



**Schedule of Benefits for Marin General  
Effective January 1, 2006**

This Schedule of Benefits is a summary of important terms of your health coverage. The Plan Document must be consulted to determine the exact terms and conditions of coverage. Call Customer Service at 1-888-326-2555 regarding any questions on benefits, providers, coinsurance or copays. Please note that when you receive hospital services, two separate fees are billed, one by the facility and one by the physician. See appropriate benefit types for copay and coinsurance information. This program does not require prior authorization for services, however, it is strongly recommended that you call customer service at 1-888-326-2555 before services are rendered. Please refer to prior authorization summary attached.

<b>BENEFIT TYPE</b>	<b>MGH, NCH &amp; CPMC</b> (Only when services are available. Deductible is not applicable)	<b>PPO NETWORK PROVIDER</b> (InterPlan)	<b>NON PPO NETWORK PROVIDER</b> (*Allowed Amount Applies)
<b>AMBULANCE SERVICES</b> (Ground or air transportation)	See PPO Network or Non-PPO Network tiers	\$50 Copay (Deductible is not applicable)	\$50 Copay (Deductible is not applicable)
<b>BEHAVIORAL HEALTH</b> (Excludes medically necessary detoxification and substance abuse treatment – see below) <ul style="list-style-type: none"> <li>➤ Inpatient (Facility and Professional Charges) (30 days per calendar year)</li> <li>➤ Outpatient (50 visits per calendar year)</li> </ul> <i>This benefit is administered through United Behavioral Health.</i>	100%  See PPO Network or Non-PPO Network tiers	80% (Deductible is not applicable) \$40 copay (Deductible is not applicable)	80% (Deductible is not applicable) 60% (Deductible is not applicable)
<b>CHIROPRACTIC</b>	See PPO Network or Non-PPO Network tiers	80%	60%
<b>DEDUCTIBLES</b> (Per Calendar Year – These deductibles do not apply to the out-of-pocket maximums) <ul style="list-style-type: none"> <li>➤ Individual Deductible (Combined PPO and Non PPO Network Providers)</li> <li>➤ Maximum Deductible Per Family (Combined PPO and Non PPO Network Providers)</li> </ul>	None  None	\$100  \$300	\$100  \$300
<b>DETOXIFICATION</b> (Two episodes per lifetime)  <i>This benefit is administered through United Behavioral Health.</i>	100%	80% (Deductible is not applicable)	80% (Deductible is not applicable)
<b>DIAGNOSTIC OUTPATIENT RADIOLOGY &amp; LAB</b>	100%	100% (Deductible is not applicable)	80%
<b>DURABLE MEDICAL EQUIPMENT</b> (Benefits / Eligibility Screen recommended for physician / ancillary office dispensed DME and for non-office vendor dispensed DME greater than \$250) <i>Please Note: if the rental cost exceeds the purchase price, the reimbursement will not exceed the purchase price.</i>	See PPO Network or Non-PPO Network tiers	80%	60%
<b>EMERGENCY ROOM FACILITY</b> <i>Please Note: Non-emergency use is not covered Copay is waived if admitted to hospital</i>	100%	\$50 Copay (Deductible is not applicable)	\$50 Copay (Deductible is not applicable)
<b>EMERGENCY ROOM PROFESSIONAL SERVICES</b> <i>Please Note: Non-emergency use is not covered</i>	See PPO Network or Non-PPO Network tiers	\$50 Copay (Deductible is not applicable)	\$50 Copay (Deductible is not applicable)

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<b>FAMILY PLANNING SERVICES</b>			
➤ Contraceptive devices and injectibles	See PPO Network or Non-PPO Network tiers	\$15 Copay (Deductible is not applicable)	60% (Deductible is not applicable)
➤ Voluntary Termination of Pregnancy	100%- Facility only	80%	60%
➤ Tubal Ligation	100%- Facility only	80%	60%
➤ Vasectomy	100%- Facility only	80%	60%
➤ Prenatal Care (Includes offices visits, labs, 2 ultrasounds in the physician's office)	See PPO Network or Non-PPO Network tiers	\$100 Copay per pregnancy (Deductible is not applicable)	60% (Deductible is not applicable)
➤ Hospital Delivery	100%-Facility Only	80%	60%
➤ Infertility (diagnosis only)	See PPO Network or Non-PPO Network tiers	50%	25%
<b>HOME HEALTH CARE</b>	100%	100%	100%
<b>HOSPICE</b>	See PPO Network or Non-PPO Network tiers	80%	60%
<b>HOSPITAL SERVICES</b> (other than outpatient surgery center)			
<b>Facility</b>			
➤ Inpatient	100%	90%	75%
➤ Outpatient	100%	90%	75%
<b>Professional Charges</b>			
➤ Inpatient and Outpatient	See PPO Network or Non-PPO Network tiers	90%	75%
<b>IV INFUSION</b>			
➤ Chemotherapy	100%	100%	60%
➤ Hemodialysis	100%	100%	60%
<b>LIFETIME MAXIMUM</b> Total for services performed at MGH, NCH, MHC, PPO and Non PPO Network Providers (combined)	\$5,000,000	\$5,000,000	\$5,000,000
<b>OUT-OF-POCKET MAXIMUMS (Per Calendar Year)</b>			
➤ Per Individual	None	\$2,000	\$4,000
➤ Per Family	None	\$6,000	\$12,000
<b>OUTPATIENT SURGERY (at surgery center)</b>			
➤ Facility	100%	80%	60%
➤ Professional Charges	See PPO Network or Non-PPO Network tiers	80%	60%

