

***Summitt Trucking PREFERRED Plan
Blue AccessSM (PPO)
Summary of Benefits, Effective February 1, 2007***

Covered Benefits	Network	Non-Network
Deductible (Single/Family)	\$1,000/\$3,000	\$2,000/\$6,000
Out-of-Pocket Maximum (Single/Family)	\$2,500/\$5,000	\$5,000/\$10,000
Physician Home and Office Services (PCP/SCP) Primary Care Physician (PCP)/Specialty Care Physician (SCP) Including office surgeries and allergy serum:	\$25/\$40	50%
<ul style="list-style-type: none"> allergy injections (PCP and SCP) 	\$5	50%
<ul style="list-style-type: none"> allergy testing 	20%	50%
<ul style="list-style-type: none"> routine and non-routine mammograms (regardless of outpatient setting) 	\$25	50%
<ul style="list-style-type: none"> diabetic education (regardless of outpatient setting) 	\$25	50%
<ul style="list-style-type: none"> certain medical nutritional therapy (regardless of outpatient setting) 	\$25	Not Covered
<ul style="list-style-type: none"> MRAs, MRIs, PETS, C-Scans, Nuclear Cardiology Imaging Studies and non-maternity related Ultrasounds 	20%	50%
Preventive Care Services Services include but are not limited to: Routine Exams, Pelvic Exams, Pap testing, PSA tests, immunizations ¹ , Annual diabetic eye exam, Routine Vision and Hearing exams		
<ul style="list-style-type: none"> Physician Home and Office Visits (PCP/SCP) 	\$25/\$40	50%
<ul style="list-style-type: none"> Other Outpatient Services @ Hospital/Alternative Care Facility 	20%	50%
Emergency and Urgent Care		
<ul style="list-style-type: none"> Emergency Room Services @ Hospital (facility/other covered services) <i>(copayment waived if admitted)</i> 	\$100	\$100
<ul style="list-style-type: none"> Urgent Care Center Services 	\$50	\$50
Inpatient and Outpatient Professional Services Include, but are not limited to:	20%	50%
<ul style="list-style-type: none"> Medical Care visits (1 per day), Intensive Medical Care, Concurrent Care, Consultations, Surgery and administration of general anesthesia and Newborn exams 		
Inpatient Facility Services Unlimited days except for:	20%	50%
<ul style="list-style-type: none"> 60 days Network/Non-Network combined for physical medicine/rehab (limit includes Day Rehabilitation Therapy Services on an outpatient basis) 		
<ul style="list-style-type: none"> 90 days Network/Non-Network combined for skilled nursing facility 		
Outpatient Surgery Hospital/Alternative Care Facility	20%	50%
<ul style="list-style-type: none"> Surgery and administration of general anesthesia 		
Other Outpatient Services (including but not limited to):	20%	50%
<ul style="list-style-type: none"> Non Surgical Outpatient Services for example: MRIs, C-Scans, Chemotherapy, Ultrasounds and other diagnostic outpatient services. 		
<ul style="list-style-type: none"> Home Care Services (Network/Non-Network combined) 90 visits (excludes IV Therapy) 		
<ul style="list-style-type: none"> Durable Medical Equipment and Orthotics (Network/Non-network combined) \$4,000 benefit maximum (excluding Prosthetic Devices and Medical Supplies) 		
<ul style="list-style-type: none"> Prosthetic Devices \$4,000 benefit maximum 		
<ul style="list-style-type: none"> Physical Medicine Therapy Day Rehabilitation programs 		
<ul style="list-style-type: none"> Hospice Care 	20%	20%
<ul style="list-style-type: none"> Ambulance Services 	20%	20%

