

# HealthAmerica Small Business Solutions

2011 Plan Year • PPO Products for Southeastern Pennsylvania (2-50 Eligible Employees)

Plan Name		Participating Providers											Non-participating Providers		
		Primary Care Physician & Specialist Office Visit	Preventive Care Copay	Medical Injectable Copay (after deductible)	Urgent Care/ Emergency Room Copay	Deductible	Coinsurance (after deductible)	Inpatient Copay	Outpatient Surgery Copay	Outpatient Diagnostic X-Ray Copay	Major Radiology Copay	Out-of-Pocket Maximum*	Deductible	Coinsurance (after deductible)	Coinsurance Maximum
<b>Premier</b>	Premier PPO \$10\$10	\$10/\$10	\$0	\$75	\$10/\$150	\$0	0%	0%	0%	0%	\$125	None	\$500 (2x)	30%	\$3,000 (2x)
	Premier PPO \$10\$20	\$10/\$20	\$0	\$0	\$50/\$150	\$0	0%	\$100/day to 5 max	\$50	\$20	\$150	\$3,000 (2x)	\$300 (3x)	20%	\$3,000 (3x)
	Premier PPO \$15\$30	\$15/\$30	\$0	\$75	\$30/\$150	\$0	0%	0%	0%	0%	\$125	None	\$750 (2x)	30%	\$3,000 (2x)
	Premier PPO \$20\$40	\$20/\$40	\$0	\$0	\$50/\$150	\$0	0%	\$250/day to 5 max	\$150	\$40	\$150	\$3,000 (2x)	\$300 (3x)	20%	\$3,000 (3x)
	Premier PPO \$25\$50	\$25/\$50	\$0	\$75	\$50/\$150	\$0	0%	\$500/day to 5 max	0%	\$50	\$150	None	\$2,000 (2x)	30%	\$3,000 (2x)
	Premier PPO \$2500 (1x)	\$20/\$40	\$0	\$0	\$40/\$125	\$2,500 (1x)	0%	ded/0%	ded/0%	ded/0%	ded/0%	None	\$5,000 (1x)	20%	\$10,000 (1x)
	Premier PPO \$4000 (1x)	\$25/\$50	\$0	\$0	\$50/\$125	\$4,000 (1x)	0%	ded/0%	ded/0%	ded/0%	ded/0%	None	\$6,000 (1x)	20%	\$5,000 (1x)
	Premier PPO \$7500 (1x)	\$25/\$50	\$0	\$0	\$50/\$125	\$7,500 (1x)	0%	ded/0%	ded/0%	ded/0%	ded/0%	None	\$10,000 (1x)	20%	\$5,000 (1x)
	Premier PPO \$10000 (1x)	\$25/\$50	\$0	\$0	\$50/\$125	\$10,000 (1x)	0%	ded/0%	ded/0%	ded/0%	ded/0%	None	\$12,000 (1x)	20%	\$5,000 (1x)
		Primary Care Physician & Specialist Office Visit	Preventive Care Copay	Medical Injectable Copay (after deductible)	Urgent Care/ Emergency Room Copay	Deductible (only applies to IP/OP surgery and services)	Coinsurance (after deductible)	Inpatient Copay (after deductible)	Outpatient Surgery Copay (after deductible)	Outpatient Diagnostic X-Ray Copay	Major Radiology Copay	Out-of-Pocket Maximum*	Deductible	Coinsurance (after deductible)	Coinsurance Maximum
<b>Saver</b>	Premier Saver PPO \$500	\$10/\$20	\$0	\$0	\$50/\$150	\$500 (2x)	0%	0%	0%	\$20	\$150	\$3,000 (2x)	\$500 (2x)	50%	\$3,000 (2x)
	Premier Saver PPO \$1000	\$15/\$30	\$0	\$0	\$50/\$150	\$1,000 (2x)	0%	0%	0%	\$30	\$150	\$3,000 (2x)	\$1,000 (2x)	50%	\$3,000 (2x)
	Premier Saver PPO \$1500	\$15/\$30	\$0	\$0	\$50/\$150	\$1,500 (2x)	0%	0%	0%	\$30	\$150	\$3,000 (2x)	\$1,500 (2x)	50%	\$3,000 (2x)
	Premier Saver PPO \$2000	\$20/\$40	\$0	\$0	\$50/\$150	\$2,000 (2x)	0%	0%	0%	\$40	\$150	\$3,000 (2x)	\$2,000 (2x)	50%	\$3,000 (2x)
	Premier Saver PPO \$2500	\$25/\$50	\$0	\$0	\$50/\$150	\$2,500 (2x)	0%	0%	0%	\$50	\$150	\$3,000 (2x)	\$5,000 (2x)	30%	\$10,000 (2x)
	Premier Saver PPO \$3000	\$25/\$50	\$0	\$0	\$50/\$150	\$3,000 (2x)	0%	0%	0%	\$50	\$150	\$4,000 (2x)	\$5,000 (2x)	30%	\$10,000 (2x)
		Primary Care Physician & Specialist Office Visit	Preventive Care Copay	Medical Injectable Copay (after deductible)	Urgent Care/ Emergency Room Copay (after deductible)	Deductible	Coinsurance (after deductible)	Inpatient Copay (after deductible)	Outpatient Surgery Copay	Outpatient Diagnostic X-Ray Copay	Major Radiology Copay	Out-of-Pocket Maximum*	Deductible	Coinsurance (after deductible)	Coinsurance Maximum
<b>Choice</b>	*Choice PPO \$1500	\$20/\$40	\$0	\$75	\$40/\$150	\$1,500 (3x)	0%	0%	\$100	\$50	\$125	None	\$3,000 (3x)	30%	\$10,000 (3x)
	*Choice PPO \$2500	\$20/\$40	\$0	\$75	\$40/\$150	\$2,500 (3x)	0%	0%	\$100	\$50	\$125	None	\$5,000 (3x)	30%	\$10,000 (3x)
	*Choice PPO \$4000	\$20/\$40	\$0	\$75	\$40/\$150	\$4,000 (3x)	0%	0%	\$100	\$50	\$125	None	\$8,000 (3x)	30%	\$10,000 (3x)

# HealthAmerica Small Business Solutions *continued*



Plan Name	Participating Providers											Non-participating Providers			
	Primary Care Physician & Specialist Office Visit	Preventive Care Copay	Medical Injectable Copay (after deductible)	Urgent Care/ Emergency Room Copay (after deductible)	Deductible	Coinsurance (after deductible)	Inpatient Copay (after deductible)	Outpatient Surgery Copay (after deductible)	Outpatient Diagnostic X-Ray Copay (after deductible)	Major Radiology Copay (after deductible)	Out-of-Pocket Maximum*	Deductible	Coinsurance (after deductible)	Coinsurance Maximum	
<b>HSA Compatible</b>	**FlexChoice QHDHP PPO \$1,250	\$15/\$25	\$0	\$0	\$50/\$150	\$1,250 (2x)	0%	0%	0%	0%	\$150	\$3,000 (2x)	\$2,500 (x2)	20%	\$10,000 (2x)
	**FlexChoice QHDHP PPO \$1,500	\$15/\$25	\$0	\$0	\$25/\$125	\$1,500 (2x)	0%	0%	0%	0%	0%	\$3,000 (2x)	\$3,000 (2x)	20%	\$10,000 (2x)
	**FlexChoice QHDHP PPO \$2,000	\$15/\$25	\$0	\$0	\$25/\$125	\$2,000 (2x)	0%	0%	0%	0%	0%	\$4,000 (2x)	\$4,000 (2x)	20%	\$10,000 (2x)
	**FlexChoice QHDHP PPO \$2,500 (1x)	\$15/\$25	\$0	\$0	\$50/\$150	\$2,500 (1x)	0%	0%	0%	0%	\$150	\$4,000 (1x)	\$5,000 (1x)	20%	\$10,000 (1x)
	**FlexChoice QHDHP PPO \$2,500	\$0	\$0	\$0	\$50/\$150	\$2,500 (2x)	0%	0%	0%	0%	\$150	\$4,000 (2x)	\$5,000 (2x)	30%	\$10,000 (2x)
	**FlexChoice QHDHP PPO \$4,000 (1x)	\$20/\$40	\$0	\$0	\$50/\$150	\$4,000 (1x)	0%	0%	0%	0%	\$150	\$5,000 (1x)	\$5,000 (1x)	20%	\$10,000 (1x)

### Notes Regarding All Plans

- Lifetime Maximums are unlimited.
  - Deductible at the participating provider level may not apply to qualified preventive services; see your Schedule of Benefits to determine if deductibles are waived for qualified preventive services.
  - Mandatory generic Rx riders apply an ancillary charge for any brand drugs when generic options are available in the same drug class.
  - \* These plans include Rx plan \$10/\$35/\$60.
  - \*\* These plans include Rx plan \$3/\$10/\$20/\$45 and \$3/\$10/\$35/\$60.
- Pennsylvania in-area PPO and CCPPO (POS) products are underwritten by HealthAssurance Pennsylvania, Inc. (d.b.a. HealthAmerica). All out-of-area PPO products are underwritten by Coventry Health and Life Insurance Company (d.b.a. HealthAmerica). This brochure is not a contract. It is intended solely to provide you with an overview of the plan and you should not rely on it when trying to determine whether a service, etc. is covered under your health benefit plan. Complete details of benefits, terms and exclusions are set forth in the group contract. **This managed care plan may not cover all your health care expenses. Read your contract carefully to determine which health care services are covered. If you have any questions call us at 866-522-3886.**

Prescription Drug Plan – Retail					
Rx Plans Available	Tier 1A (if needed)	Tier 1	Tier 2	Tier 3	Type
\$3/\$10/\$20/\$45	\$3	\$10	\$20	\$45	Mandatory generic
\$3/\$10/\$25/\$50	\$3	\$10	\$25	\$50	Mandatory generic
\$3/\$10/\$35/\$60	\$3	\$10	\$35	\$60	Incentive OR Mandatory
\$3/\$15/\$30/\$55	\$3	\$15	\$30	\$55	Mandatory generic
\$3/\$15/\$35/\$60	\$3	\$15	\$35	\$60	Mandatory generic
\$3/\$20/\$40/\$70	\$3	\$20	\$40	70	Incentive OR Mandatory
\$3/\$10/\$50% Closed Formulary	\$3	\$10	50% (50% Mail Order)	No Coverage	Mandatory generic
Mail Order	2	2	2.5	3	

### Prescription Drug Tier Level Descriptions

- Tier 1A:** Includes common antibiotics, pain relievers, acid reducers, anti-depressants, blood pressure and cholesterol lowering drugs, and more.
- Tier 1:** Includes more generic and a few selected OTC (over-the-counter) drugs.
- Tier 2:** Preferred brand-name drugs.
- Tier 3:** Nonpreferred brand-name, and a few nonpreferred generic drugs. These drugs may have a lower cost alternative on Tier 1 or Tier 2.
- \*No deductible Tier 1.
- \*\*Riders available for qualified benefit plans.

<b>DEDUCTIBLES AND MAXIMUMS</b>	<b>Participating MEMBER RESPONSIBILITY</b>	<b>Non-Participating MEMBER RESPONSIBILITY</b>
<b>Annual Deductible</b> (Inpatient and Infertility deductibles apply separately from annual deductible)		
Individual	None	\$500
Family (aggregate)	None	\$1,000
<b>Out-of-Pocket Maximum</b> (excludes deductibles and copays)		
Individual	None	\$3,000
Family (aggregate)	None	\$6,000
<b>OUTPATIENT SERVICES</b>	<b>Participating MEMBER RESPONSIBILITY</b>	<b>Non-Participating MEMBER RESPONSIBILITY</b>
<b>Physician Services (for illness or injury)</b>	<b>(office visit NOT subject to deductible)</b>	
Primary Care Visit (PCP)	\$10 Copay	30% Eligible Charges (after annual deductible)
Specialist Visit (SCP)	\$10 Copay	30% Eligible Charges (after annual deductible)
<b>Preventive Services*</b>	<b>(office visit NOT subject to deductible)</b>	
Gynecological Exam (PCP/SCP)	\$0 Copay	30% Eligible Charges (after annual deductible)
Well Child Visit	\$0 Copay	30% Eligible Charges (after annual deductible)
Adult Physical Visit	\$0 Copay	30% Eligible Charges (after annual deductible)
Routine Pediatric Immunizations	0%	30% Eligible Charges
Hearing Exams (under age 18)	0%	30% Eligible Charges (after annual deductible)
Routine Mammograms	0%	30% Eligible Charges (after annual deductible)
Routine Colonoscopies***	0%	30% Eligible Charges (after annual deductible)
<b>Medical Injectable</b> (Therapies including but not limited to: Remicade, Tysabri, Amevive, Boniva, Reclast)	\$75 Copay	30% Eligible Charges (after annual deductible)
<b>Allergy Testing &amp; Allergy Serum</b>	0%	30% Eligible Charges (after annual deductible)
<b>Chiropractic Care</b> (x-rays are subject to deductible) Maximum 20 visits per contract year	\$10 Copay	30% Eligible Charges (after annual deductible)
<b>Outpatient Surgery</b>	0%	30% Eligible Charges (after annual deductible)
<b>Lab Services</b>	0%	30% Eligible Charges (after annual deductible)
<b>Diagnostic X-ray</b>	0%	30% Eligible Charges (after annual deductible)
<b>Radiology</b> (CAT, MRI, Ultrasound, PET)	\$125 Copay	30% Eligible Charges (after annual deductible)
<b>HOSPITAL SERVICES</b>	<b>Participating MEMBER RESPONSIBILITY</b>	<b>Non-Participating MEMBER RESPONSIBILITY</b>
<b>Hospital Care</b>		
Semi-private room (private room if medically necessary)	0%	30% Eligible Charges (after annual deductible)
Physician and Surgeon Fees	0%	30% Eligible Charges (after annual deductible)
Surgery	0%	30% Eligible Charges (after annual deductible)
Lab and X-ray services	0%	30% Eligible Charges (after annual deductible)
All Medically Necessary Ancillary Services	0%	30% Eligible Charges (after annual deductible)
Anesthesia	0%	30% Eligible Charges (after annual deductible)
Administration of Blood	0%	30% Eligible Charges (after annual deductible)
Blood Products	0%	30% Eligible Charges (after annual deductible)
Therapy Services (Chemotherapy & Radiation Therapy)	0%	30% Eligible Charges (after annual deductible)
<b>MATERNITY SERVICES</b>	<b>Participating MEMBER RESPONSIBILITY</b>	<b>Non-Participating MEMBER RESPONSIBILITY</b>
<b>Pregnancy Care</b> (PCP/SCP) (copay for the first office visit only)	\$10 Copay	30% Eligible Charges (after annual deductible)
<b>Delivery</b>	0%	30% Eligible Charges (after annual deductible)
<b>FAMILY PLANNING</b>	<b>Participating MEMBER RESPONSIBILITY</b>	<b>Non-Participating MEMBER RESPONSIBILITY</b>
<b>Infertility Counseling/Testing/Services</b>	\$300 One Time Deductible Then Coinsurance Applies	
<b>Tubal Ligation/Vasectomy</b>	0%	30% Eligible Charges (after annual deductible) \$2,400 combined benefit maximum
<b>PRESCRIPTION DRUGS</b>	<b>Participating MEMBER RESPONSIBILITY</b>	<b>Non-Participating MEMBER RESPONSIBILITY</b>
(Includes oral contraceptives & managed formulary. Mandatory generic substitution may apply)	<b>Refer to the RX Select formulary to identify which drugs do not require authorization. Quantity limits still apply.</b> <b>VARIOUS RIDERS AVAILABLE</b> <b>COVERED ONLY AT PARTICIPATING PHARMACIES</b>	
<b>EMERGENCY CARE</b>	<b>Participating MEMBER RESPONSIBILITY</b>	<b>Non-Participating MEMBER RESPONSIBILITY</b>
Urgent Care Center	\$10 Copay	
Emergency Room Services (not subject to deductible)	0% after \$150 Copay (ER Copay waived if admitted)	
<b>REHABILITATION SERVICES</b>	<b>Participating MEMBER RESPONSIBILITY</b>	<b>Non-Participating MEMBER RESPONSIBILITY</b>
<b>Occupational, Speech, Physical Therapy</b>	0%	30% Eligible Charges (after annual deductible)
	45 inpatient days per contract year 30 outpatient visits per contract year	

<b>MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES</b>		
	<b>Participating MEMBER RESPONSIBILITY</b>	<b>Non-Participating MEMBER RESPONSIBILITY</b>
<b>General Mental Health:</b>	<i>(Mental health services must be preauthorized)</i>	
Inpatient	0%	30% Eligible Charges (after annual deductible)
	<i>30 days per contract year 90 day lifetime benefit maximum</i>	
Physician Services (Outpatient)	\$10 Copay per visit	30% Eligible Charges (after annual deductible)
	<i>20 outpatient visits maximum per contract year</i>	
<b>Serious Mental Health:</b>		
Inpatient	0%	30% Eligible Charges (after annual deductible)
	<i>30 days per contract year 90 day lifetime benefit maximum</i>	
Physician Services (Outpatient)	\$10 Copay per visit	30% Eligible Charges (after annual deductible)
	<i>60 outpatient visits maximum per contract year</i>	
<b>Substance Abuse:</b>		
Inpatient Detoxification	0%	30% Eligible Charges (after annual deductible)
	<i>7 days maximum per admission 4 admission benefit maximum</i>	
Inpatient Rehabilitation	0%	30% Eligible Charges (after annual deductible)
	<i>30 days maximum per contract year 90 days benefit maximum</i>	
Transitional Partial Hospitalization	0%	30% Eligible Charges (after annual deductible)
	<i>60 visits per contract year 120 visits per benefit maximum</i>	
<b>OTHER BENEFITS</b>		
	<b>Participating MEMBER RESPONSIBILITY</b>	<b>Non-Participating MEMBER RESPONSIBILITY</b>
<b>Claim Forms Required</b>	No	Yes
<b>Durable Medical Equipment (DME)</b> – Limited to once every 2 years for irreparable damage and/or normal wear.	0%	30% Eligible Charges (after annual deductible)
<b>Corrective Appliances</b>	0%	30% Eligible Charges (after annual deductible)
<b>Home Health Care Services</b>	0% <i>120 visits per contract year</i>	30% Eligible Charges (after annual deductible) <i>60 visits per contract year</i>
	<i>120 visits combined per contract year</i>	
<b>Hospice Care</b>	0%	30% Eligible Charges (after annual deductible)
<b>Skilled Nursing Facility</b>	0% <i>100 inpatient days per contract year</i>	30% Eligible Charges (after annual deductible) <i>50 inpatient days per contract year</i>
	<i>100 days combined maximum per contract year</i>	
<b>Dental Services</b>		
Emergency treatment of dental injury	0%	30% Eligible Charges (after annual deductible)
Removal of Third Molars	0%	30% Eligible Charges (after annual deductible)
<b>Vision Services</b>	<b>Vision One Eyecare Program®:</b> Receive immediate savings on all eyecare needs--discounts on frames, lenses, disposable contacts, and even LASIK surgery--at participating providers through the EyeMed Vision Care network.	
<b>Health Education</b>	Members receive reimbursement of the cost of approved wellness programs offered through local hospitals and organizations.**	
<b>PRECERTIFICATION REQUIREMENT</b>	By Physician	By Patient
When using a nonparticipating provider, the member must obtain precertification of nonemergency hospital and other facility (e.g., skilled nursing facilities, rehabilitation facilities, drug and alcohol treatment facilities) admissions, outpatient surgery and certain other services as stated in the Group Contract. If these services or admissions are not precertified and the service is not medically necessary, the member may be responsible for 100% of the cost of the services.		
<b>LIFETIME MAXIMUM</b>	Unlimited	
<b>Autism Spectrum Disorders are covered pursuant to state mandates for groups with 51 or more employees.</b>		
This is not a contract. It is intended solely to provide you with an overview of the plan. Complete details of benefits, terms and exclusions are governed by your Group Contract. <b>This managed care plan may not cover all your health care expenses. Read your contract carefully to determine which health care services are covered. If you have questions call us at 800.788.8445 in Central/Eastern Pennsylvania, and 800.735.4404 in Western Pennsylvania and Ohio.</b>		
Benefits are administered on a contract year basis. Coinsurance is based on Eligible Charges as defined in your Certificate of Insurance. For non-participating providers, Eligible Charges are based on the lesser of the provider's billed charges or our Out-of-Network Rate, which is defined in your Certificate of Insurance. <b>In addition to your copay or coinsurance, you are responsible for paying nonparticipating providers the difference between our out-of-network rate and their actual charge for nonemergency services. Your out-of-pocket costs for nonemergency care from nonparticipating providers may be substantial.</b>		
<i>Dependent Coverage Age Limit is 26</i>		
*If your Schedule of Benefits indicates that you have a Qualified High Deductible Health Plan., you must consult your group benefit documents for a specific description and the terms and conditions of your coverage for these benefits. Also, some covered services that you receive during a preventive service office visit may not qualify as preventive services under the group contract and, consequently, will be subject to applicable deductibles. In order to be exempt from applicable deductibles, preventive services must qualify as preventive services under the group contract and Section 223 of the Internal Revenue Code.		
*** The physician must bill the claim with a preventive diagnosis code in order to apply under preventive benefits coverage.		
<b>This document neither affirmatively nor negatively amends, extends, or alters the terms of or the coverage afforded by policy referenced herein</b>		
**Reimbursement for Weight Management programs is limited to \$350 per calendar year per member.		

<b>DEDUCTIBLES AND MAXIMUMS</b>	<b>Participating MEMBER RESPONSIBILITY</b>	<b>Non-Participating MEMBER RESPONSIBILITY</b>
<b>Annual Deductible</b>		
Individual	None	\$300
Family (aggregate)	None	\$900
<b>Out-of-Pocket Maximum (includes deductibles, copays and coinsurance; excludes Rx copays)</b>		
Individual	\$3,000	\$3,000
Family (aggregate)	\$6,000	\$9,000
<b>OUTPATIENT SERVICES</b>	<b>Participating MEMBER RESPONSIBILITY</b>	<b>Non-Participating MEMBER RESPONSIBILITY</b>
<b>Physician Services (for illness or injury)</b>		
Primary Care Visit (PCP)	\$10 Copay	20% Eligible Charges (after annual deductible)
Specialist Visit (SCP)	\$20 Copay	20% Eligible Charges (after annual deductible)
<b>Preventive Services*</b>		
Gynecological Exam (PCP/SCP)	\$0 Copay	20% Eligible Charges (after annual deductible)
Well Child Visit	\$0 Copay	20% Eligible Charges (after annual deductible)
Adult Physical Visit	\$0 Copay	20% Eligible Charges (after annual deductible)
Routine Pediatric Immunizations	0%	20% Eligible Charges
Hearing Exams (under age 18)	0%	20% Eligible Charges (after annual deductible)
Routine Mammograms	0%	20% Eligible Charges (after annual deductible)
<b>Allergy Testing &amp; Allergy Serum</b>	0%	20% Eligible Charges (after annual deductible)
<b>Chiropractic Care</b>	\$20 Copay	20% Eligible Charges (after annual deductible)
Maximum 20 visits per contract year		
<b>Outpatient Surgery</b>	\$50 Copay	20% Eligible Charges (after annual deductible)
<b>Lab Services</b>	0%	20% Eligible Charges (after annual deductible)
<b>Diagnostic X-ray</b>	\$20 Copay	20% Eligible Charges (after annual deductible)
<b>Radiology (CAT, MRI, Ultrasound)</b>	\$150 Copay	20% Eligible Charges (after annual deductible)
<b>HOSPITAL SERVICES</b>	<b>Participating MEMBER RESPONSIBILITY</b>	<b>Non-Participating MEMBER RESPONSIBILITY</b>
<b>Hospital Care</b>		
Semi-private room (private room if medically necessary)	\$100/day, 5 day maximum	20% Eligible Charges (after annual deductible)
Physician and Surgeon Fees	0%	20% Eligible Charges (after annual deductible)
Surgery	0%	20% Eligible Charges (after annual deductible)
Lab and X-ray services	0%	20% Eligible Charges (after annual deductible)
All Medically Necessary Ancillary Services	0%	20% Eligible Charges (after annual deductible)
Anesthesia	0%	20% Eligible Charges (after annual deductible)
Administration of Blood	0%	20% Eligible Charges (after annual deductible)
Blood Products	0%	20% Eligible Charges (after annual deductible)
Therapy Services (Chemotherapy & Radiation Therapy)	0%	20% Eligible Charges (after annual deductible)
<b>MATERNITY SERVICES</b>	<b>Participating MEMBER RESPONSIBILITY</b>	<b>Non-Participating MEMBER RESPONSIBILITY</b>
<b>Pregnancy Care (PCP/SCP)</b> (copay for the first office visit only)	\$10/\$20 Copay	20% Eligible Charges (after annual deductible)
Delivery	\$100/day, 5 day maximum	20% Eligible Charges (after annual deductible)
<b>FAMILY PLANNING</b>	<b>Participating MEMBER RESPONSIBILITY</b>	<b>Non-Participating MEMBER RESPONSIBILITY</b>
<b>Infertility Counseling/Testing/Services</b>	\$300 one time deductible then coinsurance applies; (\$2,400 combined benefit maximum for infertility)	
<b>Tubal Ligation/Vasectomy</b>	0%	20% Eligible Charges (after annual deductible)
<b>PRESCRIPTION DRUGS</b>	<b>Participating MEMBER RESPONSIBILITY</b>	<b>Non-Participating MEMBER RESPONSIBILITY</b>
(Includes oral contraceptives & managed formulary. Mandatory generic substitution may apply)	<b>Refer to the RX Select formulary to identify which drugs do not require authorization. Quantity limits still apply.</b> <b>VARIOUS RIDERS AVAILABLE</b> <b>COVERED ONLY AT PARTICIPATING PHARMACIES</b>	
<b>EMERGENCY CARE</b>	<b>Participating MEMBER RESPONSIBILITY</b>	<b>Non-Participating MEMBER RESPONSIBILITY</b>
Urgent Care Center		\$50 Copay
Emergency Room Services (not subject to deductible)	\$150 Copay (ER Copay waived if admitted)	
<b>REHABILITATION SERVICES</b>	<b>Participating MEMBER RESPONSIBILITY</b>	<b>Non-Participating MEMBER RESPONSIBILITY</b>
<b>Occupational, Speech, Physical Therapy</b>	0%	20% Eligible Charges (after annual deductible)
	\$100/day, 5 day maximum	
	45 inpatient days per contract year 30 outpatient visits per contract year	

