Plan B12

Effective December 1, 2008

This is a summarization of plan coverage only and is not considered a binding contract. Please consult your employee benefit booklet and your master group contract for detailed information on plan use, benefit coverage and a complete listing of limitations and exclusions.

Deductible		**Participating Provider Out-of-Pocket**		**Non-Participating Provider Out-of-Pocket**
Individual	Family	Individual	Family	Per Person
$1,000	$3,000	$3,000	$6,000	$5,000
Lifetime Maximum Benefit: $2,000,000		**All benefits are available after the deductible, then to the out-of-pocket maximum, unless otherwise stated.**		

Benefits:	**Participating Providers**	**Non-Participating Providers**
PREVENTIVE CARE SERVICES - *Please refer to the benefits section for additional information and limitations.*		
Routine physical exams ($150 preventive benefit maximum)	100% after $25 Copayment, deductible waived, to preventive benefit maximum	80% after $25 Copayment, deductible waived, to preventive benefit maximum
Routine Lab and X-ray ($150 preventive benefit maximum)	80% with the deductible waived to the preventive benefit maximum	60% with the deductible waived to the preventive benefit maximum
Immunizations & Vaccinations	80% with the deductible waived	60% with the deductible waived
Women's routine mammograms		
Women's routine pelvic exams and Pap smear	100% after $25 Copayment, deductible waived, to preventive benefit maximum	80% after $25 Copayment, deductible waived, to preventive benefit maximum
PHYSICIAN / PROVIDER SERVICES		
Office Visits	$25 copayment, then paid at 100%, with the deductible waived	$25 copayment, then paid at 80%, with the deductible waived
Allergy Injections		
HOSPITAL SERVICES		
Inpatient & Outpatient Surgery, Room & Ancillary and Physician Services	80%	60%
MATERNITY SERVICES		
Prenatal, Delivery and Postnatal Physician and Hospital Services	80%	60%
EMERGENCY SERVICES		
Urgent Care Facility	$25 copayment, then paid at 100%, with the deductible waived	$25 copayment, then paid at 80%, with the deductible waived
Ambulance, to nearest hospital, see limitations	80%	80%
Hospital Emergency Room	80% after a $100 copayment per visit, with the deductible waived	60% after a $100 copayment per visit, with the deductible waived
OTHER FACILITIES AND SERVICES		
Outpatient Diagnostic Lab and X-Ray	80%, with deductible waived for the first $500	60%, with the deductible waived for the first $500
Outpatient imaging procedures, including CT Scans, MRIs and PET scans	80%	60%
Therapeutic Injections		
Outpatient Rehabilitation, see limitations		
Skilled Nursing Facility, see limitations		
Durable Medical Equipment, see limitations	80%	50%
Home Health Care, see limitations		

LIMITATIONS, EXCLUSIONS & EXCLUDED SERVICES

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GENERAL LIMITATIONS

- All plans have a 6-month pre-existing condition exclusion period.
- Ambulance, Air - $3,000 calendar year benefit maximum.
- Biofeedback - $800 calendar year benefit maximum.
- Copayments do not accumulate toward the calendar year deductible. Enrollees will continue to be responsible for their plan copayments after the deductible has been met. Not all services apply to the deductible.
- Deductible amounts are different depending on whether treatment is provided by a preferred, affiliated or non-par providers. These amounts are calculated separately, and do not combine for a total deductible amount.
- Deductibles and copayments do not accumulate toward the calendar year out-of-pocket Maximum. Enrollees will continue to be responsible for their plan copayments after the out-of-pocket amount has been met. Not all services are applied to the out-of-pocket maximum.
- Diabetic Self-Management Program - One program after initial diagnosis; 3 hours per year upon a change of condition, medication or treatment.
- Durable Medical Equipment - limited to $5,000 per calendar year.
- Home Health - 130 visits or $10,000 calendar year benefit maximum, whichever comes first.
- Lifetime maximum benefit is $2,000,000 per member.
- Medical supplies and devices - limited to medically necessary supplies & devices, see policy for specific list.
- Affilitated and non-participating providers - Enrollees will be responsible for any amounts charged in excess of the dollar amount Preferred Health would have paid preferred providers (UCR).
- Organ Transplant - $250,000 lifetime limitation; 12-month waiting period - InterLink providers paid at 100%; Non-InterLink providers paid at 50%.
- Orthotics (only for custom, prescribed orthotics).
- Out-of-pocket maximums are different depending on whether treatment is provided by a preferred, affiliated or non-par providers. These amounts are calculated separately, and do not combine for a total out-of-pocket maximum.
- Preventive exams, and lab & x-ray is limited to a combined maximum of $150 per calendar year benefit maximum.
- Rehabilitation (inpatient) - 60 days per calendar year benefit maximum.
- Rehabilitation (short-term outpatient) Includes physical, occupational and speech therapy; cardiac and pulmonary rehabilitation - for a combined $2,500 calendar year maximum.
- Residential Care for the treatment of mental health conditions is limited to 45 days per calendar year.
- Skilled Nursing Facility - 100 days per calendar year benefit maximum.

GENERAL EXCLUSIONS AND EXCLUDED SERVICES

Please review your employee benefit booklet and/or your master group contract for information on plan benefits, plan use and a complete listing of exclusions and limitations.