ASO
Options PPO Non-Differential *Plan GLI Reta Trust*

This plan provides maximum freedom for dealing with any health care situation. This incredibly flexible program lets you make your own health care decisions, including which doctors and specialists to visit. With this version of health insurance, benefits are provided for covered health services received from any physician or other licensed health care provider.

Some of the Important Benefits of Your Plan:

You have access to a Network of physicians, facilities and other health care professionals, including specialists, without designating a Primary Physician or obtaining a referral.

Benefits are available for office visits and hospital care, as well as inpatient and outpatient surgery.

Care Coordination℠ services are available to help identify and prevent delays in care for those who might need specialized help.

Emergencies are covered anywhere in the world.

Pap smears are covered.

Prenatal care is covered.

Routine check-ups are covered.

Childhood immunizations are covered.

Mammograms are covered.

Vision and hearing screenings are covered.

Options PPO Non-Differential *Benefits Summary*

Types of Coverage	Benefits / Copayment Amounts
This Benefit Summary is intended only to highlight your Benefits and should not be relied upon to fully determine coverage. This benefit plan may not cover all of your health care expenses. **More complete descriptions of Benefits and the terms under which they are provided are contained in the Summary Plan Description that you will receive upon enrolling in the Plan.** If this Benefit Summary conflicts in any way with the Summary Plan Description issued to your employer, the Summary Plan Description shall prevail. Terms that are capitalized in the Benefit Summary are defined in the Summary Plan Description. *Prior Notification is required for certain services.	**Annual Deductible:** $500 per Covered Person per calendar year, not to exceed $1000 for all Covered Persons in a family. Deductibles cross apply for both in-network and out of network benefits. **Out-of-Pocket Maximum:** $2000 per Covered Person per calendar year, not to exceed $4000 for all Covered Persons in a family. The Out-of-Pocket includes the Annual Deductible. Copayments for some Covered Health Services will never apply to the Out-of-Pocket Maximum as specified in Section 1 of the SPD. **Maximum Policy Benefit:** $5,000,000 per Covered Person.
1. Ambulance Services - Emergency only	Ground Transportation: 10% of Eligible Expenses Air Transportation: 10% of Eligible Expenses
2. Dental Services - Accident only	*10% of Eligible Expenses *Prior notification is required before follow-up treatment begins.
3. Durable Medical Equipment Benefits for Durable Medical Equipment are limited to $2,500 per calendar year. Benefits are provided for the replacement of a type of Durable Medical Equipment once every three calendar years.	*10% of Eligible Expenses *Prior notification is required when the cost is more than $1,000.
4. Emergency Health Services	100% of eligible expenses after satisfying a per visit deductible of $100. The annual deductible does not apply. The deductible does not apply toward the out pocket maximum. The deductible is waived if admitted to the hospital. *Notification is required if results in an Inpatient Stay.
5. Eye Examinations Refractive eye examinations are limited to one every other calendar year.	10% of Eligible Expenses after satisfying the deductible. Benefits include one routine vision exam, including refraction to detect vision impairment by a Network provider every other year. Please note that benefits are not available for charges connected to the purchase or fitting if eyeglasses or contact lenses.
6. Home Health Care Benefits are limited to 60 visits for skilled care services per calendar year.	*10% of Eligible Expenses
7. Hospice Care Benefits are limited to 360 days during the entire period of time a Covered Person is covered under the Plan.	*10% of Eligible Expenses
8. Hospital - Inpatient Stay	*10% of Eligible Expenses
9. Injections Received in a Physician's Office	10% per injection
10. Maternity Services	Same as 8, 11, 12 and 13 *Notification is required if Inpatient Stay exceeds 48 hours following a normal vaginal delivery or 96 hours following a cesarean section delivery.
11. Outpatient Surgery, Diagnostic and Therapeutic Services	
Outpatient Surgery	10% of Eligible Expenses
Outpatient Diagnostic Services	For lab and radiology/Xray: Covered 100% for Eligible Expenses For mammography testing: Covered 100% for Eligible Expenses
Outpatient Diagnostic/Therapeutic Services - CT Scans, Pet Scans, MRI and Nuclear Medicine	10% of Eligible Expenses
Outpatient Therapeutic Treatments	10% of Eligible Expenses
12. Physician's Office Services	$20 Copay per visit
13. Professional Fees for Surgical and Medical Services	10% of Eligible Expenses
14. Prosthetic Devices Benefits for prosthetic devices are limited to $2,500 per calendar year. Benefits are provided for the replacement of a type of Durable Medical Equipment once every three calendar years.	10% of Eligible Expenses

Types of Coverage	Benefits / Copayment Amounts
15. Reconstructive Procedures	*Same as 8, 11, 12, 13 and 14
16. Rehabilitation Services – Outpatient Therapy Benefits are limited as follows: 20 visits of physical therapy; 20 visits of occupational therapy; 20 visits of speech therapy; 20 visits of pulmonary rehabilitation; and 36 visits of cardiac rehabilitation per calendar year.	10% of Eligible Expenses
17. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services Benefits are limited to 60 days per calendar year.	*10% of Eligible Expenses
18. Transplantation Services	*10% of Eligible Expenses
19. Urgent Care Center Services	100% of eligible expenses after satisfying a per visit deductible of $50. The annual deductible does not apply. The deductible does not apply toward the out of pocket maximum.

