i>	<i>Special Limits, If Any</i>
Calendar Year Benefit Maximum	\$50,000 + balance of \$200,000 Supplemental Lifetime Fund
Calendar Year Deductible	\$100 per person (limited to \$300 per family)
Calendar Year Out-of-Pocket Maximum	\$2,500 per person (limited to \$6,000 per family)
Coinsurance	Must be in-network only
In-Network (PPO Provider):	90%
Out-of-Network (Non-PPO Provider):	0%
Services and Supplies Not Provided In-Network (such as durable medical equipment, ambulance)	70%
Benefits are paid once the calendar year deductible is met and are paid at 100% after the out-of-pocket limit is met.	
Well-Baby Care (for eligible newborn dependent children to age 2)	Plan pays 100%, not subject to deductible up to \$2,000 lifetime
Hospital Room and Board and Miscellaneous Expenses	Private room only if medically necessary (i.e., contagious diseases)
Outpatient Surgical Charges	Charges for surgical supplies are included in the physician's fee
Physician's Care	
Pre-Admission Testing	Within 14 days of hospitalization
Second Surgical Opinion	From a Board-Certified surgeon or specialist
MRIs/CT Scans	Paid at 90%, after deductible is satisfied, if Medlink is used
Kidney Dialysis	Must be administered on an outpatient basis
Chemotherapy/Radiation Therapy	Must be administered on an outpatient basis
Organ/Tissue Transplants	Must be pre-certified and in-network only; out-of-network charges are not covered
Lifetime Maximum	\$250,000, including up to:
Organ/Tissue Procurement	\$25,000
Transportation & Lodging	\$10,000
Private Nursing Care	\$10,000
Foot Orthotics	Coverage limited to \$300 per person per year up to a lifetime maximum of \$1,500 per person
Convalescent Care	Coverage limited to 45 days per spell of illness, other limitations apply
Continuing Care	When approved by Case Manager only
Outpatient Physical Therapy	When approved by Case Manager only
Medical Orthodontics	When approved by Case Manager only
Treatment for Congenital Neurological Diseases for dependent child to age 19 including physical, occupational, and speech therapy	Subject to calendar year deductible; limited to \$5,000 per calendar year when approved by a Case Manager only.
The following special coverages are paid at 70% and are not subject to the calendar year deductible unless otherwise noted.	
Medical Equipment	If you pre-certify Durable Medical Equipment; paid at 50% if not pre-certified
Wheelchair Lifetime Maximum	\$15,000
The following special coverages are paid at 50% and are not subject to the calendar year deductible unless otherwise noted.	
Temporomandibular Joint Syndrome Orthodontics (TMJ)	Maximum lifetime benefit for each eligible person of \$2,500
Orthoptic Training (for dependent children up to age 10)	Subject to the calendar year deductible; limited to 40 visits per lifetime
Rehabilitation Speech Therapy (for a child ages 2 – 5)	Subject to calendar year deductible

¹ Eligible expenses must be medically necessary and are subject to reasonable and customary limits.

Prescription Drug Program

The Prescription Drug Program covers eligible prescription drug expenses when you fill your prescription at the Midwest Benefit Pharmacy or at any network pharmacy for emergency prescriptions only. The Program's benefits are highlighted below and are explained in more detail in your Summary Plan Description.

Calendar Year Maximum	\$7,500 per person
At the Midwest Benefit Pharmacy: Walk in, call or mail	
Monday, Tuesday, Wednesday, Friday	8:00 a.m. to 6:00 p.m.
Thursday	8:00 a.m. to 7:00 p.m.
Saturday	8:00 a.m. to 12:00 p.m.
Copayment per 30-day supply:	
Generic ²	You pay \$5
Brand-name	You pay \$10
	<i>If you request a brand name medication when a generic is available, you are responsible for paying the brand name copayment plus the difference in cost between the brand name and generic.</i>
Hepatitis C Initial Course of Treatment Maximum	\$40,000 during a 12-month period
Dispensing Limitations	
• New Medications	Up to a 30-day supply
• Refills	Up to a 90-day supply
• Schedule II Medications	Up to a 30-day supply
• Diabetic Test Strips & Lancets	Up to a 100-unit (30-day) supply
Mail Order Service	The Pharmacy will mail your prescription to your home via First Class Mail, Certified Mail, or UPS.
At Any Network Pharmacy (emergency medication up to a 15-day supply)	You pay 20% of the cost of covered prescriptions at the pharmacy
At Any Non-Network Pharmacy	Not covered
At Any Convalescent/Nursing Home	Plan reimburses you for 50% of covered prescriptions
² Unless your physician specifies "do not substitute" on your prescription, all scripts will be filled with generics, whenever a generic substitute is available.	

347729/03041.024