SERVICES	Participating	Non-Participating
	MEMBER RESPONSIBILITY	MEMBER RESPONSIBILITY
<b>General Mental Health:</b> Inpatient	(Mental health services must be preauthorized)	
	\$100/day, 5 day maximum	20% Eligible Charges (after annual deductible)
Physician Services (Outpatient)	<i>30 days per contract year 90 day lifetime benefit maximum</i>	
	\$20 Copay per visit	20% Eligible Charges (after annual deductible)
<b>Serious Mental Health:</b> Inpatient	<i>20 outpatient visits maximum per contract year</i>	
	\$100/day, 5 day maximum	20% Eligible Charges (after annual deductible)
Physician Services (Outpatient)	<i>30 days per contract year 90 day lifetime benefit maximum</i>	
	\$20 Copay per visit	20% Eligible Charges (after annual deductible)
<b>Substance Abuse:</b> Inpatient Detoxification	<i>60 outpatient visits maximum per contract year</i>	
	\$100/day, 5 day maximum	20% Eligible Charges (after annual deductible)
Inpatient Rehabilitation	<i>7 days maximum per admission 4 admission benefit maximum</i>	
	\$100/day, 5 day maximum	20% Eligible Charges (after annual deductible)
Transitional Partial Hospitalization	<i>30 days maximum per contract year 90 days benefit maximum</i>	
	0%	20% Eligible Charges (after annual deductible)
	<i>60 visits per contract year 120 visits per benefit maximum</i>	
OTHER BENEFITS	Participating	Non-Participating
	MEMBER RESPONSIBILITY	MEMBER RESPONSIBILITY
<b>Claim Forms Required</b>	No	Yes
<b>Durable Medical Equipment (DME) / Corrective Appliances</b> Limited to once every 2 years for irreparable damage and/or normal wear.	50%	50% Eligible Charges (after annual deductible)
<b>Home Health Care Services</b>	0% <i>120 visits per contract year</i>	20% Eligible Charges (after annual deductible) <i>60 visits per contract year</i>
<b>Hospice Care</b>	<i>120 visits combined per contract year</i>	
<b>Skilled Nursing Facility</b>	\$100/day, 5 day maximum	20% Eligible Charges (after annual deductible)
	\$100/day, 5 day maximum	20% Eligible Charges (after annual deductible)
	<i>100 inpatient days per contract year 100 days combined maximum per contract year</i>	
<b>Dental Services</b>		
Emergency treatment of dental injury	0%	20% Eligible Charges (after annual deductible)
Removal of Third Molars	0%	20% Eligible Charges (after annual deductible)
<b>Vision Services</b>	Vision One Eyecare Program®: Receive immediate savings on all eyecare needs--discounts on frames, lenses, disposable contacts, and even LASIK surgery--at participating providers through the EyeMed Vision Care network.	
<b>Health Education</b>	Members receive reimbursement of the cost of approved wellness programs offered through local hospitals and organizations.**	
<b>PRECERTIFICATION REQUIREMENT</b>	By Physician	By Patient
When using a nonparticipating provider, the member must obtain precertification of nonemergency hospital and other facility (e.g., skilled nursing facilities, rehabilitation facilities, drug and alcohol treatment facilities) admissions, outpatient surgery and certain other services as stated in the Group Contract. If these services or admissions are not precertified and the service is not medically necessary, the member may be responsible for 100% of the cost of the services.		
<b>LIFETIME MAXIMUM</b>	Unlimited	
<p><b>Autism Spectrum Disorders are covered pursuant to state mandates for groups with 51 or more employees.</b> This is not a contract. It is intended solely to provide you with an overview of the plan. Complete details of benefits, terms and exclusions are governed by your Group Contract. <b>This managed care plan may not cover all your health care expenses. Read your contract carefully to determine which health care services are covered. If you have questions call us at 800.788.8445 in Central/Eastern Pennsylvania, and 800.735.4404 in Western Pennsylvania and Ohio.</b></p> <p>Benefits are administered on a contract year basis. Coinsurance is based on Eligible Charges as defined in your Certificate of Insurance. For non-participating providers, Eligible Charges are based on the lesser of the provider's billed charges or our Out-of-Network Rate, which is defined in your Certificate of Insurance. <b>In addition to your copay or coinsurance, you are responsible for paying nonparticipating providers the difference between our out-of-network rate and their actual charge for nonemergency services. Your out-of-pocket costs for nonemergency care from nonparticipating providers may be substantial.</b></p> <p><i>Dependent Coverage Age Limit is 26</i></p> <p>*If your Schedule of Benefits indicates that you have a Qualified High Deductible Health Plan, you must consult your group benefit documents for a specific description and the terms and conditions of your coverage for these benefits. Also, some covered services that you receive during a preventive service office visit may not qualify as preventive services under the group contract and, consequently, will be subject to applicable deductibles. In order to be exempt from applicable deductibles, preventive services must qualify as preventive services under the group contract and Section 223 of the Internal Revenue Code.</p> <p>This document neither affirmatively nor negatively amends, extends, or alters the terms of or the coverage afforded by policy referenced herein.</p> <p>**Reimbursement for Weight Management programs is limited to \$350 per calendar year per member.</p>		

<b>DEDUCTIBLES AND MAXIMUMS</b>	<b>Participating MEMBER RESPONSIBILITY</b>	<b>Non-Participating MEMBER RESPONSIBILITY</b>
<b>Annual Deductible</b> (Inpatient and Infertility deductibles apply separately from annual deductible)		
Individual	None	\$750
Family (aggregate)	None	\$1,500
<b>Out-of-Pocket Maximum</b> (excludes deductibles and copays)		
Individual	None	\$3,000
Family (aggregate)	None	\$6,000
<b>OUTPATIENT SERVICES</b>	<b>Participating MEMBER RESPONSIBILITY</b>	<b>Non-Participating MEMBER RESPONSIBILITY</b>
<b>Physician Services (for illness or injury)</b>	<b>(office visit NOT subject to deductible)</b>	
Primary Care Visit (PCP)	\$15 Copay	30% Eligible Charges (after annual deductible)
Specialist Visit (SCP)	\$30 Copay	30% Eligible Charges (after annual deductible)
<b>Preventive Services*</b>	<b>(office visit NOT subject to deductible)</b>	
Gynecological Exam (PCP/SCP)	\$0 Copay	30% Eligible Charges (after annual deductible)
Well Child Visit	\$0 Copay	30% Eligible Charges (after annual deductible)
Adult Physical Visit	\$0 Copay	30% Eligible Charges (after annual deductible)
Routine Pediatric Immunizations	0%	30% Eligible Charges
Hearing Exams (under age 18)	0%	30% Eligible Charges (after annual deductible)
Routine Mammograms	0%	30% Eligible Charges (after annual deductible)
Routine Colonoscopies***	0%	30% Eligible Charges (after annual deductible)
<b>Medical Injectable</b> (Therapies including but not limited to: Remicade, Tysabri, Amevive, Boniva, Reclast)	\$75 Copay	30% Eligible Charges (after annual deductible)
<b>Allergy Testing &amp; Allergy Serum</b>	0%	30% Eligible Charges (after annual deductible)
<b>Chiropractic Care</b> (x-rays are subject to deductible) Maximum 20 visits per contract year	\$30 Copay	30% Eligible Charges (after annual deductible)
<b>Outpatient Surgery</b>	0%	30% Eligible Charges (after annual deductible)
<b>Lab Services</b>	0%	30% Eligible Charges (after annual deductible)
<b>Diagnostic X-ray</b>	0%	30% Eligible Charges (after annual deductible)
<b>Radiology</b> (CAT, MRI, Ultrasound, PET)	\$125 Copay	30% Eligible Charges (after annual deductible)
<b>HOSPITAL SERVICES</b>	<b>Participating MEMBER RESPONSIBILITY</b>	<b>Non-Participating MEMBER RESPONSIBILITY</b>
<b>Hospital Care</b>		
Semi-private room (private room if medically necessary)	0%	30% Eligible Charges (after annual deductible)
Physician and Surgeon Fees	0%	30% Eligible Charges (after annual deductible)
Surgery	0%	30% Eligible Charges (after annual deductible)
Lab and X-ray services	0%	30% Eligible Charges (after annual deductible)
All Medically Necessary Ancillary Services	0%	30% Eligible Charges (after annual deductible)
Anesthesia	0%	30% Eligible Charges (after annual deductible)
Administration of Blood	0%	30% Eligible Charges (after annual deductible)
Blood Products	0%	30% Eligible Charges (after annual deductible)
Therapy Services (Chemotherapy & Radiation Therapy)	0%	30% Eligible Charges (after annual deductible)
<b>MATERNITY SERVICES</b>	<b>Participating MEMBER RESPONSIBILITY</b>	<b>Non-Participating MEMBER RESPONSIBILITY</b>
<b>Pregnancy Care</b> (PCP/SCP) (copay for the first office visit only)	\$15/\$30 Copay	30% Eligible Charges (after annual deductible)
<b>Delivery</b>	0%	30% Eligible Charges (after annual deductible)
<b>FAMILY PLANNING</b>	<b>Participating MEMBER RESPONSIBILITY</b>	<b>Non-Participating MEMBER RESPONSIBILITY</b>
<b>Infertility Counseling/Testing/Services</b>	\$300 One Time Deductible Then Coinsurance Applies	
<b>Tubal Ligation/Vasectomy</b>	0%	30% Eligible Charges (after annual deductible) \$2,400 combined benefit maximum
<b>PRESCRIPTION DRUGS</b>	<b>Participating MEMBER RESPONSIBILITY</b>	<b>Non-Participating MEMBER RESPONSIBILITY</b>
(Includes oral contraceptives & managed formulary. Mandatory generic substitution may apply)	<b>Refer to the RX Select formulary to identify which drugs do not require authorization. Quantity limits still apply. VARIOUS RIDERS AVAILABLE COVERED ONLY AT PARTICIPATING PHARMACIES</b>	
<b>EMERGENCY CARE</b>	<b>Participating MEMBER RESPONSIBILITY</b>	<b>Non-Participating MEMBER RESPONSIBILITY</b>
Urgent Care Center		\$30 Copay
Emergency Room Services (not subject to deductible)	0% after \$150 Copay (ER Copay waived if admitted)	
<b>REHABILITATION SERVICES</b>	<b>Participating MEMBER RESPONSIBILITY</b>	<b>Non-Participating MEMBER RESPONSIBILITY</b>
<b>Occupational, Speech, Physical Therapy</b>	0%	30% Eligible Charges (after annual deductible)
	45 inpatient days per contract year 30 outpatient visits per contract year	

<b>MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES</b>		
	<b>Participating MEMBER RESPONSIBILITY</b>	<b>Non-Participating MEMBER RESPONSIBILITY</b>
<b>General Mental Health:</b>	<i>(Mental health services must be preauthorized)</i>	
Inpatient	0%	30% Eligible Charges (after annual deductible)
	<i>30 days per contract year 90 day lifetime benefit maximum</i>	
Physician Services (Outpatient)	\$30 Copay per visit	30% Eligible Charges (after annual deductible)
	<i>20 outpatient visits maximum per contract year</i>	
<b>Serious Mental Health:</b>		
Inpatient	0%	30% Eligible Charges (after annual deductible)
	<i>30 days per contract year 90 day lifetime benefit maximum</i>	
Physician Services (Outpatient)	\$30 Copay per visit	30% Eligible Charges (after annual deductible)
	<i>60 outpatient visits maximum per contract year</i>	
<b>Substance Abuse:</b>		
Inpatient Detoxification	0%	30% Eligible Charges (after annual deductible)
	<i>7 days maximum per admission 4 admission benefit maximum</i>	
Inpatient Rehabilitation	0%	30% Eligible Charges (after annual deductible)
	<i>30 days maximum per contract year 90 days benefit maximum</i>	
Transitional Partial Hospitalization	0%	30% Eligible Charges (after annual deductible)
	<i>60 visits per contract year 120 visits per benefit maximum</i>	
<b>OTHER BENEFITS</b>		
	<b>Participating MEMBER RESPONSIBILITY</b>	<b>Non-Participating MEMBER RESPONSIBILITY</b>
<b>Claim Forms Required</b>	<b>No</b>	<b>Yes</b>
<b>Durable Medical Equipment (DME)</b> – Limited to once every 2 years for irreparable damage and/or normal wear.	0%	30% Eligible Charges (after annual deductible)
<b>Corrective Appliances</b>	0%	30% Eligible Charges (after annual deductible)
<b>Home Health Care Services</b>	0%	30% Eligible Charges (after annual deductible)
	<i>120 visits per contract year</i>	<i>60 visits per contract year</i>
	<i>120 visits combined per contract year</i>	
<b>Hospice Care</b>	0%	30% Eligible Charges (after annual deductible)
<b>Skilled Nursing Facility</b>	0%	30% Eligible Charges (after annual deductible)
	<i>100 inpatient days per contract year</i>	<i>50 inpatient days per contract year</i>
	<i>100 days combined maximum per contract year</i>	
<b>Dental Services</b>		
Emergency treatment of dental injury	0%	30% Eligible Charges (after annual deductible)
Removal of Third Molars	0%	30% Eligible Charges (after annual deductible)
<b>Vision Services</b>	<b>Vision One Eyecare Program®:</b> Receive immediate savings on all eyecare needs--discounts on frames, lenses, disposable contacts, and even LASIK surgery--at participating providers through the EyeMed Vision Care network.	
<b>Health Education</b>	Members receive reimbursement of the cost of approved wellness programs offered through local hospitals and organizations.**	
<b>PRECERTIFICATION REQUIREMENT</b>	By Physician	By Patient
When using a nonparticipating provider, the member must obtain precertification of nonemergency hospital and other facility (e.g., skilled nursing facilities, rehabilitation facilities, drug and alcohol treatment facilities) admissions, outpatient surgery and certain other services as stated in the Group Contract. If these services or admissions are not precertified and the service is not medically necessary, the member may be responsible for 100% of the cost of the services.		
<b>LIFETIME MAXIMUM</b>	Unlimited	
<p><b>Autism Spectrum Disorders are covered pursuant to state mandates for groups with 51 or more employees.</b>  This is not a contract. It is intended solely to provide you with an overview of the plan. Complete details of benefits, terms and exclusions are governed by your Group Contract. <b>This managed care plan may not cover all your health care expenses. Read your contract carefully to determine which health care services are covered. If you have questions call us at 800.788.8445 in Central/Eastern Pennsylvania, and 800.735.4404 in Western Pennsylvania and Ohio.</b>  Benefits are administered on a contract year basis. Coinsurance is based on Eligible Charges as defined in your Certificate of Insurance. For non-participating providers, Eligible Charges are based on the lesser of the provider's billed charges or our Out-of-Network Rate, which is defined in your Certificate of Insurance. <b>In addition to your copay or coinsurance, you are responsible for paying nonparticipating providers the difference between our out-of-network rate and their actual charge for nonemergency services. Your out-of-pocket costs for nonemergency care from nonparticipating providers may be substantial.</b>  <i>Dependent Coverage Age Limit is 26</i>  *If your Schedule of Benefits indicates that you have a Qualified High Deductible Health Plan., you must consult your group benefit documents for a specific description and the terms and conditions of your coverage for these benefits. Also, some covered services that you receive during a preventive service office visit may not qualify as preventive services under the group contract and, consequently, will be subject to applicable deductibles. In order to be exempt from applicable deductibles, preventive services must qualify as preventive services under the group contract and Section 223 of the Internal Revenue Code.  *** The physician must bill the claim with a preventive diagnosis code in order to apply under preventive benefits coverage.  <b>This document neither affirmatively nor negatively amends, extends, or alters the terms of or the coverage afforded by policy referenced herein</b>  <i>Reimbursement for Weight Management programs is limited to \$350 per calendar year per member.</i></p>		

<b>DEDUCTIBLES AND MAXIMUMS</b>	<b>Participating MEMBER RESPONSIBILITY</b>	<b>Non-Participating MEMBER RESPONSIBILITY</b>
<b>Annual Deductible</b>		
Individual	None	\$300
Family (aggregate)	None	\$900
<b>Out-of-Pocket Maximum (includes deductibles, copays and coinsurance; excludes Rx copays)</b>		
Individual	\$3,000	\$3,000
Family (aggregate)	\$6,000	\$9,000
<b>OUTPATIENT SERVICES</b>	<b>Participating MEMBER RESPONSIBILITY</b>	<b>Non-Participating MEMBER RESPONSIBILITY</b>
<b>Physician Services (for illness or injury)</b>		
Primary Care Visit (PCP)	\$20 Copay	20% Eligible Charges (after annual deductible)
Specialist Visit (SCP)	\$40 Copay	20% Eligible Charges (after annual deductible)
<b>Preventive Services*</b>		
Gynecological Exam (PCP/SCP)	\$0 Copay	20% Eligible Charges (after annual deductible)
Well Child Visit	\$0 Copay	20% Eligible Charges (after annual deductible)
Adult Physical Visit	\$0 Copay	20% Eligible Charges (after annual deductible)
Routine Pediatric Immunizations	0%	20% Eligible Charges
Hearing Exams (under age 18)	0%	20% Eligible Charges (after annual deductible)
Routine Mammograms	0%	20% Eligible Charges (after annual deductible)
<b>Allergy Testing &amp; Allergy Serum</b>	0%	20% Eligible Charges (after annual deductible)
<b>Chiropractic Care</b>	\$40 Copay	20% Eligible Charges (after annual deductible)
Maximum 20 visits per contract year		
<b>Outpatient Surgery</b>	\$150 Copay	20% Eligible Charges (after annual deductible)
<b>Lab Services</b>	0%	20% Eligible Charges (after annual deductible)
<b>Diagnostic X-ray</b>	\$40 Copay	20% Eligible Charges (after annual deductible)
<b>Radiology (CAT, MRI, Ultrasound)</b>	\$150 Copay	20% Eligible Charges (after annual deductible)
<b>HOSPITAL SERVICES</b>	<b>Participating MEMBER RESPONSIBILITY</b>	<b>Non-Participating MEMBER RESPONSIBILITY</b>
<b>Hospital Care</b>	\$250/day, 5 day maximum	
Semi-private room (private room if medically necessary)	0%	20% Eligible Charges (after annual deductible)
Physician and Surgeon Fees	0%	20% Eligible Charges (after annual deductible)
Surgery	0%	20% Eligible Charges (after annual deductible)
Lab and X-ray services	0%	20% Eligible Charges (after annual deductible)
All Medically Necessary Ancillary Services	0%	20% Eligible Charges (after annual deductible)
Anesthesia	0%	20% Eligible Charges (after annual deductible)
Administration of Blood	0%	20% Eligible Charges (after annual deductible)
Blood Products	0%	20% Eligible Charges (after annual deductible)
Therapy Services (Chemotherapy & Radiation Therapy)	0%	20% Eligible Charges (after annual deductible)
<b>MATERNITY SERVICES</b>	<b>Participating MEMBER RESPONSIBILITY</b>	<b>Non-Participating MEMBER RESPONSIBILITY</b>
<b>Pregnancy Care (PCP/SCP)</b>		
(copay for the first office visit only)	\$20/\$40 Copay	20% Eligible Charges (after annual deductible)
Delivery	0%	20% Eligible Charges (after annual deductible)
	\$250/day, 5 day maximum	
<b>FAMILY PLANNING</b>	<b>Participating MEMBER RESPONSIBILITY</b>	<b>Non-Participating MEMBER RESPONSIBILITY</b>
<b>Infertility Counseling/Testing/Services</b>	\$300 one time deductible then coinsurance applies; (\$2,400 combined benefit maximum for infertility)	
<b>Tubal Ligation/Vasectomy</b>	0%	20% Eligible Charges (after annual deductible)
<b>PRESCRIPTION DRUGS</b>	<b>Participating MEMBER RESPONSIBILITY</b>	<b>Non-Participating MEMBER RESPONSIBILITY</b>
(Includes oral contraceptives & managed formulary. Mandatory generic substitution may apply)	<b>Refer to the RX Select formulary to identify which drugs do not require authorization. Quantity limits still apply.</b>	
	<b>VARIOUS RIDERS AVAILABLE</b>	
	<b>COVERED ONLY AT PARTICIPATING PHARMACIES</b>	
<b>EMERGENCY CARE</b>	<b>Participating MEMBER RESPONSIBILITY</b>	<b>Non-Participating MEMBER RESPONSIBILITY</b>
Urgent Care Center		\$50 Copay
Emergency Room Services (not subject to deductible)	\$150 Copay (ER Copay waived if admitted)	
<b>REHABILITATION SERVICES</b>	<b>Participating MEMBER RESPONSIBILITY</b>	<b>Non-Participating MEMBER RESPONSIBILITY</b>
<b>Occupational, Speech, Physical Therapy</b>	0%	20% Eligible Charges (after annual deductible)
	\$250/day, 5 day maximum	
	45 inpatient days per contract year 30 outpatient visits per contract year	

SERVICES	Participating	Non-Participating
	MEMBER RESPONSIBILITY	MEMBER RESPONSIBILITY
<b>General Mental Health:</b>	(Mental health services must be preauthorized)	
Inpatient	0% \$250/day, 5 day maximum	20% Eligible Charges (after annual deductible)
	30 days per contract year 90 day lifetime benefit maximum	
Physician Services (Outpatient)	\$40 Copay per visit	20% Eligible Charges (after annual deductible)
	20 outpatient visits maximum per contract year	
<b>Serious Mental Health:</b>		
Inpatient	0% \$250/day, 5 day maximum	20% Eligible Charges (after annual deductible)
	30 days per contract year 90 day lifetime benefit maximum	
Physician Services (Outpatient)	\$40 Copay per visit	20% Eligible Charges (after annual deductible)
	60 outpatient visits maximum per contract year	
<b>Substance Abuse:</b>		
Inpatient Detoxification	0% \$250/day, 5 day maximum	20% Eligible Charges (after annual deductible)
	7 days maximum per admission 4 admission benefit maximum	
Inpatient Rehabilitation	0% \$250/day, 5 day maximum	20% Eligible Charges (after annual deductible)
	30 days maximum per contract year 90 days benefit maximum	
Transitional Partial Hospitalization	0%	20% Eligible Charges (after annual deductible)
	60 visits per contract year 120 visits per benefit maximum	
OTHER BENEFITS	Participating	Non-Participating
	MEMBER RESPONSIBILITY	MEMBER RESPONSIBILITY
<b>Claim Forms Required</b>	No	Yes
<b>Durable Medical Equipment (DME) / Corrective Appliances</b> Limited to once every 2 years for irreparable damage and/or normal wear.	50%	50% Eligible Charges (after annual deductible)
<b>Home Health Care Services</b>	0% 120 visits per contract year	20% Eligible Charges (after annual deductible) 60 visits per contract year
	120 visits combined per contract year	
<b>Hospice Care</b>	0%	20% Eligible Charges (after annual deductible)
<b>Skilled Nursing Facility</b>	\$250/day, 5 day maximum  100 inpatient days per contract year	20% Eligible Charges (after annual deductible)  50 inpatient days per contract year
	100 days combined maximum per contract year	
<b>Dental Services</b>		
Emergency treatment of dental injury	0%	20% Eligible Charges (after annual deductible)
Removal of Third Molars	0%	20% Eligible Charges (after annual deductible)
<b>Vision Services</b>	<b>Vision One Eyecare Program®:</b> Receive immediate savings on all eyecare needs--discounts on frames, lenses, disposable contacts, and even LASIK surgery--at participating providers through the EyeMed Vision Care network.	
<b>Health Education</b>	Members receive reimbursement of the cost of approved wellness programs offered through local hospitals and organizations.**	
<b>PRECERTIFICATION REQUIREMENT</b>	By Physician	By Patient
When using a nonparticipating provider, the member must obtain precertification of nonemergency hospital and other facility (e.g., skilled nursing facilities, rehabilitation facilities, drug and alcohol treatment facilities) admissions, outpatient surgery and certain other services as stated in the Group Contract. If these services or admissions are not precertified and the service is not medically necessary, the member may be responsible for 100% of the cost of the services.		
<b>LIFETIME MAXIMUM</b>	Unlimited	
<p><b>Autism Spectrum Disorders are covered pursuant to state mandates for groups with 51 or more employees.</b> This is not a contract. It is intended solely to provide you with an overview of the plan. Complete details of benefits, terms and exclusions are governed by your Group Contract. <b>This managed care plan may not cover all your health care expenses. Read your contract carefully to determine which health care services are covered. If you have questions call us at 800.788.8445 in Central/Eastern Pennsylvania, and 800.735.4404 in Western Pennsylvania and Ohio.</b></p> <p>Benefits are administered on a contract year basis. Coinsurance is based on Eligible Charges as defined in your Certificate of Insurance. For non-participating providers, Eligible Charges are based on the lesser of the provider's billed charges or our Out-of-Network Rate, which is defined in your Certificate of Insurance. <b>In addition to your copay or coinsurance, you are responsible for paying nonparticipating providers the difference between our out-of-network rate and their actual charge for nonemergency services. Your out-of-pocket costs for nonemergency care from nonparticipating providers may be substantial.</b></p> <p><i>Dependent Coverage Age Limit is 26</i></p> <p>*If your Schedule of Benefits indicates that you have a Qualified High Deductible Health Plan., you must consult your group benefit documents for a specific description and the terms and conditions of your coverage for these benefits. Also, some covered services that you receive during a preventive service office visit may not qualify as preventive services under the group contract and, consequently, will be subject to applicable deductibles. In order to be exempt from applicable deductibles, preventive services must qualify as preventive services under the group contract and Section 223 of the Internal Revenue Code.</p> <p>This document neither affirmatively nor negatively amends, extends, or alters the terms of or the coverage afforded by policy referenced herein.</p> <p>**Reimbursement for Weight Management programs is limited to \$350 per calendar year per member.</p>		

<b>DEDUCTIBLES AND MAXIMUMS</b>	<b>Participating MEMBER RESPONSIBILITY</b>	<b>Non-Participating MEMBER RESPONSIBILITY</b>
<b>Annual Deductible</b>		
Individual	None	\$2000
Family (aggregate)	None	\$4000
<b>Out-of-Pocket Maximum (excludes deductibles and copays)</b>		
Individual	None	\$3,000
Family (aggregate)	None	\$6,000
<b>OUTPATIENT SERVICES</b>	<b>Participating MEMBER RESPONSIBILITY</b>	<b>Non-Participating MEMBER RESPONSIBILITY</b>
<b>Physician Services (for illness or injury)</b>		
Primary Care Visit (PCP)	\$25 Copay	30% Eligible Charges (after annual deductible)
Specialist Visit (SCP)	\$50 Copay	30% Eligible Charges (after annual deductible)
<b>Preventive Services*</b>		
Gynecological Exam (PCP/SCP)	\$0 Copay	30% Eligible Charges (after annual deductible)
Well Child Visit	\$0 Copay	30% Eligible Charges (after annual deductible)
Adult Physical Visit	\$0 Copay	30% Eligible Charges (after annual deductible)
Routine Pediatric Immunizations	0%	30% Eligible Charges
Hearing Exams (under age 18)	0%	30% Eligible Charges (after annual deductible)
Routine Mammograms	0%	30% Eligible Charges (after annual deductible)
<i>Medical Injectable (Therapies including but not limited to: Remicade, Tysabri, Amevive, Boniva, Reclast)</i>	\$75 Copay	30% Eligible Charges (after annual deductible)
<b>Allergy Testing &amp; Allergy Serum</b>	0%	30% Eligible Charges (after annual deductible)
<b>Chiropractic Care</b>	\$50 Copay	30% Eligible Charges (after annual deductible)
Maximum 20 visits per contract year		
<b>Outpatient Surgery</b>	0%	30% Eligible Charges (after annual deductible)
<b>Lab Services</b>	0%	30% Eligible Charges (after annual deductible)
<b>Diagnostic X-ray</b>	\$50 Copay	30% Eligible Charges (after annual deductible)
<b>Radiology (CAT, MRI, Ultrasound)</b>	\$150 Copay	30% Eligible Charges (after annual deductible)
<b>HOSPITAL SERVICES</b>	<b>Participating MEMBER RESPONSIBILITY</b>	<b>Non-Participating MEMBER RESPONSIBILITY</b>
<b>Hospital Care</b>		
Semi-private room (private room if medically necessary)	\$500/day, 5 day maximum	30% Eligible Charges (after annual deductible)
Physician and Surgeon Fees	0%	30% Eligible Charges (after annual deductible)
Surgery	0%	30% Eligible Charges (after annual deductible)
Lab and X-ray services	0%	30% Eligible Charges (after annual deductible)
All Medically Necessary Ancillary Services	0%	30% Eligible Charges (after annual deductible)
Anesthesia	0%	30% Eligible Charges (after annual deductible)
Administration of Blood	0%	30% Eligible Charges (after annual deductible)
Blood Products	0%	30% Eligible Charges (after annual deductible)
Therapy Services (Chemotherapy & Radiation Therapy)	0%	30% Eligible Charges (after annual deductible)
<b>MATERNITY SERVICES</b>	<b>Participating MEMBER RESPONSIBILITY</b>	<b>Non-Participating MEMBER RESPONSIBILITY</b>
<b>Pregnancy Care (PCP/SCP)</b>	\$25/\$50 Copay	30% Eligible Charges (after annual deductible)
(copay for the first office visit only)		
Delivery	\$500/day, 5 day maximum	30% Eligible Charges (after annual deductible)
<b>FAMILY PLANNING</b>	<b>Participating MEMBER RESPONSIBILITY</b>	<b>Non-Participating MEMBER RESPONSIBILITY</b>
<b>Infertility Counseling/Testing/Services</b>	\$300 one time deductible then coinsurance applies; (\$2,400 combined benefit maximum for infertility)	
<b>Tubal Ligation/Vasectomy</b>	0%	30% Eligible Charges (after annual deductible)
<b>PRESCRIPTION DRUGS</b>	<b>Participating MEMBER RESPONSIBILITY</b>	<b>Non-Participating MEMBER RESPONSIBILITY</b>
(Includes oral contraceptives & managed formulary. Mandatory generic substitution may apply)	<b>Refer to the RX Select formulary to identify which drugs do not require authorization. Quantity limits still apply.</b> <b>VARIOUS RIDERS AVAILABLE</b> <b>COVERED ONLY AT PARTICIPATING PHARMACIES</b>	
<b>EMERGENCY CARE</b>	<b>Participating MEMBER RESPONSIBILITY</b>	<b>Non-Participating MEMBER RESPONSIBILITY</b>
Urgent Care Center		\$50 Copay
Emergency Room Services (not subject to deductible)		\$150 Copay (ER Copay waived if admitted)
<b>REHABILITATION SERVICES</b>	<b>Participating MEMBER RESPONSIBILITY</b>	<b>Non-Participating MEMBER RESPONSIBILITY</b>
<b>Occupational, Speech, Physical Therapy</b>	\$500/day, 5 day maximum	30% Eligible Charges (after annual deductible)
	45 inpatient days per contract year 30 outpatient visits per contract year	

MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES		Participating MEMBER RESPONSIBILITY	Non-Participating MEMBER RESPONSIBILITY
<b>General Mental Health:</b>		(Mental health services must be preauthorized)	
Inpatient		\$500/day, 5 day maximum	30% Eligible Charges (after annual deductible)
		<i>30 days per contract year/90 day lifetime benefit maximum</i>	
Physician Services (Outpatient)		\$50 Copay per visit	30% Eligible Charges (after annual deductible)
		<i>20 outpatient visits maximum per contract year</i>	
<b>Serious Mental Health:</b>			
Inpatient		\$500/day, 5 day maximum	30% Eligible Charges (after annual deductible)
		<i>30 days per contract year/90 day lifetime benefit maximum</i>	
Physician Services (Outpatient)		\$50 Copay per visit	30% Eligible Charges (after annual deductible)
		<i>60 outpatient visits maximum per contract year</i>	
<b>Substance Abuse:</b>			
Inpatient Detoxification		\$500/day, 5 day maximum	30% Eligible Charges (after annual deductible)
		<i>7 days maximum per admission/4 admission benefit maximum</i>	
Inpatient Rehabilitation		\$500/day, 5 day maximum	30% Eligible Charges (after annual deductible)
		<i>30 days per contract year/90 day lifetime benefit maximum</i>	
Transitional Partial Hospitalization		0%	30% Eligible Charges (after annual deductible)
		<i>60 visits per contract year/120 visits per benefit maximum</i>	
OTHER BENEFITS		Participating MEMBER RESPONSIBILITY	Non-Participating MEMBER RESPONSIBILITY
<b>Claim Forms Required</b>		No	Yes
<b>Durable Medical Equipment (DME) / Corrective Appliances</b> Limited to once every 2 years for irreparable damage and/or normal wear.		50%	50% Eligible Charges (after annual deductible)
<b>Home Health Care Services</b>		0%	30% Eligible Charges (after annual deductible)
		<i>120 visits per contract year</i>	<i>60 visits per contract year</i>
		<i>120 visits combined per contract year</i>	
<b>Hospice Care</b>		\$500/day, 5 day maximum	30% Eligible Charges (after annual deductible)
<b>Skilled Nursing Facility</b>		\$500/day, 5 day maximum	30% Eligible Charges (after annual deductible)
		<i>100 inpatient days per contract year</i>	<i>50 inpatient days per contract year</i>
		<i>100 days combined maximum per contract year</i>	
<b>Dental Services</b>			
Emergency treatment of dental injury		0%	30% Eligible Charges (after annual deductible)
Removal of Third Molars		0%	30% Eligible Charges (after annual deductible)
<b>Vision Services</b>	<b>Vision One Eyecare Program®:</b> Receive immediate savings on all eyecare needs--discounts on frames, lenses, disposable contacts, and even LASIK surgery--at participating providers through the EyeMed Vision Care network.		
<b>Health Education</b>	Members receive reimbursement of the cost of approved wellness programs offered through local hospitals and organizations.**		
<b>PRECERTIFICATION REQUIREMENT</b>		By Physician	By Patient
When using a nonparticipating provider, the member must obtain precertification of nonemergency hospital and other facility (e.g., skilled nursing facilities, rehabilitation facilities, drug and alcohol treatment facilities) admissions, outpatient surgery and certain other services as stated in the Group Contract. If these services or admissions are not precertified and the service is not medically necessary, the member may be responsible for 100% of the cost of the services.			
<b>LIFETIME MAXIMUM</b>		Unlimited	
<p><b>Autism Spectrum Disorders are covered pursuant to state mandates for groups with 51 or more employees.</b>  This is not a contract. It is intended solely to provide you with an overview of the plan. Complete details of benefits, terms and exclusions are governed by your Group Contract. <b>This managed care plan may not cover all your health care expenses. Read your contract carefully to determine which health care services are covered. If you have questions call us at 800.788.8445 in Central/Eastern Pennsylvania, and 800.735.4404 in Western Pennsylvania and Ohio.</b>  Benefits are administered on a contract year basis. Coinsurance is based on Eligible Charges as defined in your Certificate of Insurance. For non-participating providers, Eligible Charges are based on the lesser of the provider's billed charges or our Out-of-Network Rate, which is defined in your Certificate of Insurance. <b>In addition to your copay or coinsurance, you are responsible for paying nonparticipating providers the difference between our out-of-network rate and their actual charge for nonemergency services. Your out-of-pocket costs for nonemergency care from nonparticipating providers may be substantial.</b>  <i>Dependent Coverage Age Limit is 26</i>  *If your Schedule of Benefits indicates that you have a Qualified High Deductible Health Plan., you must consult your group benefit documents for a specific description and the terms and conditions of your coverage for these benefits. Also, some covered services that you receive during a preventive service office visit may not qualify as preventive services under the group contract and, consequently, will be subject to applicable deductibles. In order to be exempt from applicable deductibles, preventive services must qualify as preventive services under the group contract and Section 223 of the Internal Revenue Code.  This document neither affirmatively nor negatively amends, extends, or alters the terms of or the coverage afforded by policy referenced herein.  **Reimbursement for Weight Management programs is limited to \$350 per calendar year per member.</p>			

<b>DEDUCTIBLES AND MAXIMUMS</b>	<b>Participating MEMBER RESPONSIBILITY</b>	<b>Non-Participating MEMBER RESPONSIBILITY</b>
<b>Annual Deductible</b> (Inpatient and Infertility deductibles apply separately from annual deductible)		
Individual	\$2,500	\$5,000
Family	\$2,500	\$5,000
<b>Out-of-Pocket Maximum</b> (excludes deductibles and copays)		
Individual	None	\$10,000
Family (aggregate)	None	\$10,000
<b>OUTPATIENT SERVICES</b>	<b>Participating MEMBER RESPONSIBILITY</b>	<b>Non-Participating MEMBER RESPONSIBILITY</b>
<b>Physician Services (for illness or injury)</b>	(office visit NOT subject to deductible)	
Primary Care Visit (PCP)	\$20	20% Eligible Charges (after annual deductible)
Specialist Visit (SCP)	\$40	20% Eligible Charges (after annual deductible)
<b>Preventive Services*</b>	(office visit NOT subject to deductible)	
Gynecological Exam (PCP/SCP)	\$0 Copay	20% Eligible Charges (after annual deductible)
Well Child Visit	\$0 Copay	20% Eligible Charges (after annual deductible)
Adult Physical Visit	\$0 Copay	20% Eligible Charges (after annual deductible)
Routine Pediatric Immunizations	0%	20% Eligible Charges
Hearing Exams (under age 18)	0%	20% Eligible Charges (after annual deductible)
Routine Mammograms	0%	20% Eligible Charges (after annual deductible)
Routine Colonoscopies***	0%	20% Eligible Charges (after annual deductible)
<b>Allergy Testing &amp; Allergy Serum</b>	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
<b>Chiropractic Care</b> (x-rays are subject to deductible) Maximum 20 visits per contract year	\$40 (not subject to annual deductible)	20% Eligible Charges (after annual deductible)
<b>Outpatient Surgery</b>	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
<b>Lab Services</b>	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
<b>Diagnostic X-ray</b>	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
<b>Radiology</b> (CAT, MRI, Ultrasound, PET)	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
<b>HOSPITAL SERVICES</b>	<b>Participating MEMBER RESPONSIBILITY</b>	<b>Non-Participating MEMBER RESPONSIBILITY</b>
<b>Hospital Care</b>		
Semi-private room (private room if medically necessary)	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Physician and Surgeon Fees	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Surgery	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Lab and X-ray services	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
All Medically Necessary Ancillary Services	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Anesthesia	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Administration of Blood	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Blood Products	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Therapy Services (Chemotherapy & Radiation Therapy)	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
<b>MATERNITY SERVICES</b>	<b>Participating MEMBER RESPONSIBILITY</b>	<b>Non-Participating MEMBER RESPONSIBILITY</b>
<b>Pregnancy Care</b> (PCP/SCP) (copay for the first office visit only)	\$20/\$40 (not subject to annual deductible)	20% Eligible Charges (after annual deductible)
<b>Delivery</b>	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
<b>FAMILY PLANNING</b>	<b>Participating MEMBER RESPONSIBILITY</b>	<b>Non-Participating MEMBER RESPONSIBILITY</b>
<b>Infertility Counseling/Testing/Services</b>	\$300 One Time Deductible Then Coinsurance Applies	
<b>Tubal Ligation/Vasectomy</b>	0% (after annual deductible)	20% Eligible Charges (after annual deductible) \$2,400 combined benefit maximum
<b>PRESCRIPTION DRUGS</b>	<b>Participating MEMBER RESPONSIBILITY</b>	<b>Non-Participating MEMBER RESPONSIBILITY</b>
(Includes oral contraceptives & managed formulary. Mandatory generic substitution may apply)	<b>Refer to the RX Select formulary to identify which drugs do not require authorization. Quantity limits still apply.</b> <b>VARIOUS RIDERS AVAILABLE</b> <b>COVERED ONLY AT PARTICIPATING PHARMACIES</b>	
<b>EMERGENCY CARE</b>	<b>Participating MEMBER RESPONSIBILITY</b>	<b>Non-Participating MEMBER RESPONSIBILITY</b>
Urgent Care Center		\$40 Copay
Emergency Room Services (not subject to deductible)		0% after \$125 Copay (ER Copay waived if admitted)
<b>REHABILITATION SERVICES</b>	<b>Participating MEMBER RESPONSIBILITY</b>	<b>Non-Participating MEMBER RESPONSIBILITY</b>
<b>Occupational, Speech, Physical Therapy</b>	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
		45 inpatient days per contract year 30 outpatient visits per contract year

MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES		Participating MEMBER RESPONSIBILITY	Non-Participating MEMBER RESPONSIBILITY
<i>(Mental health services must be preauthorized)</i>			
General Mental Health: Inpatient	0% (after annual deductible)	20% Eligible Charges (after annual deductible)	
	30 days per contract year 90 day lifetime benefit maximum		
Physician Services (Outpatient)	\$40 Copay per visit	20% Eligible Charges (after annual deductible)	
	20 outpatient visits maximum per contract year		
Serious Mental Health: Inpatient	0% (after annual deductible)	20% Eligible Charges (after annual deductible)	
	30 days per contract year 90 day lifetime benefit maximum		
Physician Services (Outpatient)	\$40 Copay per visit	20% Eligible Charges (after annual deductible)	
	60 outpatient visits maximum per contract year		
Substance Abuse: Inpatient Detoxification	0% (after annual deductible)	20% Eligible Charges (after annual deductible)	
	7 days maximum per admission 4 admission benefit maximum		
Inpatient Rehabilitation	0% (after annual deductible)	20% Eligible Charges (after annual deductible)	
	30 days maximum per contract year 90 days benefit maximum		
Transitional Partial Hospitalization	0% (after annual deductible)	20% Eligible Charges (after annual deductible)	
	60 visits per contract year 120 visits per benefit maximum		
OTHER BENEFITS		Participating MEMBER RESPONSIBILITY	Non-Participating MEMBER RESPONSIBILITY
<b>Claim Forms Required</b>		No	Yes
<b>Durable Medical Equipment (DME)</b> – Limited to once every 2 years for irreparable damage and/or normal wear.		0% (after annual deductible)	20% Eligible Charges (after annual deductible)
<b>Corrective Appliances</b>		0% (after annual deductible)	20% Eligible Charges (after annual deductible)
<b>Home Health Care Services</b>		0% (after annual deductible) 120 visits per contract year	20% Eligible Charges (after annual deductible) 60 visits per contract year
		120 visits combined per contract year	
<b>Hospice Care</b>		0% (after annual deductible)	20% Eligible Charges (after annual deductible)
<b>Skilled Nursing Facility</b>		0% (after annual deductible)	20% Eligible Charges (after annual deductible)
		100 inpatient days per contract year 100 days combined maximum per contract year	50 inpatient days per contract year
<b>Dental Services</b> Emergency treatment of dental injury Removal of Third Molars		0% (after annual deductible) 0% (after annual deductible)	20% Eligible Charges (after annual deductible) 20% Eligible Charges (after annual deductible)
<b>Vision Services</b>		<b>Vision One Eyecare Program®:</b> Receive immediate savings on all eyecare needs--discounts on frames, lenses, disposable contacts, and even LASIK surgery--at participating providers through the EyeMed Vision Care network.	
<b>Health Education</b>		Members receive reimbursement of the cost of approved wellness programs offered through local hospitals and organizations.**	
<b>PRECERTIFICATION REQUIREMENT</b>		By Physician	By Patient
When using a nonparticipating provider, the member must obtain precertification of nonemergency hospital and other facility (e.g., skilled nursing facilities, rehabilitation facilities, drug and alcohol treatment facilities) admissions, outpatient surgery and certain other services as stated in the Group Contract. If these services or admissions are not precertified, and the service is not medically necessary the member may be responsible for, 100% of the cost of the services.			
<b>LIFETIME MAXIMUM</b>		Unlimited	
<b>Autism Spectrum Disorders are covered pursuant to state mandates for groups with 51 or more employees.</b> This is not a contract. It is intended solely to provide you with an overview of the plan. Complete details of benefits, terms and exclusions are governed by your Group Contract. <b>This managed care plan may not cover all your health care expenses. Read your contract carefully to determine which health care services are covered. If you have questions call us at 800.788.8445 in Central/Eastern Pennsylvania, and 800.735.4404 in Western Pennsylvania and Ohio.</b> Benefits are administered on a contract year basis. Coinsurance is based on Eligible Charges as defined in your Certificate of Insurance. For non-participating providers, Eligible Charges are based on the lesser of the provider's billed charges or our Out-of-Network Rate, which is defined in your Certificate of Insurance. <b>In addition to your copay or coinsurance, you are responsible for paying nonparticipating providers the difference between our out-of-network rate and their actual charge for nonemergency services. Your out-of-pocket costs for nonemergency care from nonparticipating providers may be substantial.</b> <i>Dependent Coverage Age Limit is 26</i> *If your Schedule of Benefits indicates that you have a Qualified High Deductible Health Plan., you must consult your group benefit documents for a specific description and the terms and conditions of your coverage for these benefits. Also, some covered services that you receive during a preventive service office visit may not qualify as preventive services under the group contract and, consequently, will be subject to applicable deductibles. In order to be exempt from applicable deductibles, preventive services must qualify as preventive services under the group contract and Section 223 of the Internal Revenue Code. *** The physician must bill the claim with a preventive diagnosis code in order to apply under preventive benefits coverage. <b>This document neither affirmatively nor negatively amends, extends, or alters the terms of or the coverage afforded by policy referenced herein</b> **Reimbursement for Weight Management programs is limited to \$350 per calendar year per member.			

<b>DEDUCTIBLES AND MAXIMUMS</b>	<b>Participating MEMBER RESPONSIBILITY</b>	<b>Non-Participating MEMBER RESPONSIBILITY</b>
<b>Annual Deductible</b> (Inpatient and Infertility deductibles apply separately from annual deductible)		
Individual	\$4,000	\$6,000
Family	\$4,000	\$6,000
<b>Out-of-Pocket Maximum</b> (excludes deductibles and copays)		
Individual	None	\$5,000
Family (aggregate)	None	\$5,000
<b>OUTPATIENT SERVICES</b>	<b>Participating MEMBER RESPONSIBILITY</b>	<b>Non-Participating MEMBER RESPONSIBILITY</b>
<b>Physician Services (for illness or injury)</b>	(office visit NOT subject to deductible)	
Primary Care Visit (PCP)	\$25	20% Eligible Charges (after annual deductible)
Specialist Visit (SCP)	\$50	20% Eligible Charges (after annual deductible)
<b>Preventive Services*</b>	(office visit NOT subject to deductible)	
Gynecological Exam (PCP/SCP)	\$0 Copay	20% Eligible Charges (after annual deductible)
Well Child Visit	\$0 Copay	20% Eligible Charges (after annual deductible)
Adult Physical Visit	\$0 Copay	20% Eligible Charges (after annual deductible)
Routine Pediatric Immunizations	0%	20% Eligible Charges (after annual deductible)
Hearing Exams (under age 18)	0%	20% Eligible Charges (after annual deductible)
Routine Mammograms	0%	20% Eligible Charges (after annual deductible)
Routine Colonoscopies***	0%	20% Eligible Charges (after annual deductible)
<b>Allergy Testing &amp; Allergy Serum</b>	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
<b>Chiropractic Care</b> (x-rays are subject to deductible) Maximum 20 visits per contract year	\$50 (not subject to annual deductible)	20% Eligible Charges (after annual deductible)
<b>Outpatient Surgery</b>	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
<b>Lab Services</b>	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
<b>Diagnostic X-ray</b>	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
<b>Radiology</b> (CAT, MRI, Ultrasound, PET)	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
<b>HOSPITAL SERVICES</b>	<b>Participating MEMBER RESPONSIBILITY</b>	<b>Non-Participating MEMBER RESPONSIBILITY</b>
<b>Hospital Care</b>	0% (after annual deductible)	
Semi-private room (private room if medically necessary)	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Physician and Surgeon Fees	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Surgery	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Lab and X-ray services	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
All Medically Necessary Ancillary Services	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Anesthesia	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Administration of Blood	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Blood Products	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Therapy Services (Chemotherapy & Radiation Therapy)	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
<b>MATERNITY SERVICES</b>	<b>Participating MEMBER RESPONSIBILITY</b>	<b>Non-Participating MEMBER RESPONSIBILITY</b>
<b>Pregnancy Care</b> (PCP/SCP) (copay for the first office visit only)	\$25/\$50 (not subject to annual deductible)	20% Eligible Charges (after annual deductible)
<b>Delivery</b>	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
<b>FAMILY PLANNING</b>	<b>Participating MEMBER RESPONSIBILITY</b>	<b>Non-Participating MEMBER RESPONSIBILITY</b>
<b>Infertility Counseling/Testing/Services</b>	\$300 One Time Deductible Then Coinsurance Applies	
<b>Tubal Ligation/Vasectomy</b>	0% (after annual deductible)	20% Eligible Charges (after annual deductible) \$2,400 combined benefit maximum
<b>PRESCRIPTION DRUGS</b>	<b>Participating MEMBER RESPONSIBILITY</b>	<b>Non-Participating MEMBER RESPONSIBILITY</b>
(Includes oral contraceptives & managed formulary. Mandatory generic substitution may apply)	<b>Refer to the RX Select formulary to identify which drugs do not require authorization. Quantity limits still apply.</b> <b>Various Riders Available</b> <b>COVERED ONLY AT PARTICIPATING PHARMACIES</b>	
<b>EMERGENCY CARE</b>	<b>Participating MEMBER RESPONSIBILITY</b>	<b>Non-Participating MEMBER RESPONSIBILITY</b>
<b>Urgent Care Center</b>	\$50 Copay	
<b>Emergency Room Services</b> (not subject to deductible)	0% after \$125 Copay (ER Copay waived if admitted)	
<b>REHABILITATION SERVICES</b>	<b>Participating MEMBER RESPONSIBILITY</b>	<b>Non-Participating MEMBER RESPONSIBILITY</b>
<b>Occupational, Speech, Physical Therapy</b>	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
	45 inpatient days per contract year 30 outpatient visits per contract year	

SERVICES	MEMBER RESPONSIBILITY	MEMBER RESPONSIBILITY
<b>General Mental Health:</b> Inpatient	<i>(Mental health services must be preauthorized)</i>	
	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
	30 days per contract year 90 day lifetime benefit maximum	
Physician Services (Outpatient)	\$50 Copay per visit	20% Eligible Charges (after annual deductible)
	20 outpatient visits maximum per contract year	
<b>Serious Mental Health:</b> Inpatient	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
	30 days per contract year 90 day lifetime benefit maximum r	
	\$50 Copay per visit	20% Eligible Charges (after annual deductible)
Physician Services (Outpatient)	60 outpatient visits maximum per contract year	
<b>Substance Abuse:</b> Inpatient Detoxification	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
	7 days maximum per admission 4 admission benefit maximum	
Inpatient Rehabilitation	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
	30 days maximum per contract year 90 days benefit maximum	
Transitional Partial Hospitalization	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
	60 visits per contract year 120 visits per benefit maximum	
OTHER BENEFITS	Participating MEMBER RESPONSIBILITY	Non-Participating MEMBER RESPONSIBILITY
<b>Claim Forms Required</b>	<b>No</b>	<b>Yes</b>
<b>Durable Medical Equipment (DME)</b> – Limited to once every 2 years for irreparable damage and/or normal wear.	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
<b>Corrective Appliances</b>	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
<b>Home Health Care Services</b>	0% (after annual deductible) 120 visits per contract year	20% Eligible Charges (after annual deductible) 60 visits per contract year
	120 visits combined per contract year	
<b>Hospice Care</b>	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
<b>Skilled Nursing Facility</b>	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
	100 inpatient days per contract year 100 days combined maximum per contract year	50 inpatient days per contract year
<b>Dental Services</b> Emergency treatment of dental injury Removal of Third Molars	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
<b>Vision Services</b>	<b>Vision One Eyecare Program®:</b> Receive immediate savings on all eyecare needs--discounts on frames, lenses, disposable contacts, and even LASIK surgery--at participating providers through the EyeMed Vision Care network.	
<b>Health Education</b>	Members receive reimbursement of the cost of approved wellness programs offered through local hospitals and organizations.**	
<b>PRECERTIFICATION REQUIREMENT</b>	By Physician	By Patient
When using a nonparticipating provider, the member must obtain precertification of nonemergency hospital and other facility (e.g., skilled nursing facilities, rehabilitation facilities, drug and alcohol treatment facilities) admissions, outpatient surgery and certain other services as stated in the Group Contract. If these services or admissions are not precertified, and the service is not medically necessary the member may be responsible for, 100% of the cost of the services.		
<b>LIFETIME MAXIMUM</b>	Unlimited	
<b>Autism Spectrum Disorders are covered pursuant to state mandates for groups with 51 or more employees.</b>		
This is not a contract. It is intended solely to provide you with an overview of the plan. Complete details of benefits, terms and exclusions are governed by your Group Contract. <b>This managed care plan may not cover all your health care expenses. Read your contract carefully to determine which health care services are covered. If you have questions call us at 800.788.8445 in Central/Eastern Pennsylvania, and 800.735.4404 in Western Pennsylvania and Ohio.</b>		
Benefits are administered on a contract year basis. Coinsurance is based on Eligible Charges as defined in your Certificate of Insurance. For non-participating providers, Eligible Charges are based on the lesser of the provider's billed charges or our Out-of-Network Rate, which is defined in your Certificate of Insurance. <b>In addition to your copay or coinsurance, you are responsible for paying nonparticipating providers the difference between our out-of-network rate and their actual charge for nonemergency services. Your out-of-pocket costs for nonemergency care from nonparticipating providers may be substantial.</b>		
<i>Dependent Coverage Age Limit is 26</i>		
*If your Schedule of Benefits indicates that you have a Qualified High Deductible Health Plan,, you must consult your group benefit documents for a specific description and the terms and conditions of your coverage for these benefits. Also, some covered services that you receive during a preventive service office visit may not qualify as preventive services under the group contract and, consequently, will be subject to applicable deductibles. In order to be exempt from applicable deductibles, preventive services must qualify as preventive services under the group contract and Section 223 of the Internal Revenue Code.		
*** The physician must bill the claim with a preventive diagnosis code in order to apply under preventive benefits coverage.		
<b>This document neither affirmatively nor negatively amends, extends, or alters the terms of or the coverage afforded by policy referenced herein</b>		
**Reimbursement for Weight Management programs is limited to \$350 per calendar year per member.		

<b>DEDUCTIBLES AND MAXIMUMS</b>	<b>Participating MEMBER RESPONSIBILITY</b>	<b>Non-Participating MEMBER RESPONSIBILITY</b>
<b>Annual Deductible</b> (Inpatient and Infertility deductibles apply separately from annual deductible)		
Individual	\$7,500	\$10,000
Family	\$7,500	\$10,000
<b>Out-of-Pocket Maximum</b> (excludes deductibles and copays)		
Individual	None	\$5,000
Family (aggregate)	None	\$5,000
<b>OUTPATIENT SERVICES</b>	<b>Participating MEMBER RESPONSIBILITY</b>	<b>Non-Participating MEMBER RESPONSIBILITY</b>
<b>Physician Services (for illness or injury)</b>	(office visit NOT subject to deductible)	
Primary Care Visit (PCP)	\$25	20% Eligible Charges (after annual deductible)
Specialist Visit (SCP)	\$50	20% Eligible Charges (after annual deductible)
<b>Preventive Services*</b>	(office visit NOT subject to deductible)	
Gynecological Exam (PCP/SCP)	\$0 Copay	20% Eligible Charges (after annual deductible)
Well Child Visit	\$0 Copay	20% Eligible Charges (after annual deductible)
Adult Physical Visit	\$0 Copay	20% Eligible Charges (after annual deductible)
Routine Pediatric Immunizations	0%	20% Eligible Charges
Hearing Exams (under age 18)	0%	20% Eligible Charges (after annual deductible)
Routine Mammograms	0%	20% Eligible Charges (after annual deductible)
Routine Colonoscopies***	0%	20% Eligible Charges (after annual deductible)
<b>Allergy Testing &amp; Allergy Serum</b>	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
<b>Chiropractic Care</b> (x-rays are subject to deductible) Maximum 20 visits per contract year	\$50 (not subject to annual deductible)	20% Eligible Charges (after annual deductible)
<b>Outpatient Surgery</b>	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
<b>Lab Services</b>	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
<b>Diagnostic X-ray</b>	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
<b>Radiology</b> (CAT, MRI, Ultrasound, PET)	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
<b>HOSPITAL SERVICES</b>	<b>Participating MEMBER RESPONSIBILITY</b>	<b>Non-Participating MEMBER RESPONSIBILITY</b>
<b>Hospital Care</b>	0% (after annual deductible)	
Semi-private room (private room if medically necessary)	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Physician and Surgeon Fees	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Surgery	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Lab and X-ray services	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
All Medically Necessary Ancillary Services	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Anesthesia	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Administration of Blood	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Blood Products	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Therapy Services (Chemotherapy & Radiation Therapy)	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
<b>MATERNITY SERVICES</b>	<b>Participating MEMBER RESPONSIBILITY</b>	<b>Non-Participating MEMBER RESPONSIBILITY</b>
<b>Pregnancy Care</b> (PCP/SCP) (copay for the first office visit only)	\$25/\$50 (not subject to annual deductible)	20% Eligible Charges (after annual deductible)
<b>Delivery</b>	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
<b>FAMILY PLANNING</b>	<b>Participating MEMBER RESPONSIBILITY</b>	<b>Non-Participating MEMBER RESPONSIBILITY</b>
<b>Infertility Counseling/Testing/Services</b>	\$300 One Time Deductible Then Coinsurance Applies	
<b>Tubal Ligation/Vasectomy</b>	0% (after annual deductible)	20% Eligible Charges (after annual deductible) \$2,400 combined benefit maximum
<b>PRESCRIPTION DRUGS</b>	<b>Participating MEMBER RESPONSIBILITY</b>	<b>Non-Participating MEMBER RESPONSIBILITY</b>
(Includes oral contraceptives & managed formulary. Mandatory generic substitution may apply)	<b>Refer to the RX Select formulary to identify which drugs do not require authorization. Quantity limits still apply.</b>	
	<b>VARIOUS RIDERS AVAILABLE COVERED ONLY AT PARTICIPATING PHARMACIES</b>	
<b>EMERGENCY CARE</b>	<b>Participating MEMBER RESPONSIBILITY</b>	<b>Non-Participating MEMBER RESPONSIBILITY</b>
Urgent Care Center		\$50 Copay
Emergency Room Services (not subject to deductible)		0% after \$125 Copay (ER Copay waived if admitted)
<b>REHABILITATION SERVICES</b>	<b>Participating MEMBER RESPONSIBILITY</b>	<b>Non-Participating MEMBER RESPONSIBILITY</b>
<b>Occupational, Speech, Physical Therapy</b>	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
		45 inpatient days per contract year 30 outpatient visits per contract year

MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES		Participating MEMBER RESPONSIBILITY	Non-Participating MEMBER RESPONSIBILITY
<i>(Mental health services must be preauthorized)</i>			
General Mental Health: Inpatient	0% (after annual deductible)	20% Eligible Charges (after annual deductible)	
<i>30 days per contract year 90 day lifetime benefit maximum</i>			
Physician Services (Outpatient)	\$50 Copay per visit	20% Eligible Charges (after annual deductible)	
<i>20 outpatient visits maximum per contract year</i>			
Serious Mental Health: Inpatient	0% (after annual deductible)	20% Eligible Charges (after annual deductible)	
<i>30 days per contract year 90 day lifetime benefit maximum</i>			
Physician Services (Outpatient)	\$50 Copay per visit	20% Eligible Charges (after annual deductible)	
<i>60 outpatient visits maximum per contract year</i>			
Substance Abuse: Inpatient Detoxification	0% (after annual deductible)	20% Eligible Charges (after annual deductible)	
<i>7 days maximum per admission 4 admission benefit maximum</i>			
Inpatient Rehabilitation	0% (after annual deductible)	20% Eligible Charges (after annual deductible)	
<i>30 days maximum per contract year 90 days benefit maximum</i>			
Transitional Partial Hospitalization	0% (after annual deductible)	20% Eligible Charges (after annual deductible)	
<i>60 visits per contract year 120 visits per benefit maximum</i>			
OTHER BENEFITS		Participating MEMBER RESPONSIBILITY	Non-Participating MEMBER RESPONSIBILITY
<b>Claim Forms Required</b>		No	Yes
<b>Durable Medical Equipment (DME)</b> – Limited to once every 2 years for irreparable damage and/or normal wear.	0% (after annual deductible)	20% Eligible Charges (after annual deductible)	
<b>Corrective Appliances</b>	0% (after annual deductible)	20% Eligible Charges (after annual deductible)	
<b>Home Health Care Services</b>	0% (after annual deductible) <i>120 visits per contract year</i>	20% Eligible Charges (after annual deductible) <i>60 visits per contract year</i>	
<i>120 visits combined per contract year</i>			
<b>Hospice Care</b>	0% (after annual deductible)	20% Eligible Charges (after annual deductible)	
<b>Skilled Nursing Facility</b>	0% (after annual deductible) <i>100 inpatient days per contract year</i>	20% Eligible Charges (after annual deductible) <i>50 inpatient days per contract year</i>	
<i>100 days combined maximum per contract year</i>			
<b>Dental Services</b> Emergency treatment of dental injury Removal of Third Molars	0% (after annual deductible) 0% (after annual deductible)	20% Eligible Charges (after annual deductible) 20% Eligible Charges (after annual deductible)	
<b>Vision Services</b>	<b>Vision One Eyecare Program®:</b> Receive immediate savings on all eyecare needs--discounts on frames, lenses, disposable contacts, and even LASIK surgery--at participating providers through the EyeMed Vision Care network.		
<b>Health Education</b>	Members receive reimbursement of the cost of approved wellness programs offered through local hospitals and organizations.**		
<b>PRECERTIFICATION REQUIREMENT</b>	By Physician	By Patient	
When using a nonparticipating provider, the member must obtain precertification of nonemergency hospital and other facility (e.g., skilled nursing facilities, rehabilitation facilities, drug and alcohol treatment facilities) admissions, outpatient surgery and certain other services as stated in the Group Contract. If these services or admissions are not precertified, and the service is not medically necessary the member may be responsible for, 100% of the cost of the services.			
<b>LIFETIME MAXIMUM</b>	Unlimited		
<b>Autism Spectrum Disorders are covered pursuant to state mandates for groups with 51 or more employees.</b>			
This is not a contract. It is intended solely to provide you with an overview of the plan. Complete details of benefits, terms and exclusions are governed by your Group Contract. <b>This managed care plan may not cover all your health care expenses. Read your contract carefully to determine which health care services are covered. If you have questions call us at 800.788.8445 in Central/Eastern Pennsylvania, and 800.735.4404 in Western Pennsylvania and Ohio.</b>			
Benefits are administered on a contract year basis. Coinsurance is based on Eligible Charges as defined in your Certificate of Insurance. For non-participating providers, Eligible Charges are based on the lesser of the provider's billed charges or our Out-of-Network Rate, which is defined in your Certificate of Insurance. <b>In addition to your copay or coinsurance, you are responsible for paying nonparticipating providers the difference between our out-of-network rate and their actual charge for nonemergency services. Your out-of-pocket costs for nonemergency care from nonparticipating providers may be substantial.</b>			
<i>Dependent Coverage Age Limit is 26</i>			
*If your Schedule of Benefits indicates that you have a Qualified High Deductible Health Plan., you must consult your group benefit documents for a specific description and the terms and conditions of your coverage for these benefits. Also, some covered services that you receive during a preventive service office visit may not qualify as preventive services under the group contract and, consequently, will be subject to applicable deductibles. In order to be exempt from applicable deductibles, preventive services must qualify as preventive services under the group contract and Section 223 of the Internal Revenue Code.			
*** The physician must bill the claim with a preventive diagnosis code in order to apply under preventive benefits coverage.			
<b>This document neither affirmatively nor negatively amends, extends, or alters the terms of or the coverage afforded by policy referenced herein</b>			
<i>**Reimbursement for Weight Management programs is limited to \$350 per calendar year per member.</i>			

<b>DEDUCTIBLES AND MAXIMUMS</b>	<b>Participating MEMBER RESPONSIBILITY</b>	<b>Non-Participating MEMBER RESPONSIBILITY</b>
<b>Annual Deductible</b> (Inpatient and Infertility deductibles apply separately from annual deductible)		
Individual	\$10,000	\$12,000
Family	\$10,000	\$12,000
<b>Out-of-Pocket Maximum</b> (excludes deductibles and copays)		
Individual	None	\$5,000
Family (aggregate)	None	\$5,000
<b>OUTPATIENT SERVICES</b>	<b>Participating MEMBER RESPONSIBILITY</b>	<b>Non-Participating MEMBER RESPONSIBILITY</b>
<b>Physician Services (for illness or injury)</b>	(office visit NOT subject to deductible)	
Primary Care Visit (PCP)	\$25	20% Eligible Charges (after annual deductible)
Specialist Visit (SCP)	\$50	20% Eligible Charges (after annual deductible)
<b>Preventive Services*</b>	(office visit NOT subject to deductible)	
Gynecological Exam (PCP/SCP)	\$0 Copay	20% Eligible Charges (after annual deductible)
Well Child Visit	\$0 Copay	20% Eligible Charges (after annual deductible)
Adult Physical Visit	\$0 Copay	20% Eligible Charges (after annual deductible)
Routine Pediatric Immunizations	0%	20% Eligible Charges (after annual deductible)
Hearing Exams (under age 18)	0%	20% Eligible Charges (after annual deductible)
Routine Mammograms	0%	20% Eligible Charges (after annual deductible)
Routine Colonoscopies***	0%	20% Eligible Charges (after annual deductible)
<b>Allergy Testing &amp; Allergy Serum</b>	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
<b>Chiropractic Care</b> (x-rays are subject to deductible) Maximum 20 visits per contract year	\$50 (not subject to annual deductible)	20% Eligible Charges (after annual deductible)
<b>Outpatient Surgery</b>	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
<b>Lab Services</b>	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
<b>Diagnostic X-ray</b>	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
<b>Radiology</b> (CAT, MRI, Ultrasound, PET)	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
<b>HOSPITAL SERVICES</b>	<b>Participating MEMBER RESPONSIBILITY</b>	<b>Non-Participating MEMBER RESPONSIBILITY</b>
<b>Hospital Care</b>		
Semi-private room (private room if medically necessary)	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Physician and Surgeon Fees	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Surgery	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Lab and X-ray services	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
All Medically Necessary Ancillary Services	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Anesthesia	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Administration of Blood	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Blood Products	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Therapy Services (Chemotherapy & Radiation Therapy)	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
<b>MATERNITY SERVICES</b>	<b>Participating MEMBER RESPONSIBILITY</b>	<b>Non-Participating MEMBER RESPONSIBILITY</b>
<b>Pregnancy Care</b> (PCP/SCP) (copay for the first office visit only)	\$25/\$50 (not subject to annual deductible)	20% Eligible Charges (after annual deductible)
<b>Delivery</b>	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
<b>FAMILY PLANNING</b>	<b>Participating MEMBER RESPONSIBILITY</b>	<b>Non-Participating MEMBER RESPONSIBILITY</b>
<b>Infertility Counseling/Testing/Services</b>	\$300 One Time Deductible Then Coinsurance Applies	
<b>Tubal Ligation/Vasectomy</b>	0% (after annual deductible)	20% Eligible Charges (after annual deductible) \$2,400 combined benefit maximum
<b>PRESCRIPTION DRUGS</b>	<b>Participating MEMBER RESPONSIBILITY</b>	<b>Non-Participating MEMBER RESPONSIBILITY</b>
(Includes oral contraceptives & managed formulary. Mandatory generic substitution may apply)	<b>Refer to the RX Select formulary to identify which drugs do not require authorization. Quantity limits still apply.</b> <b>VARIOUS RIDERS AVAILABLE</b> <b>COVERED ONLY AT PARTICIPATING PHARMACIES</b>	
<b>EMERGENCY CARE</b>	<b>Participating MEMBER RESPONSIBILITY</b>	<b>Non-Participating MEMBER RESPONSIBILITY</b>
<b>Urgent Care Center</b>		\$50 Copay
<b>Emergency Room Services</b> (not subject to deductible)	0% after \$125 Copay (ER Copay waived if admitted)	
<b>REHABILITATION SERVICES</b>	<b>Participating MEMBER RESPONSIBILITY</b>	<b>Non-Participating MEMBER RESPONSIBILITY</b>
<b>Occupational, Speech, Physical Therapy</b>	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
	45 inpatient days per contract year 30 outpatient visits per contract year	

SERVICES	MEMBER RESPONSIBILITY	MEMBER RESPONSIBILITY
<b>General Mental Health:</b> Inpatient	<i>(Mental health services must be preauthorized)</i>	
	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Physician Services (Outpatient)	<i>30 days per contract year 90 day lifetime benefit maximum</i>	
	\$50 Copay per visit	20% Eligible Charges (after annual deductible)
<b>Serious Mental Health:</b> Inpatient	<i>30 days per contract year 90 day lifetime benefit maximum</i>	
	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Physician Services (Outpatient)	<i>30 days per contract year 90 day lifetime benefit maximum</i>	
	\$50 Copay per visit	20% Eligible Charges (after annual deductible)
<b>Substance Abuse:</b> Inpatient Detoxification	<i>60 outpatient visits maximum per contract year</i>	
	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Inpatient Rehabilitation	<i>7 days maximum per admission 4 admission benefit maximum</i>	
	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Transitional Partial Hospitalization	<i>30 days maximum per contract year 90 days benefit maximum</i>	
	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
	<i>60 visits per contract year 120 visits per benefit maximum</i>	
OTHER BENEFITS	Participating MEMBER RESPONSIBILITY	Non-Participating MEMBER RESPONSIBILITY
<b>Claim Forms Required</b>	No	Yes
<b>Durable Medical Equipment (DME)</b> – Limited to once every 2 years for irreparable damage and/or normal wear.	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
<b>Corrective Appliances</b>	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
<b>Home Health Care Services</b>	0% (after annual deductible) <i>120 visits per contract year</i>	20% Eligible Charges (after annual deductible) <i>60 visits per contract year</i>
<b>Hospice Care</b>	<i>120 visits combined per contract year</i>	
<b>Skilled Nursing Facility</b>	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
<b>Dental Services</b> Emergency treatment of dental injury Removal of Third Molars	<i>100 inpatient days per contract year 100 days combined maximum per contract year</i>	
	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
<b>Vision Services</b>	0% (after annual deductible)	
<b>Health Education</b>	Members receive reimbursement of the cost of approved wellness programs offered through local hospitals and organizations.**	
<b>PRECERTIFICATION REQUIREMENT</b>	By Physician	By Patient
When using a nonparticipating provider, the member must obtain precertification of nonemergency hospital and other facility (e.g., skilled nursing facilities, rehabilitation facilities, drug and alcohol treatment facilities) admissions, outpatient surgery and certain other services as stated in the Group Contract. If these services or admissions are not precertified, and the service is not medically necessary the member may be responsible for, 100% of the cost of the services.		
<b>LIFETIME MAXIMUM</b>	Unlimited	
<b>Autism Spectrum Disorders are covered pursuant to state mandates for groups with 51 or more employees.</b>		
This is not a contract. It is intended solely to provide you with an overview of the plan. Complete details of benefits, terms and exclusions are governed by your Group Contract. <b>This managed care plan may not cover all your health care expenses. Read your contract carefully to determine which health care services are covered. If you have questions call us at 800.788.8445 in Central/Eastern Pennsylvania, and 800.735.4404 in Western Pennsylvania and Ohio.</b>		
Benefits are administered on a contract year basis. Coinsurance is based on Eligible Charges as defined in your Certificate of Insurance. For non-participating providers, Eligible Charges are based on the lesser of the provider's billed charges or our Out-of-Network Rate, which is defined in your Certificate of Insurance. <b>In addition to your copay or coinsurance, you are responsible for paying nonparticipating providers the difference between our out-of-network rate and their actual charge for nonemergency services. Your out-of-pocket costs for nonemergency care from nonparticipating providers may be substantial.</b>		
<i>Dependent Coverage Age Limit is 26</i>		
*If your Schedule of Benefits indicates that you have a Qualified High Deductible Health Plan., you must consult your group benefit documents for a specific description and the terms and conditions of your coverage for these benefits. Also, some covered services that you receive during a preventive service office visit may not qualify as preventive services under the group contract and, consequently, will be subject to applicable deductibles. In order to be exempt from applicable deductibles, preventive services must qualify as preventive services under the group contract and Section 223 of the Internal Revenue Code.		
*** The physician must bill the claim with a preventive diagnosis code in order to apply under preventive benefits coverage.		
<b>This document neither affirmatively nor negatively amends, extends, or alters the terms of or the coverage afforded by policy referenced herein</b>		
<i>Reimbursement for Weight Management programs is limited to \$350 per calendar year per member.</i>		

DEDUCTIBLES AND MAXIMUMS	Participating MEMBER RESPONSIBILITY	Non-Participating MEMBER RESPONSIBILITY
<b>Annual Deductible</b> ( <i>applies to in-network inpatient hospital-type services/outpatient surgery</i> )		
Individual		\$500
Family (aggregate)		\$1,000
<b>Out-of-Pocket Maximum</b> ( <i>includes deductibles, copays and coinsurance; excludes Rx copays</i> )		
Individual		\$3,000
Family (aggregate)		\$6,000
OUTPATIENT SERVICES	Participating MEMBER RESPONSIBILITY	Non-Participating MEMBER RESPONSIBILITY
<b>Physician Services (for illness or injury)</b>	(office visit NOT subject to deductible)	
Primary Care Visit (PCP)	\$10 Copay	50% Eligible Charges (after annual deductible)
Specialist Visit (SCP)	\$20 Copay	50% Eligible Charges (after annual deductible)
<b>Preventive Services*</b>	(office visit NOT subject to deductible)	
Gynecological Exam (PCP/SCP)	\$0 Copay	50% Eligible Charges (after annual deductible)
Well Child Visit	\$0 Copay	50% Eligible Charges (after annual deductible)
Adult Physical Visit	\$0 Copay	50% Eligible Charges (after annual deductible)
Routine Pediatric Immunizations	0%	50% Eligible Charges
Hearing Exams (under age 18)	0%	50% Eligible Charges (after annual deductible)
Routine Mammograms	0%	50% Eligible Charges (after annual deductible)
<b>Allergy Testing &amp; Allergy Serum</b>	0% (not subject to deductible)	50% Eligible Charges (after annual deductible)
<b>Chiropractic Care</b>	\$20 Copay (not subject to deductible)	50% Eligible Charges (after annual deductible)
Maximum 20 visits per contract year		
<b>Outpatient Surgery</b>	0% (after annual deductible)	50% Eligible Charges (after annual deductible)
<b>Lab Services</b>	\$0 copay (not subject to deductible)	50% Eligible Charges (after annual deductible)
<b>Diagnostic X-ray</b>	\$20 Copay (not subject to deductible)	50% Eligible Charges (after annual deductible)
<b>Radiology (CAT, MRI, Ultrasound)</b>	\$150 Copay (not subject to deductible)	50% Eligible Charges (after annual deductible)
HOSPITAL SERVICES	Participating MEMBER RESPONSIBILITY	Non-Participating MEMBER RESPONSIBILITY
<b>Hospital Care</b>		
Semi-private room (private room if medically necessary)	0% (after annual deductible)	50% Eligible Charges (after annual deductible)
Physician and Surgeon Fees	0% (after annual deductible)	50% Eligible Charges (after annual deductible)
Surgery	0% (after annual deductible)	50% Eligible Charges (after annual deductible)
Lab and X-ray services	0% (after annual deductible)	50% Eligible Charges (after annual deductible)
All Medically Necessary Ancillary Services	0% (after annual deductible)	50% Eligible Charges (after annual deductible)
Anesthesia	0% (after annual deductible)	50% Eligible Charges (after annual deductible)
Administration of Blood	0% (after annual deductible)	50% Eligible Charges (after annual deductible)
Blood Products	0% (after annual deductible)	50% Eligible Charges (after annual deductible)
Therapy Services (Chemotherapy & Radiation Therapy)	0% (after annual deductible)	50% Eligible Charges (after annual deductible)
MATERNITY SERVICES	Participating MEMBER RESPONSIBILITY	Non-Participating MEMBER RESPONSIBILITY
<b>Pregnancy Care (PCP/SCP)</b>		
(copay for the first office visit only)	\$10/\$20 Copay (not subject to deductible)	50% Eligible Charges (after annual deductible)
Delivery	0% (after annual deductible)	50% Eligible Charges (after annual deductible)
FAMILY PLANNING	Participating MEMBER RESPONSIBILITY	Non-Participating MEMBER RESPONSIBILITY
<b>Infertility Counseling/Testing/Services</b> ( <i>outpatient services</i> )	\$300 one time deductible then coinsurance applies; (\$2,400 combined benefit maximum for infertility)	
<b>Tubal Ligation/Vasectomy</b>	0% (not subject to deductible in office setting) 0% (after deductible inpatient/outpatient surgery setting)	50% Eligible Charges (after annual deductible)
PRESCRIPTION DRUGS	Participating MEMBER RESPONSIBILITY	Non-Participating MEMBER RESPONSIBILITY
(Includes oral contraceptives & managed formulary. Mandatory generic substitution may apply)	Refer to the RX Select formulary to identify which drugs do not require authorization. Quantity limits still apply. <b>VARIOUS RIDERS AVAILABLE          COVERED ONLY AT PARTICIPATING PHARMACIES</b>	
EMERGENCY CARE	Participating MEMBER RESPONSIBILITY	Non-Participating MEMBER RESPONSIBILITY
Urgent Care Center	\$50 Copay (not subject to deductible)	
Emergency Room Services (not subject to deductible unless admitted)	\$150 Copay (ER Copay waived if admitted)	
REHABILITATION SERVICES	Participating MEMBER RESPONSIBILITY	Non-Participating MEMBER RESPONSIBILITY
<b>Occupational, Speech, Physical Therapy</b>	Inpatient - 0% (after annual deductible) Outpatient - \$20 Copay (not subject to deductible)	50% Eligible Charges (after annual deductible)
	45 inpatient days per contract year 30 outpatient visits per contract year	

MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES	Participating MEMBER RESPONSIBILITY	Non-Participating MEMBER RESPONSIBILITY
<b>General Mental Health:</b> Inpatient	(Mental health services must be preauthorized)	
	0% (after annual deductible)	50% Eligible Charges (after annual deductible)
Physician Services (Outpatient)	30 days per contract year 90 days lifetime benefit maximum	
	\$20 Copay per visit	50% Eligible Charges (after annual deductible)
<b>Serious Mental Health:</b> Inpatient	20 outpatient visits maximum per contract year	
	0% (after annual deductible)	50% Eligible Charges (after annual deductible)
Physician Services (Outpatient)	30 days per contract year 90 days lifetime benefit maximum	
	\$20 Copay per visit	50% Eligible Charges (after annual deductible)
<b>Substance Abuse:</b> Inpatient Detoxification	60 outpatient visits maximum per contract year	
	0% (after annual deductible)	50% Eligible Charges (after annual deductible)
Inpatient Rehabilitation	7 days maximum per admission 4 admission benefit maximum	
	0% (after annual deductible)	50% Eligible Charges (after annual deductible)
Transitional Partial Hospitalization	30 days maximum per contract year 90 days benefit maximum	
	0% (not subject to deductible)	50% Eligible Charges (after annual deductible)
	60 visits per contract year 120 visits per benefit maximum	
OTHER BENEFITS	Participating MEMBER RESPONSIBILITY	Non-Participating MEMBER RESPONSIBILITY
<b>Claim Forms Required</b>	No	Yes
<b>Durable Medical Equipment (DME) / Corrective Appliances</b> Limited to once every 2 years for irreparable damage and/or normal wear.	50% (not subject to deductible)	50% Eligible Charges (after annual deductible)
<b>Home Health Care Services</b>	0% (not subject to deductible) 120 visits per contract year	50% Eligible Charges (after annual deductible) 60 visits per contract year
<b>Hospice Care</b>	120 visits combined per contract year	
<b>Skilled Nursing Facility</b>	0% (after annual deductible) 100 inpatient days per contract year	50% Eligible Charges (after annual deductible) 50 inpatient days per contract year
<b>Dental Services</b> Emergency treatment of dental injury Removal of Third Molars	100 days combined maximum per contract year	
<b>Vision Services</b>	Inpatient - 0% (after annual deductible) Outpatient - \$20 Copay (not subject to deductible)	
<b>Health Education</b>	50% Eligible Charges (after annual deductible)	
<b>PRECERTIFICATION REQUIREMENT</b>	By Physician	By Patient
When using a nonparticipating provider, the member must obtain precertification of nonemergency hospital and other facility (e.g., skilled nursing facilities, rehabilitation facilities, drug and alcohol treatment facilities) admissions, outpatient surgery and certain other services as stated in the Group Contract. If these services or admissions are not precertified and the service is not medically necessary, the member may be responsible for 100% of the cost of the services.		
<b>LIFETIME MAXIMUM</b>	Unlimited	
<p><b>Autism Spectrum Disorders are covered pursuant to state mandates for groups with 51 or more employees.</b></p> <p>This is not a contract. It is intended solely to provide you with an overview of the plan. Complete details of benefits, terms and exclusions are governed by your Group Contract. <b>This managed care plan may not cover all your health care expenses. Read your contract carefully to determine which health care services are covered. If you have questions call us at 800.788.8445 in Central/Eastern Pennsylvania, and 800.735.4404 in Western Pennsylvania and Ohio.</b></p> <p>Benefits are administered on a contract year basis. Coinsurance is based on Eligible Charges as defined in your Certificate of Insurance. For non-participating providers, Eligible Charges are based on the lesser of the provider's billed charges or our Out-of-Network Rate, which is defined in your Certificate of Insurance. <b>In addition to your copay or coinsurance, you are responsible for paying nonparticipating providers the difference between our out-of-network rate and their actual charge for nonemergency services. Your out-of-pocket costs for nonemergency care from nonparticipating providers may be substantial.</b></p> <p><i>Dependent Coverage Age Limit is 26</i></p> <p>*If your Schedule of Benefits indicates that you have a Qualified High Deductible Health Plan., you must consult your group benefit documents for a specific description and the terms and conditions of your coverage for these benefits. Also, some covered services that you receive during a preventive service office visit may not qualify as preventive services under the group contract and, consequently, will be subject to applicable deductibles. In order to be exempt from applicable deductibles, preventive services must qualify as preventive services under the group contract and Section 223 of the Internal Revenue Code.</p> <p>This document neither affirmatively nor negatively amends, extends, or alters the terms of or the coverage afforded by policy referenced herein.</p> <p><b>**Reimbursement for Weight Management programs is limited to \$350 per calendar year per member.</b></p>		

DEDUCTIBLES AND MAXIMUMS	Participating MEMBER RESPONSIBILITY	Non-Participating MEMBER RESPONSIBILITY
<b>Annual Deductible</b> ( <i>applies to in-network inpatient hospital-type services/outpatient surgery</i> )		
Individual		\$1,000
Family (aggregate)		\$2,000
<b>Out-of-Pocket Maximum</b> ( <i>includes deductibles, copays and coinsurance; excludes Rx copays</i> )		
Individual		\$3,000
Family (aggregate)		\$6,000
OUTPATIENT SERVICES	Participating MEMBER RESPONSIBILITY	Non-Participating MEMBER RESPONSIBILITY
<b>Physician Services (for illness or injury)</b>	(office visit NOT subject to deductible)	
Primary Care Visit (PCP)	\$15 Copay	50% Eligible Charges (after annual deductible)
Specialist Visit (SCP)	\$30 Copay	50% Eligible Charges (after annual deductible)
<b>Preventive Services*</b>	(office visit NOT subject to deductible)	
Gynecological Exam (PCP/SCP)	\$0 Copay	50% Eligible Charges (after annual deductible)
Well Child Visit	\$0 Copay	50% Eligible Charges (after annual deductible)
Adult Physical Visit	\$0 Copay	50% Eligible Charges (after annual deductible)
Routine Pediatric Immunizations	0%	50% Eligible Charges
Hearing Exams (under age 18)	0%	50% Eligible Charges (after annual deductible)
Routine Mammograms	0%	50% Eligible Charges (after annual deductible)
<b>Allergy Testing &amp; Allergy Serum</b>	0% (not subject to deductible)	50% Eligible Charges (after annual deductible)
<b>Chiropractic Care</b>	\$30 Copay (not subject to deductible)	50% Eligible Charges (after annual deductible)
Maximum 20 visits per contract year		
<b>Outpatient Surgery</b>	0% (after annual deductible)	50% Eligible Charges (after annual deductible)
<b>Lab Services</b>	\$0 copay (not subject to deductible)	50% Eligible Charges (after annual deductible)
<b>Diagnostic X-ray</b>	\$30 Copay (not subject to deductible)	50% Eligible Charges (after annual deductible)
<b>Radiology</b> (CAT, MRI, Ultrasound)	\$150 Copay (not subject to deductible)	50% Eligible Charges (after annual deductible)
HOSPITAL SERVICES	Participating MEMBER RESPONSIBILITY	Non-Participating MEMBER RESPONSIBILITY
<b>Hospital Care</b>		
Semi-private room (private room if medically necessary)	0% (after annual deductible)	50% Eligible Charges (after annual deductible)
Physician and Surgeon Fees	0% (after annual deductible)	50% Eligible Charges (after annual deductible)
Surgery	0% (after annual deductible)	50% Eligible Charges (after annual deductible)
Lab and X-ray services	0% (after annual deductible)	50% Eligible Charges (after annual deductible)
All Medically Necessary Ancillary Services	0% (after annual deductible)	50% Eligible Charges (after annual deductible)
Anesthesia	0% (after annual deductible)	50% Eligible Charges (after annual deductible)
Administration of Blood	0% (after annual deductible)	50% Eligible Charges (after annual deductible)
Blood Products	0% (after annual deductible)	50% Eligible Charges (after annual deductible)
Therapy Services (Chemotherapy & Radiation Therapy)	0% (after annual deductible)	50% Eligible Charges (after annual deductible)
MATERNITY SERVICES	Participating MEMBER RESPONSIBILITY	Non-Participating MEMBER RESPONSIBILITY
<b>Pregnancy Care</b> (PCP/SCP)		
(copay for the first office visit only)	\$15/\$30 Copay (not subject to deductible)	50% Eligible Charges (after annual deductible)
Delivery	0% (after annual deductible)	50% Eligible Charges (after annual deductible)
FAMILY PLANNING	Participating MEMBER RESPONSIBILITY	Non-Participating MEMBER RESPONSIBILITY
<b>Infertility Counseling/Testing/Services</b> ( <i>outpatient services</i> )	\$300 one time deductible then coinsurance applies; (\$2,400 combined benefit maximum for infertility)	
<b>Tubal Ligation/Vasectomy</b>	0% (not subject to deductible in office setting) 0% (after deductible inpatient/outpatient surgery setting)	50% Eligible Charges (after annual deductible)
PRESCRIPTION DRUGS	Participating MEMBER RESPONSIBILITY	Non-Participating MEMBER RESPONSIBILITY
(Includes oral contraceptives & managed formulary. Mandatory generic substitution may apply)	<b>VARIOUS RIDERS AVAILABLE COVERED ONLY AT PARTICIPATING PHARMACIES</b>	
EMERGENCY CARE	Participating MEMBER RESPONSIBILITY	Non-Participating MEMBER RESPONSIBILITY
Urgent Care Center		\$50 Copay (not subject to deductible)
Emergency Room Services (not subject to deductible unless admitted)		\$150 Copay (ER Copay waived if admitted)
REHABILITATION SERVICES	Participating MEMBER RESPONSIBILITY	Non-Participating MEMBER RESPONSIBILITY
<b>Occupational, Speech, Physical Therapy</b>	Inpatient - 0% (after annual deductible) Outpatient - \$30 Copay (not subject to deductible)	50% Eligible Charges (after annual deductible)
	<i>45 inpatient days per contract year 30 outpatient visits per contract year</i>	

MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES	Participating MEMBER RESPONSIBILITY	Non-Participating MEMBER RESPONSIBILITY
<b>General Mental Health:</b> Inpatient	(Mental health services must be preauthorized)	
	0% (after annual deductible)	50% Eligible Charges (after annual deductible)
Physician Services (Outpatient)	30 days per contract year 90 days lifetime benefit maximum	
	\$30 Copay per visit	50% Eligible Charges (after annual deductible)
<b>Serious Mental Health:</b> Inpatient	20 outpatient visits maximum per contract year	
	0% (after annual deductible)	50% Eligible Charges (after annual deductible)
Physician Services (Outpatient)	30 days per contract year 90 days lifetime benefit maximum	
	\$30 Copay per visit	50% Eligible Charges (after annual deductible)
<b>Substance Abuse:</b> Inpatient Detoxification	60 outpatient visits maximum per contract year	
	0% (after annual deductible)	50% Eligible Charges (after annual deductible)
Inpatient Rehabilitation	7 days maximum per admission 4 admission benefit maximum	
	0% (after annual deductible)	50% Eligible Charges (after annual deductible)
Transitional Partial Hospitalization	30 days maximum per contract year 90 days benefit maximum	
	0% (not subject to deductible)	50% Eligible Charges (after annual deductible)
	60 visits per contract year 120 visits per benefit maximum	
OTHER BENEFITS	Participating MEMBER RESPONSIBILITY	Non-Participating MEMBER RESPONSIBILITY
<b>Claim Forms Required</b>	No	Yes
<b>Durable Medical Equipment (DME) / Corrective Appliances</b> Limited to once every 2 years for irreparable damage and/or normal wear.	50% (not subject to deductible)	50% Eligible Charges (after annual deductible)
<b>Home Health Care Services</b>	0% (not subject to deductible) 120 visits per contract year	50% Eligible Charges (after annual deductible) 60 visits per contract year
<b>Hospice Care</b>	120 visits combined per contract year	
<b>Skilled Nursing Facility</b>	0% (after annual deductible) 100 inpatient days per contract year	50% Eligible Charges (after annual deductible) 50 inpatient days per contract year
<b>Dental Services</b> Emergency treatment of dental injury Removal of Third Molars	100 days combined maximum per contract year	
<b>Vision Services</b>	Inpatient - 0% (after annual deductible) Outpatient - \$30 Copay (not subject to deductible)	
<b>Health Education</b>	50% Eligible Charges (after annual deductible)	
<b>PRECERTIFICATION REQUIREMENT</b>	By Physician	By Patient
When using a nonparticipating provider, the member must obtain precertification of nonemergency hospital and other facility (e.g., skilled nursing facilities, rehabilitation facilities, drug and alcohol treatment facilities) admissions, outpatient surgery and certain other services as stated in the Group Contract. If these services or admissions are not precertified and the service is not medically necessary, the member may be responsible for 100% of the cost of the services.		
<b>LIFETIME MAXIMUM</b>	Unlimited	
<p><b>Autism Spectrum Disorders are covered pursuant to state mandates for groups with 51 or more employees.</b>  This is not a contract. It is intended solely to provide you with an overview of the plan. Complete details of benefits, terms and exclusions are governed by your Group Contract. <b>This managed care plan may not cover all your health care expenses. Read your contract carefully to determine which health care services are covered. If you have questions call us at 800.788.8445 in Central/Eastern Pennsylvania, and 800.735.4404 in Western Pennsylvania and Ohio.</b>  Benefits are administered on a contract year basis. Coinsurance is based on Eligible Charges as defined in your Certificate of Insurance. For non-participating providers, Eligible Charges are based on the lesser of the provider's billed charges or our Out-of-Network Rate, which is defined in your Certificate of Insurance. <b>In addition to your copay or coinsurance, you are responsible for paying nonparticipating providers the difference between our out-of-network rate and their actual charge for nonemergency services. Your out-of-pocket costs for nonemergency care from nonparticipating providers may be substantial.</b>  <i>Dependent Coverage Age Limit is 26</i>  *If your Schedule of Benefits indicates that you have a Qualified High Deductible Health Plan., you must consult your group benefit documents for a specific description and the terms and conditions of your coverage for these benefits. Also, some covered services that you receive during a preventive service office visit may not qualify as preventive services under the group contract and, consequently, will be subject to applicable deductibles. In order to be exempt from applicable deductibles, preventive services must qualify as preventive services under the group contract and Section 223 of the Internal Revenue Code.  This document neither affirmatively nor negatively amends, extends, or alters the terms of or the coverage afforded by policy referenced herein.  **Reimbursement for Weight Management programs is limited to \$350 per calendar year per member.</p>		

DEDUCTIBLES AND MAXIMUMS	Participating MEMBER RESPONSIBILITY	Non-Participating MEMBER RESPONSIBILITY
<b>Annual Deductible</b> ( <i>applies to in-network inpatient hospital-type services/outpatient surgery</i> )		
Individual		\$1,500
Family (aggregate)		\$3,000
<b>Out-of-Pocket Maximum</b> ( <i>includes deductibles, copays and coinsurance; excludes Rx copays</i> )		
Individual		\$3,000
Family (aggregate)		\$6,000
OUTPATIENT SERVICES	Participating MEMBER RESPONSIBILITY	Non-Participating MEMBER RESPONSIBILITY
<b>Physician Services (for illness or injury)</b>	(office visit NOT subject to deductible)	
Primary Care Visit (PCP)	\$15 Copay	50% Eligible Charges (after annual deductible)
Specialist Visit (SCP)	\$30 Copay	50% Eligible Charges (after annual deductible)
<b>Preventive Services*</b>	(office visit NOT subject to deductible)	
Gynecological Exam (PCP/SCP)	\$0 Copay	50% Eligible Charges (after annual deductible)
Well Child Visit	\$0 Copay	50% Eligible Charges (after annual deductible)
Adult Physical Visit	\$0 Copay	50% Eligible Charges (after annual deductible)
Routine Pediatric Immunizations	0%	50% Eligible Charges
Hearing Exams (under age 18)	0%	50% Eligible Charges (after annual deductible)
Routine Mammograms	0%	50% Eligible Charges (after annual deductible)
<b>Allergy Testing &amp; Allergy Serum</b>	0% (not subject to deductible)	50% Eligible Charges (after annual deductible)
<b>Chiropractic Care</b>	\$30 Copay (not subject to deductible)	50% Eligible Charges (after annual deductible)
Maximum 20 visits per contract year		
<b>Outpatient Surgery</b>	0% (after annual deductible)	50% Eligible Charges (after annual deductible)
<b>Lab Services</b>	\$0 copay (not subject to deductible)	50% Eligible Charges (after annual deductible)
<b>Diagnostic X-ray</b>	\$30 Copay (not subject to deductible)	50% Eligible Charges (after annual deductible)
<b>Radiology</b> (CAT, MRI, Ultrasound)	\$150 Copay (not subject to deductible)	50% Eligible Charges (after annual deductible)
HOSPITAL SERVICES	Participating MEMBER RESPONSIBILITY	Non-Participating MEMBER RESPONSIBILITY
<b>Hospital Care</b>		
Semi-private room (private room if medically necessary)	0% (after annual deductible)	50% Eligible Charges (after annual deductible)
Physician and Surgeon Fees	0% (after annual deductible)	50% Eligible Charges (after annual deductible)
Surgery	0% (after annual deductible)	50% Eligible Charges (after annual deductible)
Lab and X-ray services	0% (after annual deductible)	50% Eligible Charges (after annual deductible)
All Medically Necessary Ancillary Services	0% (after annual deductible)	50% Eligible Charges (after annual deductible)
Anesthesia	0% (after annual deductible)	50% Eligible Charges (after annual deductible)
Administration of Blood	0% (after annual deductible)	50% Eligible Charges (after annual deductible)
Blood Products	0% (after annual deductible)	50% Eligible Charges (after annual deductible)
Therapy Services (Chemotherapy & Radiation Therapy)	0% (after annual deductible)	50% Eligible Charges (after annual deductible)
MATERNITY SERVICES	Participating MEMBER RESPONSIBILITY	Non-Participating MEMBER RESPONSIBILITY
<b>Pregnancy Care</b> (PCP/SCP) (copay for the first office visit only)	\$15/\$30 Copay (not subject to deductible)	50% Eligible Charges (after annual deductible)
Delivery	0% (after annual deductible)	50% Eligible Charges (after annual deductible)
FAMILY PLANNING	Participating MEMBER RESPONSIBILITY	Non-Participating MEMBER RESPONSIBILITY
<b>Infertility Counseling/Testing/Services</b> ( <i>outpatient services</i> )	\$300 one time deductible then coinsurance applies; (\$2,400 combined benefit maximum for infertility)	
<b>Tubal Ligation/Vasectomy</b>	0% (not subject to deductible in office setting) 0% (after deductible inpatient/outpatient surgery setting)	50% Eligible Charges (after annual deductible)
PRESCRIPTION DRUGS	Participating MEMBER RESPONSIBILITY	Non-Participating MEMBER RESPONSIBILITY
(Includes oral contraceptives & managed formulary. Mandatory generic substitution may apply)	<b>Refer to the RX Select formulary to identify which drugs do not require authorization. Quantity limits still apply.</b> <b>VARIOUS RIDERS AVAILABLE</b> <b>COVERED ONLY AT PARTICIPATING PHARMACIES</b>	
EMERGENCY CARE	Participating MEMBER RESPONSIBILITY	Non-Participating MEMBER RESPONSIBILITY
Urgent Care Center	\$50 Copay (not subject to deductible)	50% Eligible Charges (after annual deductible)
Emergency Room Services (not subject to deductible unless admitted)	\$150 Copay (ER Copay waived if admitted)	
REHABILITATION SERVICES	Participating MEMBER RESPONSIBILITY	Non-Participating MEMBER RESPONSIBILITY
<b>Occupational, Speech, Physical Therapy</b>	Inpatient - 0% (after annual deductible) Outpatient - \$30 Copay (not subject to deductible)	50% Eligible Charges (after annual deductible)
	<i>45 inpatient days per contract year</i> <i>30 outpatient visits per contract year</i>	

MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES		Participating MEMBER RESPONSIBILITY	Non-Participating MEMBER RESPONSIBILITY
<b>General Mental Health:</b>		(Mental health services must be preauthorized)	
Inpatient		0% (after annual deductible)	50% Eligible Charges (after annual deductible)
		<i>30 days per contract year 90 days lifetime benefit maximum</i>	
Physician Services (Outpatient)		\$30 Copay per visit	50% Eligible Charges (after annual deductible)
		<i>20 outpatient visits maximum per contract year</i>	
<b>Serious Mental Health:</b>			
Inpatient		0% (after annual deductible)	50% Eligible Charges (after annual deductible)
		<i>30 days per contract year 90 days lifetime benefit maximum</i>	
Physician Services (Outpatient)		\$30 Copay per visit	50% Eligible Charges (after annual deductible)
		<i>60 outpatient visits maximum per contract year</i>	
<b>Substance Abuse:</b>			
Inpatient Detoxification		0% (after annual deductible)	50% Eligible Charges (after annual deductible)
		<i>7 days maximum per admission 4 admission benefit maximum</i>	
Inpatient Rehabilitation		0% (after annual deductible)	50% Eligible Charges (after annual deductible)
		<i>30 days maximum per contract year 90 days benefit maximum</i>	
Transitional Partial Hospitalization		0% (not subject to deductible)	50% Eligible Charges (after annual deductible)
		<i>60 visits per contract year 120 visits per benefit maximum</i>	
OTHER BENEFITS		Participating MEMBER RESPONSIBILITY	Non-Participating MEMBER RESPONSIBILITY
<b>Claim Forms Required</b>		No	Yes
<b>Durable Medical Equipment (DME) / Corrective Appliances</b> Limited to once every 2 years for irreparable damage and/or normal wear.		50% (not subject to deductible)	50% Eligible Charges (after annual deductible)
<b>Home Health Care Services</b>		0% (not subject to deductible) <i>120 visits per contract year</i>	50% Eligible Charges (after annual deductible) <i>60 visits per contract year</i>
		<i>120 visits combined per contract year</i>	
<b>Hospice Care</b>		0% (after annual deductible)	50% Eligible Charges (after annual deductible)
<b>Skilled Nursing Facility</b>		0% (after annual deductible) <i>100 inpatient days per contract year</i>	50% Eligible Charges (after annual deductible) <i>50 inpatient days per contract year</i>
		<i>100 days combined maximum per contract year</i>	
<b>Dental Services</b> Emergency treatment of dental injury Removal of Third Molars		Inpatient – 0% (after annual deductible) Outpatient - \$30 Copay (not subject to deductible)	50% Eligible Charges (after annual deductible)
<b>Vision Services</b>		<b>Vision One Eyecare Program®:</b> Receive immediate savings on all eyecare needs--discounts on frames, lenses, disposable contacts, and even LASIK surgery--at participating providers through the EyeMed Vision Care network.	
<b>Health Education</b>		Members receive reimbursement of the cost of approved wellness programs offered through local hospitals and organizations.**	
<b>PRECERTIFICATION REQUIREMENT</b>		By Physician	By Patient
When using a nonparticipating provider, the member must obtain precertification of nonemergency hospital and other facility (e.g., skilled nursing facilities, rehabilitation facilities, drug and alcohol treatment facilities) admissions, outpatient surgery and certain other services as stated in the Group Contract. If these services or admissions are not precertified, the member may be responsible for an additional financial penalty stated above or, if the service is not medically necessary, 100% (after annual deductible) of the cost of the services.			
<b>LIFETIME MAXIMUM</b>		Unlimited	
<b>Autism Spectrum Disorders are covered pursuant to state mandates for groups with 51 or more employees.</b>			
This is not a contract. It is intended solely to provide you with an overview of the plan. Complete details of benefits, terms and exclusions are governed by your Group C contract. <b>This managed care plan may not cover all your health care expenses. Read your contract carefully to determine which health care services are covered. If you have questions call us at 800.788.8445 in Central/Eastern Pennsylvania, and 800.735.4404 in Western Pennsylvania and Ohio.</b>			
Benefits are administered on a contract year basis. Coinsurance is based on Eligible Charges as defined in your Certificate of Insurance. For non-participating providers, Eligible Charges are based on the lesser of the provider's billed charges or our Out-of-Network Rate, which is defined in your Certificate of Insurance. <b>In addition to your copay or coinsurance, you are responsible for paying nonparticipating providers the difference between our out-of-network rate and their actual charge for nonemergency services. Your out-of-pocket costs for nonemergency care from nonparticipating providers may be substantial.</b>			
<i>Dependent Coverage Age Limit is 26</i>			
*If your Schedule of Benefits indicates that you have a Qualified High Deductible Health Plan., you must consult your group benefit documents for a specific description and the terms and conditions of your coverage for these benefits. Also, some covered services that you receive during a preventive service office visit may not qualify as preventive services under the group contract and, consequently, will be subject to applicable deductibles. In order to be exempt from applicable deductibles, preventive services must qualify as preventive services under the group contract and Section 223 of the Internal Revenue Code.			
This document neither affirmatively nor negatively amends, extends, or alters the terms of or the coverage afforded by policy referenced herein.			
**Reimbursement for Weight Management programs is limited to \$350 per calendar year per member.			

<b>DEDUCTIBLES AND MAXIMUMS</b>	<b>Participating MEMBER RESPONSIBILITY</b>	<b>Non-Participating MEMBER RESPONSIBILITY</b>
<b>Annual Deductible</b> (applies to in-network inpatient hospital-type services/outpatient surgery)		
Individual		\$2,000
Family (aggregate)		\$4,000
<b>Out-of-Pocket Maximum</b> (includes deductibles, copays and coinsurance; excludes Rx copays)		
Individual		\$3,000
Family (aggregate)		\$6,000
<b>OUTPATIENT SERVICES</b>	<b>Participating MEMBER RESPONSIBILITY</b>	<b>Non-Participating MEMBER RESPONSIBILITY</b>
<b>Physician Services (for illness or injury)</b>	(office visit NOT subject to deductible)	
Primary Care Visit (PCP)	\$20 Copay	50% Eligible Charges (after annual deductible)
Specialist Visit (SCP)	\$40 Copay	50% Eligible Charges (after annual deductible)
<b>Preventive Services*</b>	(office visit NOT subject to deductible)	
Gynecological Exam (PCP/SCP)	\$0 Copay	50% Eligible Charges (after annual deductible)
Well Child Visit	\$0 Copay	Not Covered
Adult Physical Visit	\$0 Copay	Not Covered
Routine Pediatric Immunizations	0%	50% Eligible Charges
Hearing Exams (under age 18)	0%	50% Eligible Charges (after annual deductible)
Routine Mammograms	0%	50% Eligible Charges (after annual deductible)
<b>Allergy Testing &amp; Allergy Serum</b>	0% (not subject to deductible)	50% Eligible Charges (after annual deductible)
<b>Chiropractic Care</b>	\$40 Copay (not subject to deductible)	50% Eligible Charges (after annual deductible)
Maximum 20 visits per contract year		
<b>Outpatient Surgery</b>	0% (after annual deductible)	50% Eligible Charges (after annual deductible)
<b>Lab Services</b>	\$0 copay (not subject to deductible)	50% Eligible Charges (after annual deductible)
<b>Diagnostic X-ray</b>	\$40 Copay (not subject to deductible)	50% Eligible Charges (after annual deductible)
<b>Radiology</b> (CAT, MRI, Ultrasound)	\$150 Copay (not subject to deductible)	50% Eligible Charges (after annual deductible)
<b>HOSPITAL SERVICES</b>	<b>Participating MEMBER RESPONSIBILITY</b>	<b>Non-Participating MEMBER RESPONSIBILITY</b>
<b>Hospital Care</b>		
Semi-private room (private room if medically necessary)	0% (after annual deductible)	50% Eligible Charges (after annual deductible)
Physician and Surgeon Fees	0% (after annual deductible)	50% Eligible Charges (after annual deductible)
Surgery	0% (after annual deductible)	50% Eligible Charges (after annual deductible)
Lab and X-ray services	0% (after annual deductible)	50% Eligible Charges (after annual deductible)
All Medically Necessary Ancillary Services	0% (after annual deductible)	50% Eligible Charges (after annual deductible)
Anesthesia	0% (after annual deductible)	50% Eligible Charges (after annual deductible)
Administration of Blood	0% (after annual deductible)	50% Eligible Charges (after annual deductible)
Blood Products	0% (after annual deductible)	50% Eligible Charges (after annual deductible)
Therapy Services (Chemotherapy & Radiation Therapy)	0% (after annual deductible)	50% Eligible Charges (after annual deductible)
<b>MATERNITY SERVICES</b>	<b>Participating MEMBER RESPONSIBILITY</b>	<b>Non-Participating MEMBER RESPONSIBILITY</b>
<b>Pregnancy Care</b> (PCP/SCP)		
(copay for the first office visit only)	\$20/\$40 Copay (not subject to deductible)	50% Eligible Charges (after annual deductible)
Delivery	0% (after annual deductible)	50% Eligible Charges (after annual deductible)
<b>FAMILY PLANNING</b>	<b>Participating MEMBER RESPONSIBILITY</b>	<b>Non-Participating MEMBER RESPONSIBILITY</b>
<b>Infertility Counseling/Testing/Services</b> (outpatient services)	\$300 one time deductible then coinsurance applies; (\$2,400 combined benefit maximum for infertility)	
<b>Tubal Ligation/Vasectomy</b>	0% (not subject to deductible in office setting) 0% (after deductible inpatient/outpatient surgery setting)	50% Eligible Charges (after annual deductible)
<b>PRESCRIPTION DRUGS</b>	<b>Participating MEMBER RESPONSIBILITY</b>	<b>Non-Participating MEMBER RESPONSIBILITY</b>
(Includes oral contraceptives & managed formulary. Mandatory generic substitution may apply)	<b>Refer to the RX Select formulary to identify which drugs do not require authorization. Quantity limits still apply.</b>	
	<b>VARIOUS RIDERS AVAILABLE COVERED ONLY AT PARTICIPATING PHARMACIES</b>	
<b>EMERGENCY CARE</b>	<b>Participating MEMBER RESPONSIBILITY</b>	<b>Non-Participating MEMBER RESPONSIBILITY</b>
Urgent Care Center		\$50 Copay (not subject to deductible)
Emergency Room Services (not subject to deductible unless admitted)		\$150 Copay (ER Copay waived if admitted)
<b>REHABILITATION SERVICES</b>	<b>Participating MEMBER RESPONSIBILITY</b>	<b>Non-Participating MEMBER RESPONSIBILITY</b>
<b>Occupational, Speech, Physical Therapy</b>	Inpatient - 0% (after annual deductible) Outpatient - \$40 Copay (not subject to deductible)	50% Eligible Charges (after annual deductible)
	45 inpatient days per contract year 30 outpatient visits per contract year	

MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES	Participating MEMBER RESPONSIBILITY	Non-Participating MEMBER RESPONSIBILITY
<b>General Mental Health:</b> Inpatient	(Mental health services must be preauthorized)	
	0% (after annual deductible)	50% Eligible Charges (after annual deductible)
Physician Services (Outpatient)	<i>30 days per contract year 90 days lifetime benefit maximum</i>	
	\$40 Copay per visit	50% Eligible Charges (after annual deductible)
<b>Serious Mental Health:</b> Inpatient	<i>30 days per contract year 90 days lifetime benefit maximum</i>	
	0% (after annual deductible)	50% Eligible Charges (after annual deductible)
Physician Services (Outpatient)	<i>30 days per contract year 90 days lifetime benefit maximum</i>	
	\$40 Copay per visit	50% Eligible Charges (after annual deductible)
<b>Substance Abuse:</b> Inpatient Detoxification	<i>60 outpatient visits maximum per contract year</i>	
	0% (after annual deductible)	50% Eligible Charges (after annual deductible)
Inpatient Rehabilitation	<i>7 days maximum per admission 4 admission benefit maximum</i>	
	0% (after annual deductible)	50% Eligible Charges (after annual deductible)
Transitional Partial Hospitalization	<i>30 days maximum per contract year 90 days benefit maximum</i>	
	0% (not subject to deductible)	50% Eligible Charges (after annual deductible)
	<i>60 visits per contract year 120 visits per benefit maximum</i>	
OTHER BENEFITS	Participating MEMBER RESPONSIBILITY	Non-Participating MEMBER RESPONSIBILITY
<b>Claim Forms Required</b>	No	Yes
<b>Durable Medical Equipment (DME) / Corrective Appliances</b> Limited to once every 2 years for irreparable damage and/or normal wear.	50% (not subject to deductible)	50% Eligible Charges (after annual deductible)
<b>Home Health Care Services</b>	0% (not subject to deductible) <i>120 visits per contract year</i>	50% Eligible Charges (after annual deductible) <i>60 visits per contract year</i>
<b>Hospice Care</b>	<i>120 visits combined per contract year</i>	
<b>Skilled Nursing Facility</b>	0% (after annual deductible)	50% Eligible Charges (after annual deductible)
<b>Dental Services</b> Emergency treatment of dental injury Removal of Third Molars	0% (after annual deductible)	50% Eligible Charges (after annual deductible)
<b>Vision Services</b>	0% (after annual deductible) <i>100 inpatient days per contract year 100 days combined maximum per contract year</i>	
<b>Health Education</b>	Inpatient - 0% (after annual deductible) Outpatient - \$40 Copay (not subject to deductible)	
<b>Vision One Eyecare Program®:</b>	50% Eligible Charges (after annual deductible)	
Receive immediate savings on all eyecare needs--discounts on frames, lenses, disposable contacts, and even LASIK surgery--at participating providers through the EyeMed Vision Care network.		
Members receive reimbursement of the cost of approved wellness programs offered through local hospitals and organizations.**		
<b>PRECERTIFICATION REQUIREMENT</b>	By Physician	By Patient
When using a nonparticipating provider, the member must obtain precertification of nonemergency hospital and other facility (e.g., skilled nursing facilities, rehabilitation facilities, drug and alcohol treatment facilities) admissions, outpatient surgery and certain other services as stated in the Group Contract. If these services or admissions are not precertified and the service is not medically necessary, the member may be responsible for 100% of the cost of the services.		
<b>LIFETIME MAXIMUM</b>	Unlimited	
<b>Autism Spectrum Disorders are covered pursuant to state mandates for groups with 51 or more employees.</b>		
This is not a contract. It is intended solely to provide you with an overview of the plan. Complete details of benefits, terms and exclusions are governed by your Group Contract. <b>This managed care plan may not cover all your health care expenses. Read your contract carefully to determine which health care services are covered. If you have questions call us at 800.788.8445 in Central/Eastern Pennsylvania, and 800.735.4404 in Western Pennsylvania and Ohio.</b>		
Benefits are administered on a contract year basis. Coinsurance is based on Eligible Charges as defined in your Certificate of Insurance. For non-participating providers, Eligible Charges are based on the lesser of the provider's billed charges or our Out-of-Network Rate, which is defined in your Certificate of Insurance. <b>In addition to your copay or coinsurance, you are responsible for paying nonparticipating providers the difference between our out-of-network rate and their actual charge for nonemergency services. Your out-of-pocket costs for nonemergency care from nonparticipating providers may be substantial.</b>		
<i>Dependent Coverage Age Limit is 26.</i>		
*If your Schedule of Benefits indicates that you have a Qualified High Deductible Health Plan., you must consult your group benefit documents for a specific description and the terms and conditions of your coverage for these benefits. Also, some covered services that you receive during a preventive service office visit may not qualify as preventive services under the group contract and, consequently, will be subject to applicable deductibles. In order to be exempt from applicable deductibles, preventive services must qualify as preventive services under the group contract and Section 223 of the Internal Revenue Code.		
This document neither affirmatively nor negatively amends, extends, or alters the terms of or the coverage afforded by policy referenced herein.		
**Reimbursement for Weight Management programs is limited to \$350 per calendar year per member.		

