Major Medical Deductible Plans

Effective July 1, 2006

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Plan Options:		Deductibles		Participating Provider Out-of-Pocket		Non-Participating Provider Out-of-Pocket
	Plan	Individual	Family	Individual	Family	Per Person
MM250-24	**A70**	$250	$500	$2,000	$4,000	$5,000
MM250-36	**A71**	$250	$750	$3,000	$6,000	$5,000
MM500-24	**A72**	$500	$1,000	$2,000	$4,000	$5,000
MM500-36	**A73**	$500	$1,500	$3,000	$6,000	$5,000
MM750-24	**A74**	$750	$1,500	$2,000	$4,000	$5,000
MM750-36	**A75**	$750	$2,250	$3,000	$6,000	$5,000
MM1000-24	**A76**	$1,000	$2,000	$2,500	$5,000	$6,000
MM1000-36	**A77**	$1,000	$3,000	$3,500	$7,000	$6,000
MM1500-24	**A78**	$1,500	$3,000	$2,500	$5,000	$6,000
MM1500-36	**A79**	$1,500	$4,500	$3,500	$7,000	$6,000
MM2000-24	**A80**	$2,000	$4,000	$3,000	$6,000	$7,000
MM2000-36	**A81**	$2,000	$6,000	$4,000	$8,000	$7,000
MM2500-24	**A82**	$2,500	$5,000	$3,000	$6,000	$7,000
MM2500-36	**A83**	$2,500	$7,500	$4,000	$8,000	$7,000
MM3000-24	**A84**	$3,000	$6,000	$4,000	$8,000	$8,000
MM3000-36	**A85**	$3,000	$9,000	$5,000	$10,000	$8,000
Lifetime Benefit Maximum:		**$2,000,000**				

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	60% with the deductible waived to the benefit maximum
Immunizations & Vaccinations	80% with the deductible waived	60% with the deductible waived
Women's Routine Mammograms, pelvic exams and Pap smear	80% with the deductible waived	60% with the deductible waived
PHYSICIAN / PROVIDER SERVICES		
Office Visits	80%	60%
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	80%	60%
Ambulance, to nearest hospital, see limitations	80%	80%
Hospital Emergency Room	80%, after a $100 copayment per visit	60%, after a $100 copayment per visit

OTHER FACILITIES AND SERVICES		
Outpatient Diagnostic Lab and X-Ray	80%	60%
Allergy & other 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.
- 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 deductibles and 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 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.
- Prescription drugs, including "take home" or discharge medication, or over the counter drugs and vitamins; except as provided in the benefits section of the master group contract, or if selected on the employer/group agreement and as described in the prescription drug supplemental benefit endorsement.
- 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.