Covered Benefits	Network	Non-Network
Outpatient Therapy Services (Combined Network and Non-Network limits apply) <ul style="list-style-type: none"> Physician Home and Office Visits (PCP/SCP) Other Outpatient Services @ Hospital/Alternative Care Facility Limits apply to: <ul style="list-style-type: none"> Physical therapy: 20 visits Occupational therapy: 20 visits Manipulation therapy: 12 visits Speech therapy: 20 visits 	\$25/\$40 20%	50% 50%
Behavioral Health Services: Mental Health and Substance Abuse² <ul style="list-style-type: none"> Inpatient Facility Services Physician Home and Office Visits (PCP/SCP) Other Outpatient Services @ Hospital/Alternative Care Facility 	20% \$25/\$40 20%	50% 50% 50%
Human Organ and Tissue Transplants³ <ul style="list-style-type: none"> Acquisition and transplant procedures, harvest and storage 	No copayment/coinsurance	50%
Prescription Drug Options:⁴ Network Tier structure equals 1/2/3 (and 4, if applicable) <ul style="list-style-type: none"> Network Retail Pharmacies: (30-day supply) Includes diabetic test strip Anthem Rx Direct Mail Service: (90-day supply) Includes diabetic test strip 	\$10/\$25/\$40 \$20/\$65/\$100	50%, min \$40 ⁵ Not covered
Lifetime Maximum (Combined Network and Non-Network)⁶ <ul style="list-style-type: none"> Medical Surgical Treatment of Morbid Obesity (contributes toward the medical lifetime maximum) 	\$5 million Not covered	\$5 million Not covered

Notes:

- Prescription Drug deductibles/copayments/coinsurance and Non-network Human Organ and Tissue Transplants are excluded from the Out-of-pocket limits.
- Deductible(s) apply only to covered medical services listed with a percentage (%) coinsurance. However, the deductible does not apply to Emergency Room Services @ Hospital where a percentage (%) coinsurance applies to other covered services.
- Network and Non-network deductibles, copayments, coinsurance and out-of-pocket maximums are separate and do not accumulate toward each other.
- Dependent Age: to the end of the calendar year which the child attains age 19; or to the end of the calendar year which the child attains age 24 if the child qualifies as a full-time student.
- Specialist copayment is applicable to all Specialists excluding General Physicians, Internist, Pediatricians, OB/GYN's and Geriatrics or any other Network Provider as allowed by the plan.
- Physicians Home and office visit copayment also applies if the office visit is billed with allergy injections.
- No copayment/coinsurance means no deductible/copayment/coinsurance up to the maximum allowable amount. 0% means no coinsurance up to the maximum allowable amount. However, when choosing a Non-network provider, the member is responsible for any balance due after the plan payment.
- PCP is a Network Provider who is a practitioner that specializes in family practice, general practice, internal medicine, pediatrics, obstetrics/gynecology, geriatrics or any other Network provider as allowed by the plan.
- SCP is a Network Provider, other than a Primary Care Physician, who provides services within a designated specialty area of practice.
- Certain diabetic and asthmatic supplies have no deductible/copayment/coinsurance up to the maximum allowable amount at network pharmacies except diabetic test strips.
- Benefit period = calendar year

¹These covered services are not subject to the deductible/copayment if you have a flat dollar copayment and if rendered without an office visit.

²We encourage you to contact Our Mental Health Subcontractor to assure the use of appropriate procedures, setting and medical necessity. Refer to Schedule of Benefits for limitations.

³Kidney and Cornea are treated the same as any other illness and subject to the medical benefits.

⁴If applicable, all prescription drug expenses except tier 1, (Network/Non-network, Retail/Mail-service combined) apply to the per individual deductible. Once the deductible is met, the appropriate copayment applies. -Also if applicable, the Prescription Drug out of pocket maximum applies to Network Retail and Mail-Service combined.

⁵Rx non-network diabetic/asthmatic supplies not covered except diabetic test strips.

⁶All prescription Drugs do not accumulate toward the Medical Lifetime Maximum. However, once the Medical Lifetime Maximum is met, no additional Prescription Drug claims will be paid.

Precertification:

- Members are encouraged to always obtain prior approval when using non-network providers. Precertification will help avoid any unnecessary reduction in benefits for non-covered or non-medically necessary services.

Pre-existing Exclusion Period:

We will not provide benefits for services, supplies or charges for any pre-existing condition for the time period specified below (subject to HIPAA portability requirements):
 12 months after the member's enrollment date

A pre-existing condition is a condition (mental or physical) which was present and for which medical advice, diagnosis, care or treatment was recommended or received within the 6 month period ending on the member's enrollment date. Pregnancy and domestic violence are not considered a pre-existing condition. Genetic information may not be used as a condition in the absence of a diagnosis.

This summary of benefits is intended to be a brief outline of coverage. The entire provisions of benefits and exclusions are contained in the Group Contract, Certificate and Schedule of Benefits. In the event of a conflict between the Group Contract and this description, the terms of the Group Contract will prevail.