Additional Benefits

Mental Health and Substance Abuse Services - Outpatient Must receive prior authorization through the Mental Health/Substance Abuse Designee.	$20 copay per individual visit, $10 copay for group visit
Mental Health and Substance Abuse Services - Inpatient and Intermediate Must receive prior authorization through the Mental Health/Substance Abuse Designee.	10% of Eligible Expenses
Spinal Treatment Benefits include diagnosis and related services and are limited to one visit and treatment per day. Benefits are limited to 24 visits per calendar year.	$20 copay per visit
Acupuncture Benefits are limited to 24 visits per calendar year.	10% of eligible expenses after satisfying the deductible. Any combination of Network and Non-Network benefit is limited to 24 visits per calendar year.

Except as may be specifically provided in Section 1 of the Summary Plan Description (SPD) or through a Rider to the Plan, the following are not covered:

A. Alternative Treatments

Acupressure; hypnotism; rolfing; massage therapy; aromatherapy; and other forms of alternative treatment.

B. Comfort or Convenience

Personal comfort or convenience items or services such as television; telephone; barber or beauty service; guest service; supplies, equipment and similar incidental services and supplies for personal comfort including air conditioners, air purifiers and filters, batteries and battery chargers, dehumidifiers and humidifiers; devices or computers to assist in communication and speech.

C. Dental

Except as specifically described as covered in Section 1 of the SPD for services to repair a sound natural tooth that has documented accident-related damage, dental services are excluded. There is no coverage for services provided for the prevention, diagnosis, and treatment of the teeth, jawbones or gums (including extraction, restoration, and replacement of teeth, medical or surgical treatments of dental conditions, and services to improve dental clinical outcomes). Dental implants and dental braces are excluded. Dental x-rays, supplies and appliances and all associated expenses arising out of such dental services (including hospitalizations and anesthesia) are excluded, except as might otherwise be required for transplant preparation, initiation of immunosuppressives, or the direct treatment of acute traumatic Injury, cancer, or cleft palate. Treatment for congenitally missing, malpositioned, or super numerary teeth is excluded, even if part of a Congenital Anomaly.

D. Drugs

Prescription drug products for outpatient use that are filled by a prescription order or refill. Self-injectable medications. Non-injectable medications given in a Physician's office except as required in an Emergency. Over-the-counter drugs and treatments.

E. Experimental, Investigational or Unproven Services

Experimental, Investigational or Unproven Services are excluded. The fact that an Experimental, Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Benefits if the procedure is considered to be Experimental, Investigational or Unproven in the treatment of that particular condition.

F. Foot Care

Routine foot care (including the cutting or removal of corns and calluses); nail trimming, cutting, or debriding; hygienic and preventive maintenance foot care; treatment of flat feet or subluxation of the foot; shoe orthotics.

G. Medical Supplies and Appliances

Devices used specifically as safety items or to affect performance primarily in sports-related activities. Prescribed or non-prescribed medical supplies and disposable supplies including but not limited to elastic stockings, ace bandages, gauze and dressings, ostomy supplies, syringes and diabetic test strips. Orthotic appliances that straighten or re-shape a body part (including cranial banding and some types of braces). Tubings and masks are not covered except when used with Durable Medical Equipment as described in Section 1 of the SPD.

H. Mental Health/Substance Abuse

Services performed in connection with conditions not classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Services that extend beyond the period necessary for short-term evaluation, diagnosis, treatment, or crisis intervention. Mental Health treatment of insomnia and other sleep disorders, neurological disorders, and other disorders with a known physical basis.

Treatment of conduct and impulse control disorders, personality disorders, paraphilias and other Mental Illnesses that will not substantially improve beyond the current level of functioning, or that are not subject to favorable modification or management according to prevailing national standards of clinical practice, as reasonably determined by the Mental Health/Substance Abuse Designee.

Services utilizing methadone treatment as maintenance, L.A.A.M. (1-Alpha-Acetyl-Methadol), Cyclazocine, or their equivalents. Treatment provided in connection with or to comply with involuntary commitments, police detentions and other similar arrangements, unless authorized by the Mental Health/Substance Abuse Designee. Residential treatment services. Services or supplies that in the reasonable judgment of the Mental Health/Substance Abuse Designee are not, for example, consistent with certain national standards or professional research further described in Section 2 of the SPD.

