



ACTIVE FEE-FOR-SERVICE BENEFIT SUMMARY

The following comparison is **only a summary** of the major features of the Plan. Not all exclusions and limitations have been included.

Important! You must pre-certify your hospital confinements.

If you do not pre-certify your hospital stay, the hospital benefits that would usually be payable will be reduced by 10%.

**BENEFITS
EFFECTIVE
MARCH 1, 2011**

COMPREHENSIVE MAJOR MEDICAL BENEFITS

Maximum Lifetime Benefit: \$5,000,000 per person

Out of Pocket Maximum:

If you use a Contracting Provider, your out-of-pocket maximum expense will be \$2,000.00 per person or \$4,000 per family, per calendar year. If you use a Non-Contracting Provider, your out-of-pocket maximum expense will be \$3,000 per person or \$9,000 per family, per calendar year. When your applicable co-payment limit is reached, benefits will be paid at 100% for the balance of the calendar year (50% for extended care facility).

ACTIVE PARTICIPANTS & DEPENDENTS

Fee-For-Service Plan (Benefits paid by the Plan)	Contracting Provider	Non-Contracting Provider
Calendar Year Deductible	\$250 / \$500; NEVER WAIVED WHEN APPLICABLE	\$500 per person, \$1,500 per family; NEVER WAIVED WHEN APPLICABLE
Office Visit	100% of contract rate after a \$20 co-payment Deductible Does Not Apply	60% of covered charges; Deductible Applies
Emergency Room	90% of contract rate; Deductible Applies	60% of covered charges; Deductible Applies
Inpatient Hospital	90% of contract rate; Deductible Applies	60% of covered charges; Deductible Applies
Outpatient Surgery	90% of contract rate; Deductible Applies Certain Surgeries May Require Pre-Authorization	60% of covered charges; Deductible Applies Certain Surgeries May Require Pre-Authorization
Chiropractor & Acupuncture	100% of contract rate after a \$20 co-payment; up to a maximum benefit of \$2,000 per calendar year	60% of covered charges to a maximum payment of \$2,000 per calendar year
Outpatient Therapy (Physical & Respiratory)	100% of contract rate after a \$20 co-payment; up to a maximum benefit of \$2,000 per calendar year <i>*Additional benefit for Physical Therapy only after major accident or major surgery.</i>	60% of covered charges to a maximum payment of \$2,000 per calendar year; <i>*Additional benefit for Physical Therapy only after major accident for major surgery.</i>
Routine Physical Care and Routine Female Care,	100% of contract rate after a \$20 co-payment; up to a maximum benefit of \$300 per calendar year Deductible Does Not Apply	60% of covered charges; \$300 per calendar year Deductible Applies
Well Baby Care	100% of contract rate after a \$20 co-payment; up to a maximum benefit of \$600 per calendar year Deductible Does Not Apply	60% of covered charges up to a maximum benefit of \$600 per calendar year; Deductible Applies
Infertility	Not covered	Not covered
Vasectomy, Tubal Ligation, Elective Abortions	80% of contract rate; Deductible Applies Outpatient Surgery	60% of covered charges; Deductible Applies Outpatient Surgery
Emergency Ground Ambulance	No contract provider (See non-contracting benefit)	\$50 co-payment per ground transport Deductible Does Not Apply
Home Health Care, Medical Supplies, Orthopedic Braces, Prosthetic Appliances	90% of contract rate after a \$20 co-payment Deductible Applies	60% of covered charges Deductible Applies
Lab and X-Ray	100% after a \$20 co-payment	60% of covered charges
Extended Care Facility	45% of covered charges; 55 days per period of disability; minimum 5-day inpatient hospital stay required prior to admission; must be readmitted within 7 days of discharge	35% of covered charges; 55 days per period of disability; minimum 5-day inpatient hospital stay required prior to admission; must be readmitted within 7 days of discharge
Behavioral / Mental Health	Pre-authorization required by MHN (800) 977-7962 Member and Eligible Dependent Benefit	No Benefit Available Out of Network
Inpatient Treatment	90% up to a maximum benefit of 30-days per calendar year; Deductible Applies	
Outpatient Treatment	\$30 (individual) \$15 (group) Maximum 30 visits per calendar year Deductible Does Not Apply	
Chemical Dependency	Pre-authorization required by MHN (800) 977-7962 / Member Benefit Only	No Benefit Available Out of Network

ACTIVE PARTICIPANTS & DEPENDENTS (continued)

Fee-For-Service Plan (Benefits paid by the Plan)	Contracting Provider	Non-Contracting Provider
Outpatient	100% after a \$20 co-payment; coverage limited to two episodes per lifetime	
Inpatient	90% up to a maximum benefit of 30 days per calendar year limited to two episode per lifetime; Deductible Applies	
Detoxification	90% limited to one episode per calendar year up to a maximum of \$4,000 per calendar year and coverage is limited to two episodes per lifetime; Deductible Applies	
*Prescription Drug Benefit EnvisionRxOptions (800) 361-4542		All prescriptions must be provided through an EnvisionRxOptions Retail Pharmacy or Orchard Pharmaceuticals Mail Order Service to be covered.
Retail Network Walk-in	30-day supply	
Generic	\$10 co-payment	
Formulary Brand Name	\$20 co-payment per prescription	
Non-Formulary Brand Name	\$40 co-payment per prescription; \$20 co-payment for 3 month grace period for non-formulary drugs; \$40 co-payment if not changed to formulary brand name in the 4 th month	
Mail Order	90-day supply	
Generic	\$20 co-payment	
Formulary Brand Name	\$40.00 co-payment	
Non-Formulary Brand Name	\$80 co-payment per prescription; \$40 co-payment for 3 month grace period for non-formulary drugs; \$80 co-payment if not changed to formulary brand name in the 4 th month	
Supplemental Accident Benefit	80% of contract rate; Deductible Does Not Apply	100% of covered charges incurred within 90 days of an accident up to a maximum payment of \$300 for medical and \$100 X-ray and lab services per accident Deductible Does Not Apply
Hearing Care (Exams)	100% of contract rate up to \$100 maximum per calendar year; Deductible Does Not Apply	100% of covered charges; up to \$100 per calendar year maximum; Deductible Does Not Apply
Hearing Aid Benefit	100% of covered charges up to a maximum payment of \$2,000 per device; 1 device per ear (once every 3 years to the date); Deductible Does Not Apply	100% of covered charges up to a maximum payment of \$2,000 per device; 1 device per ear (once every 3 years to the date); Deductible Does Not Apply
Vision Benefit Vision Service Plan (800) 877-7195	\$25 deductible per 12 months; Vision exam once per 12 months; Lenses: once each 12 months; 2 nd pair glasses: for member only, \$10 deductible per 12 months	Not Covered (must use VSP or Spectera Vision Provider)
Frames	\$150 frame allowance plus lens extras; once every 24 months for member and dependents	" " " " " "
Contact Lenses	\$150 allowance	" " " " " "
Spectera Vision (800) 839-3242	\$10 exam and \$10 materials co-payment; Vision exam once per 12 months; Lenses: once each 12 months; 2 nd pair glasses: for member only, \$10 deductible per 12 months	" " " " " "
Frames	\$50 frame allowance; once every 24 months for members and dependents	" " " " " "
Contact Lenses	\$105 allowance	" " " " " "
FFS Dental Benefits Delta Dental PPO (800) 765-6003	Contact Delta Dental for Fee Schedule Information	Contact Delta Dental for Fee Schedule Information

FOR ADDITIONAL BENEFIT INFORMATION PLEASE CONTACT THE TRUST FUND OFFICE AT (800) 527-4613