

Benefits Summary

<i>Services Covered</i>	<i>In-Network Providers</i>	<i>Non-Network Providers</i>
Physician & Other Medical Professional Charges		
Well Adult Care (Employee and Spouse only)	100%	50% after deductible
Preventive Prostate Screening: Age 20 to 40: one PSA test every 3 years Age 40 and over: one PSA test per year	100%	50% after deductible
Routine Mammograms Age 35 to 40: one routine per five year period Age 40 and over: one routine per year	100%	50% after deductible
Routine Colon Cancer Screening: Over Age 40: one rectal exam per year Over Age 50: one stool slide test per year	100%	50% after deductible
Routine Proctosigmoidoscopy: One every 3 years	100%	50% after deductible
Well Child Care	100%	50% after deductible
Physician/Hospital/Other Facility/Professional Charges		
Office Visit (Non-Wellness)	\$20 or \$30 Co-Pay, then 100%	50% after deductible
Urgent Care	\$40 or \$60 Co-Pay, then 100%	50% after deductible
Hospital Facilities	70% after deductible	50% after deductible
Inpatient/Outpatient Physician	70% after deductible	50% after deductible
Outpatient Services - Radiology, Lab	70% after deductible	50% after deductible
Outpatient Surgery	70% after deductible	50% after deductible
Maternity	70% after deductible	50% after deductible
Emergency Room	\$150 Co-Pay, then 70% waived if admitted	\$150 Co-Pay, then 70% waived if admitted
Mental Nervous		
Inpatient	70% after deductible Maximum 10 days per Calendar Year	50% after deductible Maximum 10 days per Calendar Year
Outpatient	70% after deductible Maximum 10 visits per Calendar Year	50% after deductible Maximum 10 visits per Calendar Year
Substance Abuse		
Inpatient	70% after deductible Maximum 10 days per Calendar Year	50% after deductible Maximum 10 days per Calendar Year
Outpatient	70% after deductible Maximum 10 visits per Calendar Year	50% after deductible Maximum 10 visits per Calendar Year
Organ Transplant		
	70% after deductible At Centers of Excellence	\$250,000 per occurrence At Non-Centers of Excellence
Ambulance		
Air Ambulance (subject to \$5,000 maximum)	70% after deductible	50% after deductible
Home Health Care (Maximum \$100 per visit, 45 visits PCY)	70% after deductible	50% after deductible
Physical/Speech Therapy (25 visits per service)	70% after deductible	50% after deductible
Skilled Nursing Facility (30 days for each care period)	70% after deductible	50% after deductible
Durable Medical Equipment & Prosthetic Devices	70% after deductible	50% after deductible
Other Services		
Vision	\$100 per Covered Person per year	
Spinal Manipulation/Chiropractic (\$50 limit per visit, 10 visits per year)	70%	50%
Deductible/Coinsurance Options		
Deductible Options (3 per family)	\$250, \$500, \$1,000, \$1,500, \$2,000, \$3,000, \$4,000, \$5,000	\$750, \$1,500, \$3,000, \$4,500, \$6,000, \$9,000, \$12,000, \$15,000
Opt. 1 Annual Out-of-Pocket Maximum – Individual	\$4,500** (30% of \$15,000)	\$7,500** (50% of \$15,000)
Opt. 2 Annual Out-of-Pocket Maximum – Individual	\$6,000** (30% of \$20,000)	\$10,000** (50% of \$20,000)
Opt. 3 Annual Out-of-Pocket Maximum – Individual	\$3,750** (30% of \$12,500)	\$6,250** (50% of \$12,500)
Annual Out-of-Pocket Maximum – Family	2 times individual maximum	2 times individual maximum
Covered Individual Annual Maximum	\$5,000,000	

** Only applicable coinsurance percentages will accumulate towards satisfying out-of-pocket maximums. Deductibles not included in out-of-pocket maximums.
NOTE: The deductible, out-of-pocket limit and maximums can be combined or separate for both the network and non-network providers.

Other Plan Information

- Pre-existing conditions may apply to enrollees age 19 and over.
- If a generic drug is available but not dispensed, the Insured may be required to pay the difference between the generic and brand name drug cost.
- Treatments of any condition for which benefits are recovered under any Workers Compensation or Occupational Disease Law are excluded.
- Emergency/Life Threatening services performed at non-network hospitals will be paid at the in-network benefit levels contained in the policy. Included as covered under the in-network benefits are: emergency room charges, emergency room physicians, laboratory and x-ray charges, radiologist and other charges incurred while being treated in the emergency room.
- Each child who is under the age of 26 years old, and who is not eligible for coverage under their employer will be covered under this Plan. When the dependent child reaches age 26, coverage will run through the end of the month of the child's 26th birthday.

This is a general outline of covered benefits. It does not include all policy exclusions, reductions of benefits, or terms under which the policy may be continued or discontinued. For costs and complete details of the coverage, call or write your insurance agent or Preferred United Plans of Michigan.