

HSA Eligible Plans

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.

Plan Options:		Participating Provider Deductible		Non-Participating Provider Deductible		Participating Provider Out-of-Pocket		Non-Participating Provider Out-of-Pocket	
	Plan #	Individual *	Family	Individual *	Family	Individual *	Family	Individual *	Family
H100080	A51	\$1,100	\$2,200	\$2,000	\$4,000	\$3,000	\$6,000	\$6,000	\$12,000
H150080	A52	\$1,500	\$3,000	\$3,000	\$6,000	\$5,000	\$10,000	\$10,000	\$20,000
H200080	A53	\$2,000	\$4,000	\$4,000	\$8,000	\$5,000	\$10,000	\$10,000	\$20,000
H265080	A54	\$2,650	\$5,250	\$5,200	\$10,300	\$5,100	\$10,200	\$10,000	\$20,000
H5000100	A55	\$5,000	\$10,000	\$10,000	\$20,000	\$5,000	\$10,000	\$10,000	\$20,000
Lifetime Benefit Maximum:		\$2,000,000							
* The individual deductible applies only if the employee enrolls without dependents. If the employee and one or more dependents enroll, only the family deductible applies.									
Benefits:		Participating Providers				Non-Participating Providers			
All benefits are available after the deductible, then to the out-of-pocket maximum, unless otherwise stated.									
PREVENTIVE CARE SERVICES									
Routine physical exams, and lab & x-ray (limited to \$150 combined maximum per calendar year)	80% with the deductible waived to the benefit maximum (Plan H5000100 is covered at 100%)				50% with the deductible waived to the benefit maximum (Plan H5000100 is covered at 100%)				
Immunizations and Vaccinations	80% with the deductible waived (Plan H5000100 is covered at 100%)				50% with the deductible waived (Plan H5000100 is covered at 100%)				
Women's Routine Mammograms, pelvic exams and Pap smear	80% with the deductible waived (Plan H5000100 is covered at 100%)				50% with the deductible waived (Plan H5000100 is covered at 100%)				
PHYSICIAN / PROVIDER SERVICES									
Office Visits	80% (Plan H5000100 is covered at 100%)				50% (Plan H5000100 is covered at 100%)				
PRESCRIPTION DRUGS									
Outpatient prescription drugs for covered services	80% (Plan H5000100 is covered at 100%)				80% (Plan H5000100 is covered at 100%)				
HOSPITAL SERVICES									
Inpatient & Outpatient Surgery, Room & Ancillary and Physician Services	80% (Plan H5000100 is covered at 100%)				50% (Plan H5000100 is covered at 100%)				
MATERNITY SERVICES									
Prenatal, Delivery and Postnatal Physician and Hospital Services	80% (Plan H5000100 is covered at 100%)				50% (Plan H5000100 is covered at 100%)				
EMERGENCY SERVICES									
Urgent Care Facility	80% (Plan H5000100 is covered at 100%)				50% (Plan H5000100 is covered at 100%)				
Ambulance, to nearest hospital, see limitations	80% (Plan H5000100 is covered at 100%)				80% (Plan H5000100 is covered at 100%)				
Hospital Emergency Room	80%, after a \$100 copayment per visit (Plan H5000100 is covered at 100%)				50%, after a \$100 copayment per visit (Plan H5000100 is covered at 100%)				

OTHER FACILITIES AND SERVICES

Outpatient Diagnostic Lab and X-Ray	80% (Plan H5000100 is covered at 100%)	50% (Plan H5000100 is covered at 100%)
Allergy & other Therapeutic Injections		
Durable Medical Equipment, see limitations		
Home Health Care, see limitations		
Outpatient Rehabilitation, see limitations		
Skilled Nursing Facility, 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.
- 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.
- Non-participating providers - Enrollees will be responsible for any amounts charged in excess of the Preferred Health 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).
- Out-of-pocket copayments do not accumulate toward the calendar year out-of-pocket limit. 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.
- Out-of-pocket maximums and deductibles are different dependent on whether treatment is provided by a participating provider or a non-participating provider. 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.
- 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.