EXHIBIT 1 TO THE DECLARATION OF DANIEL R. HALEM

EXHIBIT D

	Plan maximums are combined for care received from a preferred or non-preferred provider.	
Calendar Year Deductible Individual Family Maximum 4th Quarter Carryover	N/A N/A N/A	$200 $500 Yes
Coinsurance Out-of-Pocket Limit (excluding deductible) Individual Family Maximum	100% N/A N/A	80% $1,000 $2,500
Medical Lifetime Maximum	UNLIMITED	UNLIMITED
Physician Office Visit	100% after $10 co-pay	80% after deductible
Lab & X-Ray Services	100%	80% after deductible
Inpatient Hospital Room & Board Physician Services	100% 100%	80% after deductible 80% after deductible
Emergency Room	100%	80% after deductible
Maternity Prenatal & Postnatal Care Delivery/Newborn Nursery Care	100% after $10 co-pay 100%	80% after deductible 80% after deductible
Well-Child Care (Including office visits, immunizations, etc.)	In the first year of life, 6 exams are covered at 100%, in the second year of life, 3 exams are covered. From age 2 to 6, one exam is covered every year, after age 6, one exam is covered every other year through age 18.	In the first year of life, 6 exams are covered at 100%, in the second year of life, 3 exams are covered. From age 2 to 6, one exam is covered every year, after age 6, one exam is covered every other year through age 18.

Medical Plan 26	In-Network	Out-of-Network
Private Duty Nursing (Subject to carrier's determination of medical necessity and approval)	Covered Out-of-Network	The first $2,000 in eligible charges are covered at 80% after deductible, subject to regular plan co-insurance thereafter, (80% coinsurance will apply to the first $2,000 of private duty nursing charges and does not count toward satisfying the out of pocket maximums).
Chiropractic Care (Spinal Manipulation)	100% after $10 co-pay up to 30 visits per calendar year.	80% after deductible up to 30 visits per calendar year.
Disease or Deformity of the Feet	100% after $10 co-pay up to $2,500 per calendar year.	80% after deductible up to $2,500 per calendar year.
Mental/Nervous Care		
Inpatient	30 days per calendar year. Mandated as any other illness.	30 days per calendar year. Mandated as any other illness
Outpatient	$50 per visit maximum 30 visits per calendar year.	$50 per visit maximum 30 visits per calendar year.
Alcohol and Drug Abuse		
Inpatient (Confined to a Hospital, Alcohol Abuse Center or Drug Abuse Center)	60 days per calendar year Mandated as any other illness	60 days per calendar year Mandated as any other illness
Outpatient (Treatment must be rendered in facilities in NY State that are certified by: (a) the division of alcoholism and alcohol abuse; and (b) the division of drug abuse services respectively; as medically supervised ambulatory drug abuse programs).	100% after $10 co-pay up to 60 visits per benefit year. Of these, 20 visits may be for other family members.	80% after deductible up to 60 visits per benefit year. Of these, 20 visits may be for other family members.
Second Surgical Opinion (if required)	Doctor's Responsibility	Employee's Responsibility
Penalty for Non-Compliance	Doctor's Responsibility	$500 per occurrence
Hospital Precertification Review	Doctor's Responsibility	Employee's Responsibility
Penalty for Non-Compliance	Doctor's Responsibility	$500 per occurrence
All Other Covered Charges (ie., Drugs Supplies, Durable Medical Equipment, Ambulance, etc.)	Covered Out-of-Network	80% after deductible

This is intended only as a general summary of benefits. A more complete description of benefits and the terms under which they are provided, including limitations and exclusions, are contained in the Group Certificate Booklet.PPO94NY

EXHIBIT D

GUARDIAN

PROPOSED PPO PLAN WHICH DUPLICATES STAFF DENTAL PLAN
NBA REFEREE / POLICY 208282

PPO Dental Plan ZD
DentalGuard 3

The Guardian PPO ZD	In-Network	Out-of-Network
Calendar Year Deductible · Individual · Family Note: The deductible and maximums are combined for in and out-of-network services.	$50.00 3 per family	$50.00 3 per family
Annual Maximum	$2,000	$2,000
Preventive and Diagnostic Services · Oral Examinations · X-rays · Teeth Cleaning · Fluoride Treatments for Children · Space Maintainers · Topical Sealants	100%	100%
Basic Services · Laboratory Tests · Fillings · Root Canals	80%	80%
Major Services · Gold and Porcelain Fillings · Gold and Porcelain Crowns · Installation of Bridgework and Crowns	60%	50%
Deductible Waived for Preventive Services	Yes	No
Child Orthodontia UNTIL AGE 19 Note: Ortho is not part of the network and is reimbursed the same regardless of the provider used.	50% to a lifetime maximum of $2,000	50% to a lifetime maximum of $2,000