

Basic Plan

Effective July 1, 2006

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.

Calendar Year Deductible Individual / Family	Not Applicable
Stop-Loss Maximum Maximum out-of-pocket amounts for covered services, after deductible, before PHP pays 100%	\$3750/\$7500 Individual/Family
Lifetime Maximum	\$1,000,000
PLAN BENEFITS	
All benefits are available after the deductible, then to the out-of-pocket or stop loss maximum unless otherwise stated.	
BENEFITS:	ALL QUALIFIED PRACTITIONERS
PREVENTIVE CARE SERVICES	
Routine Physical Exams	\$15 Copay *
Routine Lab and X-Ray	Not Covered
Routine Immunizations/ Vaccinations	\$15 Copay *
Well-Baby Care	
Women's Routine Mammograms	
Women's Annual Exams	
PHYSICIAN / PROVIDER SERVICES	
Office Visits	50%
HOSPITAL SERVICES	
Inpatient & Outpatient Surgery; Room & Ancillary and Physician Services	50%
MATERNITY SERVICES	
Office Visits, Doctor Delivery, and Hospital Charges	50%
EMERGENCY SERVICES	
Urgent Care Facility	50%
Hospital Emergency Room	
Ambulance	
OTHER FACILITIES AND SERVICES	
Outpatient Diagnostic Lab and X-Ray	50%
Allergy & other Therapeutic Injections	
Durable Medical Equipment, Prosthetics and Orthotics	
Home Health Care	
Outpatient Rehabilitation	
Skilled Nursing Facility	

*** Deductible Waived**

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LIMITATIONS, EXCLUSIONS & EXCLUDED SERVICES

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GENERAL LIMITATIONS

- All plans have a 6-month pre-existing condition exclusion period.
- Ambulance, Ground - To nearest hospital only; Air Ambulance is not covered.
- Biofeedback - \$800 calendar year benefit maximum.
- Diabetic Self-Management Program - One program after initial diagnosis; 3 hours per year upon a change of condition, medication or treatment.
- Home Health - 60 consecutive days per condition.
- Lifetime maximum benefit is \$1,000,000 per member.
- Medical supplies and devices - limited to medically necessary supplies & devices, see policy for specific list.
- Non-participating providers - Enrollees will be responsible for any amounts charged in excess of the PHP negotiated fees with participating providers.
- 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).
- Deductibles and copayments do not accumulate toward the calendar year stop-loss limit. Enrollees will continue to be responsible for their plan copayments after the stop-loss amount has been met. Not all services are applied to the stop-loss maximum.
- Rehabilitation (inpatient) - 30 days per calendar year benefit maximum; 60 days per calendar year maximum for head or spinal cord injury.
- Rehabilitation (short-term outpatient) Includes physical, occupational and speech therapy; cardiac and pulmonary rehabilitation - 30 visits within a 60-day period.
- Skilled Nursing Facility - 20 days per calendar year benefit maximum.

GENERAL EXCLUSIONS AND EXCLUDED SERVICES

Please review your employee benefit booklet and/or your master group contract for a complete listing of exclusions and limitations.