DEDUCTIBLES AND MAXIMUMS	Participating MEMBER RESPONSIBILITY	Non-Participating MEMBER RESPONSIBILITY
<b>Annual Deductible</b> ( <i>applies to in-network inpatient hospital-type services/outpatient surgery</i> )		
Individual	\$2,500	\$5,000
Family (aggregate)	\$5,000	\$10,000
<b>Out-of-Pocket Maximum</b> ( <i>includes deductibles, copays and coinsurance; excludes Rx copays</i> )		
Individual	\$3,000	\$10,000
Family (aggregate)	\$6,000	\$20,000
OUTPATIENT SERVICES	Participating MEMBER RESPONSIBILITY	Non-Participating MEMBER RESPONSIBILITY
<b>Physician Services (for illness or injury)</b>	(office visit NOT subject to deductible)	
Primary Care Visit (PCP)	\$25 Copay	30% Eligible Charges (after annual deductible)
Specialist Visit (SCP)	\$50 Copay	30% Eligible Charges (after annual deductible)
<b>Preventive Services*</b>	(office visit NOT subject to deductible)	
Gynecological Exam (PCP/SCP)	\$0 Copay	30% Eligible Charges (after annual deductible)
Well Child Visit	\$0 Copay	30% Eligible Charges (after annual deductible)
Adult Physical Visit	\$0 Copay	30% Eligible Charges (after annual deductible)
Routine Pediatric Immunizations	0%	30% Eligible Charges
Hearing Exams (under age 18)	0%	30% Eligible Charges (after annual deductible)
Routine Mammograms	0%	30% Eligible Charges (after annual deductible)
<b>Allergy Testing &amp; Allergy Serum</b>	0% (not subject to deductible)	30% Eligible Charges (after annual deductible)
<b>Chiropractic Care</b>	\$50 Copay (not subject to deductible)	30% Eligible Charges (after annual deductible)
Maximum 20 visits per contract year		
<b>Outpatient Surgery</b>	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
<b>Lab Services</b>	\$0 copay (not subject to deductible)	30% Eligible Charges (after annual deductible)
<b>Diagnostic X-ray</b>	\$50 Copay (not subject to deductible)	30% Eligible Charges (after annual deductible)
<b>Radiology</b> (CAT, MRI, Ultrasound)	\$150 Copay (not subject to deductible)	30% Eligible Charges (after annual deductible)
HOSPITAL SERVICES	Participating MEMBER RESPONSIBILITY	Non-Participating MEMBER RESPONSIBILITY
<b>Hospital Care</b>		
Semi-private room (private room if medically necessary)	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
Physician and Surgeon Fees	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
Surgery	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
Lab and X-ray services	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
All Medically Necessary Ancillary Services	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
Anesthesia	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
Administration of Blood	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
Blood Products	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
Therapy Services (Chemotherapy & Radiation Therapy)	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
MATERNITY SERVICES	Participating MEMBER RESPONSIBILITY	Non-Participating MEMBER RESPONSIBILITY
<b>Pregnancy Care</b> (PCP/SCP) (copay for the first office visit only)	\$25/\$50 Copay (not subject to deductible)	30% Eligible Charges (after annual deductible)
Delivery	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
FAMILY PLANNING	Participating MEMBER RESPONSIBILITY	Non-Participating MEMBER RESPONSIBILITY
<b>Infertility Counseling/Testing/Services</b> ( <i>outpatient services</i> )	\$300 one time deductible then coinsurance applies; (\$2,400 combined benefit maximum for infertility)	
<b>Tubal Ligation/Vasectomy</b>	0% (not subject to deductible in office setting) 0% (after deductible inpatient/outpatient surgery setting)	30% Eligible Charges (after annual deductible)
PRESCRIPTION DRUGS	Participating MEMBER RESPONSIBILITY	Non-Participating MEMBER RESPONSIBILITY
(Includes oral contraceptives & managed formulary. Mandatory generic substitution may apply)	<b>Refer to the RX Select formulary to identify which drugs do not require authorization. Quantity limits still apply.</b> <b>VARIOUS RIDERS AVAILABLE</b> <b>COVERED ONLY AT PARTICIPATING PHARMACIES</b>	
EMERGENCY CARE	Participating MEMBER RESPONSIBILITY	Non-Participating MEMBER RESPONSIBILITY
Urgent Care Center	\$50 Copay (not subject to deductible)	
Emergency Room Services (not subject to deductible unless admitted)	\$150 Copay (ER Copay waived if admitted)	
REHABILITATION SERVICES	Participating MEMBER RESPONSIBILITY	Non-Participating MEMBER RESPONSIBILITY
<b>Occupational, Speech, Physical Therapy</b>	Inpatient - 0% (after annual deductible) Outpatient - \$50 Copay (not subject to deductible)	30% Eligible Charges (after annual deductible)
	45 inpatient days per contract year 30 outpatient visits per contract year	

MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES		Participating MEMBER RESPONSIBILITY	Non-Participating MEMBER RESPONSIBILITY
(Mental health services must be preauthorized)			
<b>General Mental Health:</b> Inpatient	0% (after annual deductible)	30% Eligible Charges (after annual deductible)	
Physician Services (Outpatient)	\$50 Copay per visit	30% Eligible Charges (after annual deductible)	
<b>Serious Mental Health:</b> Inpatient	0% (after annual deductible)	30% Eligible Charges (after annual deductible)	
Physician Services (Outpatient)	\$50 Copay per visit	30% Eligible Charges (after annual deductible)	
<b>Substance Abuse:</b> Inpatient Detoxification	0% (after annual deductible)	30% Eligible Charges (after annual deductible)	
Inpatient Rehabilitation	0% (after annual deductible)	30% Eligible Charges (after annual deductible)	
Transitional Partial Hospitalization	0% (not subject to deductible)	30% Eligible Charges (after annual deductible)	
OTHER BENEFITS		Participating MEMBER RESPONSIBILITY	Non-Participating MEMBER RESPONSIBILITY
<b>Claim Forms Required</b>		No	Yes
<b>Durable Medical Equipment (DME) / Corrective Appliances</b> Limited to once every 2 years for irreparable damage and/or normal wear.	50% (not subject to deductible)	50% Eligible Charges (after annual deductible)	
<b>Home Health Care Services</b>	0% (not subject to deductible) <i>120 visits per contract year</i>	30% Eligible Charges (after annual deductible) <i>60 visits per contract year</i>	
<b>Hospice Care</b>	0% (after annual deductible)	30% Eligible Charges (after annual deductible)	
<b>Skilled Nursing Facility</b>	0% (after annual deductible) <i>100 inpatient days per contract year</i>	30% Eligible Charges (after annual deductible) <i>50 inpatient days per contract year</i>	
<b>Dental Services</b> Emergency treatment of dental injury Removal of Third Molars	Inpatient - 0% (after annual deductible) Outpatient - \$20 Copay (not subject to deductible)	30% Eligible Charges (after annual deductible)	
<b>Vision Services</b>	<b>Vision One Eyecare Program®:</b> Receive immediate savings on all eyecare needs--discounts on frames, lenses, disposable contacts, and even LASIK surgery--at participating providers through the EyeMed Vision Care network.		
<b>Health Education</b>	Members receive reimbursement of the cost of approved wellness programs offered through local hospitals and organizations.**		
<b>PRECERTIFICATION REQUIREMENT</b>		By Physician	By Patient
When using a nonparticipating provider, the member must obtain precertification of nonemergency hospital and other facility (e.g., skilled nursing facilities, rehabilitation facilities, drug and alcohol treatment facilities) admissions, outpatient surgery and certain other services as stated in the Group Contract. If these services or admissions are not precertified and the service is not medically necessary, the member may be responsible 100% of the cost of the services.			
<b>LIFETIME MAXIMUM</b>		Unlimited	
<p><b>Autism Spectrum Disorders are covered pursuant to state mandates for groups with 51 or more employees.</b> This is not a contract. It is intended solely to provide you with an overview of the plan. Complete details of benefits, terms and exclusions are governed by your Group Contract. <b>This managed care plan may not cover all your health care expenses. Read your contract carefully to determine which health care services are covered. If you have questions call us at 800.788.8445 in Central/Eastern Pennsylvania, and 800.735.4404 in Western Pennsylvania and Ohio.</b> Benefits are administered on a contract year basis. Coinsurance is based on Eligible Charges as defined in your Certificate of Insurance. For non-participating providers, Eligible Charges are based on the lesser of the provider's billed charges or our Out-of-Network Rate, which is defined in your Certificate of Insurance. <b>In addition to your copay or coinsurance, you are responsible for paying nonparticipating providers the difference between our out-of-network rate and their actual charge for nonemergency services. Your out-of-pocket costs for nonemergency care from nonparticipating providers may be substantial.</b> <i>Dependent Coverage Age Limit is 26</i> *If your Schedule of Benefits indicates that you have a Qualified High Deductible Health Plan, you must consult your group benefit documents for a specific description and the terms and conditions of your coverage for these benefits. Also, some covered services that you receive during a preventive service office visit may not qualify as preventive services under the group contract and, consequently, will be subject to applicable deductibles. In order to be exempt from applicable deductibles, preventive services must qualify as preventive services under the group contract and Section 223 of the Internal Revenue Code. This document neither affirmatively nor negatively amends, extends, or alters the terms of or the coverage afforded by policy referenced herein. **Reimbursement for Weight Management programs is limited to \$150 per calendar year per member.</p>			

DEDUCTIBLES AND MAXIMUMS	Participating MEMBER RESPONSIBILITY	Non-Participating MEMBER RESPONSIBILITY
<b>Annual Deductible</b> (applies to in-network inpatient hospital-type services/outpatient surgery)		
Individual	\$3,000	\$5,000
Family (aggregate)	\$6,000	\$10,000
<b>Out-of-Pocket Maximum</b> (includes deductibles, copays and coinsurance; excludes Rx copays)		
Individual	\$4,000	\$10,000
Family (aggregate)	\$8,000	\$20,000
OUTPATIENT SERVICES	Participating MEMBER RESPONSIBILITY	Non-Participating MEMBER RESPONSIBILITY
<b>Physician Services (for illness or injury)</b>	(office visit NOT subject to deductible)	
Primary Care Visit (PCP)	\$25 Copay	30% Eligible Charges (after annual deductible)
Specialist Visit (SCP)	\$50 Copay	30% Eligible Charges (after annual deductible)
<b>Preventive Services*</b>	(office visit NOT subject to deductible)	
Gynecological Exam (PCP/SCP)	\$0 Copay	30% Eligible Charges (after annual deductible)
Well Child Visit	\$0 Copay	30% Eligible Charges (after annual deductible)
Adult Physical Visit	\$0 Copay	30% Eligible Charges (after annual deductible)
Routine Pediatric Immunizations	0%	30% Eligible Charges
Hearing Exams (under age 18)	0%	30% Eligible Charges (after annual deductible)
Routine Mammograms	0%	30% Eligible Charges (after annual deductible)
<b>Allergy Testing &amp; Allergy Serum</b>	0% (not subject to deductible)	30% Eligible Charges (after annual deductible)
<b>Chiropractic Care</b>	\$50 Copay (not subject to deductible)	30% Eligible Charges (after annual deductible)
Maximum 20 visits per contract year		
<b>Outpatient Surgery</b>	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
<b>Lab Services</b>	\$0 copay (not subject to deductible)	30% Eligible Charges (after annual deductible)
<b>Diagnostic X-ray</b>	\$50 Copay (not subject to deductible)	30% Eligible Charges (after annual deductible)
<b>Radiology</b> (CAT, MRI, Ultrasound)	\$150 Copay (not subject to deductible)	30% Eligible Charges (after annual deductible)
HOSPITAL SERVICES	Participating MEMBER RESPONSIBILITY	Non-Participating MEMBER RESPONSIBILITY
<b>Hospital Care</b>		
Semi-private room (private room if medically necessary)	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
Physician and Surgeon Fees	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
Surgery	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
Lab and X-ray services	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
All Medically Necessary Ancillary Services	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
Anesthesia	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
Administration of Blood	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
Blood Products	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
Therapy Services (Chemotherapy & Radiation Therapy)	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
MATERNITY SERVICES	Participating MEMBER RESPONSIBILITY	Non-Participating MEMBER RESPONSIBILITY
<b>Pregnancy Care</b> (PCP/SCP)		
(copay for the first office visit only)	\$25/\$50 Copay (not subject to deductible)	30% Eligible Charges (after annual deductible)
Delivery	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
FAMILY PLANNING	Participating MEMBER RESPONSIBILITY	Non-Participating MEMBER RESPONSIBILITY
<b>Infertility Counseling/Testing/Services</b> (outpatient services)	\$300 one time deductible then coinsurance applies; (\$2,400 combined benefit maximum for infertility)	
<b>Tubal Ligation/Vasectomy</b>	0% (not subject to deductible in office setting) 0% (after deductible inpatient/outpatient surgery setting)	30% Eligible Charges (after annual deductible)
PRESCRIPTION DRUGS	Participating MEMBER RESPONSIBILITY	Non-Participating MEMBER RESPONSIBILITY
Includes oral contraceptives & managed formulary. Mandatory generic substitution may apply	<b>Refer to the RX Select formulary to identify which drugs do not require authorization. Quantity limits still apply.</b> <b>COVERED ONLY AT PARTICIPATING PHARMACIES</b>	
EMERGENCY CARE	Participating MEMBER RESPONSIBILITY	Non-Participating MEMBER RESPONSIBILITY
Urgent Care Center	\$50 Copay (not subject to deductible)	
Emergency Room Services (not subject to deductible unless admitted)	\$150 Copay (ER Copay waived if admitted)	
REHABILITATION SERVICES	Participating MEMBER RESPONSIBILITY	Non-Participating MEMBER RESPONSIBILITY
<b>Occupational, Speech, Physical Therapy</b>	Inpatient - 0% (after annual deductible) Outpatient - \$50 Copay (not subject to deductible)	30% Eligible Charges (after annual deductible)
	45 inpatient days per contract year 30 outpatient visits per contract year	

MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES		Participating MEMBER RESPONSIBILITY	Non-Participating MEMBER RESPONSIBILITY
(Mental health services must be preauthorized)			
<b>General Mental Health:</b> Inpatient	0% (after annual deductible)	30% Eligible Charges (after annual deductible)	
Physician Services (Outpatient)	\$50 Copay per visit	30% Eligible Charges (after annual deductible)	
<b>Serious Mental Health:</b> Inpatient	0% (after annual deductible)	30% Eligible Charges (after annual deductible)	
Physician Services (Outpatient)	\$50 Copay per visit	30% Eligible Charges (after annual deductible)	
<b>Substance Abuse:</b> Inpatient Detoxification	0% (after annual deductible)	30% Eligible Charges (after annual deductible)	
Inpatient Rehabilitation	0% (after annual deductible)	30% Eligible Charges (after annual deductible)	
Transitional Partial Hospitalization	0% (not subject to deductible)	30% Eligible Charges (after annual deductible)	
OTHER BENEFITS		Participating MEMBER RESPONSIBILITY	Non-Participating MEMBER RESPONSIBILITY
<b>Claim Forms Required</b>	No	Yes	
<b>Durable Medical Equipment (DME) / Corrective Appliances</b> Limited to once every 2 years for irreparable damage and/or normal wear.	50% (not subject to deductible)	50% Eligible Charges (after annual deductible)	
<b>Home Health Care Services</b>	0% (not subject to deductible) <i>120 visits per contract year</i>	30% Eligible Charges (after annual deductible) <i>60 visits per contract year</i>	
<b>Hospice Care</b>	0% (after annual deductible)	30% Eligible Charges (after annual deductible)	
<b>Skilled Nursing Facility</b>	0% (after annual deductible) <i>100 inpatient days per contract year</i>	30% Eligible Charges (after annual deductible) <i>50 inpatient days per contract year</i>	
<b>Dental Services</b> Emergency treatment of dental injury Removal of Third Molars	Inpatient - 0% (after annual deductible) Outpatient - \$20 Copay (not subject to deductible)	30% Eligible Charges (after annual deductible)	
<b>Vision Services</b>	<b>Vision One Eyecare Program®:</b> Receive immediate savings on all eyecare needs--discounts on frames, lenses, disposable contacts, and even LASIK surgery--at participating providers through the EyeMed Vision Care network.		
<b>Health Education</b>	Members receive reimbursement of the cost of approved wellness programs offered through local hospitals and organizations.**		
<b>PRECERTIFICATION REQUIREMENT</b>	By Physician	By Patient	
When using a nonparticipating provider, the member must obtain precertification of nonemergency hospital and other facility (e.g., skilled nursing facilities, rehabilitation facilities, drug and alcohol treatment facilities) admissions, outpatient surgery and certain other services as stated in the Group Contract. If these services or admissions are not precertified and the service is not medically necessary, the member may be responsible 100% of the cost of the services.			
<b>LIFETIME MAXIMUM</b>	Unlimited		
<p><b>Autism Spectrum Disorders are covered pursuant to state mandates for groups with 51 or more employees.</b> This is not a contract. It is intended solely to provide you with an overview of the plan. Complete details of benefits, terms and exclusions are governed by your Group Contract. <b>This managed care plan may not cover all your health care expenses. Read your contract carefully to determine which health care services are covered. If you have questions call us at 800.788.8445 in Central/Eastern Pennsylvania, and 800.735.4404 in Western Pennsylvania and Ohio.</b> Benefits are administered on a contract year basis. Coinsurance is based on Eligible Charges as defined in your Certificate of Insurance. For non-participating providers, Eligible Charges are based on the lesser of the provider's billed charges or our Out-of-Network Rate, which is defined in your Certificate of Insurance. <b>In addition to your copay or coinsurance, you are responsible for paying nonparticipating providers the difference between our out-of-network rate and their actual charge for nonemergency services. Your out-of-pocket costs for nonemergency care from nonparticipating providers may be substantial.</b> <i>Dependent Coverage Age Limit is 26</i> *If your Schedule of Benefits indicates that you have a Qualified High Deductible Health Plan, you must consult your group benefit documents for a specific description and the terms and conditions of your coverage for these benefits. Also, some covered services that you receive during a preventive service office visit may not qualify as preventive services under the group contract and, consequently, will be subject to applicable deductibles. In order to be exempt from applicable deductibles, preventive services must qualify as preventive services under the group contract and Section 223 of the Internal Revenue Code. This document neither affirmatively nor negatively amends, extends, or alters the terms of or the coverage afforded by policy referenced herein. **Reimbursement for Weight Management programs is limited to \$150 per calendar year per member.</p>			

Preferred Provider Organization

Underwritten by Health Assurance Pennsylvania, Inc.  
(d.b.a. HealthAmerica)

DEDUCTIBLES AND MAXIMUMS	Participating MEMBER RESPONSIBILITY	Non-Participating MEMBER RESPONSIBILITY
<b>Annual Deductible</b>		
Individual	\$1,500	\$3,000
Family	\$4,500	\$9,000
<b>Out-of-Pocket Maximum</b> (includes copays, deductibles and coinsurance)		
Individual	None	\$10,000
Family	None	\$30,000
OUTPATIENT SERVICES	Participating MEMBER RESPONSIBILITY	Non-Participating MEMBER RESPONSIBILITY
<b>Physician Services (for illness or injury)</b>		
Level One Visits (PCP, OBGYN, Dermatologists, Chiropractors)	\$20 Copay	30% Eligible Charges (after annual deductible)
Level Two Visits (all other office visits)	\$40 Copay (after annual deductible)	30% Eligible Charges (after annual deductible)
<b>Preventive Services*</b>		
Gynecological Exam (PCP/SCP)	\$0 Copay	30% Eligible Charges (after annual deductible)
Well Child Visit	\$0 Copay	30% Eligible Charges (after annual deductible)
Adult Physical Visit	\$0 Copay	30% Eligible Charges (after annual deductible)
Preventive Pediatric Immunizations	0%	30% Eligible Charges
Hearing Exams (under age 18)	0%	30% Eligible Charges (after annual deductible)
Routine Mammograms	0%	30% Eligible Charges (after annual deductible)
Routine Colonoscopies***	0%	30% Eligible Charges (after annual deductible)
<b>Medical Injectable</b> (Therapies including but not limited to: Remicade, Tysabri, Amevive, Boniva, Reclast)	\$75 Copay (after annual deductible)	30% Eligible Charges (after annual deductible)
<b>Allergy Testing &amp; Allergy Serum</b>	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
<b>Chiropractic Care</b> Maximum 20 visits per contract year	\$20 Copay	30% Eligible Charges (after annual deductible)
<b>Outpatient Surgery</b>	\$100 Copay (after annual deductible)	30% Eligible Charges (after annual deductible)
<b>Lab Services</b>	\$25 Copay (after annual deductible)	30% Eligible Charges (after annual deductible)
<b>Diagnostic X-ray</b>	\$50 Copay (after annual deductible)	30% Eligible Charges (after annual deductible)
<b>Radiology</b> (CAT, MRI, Ultrasound)	\$125 (after annual deductible)	30% Eligible Charges (after annual deductible)
HOSPITAL SERVICES	Participating MEMBER RESPONSIBILITY	Non-Participating MEMBER RESPONSIBILITY
<b>Hospital Care</b>		
Semi-private room (private room if medically necessary)	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
Physician and Surgeon Fees	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
Surgery	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
Lab and X-ray services	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
All Medically Necessary Ancillary Services	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
Anesthesia	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
Administration of Blood	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
Blood Products	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
Therapy Services (Chemotherapy & Radiation Therapy)	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
MATERNITY SERVICES	Participating MEMBER RESPONSIBILITY	Non-Participating MEMBER RESPONSIBILITY
<b>Pregnancy Care</b> (PCP/SCP) (copay for the first office visit only)	\$20 Copay	30% Eligible Charges (after annual deductible)
<b>Delivery</b>	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
FAMILY PLANNING	Participating MEMBER RESPONSIBILITY	Non-Participating MEMBER RESPONSIBILITY
<b>Infertility Counseling/Testing/Services</b>	\$300 one time deductible then coinsurance applies	30% Eligible Charges (after annual deductible)
<b>Tubal Ligation/Vasectomy</b>	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
		\$2400 combined benefit maximum
PRESCRIPTION DRUGS	Participating MEMBER RESPONSIBILITY	Non-Participating MEMBER RESPONSIBILITY
(Includes oral contraceptives & managed formulary. Mandatory generic substitution may apply)		
		Tier 1a = \$3 Tier 1 = \$10 Tier 2 = \$35 (after annual deductible) Tier 3 = \$60 (after annual deductible)
		<b>COVERED ONLY AT PARTICIPATING PHARMACIES</b>
EMERGENCY CARE	Participating MEMBER RESPONSIBILITY	Non-Participating MEMBER RESPONSIBILITY
<b>Urgent Care Center</b>		\$40 Copay (after annual deductible)
<b>Emergency Room Services</b>		\$150 Copay (after annual deductible) ER Copay waived if admitted
REHABILITATION SERVICES	Participating MEMBER RESPONSIBILITY	Non-Participating MEMBER RESPONSIBILITY
<b>Occupational, Speech, Physical Therapy</b>	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
		45 inpatient days per contract year 30 outpatient visits per contract year

<b>MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES</b>		<b>Participating MEMBER RESPONSIBILITY</b>	<b>Non-Participating MEMBER RESPONSIBILITY</b>
<i>(Mental health services must be preauthorized)</i>			
<b>General Mental Health:</b> Inpatient	0% (after annual deductible)	30% Eligible Charges (after annual deductible)	
	<i>30 days per contract year 90 day lifetime benefit maximum</i>		
Physician Services (Outpatient)	\$40 Copay (after annual deductible)	30% Eligible Charges (after annual deductible)	
	<i>20 outpatient visits maximum per contract year</i>		
<b>Serious Mental Health:</b> Inpatient	0% (after annual deductible)	30% Eligible Charges (after annual deductible)	
	<i>30 days per contract year 90 day lifetime benefit maximum r</i>		
Physician Services (Outpatient)	\$40 Copay (after annual deductible)	30% Eligible Charges (after annual deductible)	
	<i>60 outpatient visits maximum per contract year</i>		
<b>Substance Abuse:</b> Inpatient Detoxification	0% (after annual deductible)	30% Eligible Charges (after annual deductible)	
	<i>7 days maximum per admission 4 admission benefit maximum</i>		
Inpatient Rehabilitation	0% (after annual deductible)	30% Eligible Charges (after annual deductible)	
	<i>30 days maximum per contract year 90 days benefit maximum</i>		
Transitional Partial Hospitalization	0% (after annual deductible)	30% Eligible Charges (after annual deductible)	
	<i>60 visits per contract year 120 visits per benefit maximum</i>		
<b>OTHER BENEFITS</b>		<b>Participating MEMBER RESPONSIBILITY</b>	<b>Non-Participating MEMBER RESPONSIBILITY</b>
<b>Claim Forms Required</b>		<b>No</b>	<b>Yes</b>
<b>Durable Medical Equipment (DME)</b> – Limited to once every 2 years for irreparable damage and/or normal wear.		0% (after annual deductible)	30% Eligible Charges (after annual deductible)
<b>Corrective Appliances</b>		0% (after annual deductible)	30% Eligible Charges (after annual deductible)
<b>Home Health Care Services</b>		0% (after annual deductible) <i>120 visits per contract year</i>	30% Eligible Charges (after annual deductible) <i>60 visits per contract year</i>
		<i>120 visits combined per contract year</i>	
<b>Hospice Care</b>		0% (after annual deductible)	30% Eligible Charges (after annual deductible)
<b>Skilled Nursing Facility</b>		0% (after annual deductible) <i>100 inpatient days per contract year</i>	30% Eligible Charges (after annual deductible) <i>50 inpatient days per contract year</i>
		<i>100 days combined maximum per contract year</i>	
<b>Dental Services</b>			
Emergency treatment of dental injury		0% (after annual deductible)	30% Eligible Charges (after annual deductible)
Removal of Third Molars		0% (after annual deductible)	30% Eligible Charges (after annual deductible)
<b>Vision Services</b>	<b>Vision One Eyecare Program®:</b> Receive immediate savings on all eyecare needs--discounts on frames, lenses, disposable contacts, and even LASIK surgery--at participating providers through the EyeMed Vision Care network.		
<b>Health Education</b>	Members receive reimbursement of the cost of approved wellness programs offered through local hospitals and organizations.**		
<b>PRECERTIFICATION REQUIREMENT</b>		By Physician	By Patient
When using a nonparticipating provider, the member must obtain precertification of nonemergency hospital and other facility (e.g., skilled nursing facilities, rehabilitation facilities, drug and alcohol treatment facilities) admissions, outpatient surgery and certain other services as stated in the Group Contract. If these services or admissions are not precertified, and the service is not medically necessary, the member may be responsible for 100% of the cost of the services.			
<b>LIFETIME MAXIMUM</b>		Unlimited	
<p><b>Autism Spectrum Disorders are covered pursuant to state mandates for groups with 51 or more employees.</b></p> <p>This is not a contract. It is intended solely to provide you with an overview of the plan. Complete details of benefits, terms and exclusions are governed by your Group Contract. <b>This managed care plan may not cover all your health care expenses. Read your contract carefully to determine which health care services are covered. If you have questions call us at 800.788.8445 in Central/Eastern Pennsylvania, and 800.735.4404 in Western Pennsylvania and Ohio.</b></p> <p>Benefits are administered on a contract year basis. Coinsurance is based on Eligible Charges as defined in your Certificate of Insurance. For non-participating providers, Eligible Charges are based on the lesser of the provider's billed charges or our Out-of-Network Rate, which is defined in your Certificate of Insurance. <b>In addition to your copay or coinsurance, you are responsible for paying nonparticipating providers the difference between our out-of-network rate and their actual charge for nonemergency services. Your out-of-pocket costs for nonemergency care from nonparticipating providers may be substantial.</b></p> <p><i>Dependent Coverage Age Limit is 26</i></p> <p>*If your Schedule of Benefits indicates that you have a Qualified High Deductible Health Plan., you must consult your group benefit documents for a specific description and the terms and conditions of your coverage for these benefits. Also, some covered services that you receive during a preventive service office visit may not qualify as preventive services under the group contract and, consequently, will be subject to applicable deductibles. In order to be exempt from applicable deductibles, preventive services must qualify as preventive services under the group contract and Section 223 of the Internal Revenue Code.</p> <p>*** The physician must bill the claim with a preventive diagnosis code in order to apply under preventive benefits coverage.</p> <p><b>This document neither affirmatively nor negatively amends, extends, or alters the terms of or the coverage afforded by policy referenced herein.</b></p> <p>**Reimbursement for Weight Management programs is limited to \$350 per calendar year per member.</p>			

# Choice PPO \$2500

<b>DEDUCTIBLES AND MAXIMUMS</b>	<b>Participating MEMBER RESPONSIBILITY</b>	<b>Non-Participating MEMBER RESPONSIBILITY</b>
<b>Annual Deductible</b>		
Individual	\$2,500	\$5,000
Family	\$7,500	\$15,000
<b>Out-of-Pocket Maximum</b> (includes copays, deductibles and coinsurance)		
Individual	None	\$10,000
Family	None	\$30,000
<b>OUTPATIENT SERVICES</b>	<b>Participating MEMBER RESPONSIBILITY</b>	<b>Non-Participating MEMBER RESPONSIBILITY</b>
<b>Physician Services (for illness or injury)</b>		
Level One Visits (PCP, OBGYN, Dermatologists, Chiropractors)	\$20 Copay	30% Eligible Charges (after annual deductible)
Level Two Visits (all other office visits)	\$40 Copay (after annual deductible)	30% Eligible Charges (after annual deductible)
<b>Preventive Services*</b>		
Gynecological Exam (PCP/SCP)	\$0 Copay	30% Eligible Charges (after annual deductible)
Well Child Visit	\$0 Copay	30% Eligible Charges (after annual deductible)
Adult Physical Visit	\$0 Copay	30% Eligible Charges (after annual deductible)
Preventive Pediatric Immunizations	0%	30% Eligible Charges
Hearing Exams (under age 18)	0%	30% Eligible Charges (after annual deductible)
Routine Mammograms	0%	30% Eligible Charges (after annual deductible)
Routine Colonoscopies***	0%	30% Eligible Charges (after annual deductible)
<b>Medical Injectable</b> (Therapies including but not limited to: Remicade, Tysabri, Amevive, Boniva, Reclast)	\$75 Copay (after annual deductible)	30% Eligible Charges (after annual deductible)
<b>Allergy Testing &amp; Allergy Serum</b>	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
<b>Chiropractic Care</b> Maximum 20 visits per contract year	\$20 Copay	30% Eligible Charges (after annual deductible)
<b>Outpatient Surgery</b>	\$100 Copay (after annual deductible)	30% Eligible Charges (after annual deductible)
<b>Lab Services</b>	\$25 Copay (after annual deductible)	30% Eligible Charges (after annual deductible)
<b>Diagnostic X-ray</b>	\$50 Copay (after annual deductible)	30% Eligible Charges (after annual deductible)
<b>Radiology</b> (CAT, MRI, Ultrasound)	\$125 (after annual deductible)	30% Eligible Charges (after annual deductible)
<b>HOSPITAL SERVICES</b>	<b>Participating MEMBER RESPONSIBILITY</b>	<b>Non-Participating MEMBER RESPONSIBILITY</b>
<b>Hospital Care</b>		
Semi-private room (private room if medically necessary)	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
Physician and Surgeon Fees	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
Surgery	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
Lab and X-ray services	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
All Medically Necessary Ancillary Services	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
Anesthesia	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
Administration of Blood	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
Blood Products	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
Therapy Services (Chemotherapy & Radiation Therapy)	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
<b>MATERNITY SERVICES</b>	<b>Participating MEMBER RESPONSIBILITY</b>	<b>Non-Participating MEMBER RESPONSIBILITY</b>
<b>Pregnancy Care</b> (PCP/SCP) (copay for the first office visit only)	\$20 Copay	30% Eligible Charges (after annual deductible)
<b>Delivery</b>	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
<b>FAMILY PLANNING</b>	<b>Participating MEMBER RESPONSIBILITY</b>	<b>Non-Participating MEMBER RESPONSIBILITY</b>
	\$300 one time deductible then coinsurance applies	
<b>Infertility Counseling/Testing/Services</b>	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
<b>Tubal Ligation/Vasectomy</b>	\$2,400 combined benefit maximum	
<b>PRESCRIPTION DRUGS</b>	<b>Participating MEMBER RESPONSIBILITY</b>	<b>Non-Participating MEMBER RESPONSIBILITY</b>
(Includes oral contraceptives & managed formulary. Mandatory generic substitution may apply)	<b>Tier 1a = \$3 Tier 1 = \$10</b> <b>Tier 2 = \$35 (after annual deductible)</b> <b>Tier 3 = \$60 (after annual deductible)</b> <b>COVERED ONLY AT PARTICIPATING PHARMACIES</b>	
<b>EMERGENCY CARE</b>	<b>Participating MEMBER RESPONSIBILITY</b>	<b>Non-Participating MEMBER RESPONSIBILITY</b>
<b>Urgent Care Center</b>	\$40 Copay (after annual deductible)	
<b>Emergency Room Services</b>	\$150 Copay (after annual deductible) ER Copay waived if admitted	
<b>REHABILITATION SERVICES</b>	<b>Participating MEMBER RESPONSIBILITY</b>	<b>Non-Participating MEMBER RESPONSIBILITY</b>
<b>Occupational, Speech, Physical Therapy</b>	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
	45 inpatient days per contract year	
	30 outpatient visits per contract year	

