

Co-Pay / Deductible Plans

Effective December 1, 2008

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on plan use, benefit coverage and a complete listing of limitations and exclusions.

Plan Options:		Deductibles		Participating Provider Out-of-Pocket		Non-Participating Provider Out-of-Pocket	Office Calls, Preventive Care & Urgent Care (Deductible Waived)	
		Individual	Family	Individual	Family	Per Person		
CD	15-250	B00	\$250	\$750	\$2,000	\$4,000	\$5,000	\$15 Co-Pay, then 100% or 80%
CD	20-500	B02	\$500	\$1,500	\$2,000	\$4,000	\$5,000	\$20 Co-Pay, then 100% or 80%
CD	25-500	B04	\$500	\$1,500	\$2,000	\$4,000	\$5,000	\$25 Co-Pay, then 100% or 80%
CD	20-750	B06	\$750	\$2,250	\$2,000	\$4,000	\$5,000	\$20 Co-Pay, then 100% or 80%
CD	25-750	B08	\$750	\$2,250	\$2,000	\$4,000	\$5,000	\$25 Co-Pay, then 100% or 80%
CD	20-1000	B10	\$1,000	\$3,000	\$3,000	\$6,000	\$5,000	\$20 Co-Pay, then 100% or 80%
CD	25-1000	B12	\$1,000	\$3,000	\$3,000	\$6,000	\$5,000	\$25 Co-Pay, then 100% or 80%
CD	20-1500	B14	\$1,500	\$3,000	\$3,000	\$6,000	\$5,000	\$20 Co-Pay, then 100% or 80%
CD	25-1500	B16	\$1,500	\$3,000	\$3,000	\$6,000	\$5,000	\$25 Co-Pay, then 100% or 80%
CD	30-2000	B18	\$2,000	\$4,000	\$4,000	\$8,000	\$5,000	\$30 Co-Pay, then 100% or 80%
CD	30-2500	B20	\$2,500	\$5,000	\$5,000	\$10,000	\$5,000	\$30 Co-Pay, then 100% or 80%
Lifetime Benefit Maximum:		\$2,000,000						

Benefits:	Participating Providers	Non-Participating Provider
All benefits are available after the deductible, then to the out-of-pocket maximum, unless otherwise stated.		
PREVENTIVE CARE SERVICES		
Routine physical exams (limited to \$150 combined maximum per calendar year)	[\$---] copayment, then paid at 100%, with the deductible waived Subject to the benefit maximum	[\$---] copayment, then paid at 80% UCR, with the deductible waived Subject to the benefit maximum
Preventative lab & x-ray (limited to \$150 combined maximum per calendar year)	80% with the deductible waived Subject to the benefit max	60% UCR with the deductible waived Subject to the benefit max
Immunizations and Vaccinations	80% with the deductible waived	60% UCR with the deductible waived
Routine mammograms	80% with the deductible waived	60% UCR with the deductible waived
Women's Routine pelvic exams and Pap smear	[\$---] copayment, then paid at 100%, with the deductible waived	[\$---] copayment, then paid at 80% UCR, with the deductible waived
PHYSICIAN / PROVIDER SERVICES		
Office Visits, includes Mental Health	[\$---] copayment, then paid at 100%, with the deductible waived	[\$---] copayment, then paid at 80%, with the deductible waived
Allergy Injections		
HOSPITAL SERVICES		
Inpatient & Outpatient Surgery, Room & Ancillary and Physician Services	80%	60% UCR
MATERNITY SERVICES		
Prenatal, Delivery and Postnatal Physician and Hospital Services	80%	60% UCR
EMERGENCY SERVICES		
Urgent Care Facility	[\$---] copayment, then paid at 100%, with the deductible waived	[\$---] 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% UCR 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% UCR
Outpatient imaging procedures, including CT Scans, MRI's and PET scans	80%	60% UCR
Therapeutic Injections		
Outpatient Rehabilitation, see limitations		
Skilled Nursing Facility, see limitations		
Durable Medical Equipment, see limitations	80%	50% UCR
Home Health Care, see limitations		