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<b>PHYSICAL THERAPY</b> <ul style="list-style-type: none"> <li>➤ Inpatient</li> <li>➤ Outpatient</li> </ul>	100% 100%	80% 80%	80% 80%
<b>PHYSICIAN OFFICE VISITS</b> In-office (Includes diagnostic x-rays, basic laboratory services and minor office procedures)	See PPO Network or Non-PPO Network tiers	\$15 Copay (Deductible is not applicable)	60%
<b>PREVENTIVE CARE SERVICES</b> (refer to Preventive Health Care Guidelines for covered services) \$600 calendar year maximum for all networks combined, including lab fees. Services include: <ul style="list-style-type: none"> <li>➤ Routine Physical Exams</li> <li>➤ Annual Gynecological Exam</li> <li>➤ Screening / Mammogram</li> <li>➤ Flexible Sigmoidoscopy               <ul style="list-style-type: none"> <li>➤ In-office</li> <li>➤ Outpatient</li> </ul> </li> <li>➤ Immunizations (Excludes travel immunizations)               <ul style="list-style-type: none"> <li>➤ Birth to age 19</li> <li>➤ Adults age 20+</li> </ul> </li> <li>➤ Nutritional Education Services (R.D, C.D.E only)</li> </ul>	See PPO Network or Non-PPO Network tiers  See PPO Network or Non-PPO Network tiers  100%  See PPO Network or Non-PPO Network tiers  100%  See PPO Network or Non-PPO Network tiers  100%  See PPO Network or Non-PPO Network tiers	\$15 Copay (Deductible is not applicable)  \$15 Copay (Deductible is not applicable)  100% (Deductible is not applicable)  \$15 Copay (Deductible is not applicable)  80% (Deductible is not applicable)  100%  80%  \$15 Copay (Deductible is not applicable)	75%  75%  75%  75%  75%  75%  75%
<b>RADIATION THERAPY</b>	100%	100%	60%

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<b>SKILLED NURSING FACILITY</b>			
➤ Facility Charges (Up to 60 days per each stay)	100%	100%	60%
➤ Professional Charges (Up to 60 days per each stay)	See PPO Network or Non-PPO Network tiers	90%	60%
<b>SUBSTANCE ABUSE</b>	▶ <b>Please call 1-866-374-6060</b> ◀		
➤ Inpatient (Facility and Professional Charges) (combined inpatient and day care 30 days)	See PPO Network or Non-PPO Network tiers	\$50 Copay per day (Deductible is not applicable)	30% (Deductible is not applicable)
➤ Outpatient (Facility and Professional Charges) (combined inpatient and day care 30 days)	See PPO Network or Non-PPO Network tiers	\$25 Copay (Deductible is not applicable)	30% (Deductible is not applicable)
<i>This benefit is administered through United Behavioral Health.</i>			
<b>TRANSPLANT SERVICES</b>	See PPO Network or Non-PPO Network tiers	100% must be coordinated through Future Health Transplant Case Management	Not covered
<b>URGENT CARE SERVICES</b> (at free standing clinic)	\$15 Copay at TLHP	\$20 Copay (Deductible is not applicable)	60%
<b>PRESCRIPTION SERVICES</b>			
<b>RETAIL – 30 DAY SUPPLY ONLY</b>	\$5 Generics, \$10 Brands on Preferred Drug List, \$15 All other Brands		
<b>MAIL ORDER- 90 DAY SUPPLY</b>	\$10 Generics, \$20 Brands on Preferred Drug List, \$30 All other Brands		
<b>INJECTABLES PROGRAM-</b> through Mail order	No Copay		

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*Sutter Health Partners*  
*With You. For Life.*

## **MGH Open Choice Effective January 1, 2006\***

**Note:** This plan does not require prior authorization for services; however, it is strongly recommended that you call customer services before the below list of services are rendered.

- All hospital inpatient services including; medical/surgical, rehabilitation
- Chiropractic Services
- DME
- Electrophysiological Studies
- Home Health Services
- Home Infusion
- Hospice
- Obesity Surgery
- Occupational Therapy
- Orthotics
- Outpatient Infusion
- PET Scans
- Physical Therapy
- Procedures that are cosmetic in nature
- Prosthetics
- Self Injectables (approval obtain through injectable program 1-800-562-6223)
- Skilled Nursing Services
- Sleep Studies
- Speech Therapy
- Transplants
- Vein Stripping

This is not an inclusive list so please verify with customer service at 1-888-326-2555.