<b>MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES</b>			<b>Participating MEMBER RESPONSIBILITY</b>	<b>Non-Participating MEMBER RESPONSIBILITY</b>
<i>(Mental health services must be preauthorized)</i>				
<b>General Mental Health:</b> Inpatient	0% (after annual deductible)		30% Eligible Charges (after annual deductible)	
	<i>30 days per contract year 90 day lifetime benefit maximum</i>			
Physician Services (Outpatient)	\$40 Copay (after annual deductible)		30% Eligible Charges (after annual deductible)	
	<i>20 outpatient visits maximum per contract year</i>			
<b>Serious Mental Health:</b> Inpatient	0% (after annual deductible)		30% Eligible Charges (after annual deductible)	
	<i>30 days per contract year 90 day lifetime benefit maximum</i>			
Physician Services (Outpatient)	\$40 Copay (after annual deductible)		30% Eligible Charges (after annual deductible)	
	<i>60 outpatient visits maximum per contract year</i>			
<b>Substance Abuse:</b> Inpatient Detoxification	0% (after annual deductible)		30% Eligible Charges (after annual deductible)	
	<i>7 days maximum per admission 4 admission benefit maximum</i>			
Inpatient Rehabilitation	0% (after annual deductible)		30% Eligible Charges (after annual deductible)	
	<i>30 days maximum per contract year 90 days benefit maximum</i>			
Transitional Partial Hospitalization	0% (after annual deductible)		30% Eligible Charges (after annual deductible)	
	<i>60 visits per contract year 120 visits per benefit maximum</i>			
<b>OTHER BENEFITS</b>			<b>Participating MEMBER RESPONSIBILITY</b>	<b>Non-Participating MEMBER RESPONSIBILITY</b>
<b>Claim Forms Required</b>			<b>No</b>	<b>Yes</b>
<b>Durable Medical Equipment (DME)</b> – Limited to once every 2 years for irreparable damage and/or normal wear.			0% (after annual deductible)	30% Eligible Charges (after annual deductible)
<b>Corrective Appliances</b>			0% (after annual deductible)	30% Eligible Charges (after annual deductible)
<b>Home Health Care Services</b>			0% (after annual deductible) <i>120 visits per contract year</i>	30% Eligible Charges (after annual deductible) <i>60 visits per contract year</i>
			<i>120 visits combined per contract year</i>	
<b>Hospice Care</b>			0% (after annual deductible)	30% Eligible Charges (after annual deductible)
<b>Skilled Nursing Facility</b>			0% (after annual deductible) <i>100 inpatient days per contract year</i>	30% Eligible Charges (after annual deductible) <i>50 inpatient days per contract year</i>
			<i>100 days combined maximum per contract year</i>	
<b>Dental Services</b>				
Emergency treatment of dental injury			0% (after annual deductible)	30% Eligible Charges (after annual deductible)
Removal of Third Molars			0% (after annual deductible)	30% Eligible Charges (after annual deductible)
<b>Vision Services</b> <b>Vision One Eyecare Program®:</b> Receive immediate savings on all eyecare needs--discounts on frames, lenses, disposable contacts, and even LASIK surgery--at participating providers through the EyeMed Vision Care network.				
<b>Health Education</b> Members receive reimbursement of the cost of approved wellness programs offered through local hospitals and organizations.**				
<b>PRECERTIFICATION REQUIREMENT</b>			By Physician	By Patient
When using a nonparticipating provider, the member must obtain precertification of nonemergency hospital and other facility (e.g., skilled nursing facilities, rehabilitation facilities, drug and alcohol treatment facilities) admissions, outpatient surgery and certain other services as stated in the Group Contract. If these services or admissions are not precertified and the service is not medically necessary, the member may be responsible for 100% of the cost of the services.				
<b>LIFETIME MAXIMUM</b>			Unlimited	
<p><b>Autism Spectrum Disorders are covered pursuant to state mandates for groups with 51 or more employees.</b></p> <p>This is not a contract. It is intended solely to provide you with an overview of the plan. Complete details of benefits, terms and exclusions are governed by your Group Contract. <b>This managed care plan may not cover all your health care expenses. Read your contract carefully to determine which health care services are covered. If you have questions call us at 800.788.8445 in Central/Eastern Pennsylvania, and 800.735.4404 in Western Pennsylvania and Ohio.</b></p> <p>Benefits are administered on a contract year basis. Coinsurance is based on Eligible Charges as defined in your Certificate of Insurance. For non-participating providers, Eligible Charges are based on the lesser of the provider's billed charges or our Out-of-Network Rate, which is defined in your Certificate of Insurance. <b>In addition to your copay or coinsurance, you are responsible for paying nonparticipating providers the difference between our out-of-network rate and their actual charge for nonemergency services. Your out-of-pocket costs for nonemergency care from nonparticipating providers may be substantial.</b></p> <p><i>Dependent Coverage Age Limit is 26</i></p> <p>*If your Schedule of Benefits indicates that you have a Qualified High Deductible Health Plan,, you must consult your group benefit documents for a specific description and the terms and conditions of your coverage for these benefits. Also, some covered services that you receive during a preventive service office visit may not qualify as preventive services under the group contract and, consequently, will be subject to applicable deductibles. In order to be exempt from applicable deductibles, preventive services must qualify as preventive services under the group contract and Section 223 of the Internal Revenue Code.</p> <p>*** The physician must bill the claim with a preventive diagnosis code in order to apply under preventive benefits coverage.</p> <p><b>This document neither affirmatively nor negatively amends, extends, or alters the terms of or the coverage afforded by policy referenced herein.</b></p> <p>**Reimbursement for Weight Management programs is limited to \$350 per calendar year per member.</p>				

## Choice PPO \$4000

DEDUCTIBLES AND MAXIMUMS	Participating MEMBER RESPONSIBILITY	Non-Participating MEMBER RESPONSIBILITY
<b>Annual Deductible</b>		
Individual	\$4,000	\$8,000
Family	\$12,000	\$24,000
<b>Out-of-Pocket Maximum</b> (includes copays, deductibles and coinsurance)		
Individual	None	\$10,000
Family	None	\$30,000
OUTPATIENT SERVICES	Participating MEMBER RESPONSIBILITY	Non-Participating MEMBER RESPONSIBILITY
<b>Physician Services (for illness or injury)</b>		
Level One Visits (PCP, OBGYN, Dermatologists, Chiropractors)	\$20 Copay	30% Eligible Charges (after annual deductible)
Level Two Visits (all other office visits)	\$40 Copay (after annual deductible)	30% Eligible Charges (after annual deductible)
<b>Preventive Services*</b>		
Gynecological Exam (PCP/SCP)	\$0 Copay	30% Eligible Charges (after annual deductible)
Well Child Visit	\$0 Copay	30% Eligible Charges (after annual deductible)
Adult Physical Visit	\$0 Copay	30% Eligible Charges (after annual deductible)
Preventive Pediatric Immunizations	0%	30% Eligible Charges
Hearing Exams (under age 18)	0%	30% Eligible Charges (after annual deductible)
Routine Mammograms	0%	30% Eligible Charges (after annual deductible)
Routine Colonoscopies***	0%	30% Eligible Charges (after annual deductible)
<b>Allergy Testing &amp; Allergy Serum</b>	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
<b>Medical Injectable</b> (Therapies including but not limited to: Remicade, Tysabri, Amevive, Boniva, Reclast)	\$75 Copay (after annual deductible)	30% Eligible Charges (after annual deductible)
<b>Chiropractic Care</b> Maximum 20 visits per contract year	\$20 Copay	30% Eligible Charges (after annual deductible)
<b>Outpatient Surgery</b>	\$100 Copay (after annual deductible)	30% Eligible Charges (after annual deductible)
<b>Lab Services</b>	\$25 Copay (after annual deductible)	30% Eligible Charges (after annual deductible)
<b>Diagnostic X-ray</b>	\$50 Copay (after annual deductible)	30% Eligible Charges (after annual deductible)
<b>Radiology</b> (CAT, MRI, Ultrasound)	\$125 (after annual deductible)	30% Eligible Charges (after annual deductible)
HOSPITAL SERVICES	Participating MEMBER RESPONSIBILITY	Non-Participating MEMBER RESPONSIBILITY
<b>Hospital Care</b>		
Semi-private room (private room if medically necessary)	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
Physician and Surgeon Fees	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
Surgery	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
Lab and X-ray services	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
All Medically Necessary Ancillary Services	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
Anesthesia	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
Administration of Blood	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
Blood Products	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
Therapy Services (Chemotherapy & Radiation Therapy)	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
MATERNITY SERVICES	Participating MEMBER RESPONSIBILITY	Non-Participating MEMBER RESPONSIBILITY
<b>Pregnancy Care</b> (PCP/SCP) (copay for the first office visit only)	\$20 Copay	30% Eligible Charges (after annual deductible)
<b>Delivery</b>	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
FAMILY PLANNING	Participating MEMBER RESPONSIBILITY	Non-Participating MEMBER RESPONSIBILITY
<b>Infertility Counseling/Testing/Services</b>	\$300 one time deductible then coinsurance applies	
<b>Tubal Ligation/Vasectomy</b>	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
	<i>\$2,400 combined benefit maximum</i>	
PRESCRIPTION DRUGS	Participating MEMBER RESPONSIBILITY	Non-Participating MEMBER RESPONSIBILITY
(Includes oral contraceptives & managed formulary. Mandatory generic substitution may apply)	<b>Tier 1a = \$3 Tier 1 = \$10</b> <b>Tier 2 = \$35 (after annual deductible)</b> <b>Tier 3 = \$60 (after annual deductible)</b> <b>COVERED ONLY AT PARTICIPATING PHARMACIES</b>	
EMERGENCY CARE	Participating MEMBER RESPONSIBILITY	Non-Participating MEMBER RESPONSIBILITY
<b>Urgent Care Center</b>	\$40 Copay (after annual deductible)	
<b>Emergency Room Services</b>	\$150 Copay (after annual deductible) ER Copay waived if admitted	
REHABILITATION SERVICES	Participating MEMBER RESPONSIBILITY	Non-Participating MEMBER RESPONSIBILITY
<b>Occupational, Speech, Physical Therapy</b>	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
	<i>45 inpatient days per contract year</i>	
	<i>30 outpatient visits per contract year</i>	

<b>MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES</b>		<b>Participating MEMBER RESPONSIBILITY</b>	<b>Non-Participating MEMBER RESPONSIBILITY</b>
<b>General Mental Health:</b>		<i>(Mental health services must be preauthorized)</i>	
Inpatient		0% (after annual deductible)	30% Eligible Charges (after annual deductible)
		<i>30 days per contract year 90 day lifetime benefit maximum</i>	
Physician Services (Outpatient)		\$40 Copay (after annual deductible)	30% Eligible Charges (after annual deductible)
		<i>20 outpatient visits maximum per contract year</i>	
<b>Serious Mental Health:</b>			
Inpatient		0% (after annual deductible)	30% Eligible Charges (after annual deductible)
		<i>30 days per contract year 90 day lifetime benefit maximum</i>	
Physician Services (Outpatient)		\$40 Copay (after annual deductible)	30% Eligible Charges (after annual deductible)
		<i>60 outpatient visits maximum per contract year</i>	
<b>Substance Abuse:</b>			
Inpatient Detoxification		0% (after annual deductible)	30% Eligible Charges (after annual deductible)
		<i>7 days maximum per admission 4 admission benefit maximum</i>	
Inpatient Rehabilitation		0% (after annual deductible)	30% Eligible Charges (after annual deductible)
		<i>30 days maximum per contract year 90 days benefit maximum</i>	
Transitional Partial Hospitalization		0% (after annual deductible)	30% Eligible Charges (after annual deductible)
		<i>60 visits per contract year 120 visits per benefit maximum</i>	
<b>OTHER BENEFITS</b>		<b>Participating MEMBER RESPONSIBILITY</b>	<b>Non-Participating MEMBER RESPONSIBILITY</b>
<b>Claim Forms Required</b>		<b>No</b>	<b>Yes</b>
<b>Durable Medical Equipment (DME)</b> – Limited to once every 2 years for irreparable damage and/or normal wear.		0% (after annual deductible)	30% Eligible Charges (after annual deductible)
<b>Corrective Appliances</b>		0% (after annual deductible)	30% Eligible Charges (after annual deductible)
<b>Home Health Care Services</b>		0% (after annual deductible) <i>120 visits per contract year</i>	30% Eligible Charges (after annual deductible) <i>60 visits per contract year</i>
		<i>120 visits combined per contract year</i>	
<b>Hospice Care</b>		0% (after annual deductible)	30% Eligible Charges (after annual deductible)
<b>Skilled Nursing Facility</b>		0% (after annual deductible) <i>100 inpatient days per contract year</i>	30% Eligible Charges (after annual deductible) <i>50 inpatient days per contract year</i>
		<i>100 days combined maximum per contract year</i>	
<b>Dental Services</b>			
Emergency treatment of dental injury		0% (after annual deductible)	30% Eligible Charges (after annual deductible)
Removal of Third Molars		0% (after annual deductible)	30% Eligible Charges (after annual deductible)
<b>Vision Services</b>	<b>Vision One Eyecare Program®:</b> Receive immediate savings on all eyecare needs--discounts on frames, lenses, disposable contacts, and even LASIK surgery--at participating providers through the EyeMed Vision Care network.		
<b>Health Education</b>	Members receive reimbursement of the cost of approved wellness programs offered through local hospitals and organizations.**		
<b>PRECERTIFICATION REQUIREMENT</b>		By Physician	By Patient
When using a nonparticipating provider, the member must obtain precertification of nonemergency hospital and other facility (e.g., skilled nursing facilities, rehabilitation facilities, drug and alcohol treatment facilities) admissions, outpatient surgery and certain other services as stated in the Group Contract. If these services or admissions are not precertified and the service is not medically necessary, the member may be responsible for 100% of the cost of the services.			
<b>LIFETIME MAXIMUM</b>		Unlimited	
<b>Autism Spectrum Disorders are covered pursuant to state mandates for groups with 51 or more employees.</b>			
This is not a contract. It is intended solely to provide you with an overview of the plan. Complete details of benefits, terms and exclusions are governed by your Group Contract. <b>This managed care plan may not cover all your health care expenses. Read your contract carefully to determine which health care services are covered. If you have questions call us at 800.788.8445 in Central/Eastern Pennsylvania, and 800.735.4404 in Western Pennsylvania and Ohio.</b>			
Benefits are administered on a contract year basis. Coinsurance is based on Eligible Charges as defined in your Certificate of Insurance. For non-participating providers, Eligible Charges are based on the lesser of the provider's billed charges or our Out-of-Network Rate, which is defined in your Certificate of Insurance. <b>In addition to your copay or coinsurance, you are responsible for paying nonparticipating providers the difference between our out-of-network rate and their actual charge for nonemergency services. Your out-of-pocket costs for nonemergency care from nonparticipating providers may be substantial.</b>			
<i>Dependent Coverage Age Limit is 26</i>			
*If your Schedule of Benefits indicates that you have a Qualified High Deductible Health Plan., you must consult your group benefit documents for a specific description and the terms and conditions of your coverage for these benefits. Also, some covered services that you receive during a preventive service office visit may not qualify as preventive services under the group contract and, consequently, will be subject to applicable deductibles. In order to be exempt from applicable deductibles, preventive services must qualify as preventive services under the group contract and Section 223 of the Internal Revenue Code.			
*** The physician must bill the claim with a preventive diagnosis code in order to apply under preventive benefits coverage.			
<b>This document neither affirmatively nor negatively amends, extends, or alters the terms of or the coverage afforded by policy referenced herein.</b>			
<i>**Reimbursement for Weight Management programs is limited to \$350 per calendar year per member.</i>			

DEDUCTIBLES AND MAXIMUMS	Participating MEMBER RESPONSIBILITY	Non-Participating MEMBER RESPONSIBILITY
<b>Annual Deductible</b>		
Individual	\$1,250	\$2,500
Family	\$2,500	\$5,000
The individual deductible applies when the Subscriber has an employee only policy. For policies that include the Subscriber and one or more dependents, the family deductible must be met before any family member begins to receive the benefits listed below, including prescription drug benefits covered under the prescription drug rider (except preventive services).		
<b>Out-of-Pocket Maximum</b> (includes copays, deductibles and coinsurance)		
Individual	\$3,000	\$10,000
Family	\$6,000	\$20,000
OUTPATIENT SERVICES	Participating MEMBER RESPONSIBILITY	Non-Participating MEMBER RESPONSIBILITY
<b>Physician Services (for illness or injury)</b>		
Primary Care Visit (PCP)	\$15 Copay (after annual deductible)	20% Eligible Charges (after annual deductible)
Specialist Visit (SCP)	\$25 Copay (after annual deductible)	20% Eligible Charges (after annual deductible)
<b>Preventive Services*</b>		
Gynecological Exam (PCP/SCP)	\$0 Copay	20% Eligible Charges (after annual deductible)
Well Child Visit	\$0 Copay	20% Eligible Charges (after annual deductible)
Adult Physical Visit	\$0 Copay	20% Eligible Charges (after annual deductible)
Preventive Pediatric Immunizations	0%	20% Eligible Charges (after annual deductible)
Preventive Adult Immunizations	0%	20% Eligible Charges (after annual deductible)
Hearing Exams (under age 18)	0%	20% Eligible Charges (after annual deductible)
Routine Mammograms	0%	20% Eligible Charges (after annual deductible)
<b>Allergy Testing &amp; Allergy Serum</b>	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
<b>Chiropractic Care</b>		
Maximum 20 visits per contract year	\$25 Copay (after annual deductible)	20% Eligible Charges (after annual deductible)
<b>Outpatient Surgery</b>	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
<b>Lab Services</b>	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
<b>Diagnostic X-ray</b>	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
<b>Radiology</b> (CAT, MRI, Ultrasound)	\$150 Copay (after annual deductible)	20% Eligible Charges (after annual deductible)
HOSPITAL SERVICES	Participating MEMBER RESPONSIBILITY	Non-Participating MEMBER RESPONSIBILITY
<b>Hospital Care</b>		
Semi-private room (private room if medically necessary)	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Physician and Surgeon Fees	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Surgery	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Lab and X-ray services	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
All Medically Necessary Ancillary Services	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Anesthesia	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Administration of Blood	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Blood Products	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Therapy Services (Chemotherapy & Radiation Therapy)	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
MATERNITY SERVICES	Participating MEMBER RESPONSIBILITY	Non-Participating MEMBER RESPONSIBILITY
<b>Pregnancy Care</b> (PCP/SCP) (copay for the first office visit only)	\$15/\$25 Copay (after annual deductible)	20% Eligible Charges (after annual deductible)
<b>Delivery</b>	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
FAMILY PLANNING	Participating MEMBER RESPONSIBILITY	Non-Participating MEMBER RESPONSIBILITY
<b>Infertility Counseling/Testing/Services</b>	(\$2,400 combined benefit maximum for infertility)	
<b>Tubal Ligation/Vasectomy</b>	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
PRESCRIPTION DRUGS	Participating MEMBER RESPONSIBILITY	Non-Participating MEMBER RESPONSIBILITY
(Includes oral contraceptives & managed formulary. Mandatory generic substitution may apply)	<b>Quantity limits still apply.</b> <b>VARIOUS RIDERS AVAILABLE</b> <b>COVERED ONLY AT PARTICIPATING PHARMACIES</b> (after annual deductible)	
EMERGENCY CARE	Participating MEMBER RESPONSIBILITY	Non-Participating MEMBER RESPONSIBILITY
<b>Urgent Care Center</b>	\$50 Copay (after annual deductible)	
<b>Emergency Room Services</b>	\$150 Copay (after annual deductible) ER Copay waived if admitted	
REHABILITATION SERVICES	Participating MEMBER RESPONSIBILITY	Non-Participating MEMBER RESPONSIBILITY
<b>Occupational, Speech, Physical Therapy</b>	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
	45 inpatient days per contract year 30 outpatient visits per contract year	

MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES	Participating MEMBER RESPONSIBILITY		Non-Participating MEMBER RESPONSIBILITY	
<i>(Mental health services must be preauthorized)</i>				
General Mental Health: Inpatient	0% (after annual deductible)		20% Eligible Charges (after annual deductible)	
	<i>30 days per contract year 90 day lifetime benefit maximum</i>			
Physician Services (Outpatient)	\$25 Copay (after annual deductible)		20% Eligible Charges (after annual deductible)	
	<i>20 outpatient visits maximum per contract year</i>			
Serious Mental Health: Inpatient	0% (after annual deductible)		20% Eligible Charges (after annual deductible)	
	<i>30 days per contract year 90 day lifetime benefit maximum</i>			
Physician Services (Outpatient)	\$25 Copay (after annual deductible)		20% Eligible Charges (after annual deductible)	
	<i>60 outpatient visits maximum per contract year</i>			
Substance Abuse: Inpatient Detoxification	0% (after annual deductible)		20% Eligible Charges (after annual deductible)	
	<i>7 days maximum per admission 4 admission benefit maximum</i>			
Inpatient Rehabilitation	0% (after annual deductible)		20% Eligible Charges (after annual deductible)	
	<i>30 days maximum per contract year 90 days benefit maximum</i>			
Transitional Partial Hospitalization	0% (after annual deductible)		20% Eligible Charges (after annual deductible)	
	<i>60 visits per contract year 120 visits per benefit maximum</i>			
OTHER BENEFITS	Participating MEMBER RESPONSIBILITY		Non-Participating MEMBER RESPONSIBILITY	
Claim Forms Required	No		Yes	
Durable Medical Equipment (DME) / Corrective Appliances - Limited to once every 2 years for irreparable damage and/or normal wear.	0% (after annual deductible)		50% Eligible Charges (after annual deductible)	
Home Health Care Services	0% (after annual deductible)		20% Eligible Charges (after annual deductible)	
	<i>120 visits per contract year 60 visits per contract year 120 visits combined per contract year</i>			
Hospice Care	0% (after annual deductible)		20% Eligible Charges (after annual deductible)	
Skilled Nursing Facility	0% (after annual deductible)		20% Eligible Charges (after annual deductible)	
	<i>100 inpatient days per contract year 50 inpatient days per contract year 100 days combined maximum per contract year</i>			
Dental Services Emergency treatment of dental injury Removal of Third Molars	0% (after annual deductible)		20% Eligible Charges (after annual deductible)	
	0% (after annual deductible)		20% Eligible Charges (after annual deductible)	
Vision Services	Vision One Eyecare Program®: Receive immediate savings on all eyecare needs--discounts on frames, lenses, disposable contacts, and even LASIK surgery--at participating providers through the EyeMed Vision Care network.			
Health Education	Members receive reimbursement of the cost of approved wellness programs offered through local hospitals and organizations.**			
PRECERTIFICATION REQUIREMENT	By Physician		By Patient	
When using a nonparticipating provider, the member must obtain precertification of nonemergency hospital and other facility (e.g., skilled nursing facilities, rehabilitation facilities, drug and alcohol treatment facilities) admissions, outpatient surgery and certain other services as stated in the Group Contract. If these services or admissions are not precertified and the service is not medically necessary, the member may be responsible for 100% of the cost of the services.				
LIFETIME MAXIMUM	Unlimited			
<p><b>Autism Spectrum Disorders are covered pursuant to state mandates for groups with 51 or more employees.</b>  This is not a contract. It is intended solely to provide you with an overview of the plan. Complete details of benefits, terms and exclusions are governed by your Group Contract. <b>This managed care plan may not cover all your health care expenses. Read your contract carefully to determine which health care services are covered. If you have questions call us at 800.788.8445 in Central/Eastern Pennsylvania, and 800.735.4404 in Western Pennsylvania and Ohio.</b>  Benefits are administered on a contract year basis. Coinsurance is based on Eligible Charges as defined in your Certificate of Insurance. For non-participating providers, Eligible Charges are based on the lesser of the provider's billed charges or our Out-of-Network Rate, which is defined in your Certificate of Insurance. <b>In addition to your copay or coinsurance, you are responsible for paying nonparticipating providers the difference between our out-of-network rate and their actual charge for nonemergency services. Your out-of-pocket costs for nonemergency care from nonparticipating providers may be substantial.</b>  <i>Dependent Coverage Age Limit is 26</i>  *If your Schedule of Benefits indicates that you have a Qualified High Deductible Health Plan., you must consult your group benefit documents for a specific description and the terms and conditions of your coverage for these benefits. Also, some covered services that you receive during a preventive service office visit may not qualify as preventive services under the group contract and, consequently, will be subject to applicable deductibles. In order to be exempt from applicable deductibles, preventive services must qualify as preventive services under the group contract and Section 223 of the Internal Revenue Code.  This document neither affirmatively nor negatively amends, extends, or alters the terms of or the coverage afforded by policy referenced herein.  **Reimbursement for Weight Management programs is limited to \$350 per calendar year per member.</p>				

## FlexChoice QHDHP PPO \$1500

DEDUCTIBLES AND MAXIMUMS	Participating MEMBER RESPONSIBILITY	Non-Participating MEMBER RESPONSIBILITY
<b>Annual Deductible</b>		
Individual	\$1,500	\$3,000
Family	\$3,000	\$6,000
The individual deductible applies when the Subscriber has an employee only policy. For policies that include the Subscriber and one or more dependents, the family deductible must be met before any family member begins to receive the benefits listed below, including prescription drug benefits covered under the prescription drug rider (except preventive services).		
<b>Out-of-Pocket Maximum</b> (includes copays, deductibles and coinsurance)		
Individual	\$3,000	\$10,000
Family	\$6,000	\$20,000
OUTPATIENT SERVICES	Participating MEMBER RESPONSIBILITY	Non-Participating MEMBER RESPONSIBILITY
<b>Physician Services (for illness or injury)</b>		
Primary Care Visit (PCP)	\$15 Copay (after annual deductible)	20% Eligible Charges (after annual deductible)
Specialist Visit (SCP)	\$25 Copay (after annual deductible)	20% Eligible Charges (after annual deductible)
<b>Preventive Services*</b>		
Gynecological Exam (PCP/SCP)	\$0 Copay	20% Eligible Charges (after annual deductible)
Well Child Visit	\$0 Copay	20% Eligible Charges (after annual deductible)
Adult Physical Visit	\$0 Copay	20% Eligible Charges (after annual deductible)
Preventive Pediatric Immunizations	0%	20% Eligible Charges
Preventive Adult Immunizations	0%	20% Eligible Charges (after annual deductible)
Hearing Exams (under age 18)	0%	20% Eligible Charges (after annual deductible)
Routine Mammograms	0%	20% Eligible Charges (after annual deductible)
Routine Colonoscopies***	0%	20% Eligible Charges (after annual deductible)
<b>Allergy Testing &amp; Allergy Serum</b>	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
<b>Chiropractic Care</b>		
Maximum 20 visits per contract year	\$25 Copay (after annual deductible)	20% Eligible Charges (after annual deductible)
<b>Outpatient Surgery</b>	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
<b>Lab Services</b>	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
<b>Diagnostic X-ray</b>	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
<b>Radiology</b> (CAT, MRI, Ultrasound, PET)	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
HOSPITAL SERVICES	Participating MEMBER RESPONSIBILITY	Non-Participating MEMBER RESPONSIBILITY
<b>Hospital Care</b>		
Semi-private room (private room if medically necessary)	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Physician and Surgeon Fees	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Surgery	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Lab and X-ray services	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
All Medically Necessary Ancillary Services	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Anesthesia	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Administration of Blood	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Blood Products	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Therapy Services (Chemotherapy & Radiation Therapy)	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
MATERNITY SERVICES	Participating MEMBER RESPONSIBILITY	Self-Referral Care MEMBER RESPONSIBILITY
<b>Pregnancy Care</b> (PCP/SCP) (copay for the first office visit only)	\$15/\$25 Copay (after annual deductible)	20% Eligible Charges (after annual deductible)
<b>Delivery</b>	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
FAMILY PLANNING	Participating MEMBER RESPONSIBILITY	Non-Participating MEMBER RESPONSIBILITY
<b>Infertility Counseling/Testing/Services</b>	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
<b>Tubal Ligation/Vasectomy</b>	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
<i>\$2,400 combined benefit maximum</i>		
PRESCRIPTION DRUGS	Participating MEMBER RESPONSIBILITY	Non-Participating MEMBER RESPONSIBILITY
(Includes oral contraceptives & managed formulary. Mandatory generic substitution may apply)	<b>Refer to the RX Select formulary to identify which drugs do not require authorization. Quantity limits still apply.</b> <b>VARIOUS RIDERS AVAILABLE</b> <b>COVERED ONLY AT PARTICIPATING PHARMACIES</b> (after annual deductible)	
EMERGENCY CARE	Participating MEMBER RESPONSIBILITY	Non-Participating MEMBER RESPONSIBILITY
<b>Urgent Care Center</b>	\$25 Copay (after annual deductible)	
<b>Emergency Room Services</b>	\$125 Copay (after annual deductible) ER Copay waived if admitted	
REHABILITATION SERVICES	Participating MEMBER RESPONSIBILITY	Non-Participating MEMBER RESPONSIBILITY
<b>Occupational, Speech, Physical Therapy</b>	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
<i>45 inpatient days per contract year</i> <i>30 outpatient visits per contract year</i>		