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Plan Options:		Deductibles		Out-of-Pocket		Non Participating Provider Out-of-Pocket	Office Calls, Preventive Care & Urgent Care (Deductible Waived)
		Participating Affiliated	Non Participating	Participating Affiliated			
	Plan #	Individual	Family	Individual	Family	Per Person	
CD 15-250	B01	\$250 \$350 \$500	\$750 \$1,000 \$1,500	\$2,000 \$3,000	\$4,000 \$5,000	\$6,000	\$15 Co-Pay 100% \$25 Co-Pay 80% \$35 Co-Pay 70%
CD 20-500	B03	\$500 \$700 \$850	\$1,500 \$2,100 \$2,400	\$2,000 \$3,000	\$4,000 \$5,000	\$6,000	\$20 Co-Pay 100% \$30 Co-Pay 80% \$40 Co-Pay 70%
CD 25-500	B05	\$500 \$700 \$850	\$1,500 \$2,100 \$2,400	\$2,000 \$3,000	\$4,000 \$5,000	\$6,000	\$25 Co-Pay 100% \$35 Co-Pay 80% \$45 Co-Pay 70%
CD 20-750	B07	\$750 \$1,000 \$1,250	\$1,500 \$2,100 \$2,400	\$2,000 \$3,000	\$4,000 \$5,000	\$6,000	\$20 Co-Pay 100% \$30 Co-Pay 80% \$40 Co-Pay 70%
CD 25-750	B09	\$750 \$1,000 \$1,250	\$1,500 \$2,100 \$2,400	\$2,000 \$3,000	\$4,000 \$5,000	\$6,000	\$25 Co-Pay 100% \$35 Co-Pay 80% \$45 Co-Pay 70%
CD 20-1000	B11	\$1,000 \$1,250 \$1,500	\$3,000 \$3,500 \$4,000	\$3,000 \$3,500	\$6,000 \$7,500	\$6,000	\$20 Co-Pay 100% \$30 Co-Pay 80% \$40 Co-Pay 70%
CD 25-1000	B13	\$1,000 \$1,250 \$1,500	\$3,000 \$3,500 \$4,000	\$3,000 \$3,500	\$6,000 \$7,500	\$6,000	\$25 Co-Pay 100% \$35 Co-Pay 80% \$45 Co-Pay 70%
CD 20-1500	B15	\$1,500 \$1,750 \$2,000	\$3,000 \$3,500 \$5,000	\$3,000 \$3,500	\$6,000 \$7,500	\$6,000	\$20 Co-Pay 100% \$30 Co-Pay 80% \$40 Co-Pay 70%
CD 25-1500	B17	\$1,500 \$1,750 \$2,000	\$3,000 \$3,500 \$5,000	\$3,000 \$3,500	\$6,000 \$7,500	\$6,000	\$25 Co-Pay 100% \$35 Co-Pay 80% \$45 Co-Pay 70%
CD 30-2000	B19	\$2,000 \$2,350 \$2,500	\$4,000 \$4,700 \$5,000	\$4,000 \$4,500	\$8,000 \$8,500	\$6,000	\$30 Co-Pay 100% \$40 Co-Pay 80% \$50 Co-Pay 70%
CD 30-2500	B21	\$2,500 \$3,000 \$3,500	\$5,000 \$6,000 \$7,000	\$5,000 \$6,000	\$10,000 \$12,000	\$7,000	\$30 Co-Pay 100% \$40 Co-Pay 80% \$50 Co-Pay 70%
Lifetime Benefit Maximum:		\$2,000,000					

Benefits:	Participating Providers	Affiliated 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 (limited to \$150 combined maximum per calendar year)	[\$---] copayment, then paid at 100%, with the deductible waived Subject to the benefit maximum	[\$---] copayment, then paid at 80%UCR, with the deductible waived Subject to the benefit maximum	[\$---] copayment, then paid at 70% UCR, with the deductible waived Subject to the benefit maximum
Preventative lab & x-ray (limited to \$150 combined maximum per calendar year)	80% with the deductible waived Subject to the benefit max	70% UCR Subject to the benefit max	60% UCR Subject to the benefit max
Immunizations and Vaccinations	80% with the deductible waived	70% UCR	60% UCR
Routine Mammograms			
Women's Routine, pelvic exams and Pap smear	[\$---] copayment, then paid at 100%, with the deductible waived	[\$---] copayment, then paid at 80%UCR, with the deductible waived	[\$---] copayment, then paid at 70% UCR, with the deductible waived
PHYSICIAN / PROVIDER SERVICES			
Office Visits	[\$---] copayment, then paid at 100%, with the deductible waived	[\$---] copayment, then paid at 80%UCR, with the deductible waived	[\$---] copayment, then paid at 70% UCR, with the deductible waived
Allergy Injections			
HOSPITAL SERVICES			
Inpatient & Outpatient Surgery, Room & Ancillary and Physician Services	80%	70% UCR	60% UCR
MATERNITY SERVICES			
Prenatal, Delivery and Postnatal Physician and Hospital Services	80%	70% UCR	60% UCR
EMERGENCY SERVICES			
Urgent Care Facility	[\$---] copayment, then paid at 90%, with the deductible waived	[\$---] copayment, then paid at 90% UCR, with the deductible waived	[\$---] copayment, then paid at 90% UCR, with the deductible waived
Ambulance, to nearest hospital, see limitations	80%	80%	80%
Hospital Emergency Room	80%, after a \$100 copayment per visit, with the deductible waived	80% UCR, after a \$100 copayment per visit, with the deductible waived	80% UCR, 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	70% UCR	60% UCR
Outpatient imaging procedures, including CT Scans, MRI's and PET scans	80%	70% UCR	60% UCR
Therapeutic Injections			
Outpatient Rehabilitation, see limitations			
Skilled Nursing Facility, see limitations			
Durable Medical Equipment, see limitations	80%	70% UCR	60% UCR
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. UCR limits apply
- 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.
- Affiliated 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.
- 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,