I. Nutrition

Megavitamin and nutrition based therapy; nutritional counseling for either individuals or groups. Enteral feedings and other nutritional and electrolyte supplements, including infant formula and donor breast milk.

J. Physical Appearance

Cosmetic Procedures including, but not limited to, pharmacological regimens; nutritional procedures or treatments; salabrasion, chemosurgery and other such skin abrasion procedures associated with the removal of scars, tattoos, and/or which are performed as a treatment for acne. Replacement of an existing breast implant is excluded if the earlier breast implant was a Cosmetic Procedure. (Replacement of an existing breast implant is considered reconstructive if the initial breast implant followed mastectomy.) Physical conditioning programs such as athletic training, bodybuilding, exercise, fitness, flexibility, and diversion or general motivation. Weight loss programs for medical and non-medical reasons. Wigs, regardless of the reason for the hair loss.

K. Providers

Services performed by a provider with your same legal residence or who is a family member by birth or marriage, including spouse, brother, sister, parent or child. This includes any service the provider may perform on himself or herself. Services provided at a free-standing or Hospital-based diagnostic facility without an order written by a Physician or other provider as further described in Section 2 of the SPD (this exclusion does not apply to mammography testing).

L. Reproduction

Health services and associated expenses for infertility treatments. Surrogate parenting. The reversal of voluntary sterilization.

M. Services Provided under Another Plan

Health services for which other coverage is required by federal, state or local law to be purchased or provided through other arrangements, including but not limited to coverage required by workers' compensation, no-fault automobile insurance, or similar legislation. If coverage under workers' compensation or similar legislation is optional because you could elect it, or could have it elected for you, Benefits will not be paid for any Injury, Mental Illness or Sickness that would have been covered under workers' compensation or similar legislation had that coverage been elected. Health services for treatment of military service-related disabilities, when you are legally entitled to other coverage and facilities are reasonably available to you. Health services while on active military duty.

N. Transplants

Health services for organ or tissue transplants are excluded, except those specified as covered in Section 1 of the SPD. Any solid organ transplant that is performed as a treatment for cancer. Health services connected with the removal of an organ or tissue from you for purposes of a transplant to another person. Health services for transplants involving mechanical or animal organs. Any multiple organ transplant not listed as a Covered Health Service in Section 1 of the SPD.

O. Travel

Travel or transportation expenses, even though prescribed by a Physician. Some travel expenses related to covered transplantation services may be reimbursed at our discretion.

P. Vision and Hearing

Purchase cost of eye glasses, contact lenses, or hearing aids. Fitting charge for hearing aids, eye glasses or contact lenses. Eye exercise therapy. Surgery that is intended to allow you to see better without glasses or other vision correction including radial keratotomy, laser, and other refractive eye surgery.

Q. Other Exclusions

Health services and supplies that do not meet the definition of a Covered Health Service - see definition in Section 10 of the SPD.

Physical, psychiatric or psychological examinations, testing, vaccinations, immunizations or treatments otherwise covered under the Plan, when such services are: (1) required solely for purposes of career, education, sports or camp, travel, employment, insurance, marriage or adoption; (2) relating to judicial or administrative proceedings or orders; (3) conducted for purposes of medical research; or (4) to obtain or maintain a license of any type.

Health services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country.

Health services received after the date your coverage under the Plan ends, including health services for medical conditions arising prior to the date your coverage under the Plan ends.

Health services for which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under the Policy. In the event that a Non-Network provider waives Copayments and/or the Annual Deductible for a particular health service, no Benefits are provided for the health service for which Copayments and/or the Annual Deductible are waived. Charges in excess of Eligible Expenses or in excess of any specified limitation.

Services for the evaluation and treatment of temporomandibular joint syndrome (TMJ), whether the services are considered to be medical or dental in nature.

Upper and lower jaw bone surgery except as required for direct treatment of acute traumatic Injury or cancer. Orthognathic surgery, jaw alignment, and treatment for the temporomandibular joint, except as a treatment of obstructive sleep apnea.

Growth hormone therapy; sex transformation operations; treatment of benign gynecomastia (abnormal breast enlargement in males); medical and surgical treatment of excessive sweating (hyperhidrosis); medical and surgical treatment for snoring, except when provided as part of treatment for documented obstructive sleep apnea. Oral appliances for snoring. Custodial care; domiciliary care; private duty nursing; respite care; rest cures.

Psychosurgery. Speech therapy except as required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke or Congenital Anomaly.

This summary of Benefits is intended only to highlight your Benefits and should not be relied upon to fully determine coverage. This plan may not cover all your health care expenses. Please refer to the Summary Plan Description for a complete listing of services, limitations, exclusions and a description of all the terms and conditions of coverage. If this description conflicts in any way with the Summary Plan Description, the Summary Plan Description prevails. Terms that are capitalized in the Benefit Summary are defined in the Summary Plan Description.