

PALCO Medical and Dental Plan Summary

Effective January 1, 2008

Annual deductible	\$500/\$1500 Single/Family
Annual Out of Pocket Maximum	\$2,500/\$5,000 Single/Family
Lifetime Maximum Plan Benefit	\$1,000,000 per member

Medical Services	Benefit Amount	Comments
Physician and Podiatrist Services	80% after deductible	Requires pre-authorization for some services.
Preventive Care, up to 3 years old	80% after deductible	Includes immunizations.
Preventive Care, over 35 years old (Wellness Program)	100% no deductible. Once every 12 mos	Includes hemoccult, lipid panel, mammogram, PSA test, flu shot
Laboratory	80% after deductible	
Radiology/X-ray	80% after deductible	Requires pre-authorization for some services.
Physical, Occupational Therapy	80% after deductible	Maximum benefit 14 visits/year
Chiropractic Care	50% to maximum of \$1,000/year	Required pre-authorization after 14 visits/year.
Hospital - Emergency room	\$150 co-payment, then 80% after deductible	
Hospital - Inpatient services	80% after \$100 deductible per admit	Requires pre-authorization.
Hospital - Outpatient services	80% after deductible	Requires pre-authorization for some services.
Hospital - Urgent Care	\$50 co-payment, then 80% after deductible	
Mental Health Services - Office/Outpatient	100% after \$25 copay per visit	Maximum 25 visits/year. Access Employee Assistance Program for initial six visits.
Mental Health Services - Inpatient	80% after \$250 copayment	Maximum 30 days/year. No more than two confinements per lifetime for substance abuse.
Skilled Nursing/Convalescent Care	50% first 60 days, 25% next 30 days	Maximum benefit 90 days. Requires pre-authorization.
Durable Medical Equipment	80% after deductible	Maximum benefit \$2,000/year. Requires pre-authorization if over \$250.
Health Education	80% after deductible	
Home Health Care	80% after deductible	Maximum benefit 100 visits/year. Requires pre-authorization.
Transplants	80% after deductible	Requires pre-authorization.

Dental Services	Coverage	Comments
Plan Year Maximum Benefit	\$1,200	
Annual deductible	\$50 per member	
Type I-Preventive/Diagnostic Care	100% no deductible	Bi-annual cleaning and x-rays, other preventive/diagnostic services.
Type II-Basic Services	80% after deductible	Fillings, extractions, other general dental services.
Type III-Major Services	50% after deductible	Crowns, bridges, dentures, and other major services.
Type IV-Orthodontia	50% after deductible	Maximum \$2,000 per member available for dependents under 19 years old.

Other Benefits	Contact Information	Comments
Employee Assistance Program	707-443-1303 or 800-235-3031	Call for referral. Includes mental health (up to 6 visits/year), legal and other services.
Prescription Expenses	Health Trans 877-839-8119	Retail copayments are \$10/20/40. Mail order copays are \$20/40/100 for 90-day supply.
Vision Expenses	Superior Vision 800-507-3800	