<b>MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES</b>		<b>Participating MEMBER RESPONSIBILITY</b>	<b>Non-Participating MEMBER RESPONSIBILITY</b>
<b>General Mental Health:</b>		<i>(Mental health services must be preauthorized)</i>	
Inpatient		0% (after annual deductible)	20% Eligible Charges (after annual deductible)
		<i>30 days per contract year 90 day lifetime benefit maximum</i>	
Physician Services (Outpatient)		\$25 Copay (after annual deductible)	20% Eligible Charges (after annual deductible)
		<i>20 outpatient visits maximum per contract year</i>	
<b>Serious Mental Health:</b>			
Inpatient		0% (after annual deductible)	20% Eligible Charges (after annual deductible)
		<i>30 days per contract year 90 day lifetime benefit maximum</i>	
Physician Services (Outpatient)		\$25 Copay (after annual deductible)	20% Eligible Charges (after annual deductible)
		<i>60 outpatient visits maximum per contract year</i>	
<b>Substance Abuse:</b>			
Inpatient Detoxification		0% (after annual deductible)	20% Eligible Charges (after annual deductible)
		<i>7 days maximum per admission 4 admission benefit maximum</i>	
Inpatient Rehabilitation		0% (after annual deductible)	20% Eligible Charges (after annual deductible)
		<i>30 days per contract year 90 day lifetime benefit maximum</i>	
Transitional Partial Hospitalization		0% (after annual deductible)	20% Eligible Charges (after annual deductible)
		<i>60 visits per contract year 120 visits per benefit maximum</i>	
<b>OTHER BENEFITS</b>		<b>Participating MEMBER RESPONSIBILITY</b>	<b>Non-Participating MEMBER RESPONSIBILITY</b>
<b>Claim Forms Required</b>		<b>No</b>	<b>Yes</b>
<b>Durable Medical Equipment (DME)</b> – Limited to once every 2 years for irreparable damage and/or normal wear.		0% (after annual deductible)	20% Eligible Charges (after annual deductible)
<b>Corrective Appliances</b>		0% (after annual deductible)	20% Eligible Charges (after annual deductible)
<b>Home Health Care Services</b>		0% (after annual deductible) <i>120 visits per contract year</i>	20% Eligible Charges (after annual deductible) <i>60 visits per contract year</i>
		<i>120 visits combined per contract year</i>	
<b>Hospice Care</b>		0% (after annual deductible)	20% Eligible Charges (after annual deductible)
<b>Skilled Nursing Facility</b>		0% (after annual deductible) <i>100 inpatient days per contract year</i>	20% Eligible Charges (after annual deductible) <i>50 inpatient days per contract year</i>
		<i>100 days combined maximum per contract year</i>	
<b>Dental Services</b>			
Emergency treatment of dental injury		0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Removal of Third Molars		0% (after annual deductible)	20% Eligible Charges (after annual deductible)
<b>Vision Services</b>	<b>Vision One Eyecare Program®:</b> Receive immediate savings on all eyecare needs--discounts on frames, lenses, disposable contacts, and even LASIK surgery--at participating providers through the EyeMed Vision Care network.		
<b>Health Education</b>	Members receive reimbursement of the cost of approved wellness programs offered through local hospitals and organizations.**		
<b>PRECERTIFICATION REQUIREMENT</b>		By Physician	By Patient
When using a nonparticipating provider, the member must obtain precertification of nonemergency hospital and other facility (e.g., skilled nursing facilities, rehabilitation facilities, drug and alcohol treatment facilities) admissions, outpatient surgery and certain other services as stated in the Group Contract. If these services or admissions are not precertified and the service is not medically necessary, the member may be responsible for 100% of the cost of the services.			
<b>LIFETIME MAXIMUM</b>		Unlimited	
<b>Autism Spectrum Disorders are covered pursuant to state mandates for groups with 51 or more employees.</b>			
This is not a contract. It is intended solely to provide you with an overview of the plan. Complete details of benefits, terms and exclusions are governed by your Group Contract. <b>This managed care plan may not cover all your health care expenses. Read your contract carefully to determine which health care services are covered. If you have questions call us at 800.788.8445 in Central/Eastern Pennsylvania, and 800.735.4404 in Western Pennsylvania and Ohio.</b>			
Benefits are administered on a contract year basis. Coinsurance is based on Eligible Charges as defined in your Certificate of Insurance. For non-participating providers, Eligible Charges are based on the lesser of the provider's billed charges or our Out-of-Network Rate, which is defined in your Certificate of Insurance. <b>In addition to your copay or coinsurance, you are responsible for paying nonparticipating providers the difference between our out-of-network rate and their actual charge for nonemergency services. Your out-of-pocket costs for nonemergency care from nonparticipating providers may be substantial.</b>			
<i>Dependent Coverage Age Limit is 26</i>			
*If your Schedule of Benefits indicates that you have a Qualified High Deductible Health Plan, you must consult your group benefit documents for a specific description and the terms and conditions of your coverage for these benefits. Also, some covered services that you receive during a preventive service office visit may not qualify as preventive services under the group contract and, consequently, will be subject to applicable deductibles. In order to be exempt from applicable deductibles, preventive services must qualify as preventive services under the group contract and Section 223 of the Internal Revenue Code.			
*** The physician must bill the claim with a preventive diagnosis code in order to apply under preventive benefits coverage.			
This document neither affirmatively nor negatively amends, extends, or alters the terms of or the coverage afforded by policy referenced herein.			
**Reimbursement for Weight Management programs is limited to \$350 per calendar year per member.			

DEDUCTIBLES AND MAXIMUMS	Participating MEMBER RESPONSIBILITY	Non-Participating MEMBER RESPONSIBILITY
<b>Annual Deductible</b>		
Individual	\$2,000	\$4,000
Family	\$4,000	\$8,000
The individual deductible applies when the Subscriber has an employee only policy. For policies that include the Subscriber and one or more dependents, the family deductible must be met before any family member begins to receive the benefits listed below, including prescription drug benefits covered under the prescription drug rider (except preventive services).		
<b>Out-of-Pocket Maximum</b> (includes copays, deductibles and coinsurance)		
Individual	\$4,000	\$10,000
Family	\$8,000	\$20,000
OUTPATIENT SERVICES	Participating MEMBER RESPONSIBILITY	Non-Participating MEMBER RESPONSIBILITY
<b>Physician Services (for illness or injury)</b>		
Primary Care Visit (PCP)	\$15 Copay (after annual deductible)	20% Eligible Charges (after annual deductible)
Specialist Visit (SCP)	\$25 Copay (after annual deductible)	20% Eligible Charges (after annual deductible)
<b>Preventive Services*</b>		
Gynecological Exam (PCP/SCP)	\$0 Copay	20% Eligible Charges (after annual deductible)
Well Child Visit	\$0 Copay	20% Eligible Charges (after annual deductible)
Adult Physical Visit	\$0 Copay	20% Eligible Charges (after annual deductible)
Preventive Pediatric Immunizations	0%	20% Eligible Charges
Preventive Adult Immunizations	0%	20% Eligible Charges (after annual deductible)
Hearing Exams (under age 18)	0%	20% Eligible Charges (after annual deductible)
Routine Mammograms	0%	20% Eligible Charges (after annual deductible)
Routine Colonoscopies***	0%	20% Eligible Charges (after annual deductible)
<b>Allergy Testing &amp; Allergy Serum</b>	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
<b>Chiropractic Care</b>		
Maximum 20 visits per contract year	\$25 Copay (after annual deductible)	20% Eligible Charges (after annual deductible)
<b>Outpatient Surgery</b>	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
<b>Lab Services</b>	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
<b>Diagnostic X-ray</b>	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
<b>Radiology</b> (CAT, MRI, Ultrasound, PET)	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
HOSPITAL SERVICES	Participating MEMBER RESPONSIBILITY	Non-Participating MEMBER RESPONSIBILITY
<b>Hospital Care</b>		
Semi-private room (private room if medically necessary)	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Physician and Surgeon Fees	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Surgery	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Lab and X-ray services	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
All Medically Necessary Ancillary Services	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Anesthesia	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Administration of Blood	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Blood Products	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Therapy Services (Chemotherapy & Radiation Therapy)	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
MATERNITY SERVICES	Participating MEMBER RESPONSIBILITY	Self-Referral Care MEMBER RESPONSIBILITY
<b>Pregnancy Care</b> (PCP/SCP) (copay for the first office visit only)	\$15/\$25 Copay (after annual deductible)	20% Eligible Charges (after annual deductible)
<b>Delivery</b>	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
FAMILY PLANNING	Participating MEMBER RESPONSIBILITY	Non-Participating MEMBER RESPONSIBILITY
<b>Infertility Counseling/Testing/Services</b>	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
<b>Tubal Ligation/Vasectomy</b>	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
<i>\$2,400 combined benefit maximum</i>		
PRESCRIPTION DRUGS	Participating MEMBER RESPONSIBILITY	Non-Participating MEMBER RESPONSIBILITY
(Includes oral contraceptives & managed formulary. Mandatory generic substitution may apply)	<b>Refer to the RX Select formulary to identify which drugs do not require authorization.</b> <b>Quantity limits still apply.</b> <b>VARIOUS RIDERS AVAILABLE</b> <b>COVERED ONLY AT PARTICIPATING PHARMACIES (after annual deductible)</b>	
EMERGENCY CARE	Participating MEMBER RESPONSIBILITY	Non-Participating MEMBER RESPONSIBILITY
<b>Urgent Care Center</b>	\$25 Copay (after annual deductible)	
<b>Emergency Room Services</b>	\$125 Copay (after annual deductible) ER Copay waived if admitted	
REHABILITATION SERVICES	Participating MEMBER RESPONSIBILITY	Non-Participating MEMBER RESPONSIBILITY
<b>Occupational, Speech, Physical Therapy</b>	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
<i>45 inpatient days per contract year 30 outpatient visits per contract year</i>		

MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES		Participating MEMBER RESPONSIBILITY	Non-Participating MEMBER RESPONSIBILITY
<b>General Mental Health:</b>		<i>(Mental health services must be preauthorized)</i>	
Inpatient		0% (after annual deductible)	20% Eligible Charges (after annual deductible)
		<i>30 days per contract year 90 day lifetime benefit maximum</i>	
Physician Services (Outpatient)		\$25 Copay (after annual deductible)	20% Eligible Charges (after annual deductible)
		<i>20 outpatient visits maximum per contract year</i>	
<b>Serious Mental Health:</b>			
Inpatient		0% (after annual deductible)	20% Eligible Charges (after annual deductible)
		<i>30 days per contract year 90 day lifetime benefit maximum</i>	
Physician Services (Outpatient)		\$25 Copay (after annual deductible)	20% Eligible Charges (after annual deductible)
		<i>60 outpatient visits maximum per contract year</i>	
<b>Substance Abuse:</b>			
Inpatient Detoxification		0% (after annual deductible)	20% Eligible Charges (after annual deductible)
		<i>7 days maximum per admission 4 admission benefit maximum</i>	
Inpatient Rehabilitation		0% (after annual deductible)	20% Eligible Charges (after annual deductible)
		<i>30 days per contract year 90 day lifetime benefit maximum</i>	
Transitional Partial Hospitalization		0% (after annual deductible)	20% Eligible Charges (after annual deductible)
		<i>60 visits per contract year 120 visits per benefit maximum</i>	
OTHER BENEFITS		Participating MEMBER RESPONSIBILITY	Non-Participating MEMBER RESPONSIBILITY
<b>Claim Forms Required</b>		<b>No</b>	<b>Yes</b>
<b>Durable Medical Equipment (DME)</b> – Limited to once every 2 years for irreparable damage and/or normal wear.		0% (after annual deductible)	20% Eligible Charges (after annual deductible)
<b>Corrective Appliances</b>		0% (after annual deductible)	20% Eligible Charges (after annual deductible)
<b>Home Health Care Services</b>		0% (after annual deductible) <i>120 visits per contract year</i>	20% Eligible Charges (after annual deductible) <i>60 visits per contract year</i>
		<i>120 visits combined per contract year</i>	
<b>Hospice Care</b>		0% (after annual deductible)	20% Eligible Charges (after annual deductible)
<b>Skilled Nursing Facility</b>		0% (after annual deductible) <i>100 inpatient days per contract year</i>	20% Eligible Charges (after annual deductible) <i>50 inpatient days per contract year</i>
		<i>100 days combined maximum per contract year</i>	
<b>Dental Services</b>			
Emergency treatment of dental injury		0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Removal of Third Molars		0% (after annual deductible)	20% Eligible Charges (after annual deductible)
<b>Vision Services</b>	<b>Vision One Eyecare Program®:</b> Receive immediate savings on all eyecare needs--discounts on frames, lenses, disposable contacts, and even LASIK surgery--at participating providers through the EyeMed Vision Care network.		
<b>Health Education</b>	Members receive reimbursement of the cost of approved wellness programs offered through local hospitals and organizations.**		
<b>PRECERTIFICATION REQUIREMENT</b>		By Physician	By Patient
When using a nonparticipating provider, the member must obtain precertification of nonemergency hospital and other facility (e.g., skilled nursing facilities, rehabilitation facilities, drug and alcohol treatment facilities) admissions, outpatient surgery and certain other services as stated in the Group Contract. If these services or admissions are not precertified and the service is not medically necessary, the member may be responsible for 100% of the cost of the services.			
<b>LIFETIME MAXIMUM</b>		Unlimited	
<b>Autism Spectrum Disorders are covered pursuant to state mandates for groups with 51 or more employees.</b>			
This is not a contract. It is intended solely to provide you with an overview of the plan. Complete details of benefits, terms and exclusions are governed by your Group Contract. <b>This managed care plan may not cover all your health care expenses. Read your contract carefully to determine which health care services are covered. If you have questions call us at 800.788.8445 in Central/Eastern Pennsylvania, and 800.735.4404 in Western Pennsylvania and Ohio.</b>			
Benefits are administered on a contract year basis. Coinsurance is based on Eligible Charges as defined in your Certificate of Insurance. For non-participating providers, Eligible Charges are based on the lesser of the provider's billed charges or our Out-of-Network Rate, which is defined in your Certificate of Insurance. <b>In addition to your copay or coinsurance, you are responsible for paying nonparticipating providers the difference between our out-of-network rate and their actual charge for nonemergency services. Your out-of-pocket costs for nonemergency care from nonparticipating providers may be substantial.</b>			
<i>Dependent Coverage Age Limit is 26</i>			
*If your Schedule of Benefits indicates that you have a Qualified High Deductible Health Plan., you must consult your group benefit documents for a specific description and the terms and conditions of your coverage for these benefits. Also, some covered services that you receive during a preventive service office visit may not qualify as preventive services under the group contract and, consequently, will be subject to applicable deductibles. In order to be exempt from applicable deductibles, preventive services must qualify as preventive services under the group contract and Section 223 of the Internal Revenue Code.			
*** The physician must bill the claim with a preventive diagnosis code in order to apply under preventive benefits coverage.			
This document neither affirmatively nor negatively amends, extends, or alters the terms of or the coverage afforded by policy referenced herein.			
**Reimbursement for Weight Management programs is limited to \$350 per calendar year per member.			

## SEPA FlexChoice QHDHP PPO \$2500 1x

DEDUCTIBLES AND MAXIMUMS	Participating MEMBER RESPONSIBILITY	Non-Participating MEMBER RESPONSIBILITY
<b>Annual Deductible</b>		
Individual	\$2,500	\$5,000
Family	\$2,500	\$5,000
The individual deductible applies when the Subscriber has an employee only policy. For policies that include the Subscriber and one or more dependents, the family deductible must be met before any family member begins to receive the benefits listed below, including prescription drug benefits covered under the prescription drug rider (except preventive services).		
<b>Out-of-Pocket Maximum</b> (includes copays, deductibles and coinsurance)		
Individual	\$4,000	\$10,000
Family	\$4,000	\$10,000
OUTPATIENT SERVICES	Participating MEMBER RESPONSIBILITY	Non-Participating MEMBER RESPONSIBILITY
<b>Physician Services (for illness or injury)</b>		
Primary Care Visit (PCP)	\$15 Copay (after annual deductible)	20% Eligible Charges (after annual deductible)
Specialist Visit (SCP)	\$25 Copay (after annual deductible)	20% Eligible Charges (after annual deductible)
<b>Preventive Services*</b>		
Gynecological Exam (PCP/SCP)	\$0 Copay	20% Eligible Charges (after annual deductible)
Well Child Visit	\$0 Copay	20% Eligible Charges (after annual deductible)
Adult Physical Visit	\$0 Copay	20% Eligible Charges (after annual deductible)
Preventive Pediatric Immunizations	0%	20% Eligible Charges
Preventive Adult Immunizations	0%	20% Eligible Charges (after annual deductible)
Hearing Exams (under age 18)	0%	20% Eligible Charges (after annual deductible)
Routine Mammograms	0%	20% Eligible Charges (after annual deductible)
<b>Allergy Testing &amp; Allergy Serum</b>	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
<b>Chiropractic Care</b>		
Maximum 20 visits per contract year	\$25 Copay (after annual deductible)	20% Eligible Charges (after annual deductible)
<b>Outpatient Surgery</b>	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
<b>Lab Services</b>	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
<b>Diagnostic X-ray</b>	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
<b>Radiology</b> (CAT, MRI, Ultrasound)	\$150 Copay (after annual deductible)	20% Eligible Charges (after annual deductible)
HOSPITAL SERVICES	Participating MEMBER RESPONSIBILITY	Non-Participating MEMBER RESPONSIBILITY
<b>Hospital Care</b>		
Semi-private room (private room if medically necessary)	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Physician and Surgeon Fees	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Surgery	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Lab and X-ray services	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
All Medically Necessary Ancillary Services	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Anesthesia	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Administration of Blood	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Blood Products	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Therapy Services (Chemotherapy & Radiation Therapy)	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
MATERNITY SERVICES	Participating MEMBER RESPONSIBILITY	Non-Participating MEMBER RESPONSIBILITY
<b>Pregnancy Care</b> (PCP/SCP) (copay for the first office visit only)	\$15/\$25 Copay (after annual deductible)	20% Eligible Charges (after annual deductible)
<b>Delivery</b>	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
FAMILY PLANNING	Participating MEMBER RESPONSIBILITY	Non-Participating MEMBER RESPONSIBILITY
<b>Infertility Counseling/Testing/Services</b>	(\$2,400 combined benefit maximum for infertility)	
<b>Tubal Ligation/Vasectomy</b>	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
PRESCRIPTION DRUGS	Participating MEMBER RESPONSIBILITY	Non-Participating MEMBER RESPONSIBILITY
(Includes oral contraceptives & managed formulary. Mandatory generic substitution may apply)	<b>Refer to the RX Select formulary to identify which drugs do not require authorization.</b> <b>Quantity limits still apply.</b> <b>VARIOUS RIDERS AVAILABLE</b> <b>COVERED ONLY AT PARTICIPATING PHARMACIES (after annual deductible)</b>	
EMERGENCY CARE	Participating MEMBER RESPONSIBILITY	Non-Participating MEMBER RESPONSIBILITY
Urgent Care Center	\$50 Copay (after annual deductible)	
Emergency Room Services	\$150 Copay (after annual deductible) ER Copay waived if admitted	
REHABILITATION SERVICES	Participating MEMBER RESPONSIBILITY	Non-Participating MEMBER RESPONSIBILITY
<b>Occupational, Speech, Physical Therapy</b>	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
	<i>45 inpatient days per contract year</i> <i>30 outpatient visits per contract year</i>	

<b>MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES</b>		<b>Participating MEMBER RESPONSIBILITY</b>	<b>Non-Participating MEMBER RESPONSIBILITY</b>
<b>General Mental Health:</b>		<i>(Mental health services must be preauthorized)</i>	
Inpatient	0% (after annual deductible)	20% Eligible Charges (after annual deductible)	30 days per contract year 90 day lifetime benefit maximum
Physician Services (Outpatient)	\$25 Copay (after annual deductible)	20% Eligible Charges (after annual deductible)	20 outpatient visits maximum per contract year
<b>Serious Mental Health:</b>			
Inpatient	0% (after annual deductible)	20% Eligible Charges (after annual deductible)	30 days per contract year 90 day lifetime benefit maximum r
Physician Services (Outpatient)	\$25 Copay (after annual deductible)	20% Eligible Charges (after annual deductible)	60 outpatient visits maximum per contract year
<b>Substance Abuse:</b>			
Inpatient Detoxification	0% (after annual deductible)	20% Eligible Charges (after annual deductible)	7 days maximum per admission 4 admission benefit maximum
Inpatient Rehabilitation	0% (after annual deductible)	20% Eligible Charges (after annual deductible)	30 days maximum per contract year 90 days benefit maximum
Transitional Partial Hospitalization	0% (after annual deductible)	20% Eligible Charges (after annual deductible)	60 visits per contract year 120 visits per benefit maximum
<b>OTHER BENEFITS</b>		<b>Participating MEMBER RESPONSIBILITY</b>	<b>Non-Participating MEMBER RESPONSIBILITY</b>
<b>Claim Forms Required</b>	<b>No</b>		<b>Yes</b>
<b>Durable Medical Equipment (DME) / Corrective Appliances</b> - Limited to once every 2 years for irreparable damage and/or normal wear.	0% (after annual deductible)	50% Eligible Charges (after annual deductible)	
<b>Home Health Care Services</b>	0% (after annual deductible) 120 visits per contract year	20% Eligible Charges (after annual deductible) 60 visits per contract year	120 visits combined per contract year
<b>Hospice Care</b>	0% (after annual deductible)	20% Eligible Charges (after annual deductible)	
<b>Skilled Nursing Facility</b>	0% (after annual deductible) 100 inpatient days per contract year	20% Eligible Charges (after annual deductible) 50 inpatient days per contract year	100 days combined maximum per contract year
<b>Dental Services</b>			
Emergency treatment of dental injury	0% (after annual deductible)	20% Eligible Charges (after annual deductible)	
Removal of Third Molars	0% (after annual deductible)	20% Eligible Charges (after annual deductible)	
<b>Vision Services</b>	<b>Vision One Eyecare Program®:</b> Receive immediate savings on all eyecare needs--discounts on frames, lenses, disposable contacts, and even LASIK surgery--at participating providers through the EyeMed Vision Care network.		
<b>Health Education</b>	Members receive reimbursement of the cost of approved wellness programs offered through local hospitals and organizations.**		
<b>PRECERTIFICATION REQUIREMENT</b>	By Physician		By Patient
When using a nonparticipating provider, the member must obtain precertification of nonemergency hospital and other facility (e.g., skilled nursing facilities, rehabilitation facilities, drug and alcohol treatment facilities) admissions, outpatient surgery and certain other services as stated in the Group Contract. If these services or admissions are not precertified and the service is not medically necessary, the member may be responsible for 100% of the cost of the services.			
<b>LIFETIME MAXIMUM</b>	Unlimited		
<p><b>Autism Spectrum Disorders are covered pursuant to state mandates for groups with 51 or more employees.</b>  This is not a contract. It is intended solely to provide you with an overview of the plan. Complete details of benefits, terms and exclusions are governed by your Group Contract. <b>This managed care plan may not cover all your health care expenses. Read your contract carefully to determine which health care services are covered. If you have questions call us at 800.788.8445 in Central/Eastern Pennsylvania, and 800.735.4404 in Western Pennsylvania and Ohio.</b>  Benefits are administered on a contract year basis. Coinsurance is based on Eligible Charges as defined in your Certificate of Insurance. For non-participating providers, Eligible Charges are based on the lesser of the provider's billed charges or our Out-of-Network Rate, which is defined in your Certificate of Insurance. <b>In addition to your copay or coinsurance, you are responsible for paying nonparticipating providers the difference between our out-of-network rate and their actual charge for nonemergency services. Your out-of-pocket costs for nonemergency care from nonparticipating providers may be substantial.</b>  <i>Dependent Coverage Age Limit is 26</i>  *If your Schedule of Benefits indicates that you have a Qualified High Deductible Health Plan., you must consult your group benefit documents for a specific description and the terms and conditions of your coverage for these benefits. Also, some covered services that you receive during a preventive service office visit may not qualify as preventive services under the group contract and, consequently, will be subject to applicable deductibles. In order to be exempt from applicable deductibles, preventive services must qualify as preventive services under the group contract and Section 223 of the Internal Revenue Code.  This document neither affirmatively nor negatively amends, extends, or alters the terms of or the coverage afforded by policy referenced herein.  **Reimbursement for Weight Management programs is limited to \$350 per calendar year per member.</p>			

DEDUCTIBLES AND MAXIMUMS	Participating MEMBER RESPONSIBILITY	Non-Participating MEMBER RESPONSIBILITY
<b>Annual Deductible</b>		
Individual	\$2,500	\$5,000
Family	\$5,000	\$10,000
The individual deductible applies when the Subscriber has an employee only policy. For policies that include the Subscriber and one or more dependents, the family deductible must be met before any family member begins to receive the benefits listed below, including prescription drug benefits covered under the prescription drug rider (except preventive services).		
<b>Out-of-Pocket Maximum</b> (includes copays, deductibles and coinsurance)		
Individual	\$4,000	\$10,000
Family	\$8,000	\$20,000
OUTPATIENT SERVICES	Participating MEMBER RESPONSIBILITY	Non-Participating MEMBER RESPONSIBILITY
<b>Physician Services (for illness or injury)</b>		
Primary Care Visit (PCP)	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
Specialist Visit (SCP)	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
<b>Preventive Services*</b>		
Gynecological Exam (PCP/SCP)	0%	30% Eligible Charges (after annual deductible)
Well Child Visit	0%	30% Eligible Charges (after annual deductible)
Adult Physical Visit	0%	30% Eligible Charges (after annual deductible)
Preventive Pediatric Immunizations	0%	30% Eligible Charges (after annual deductible)
Preventive Adult Immunizations	0%	30% Eligible Charges (after annual deductible)
Hearing Exams (under age 18)	0%	30% Eligible Charges (after annual deductible)
Routine Mammograms	0%	30% Eligible Charges (after annual deductible)
<b>Allergy Testing &amp; Allergy Serum</b>	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
<b>Chiropractic Care</b>		
Maximum 20 visits per contract year	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
<b>Outpatient Surgery</b>	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
<b>Lab Services</b>	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
<b>Diagnostic X-ray</b>	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
<b>Radiology</b> (CAT, MRI, Ultrasound)	\$150 Copay (after annual deductible)	30% Eligible Charges (after annual deductible)
HOSPITAL SERVICES	Participating MEMBER RESPONSIBILITY	Non-Participating MEMBER RESPONSIBILITY
<b>Hospital Care</b>		
Semi-private room (private room if medically necessary)	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
Physician and Surgeon Fees	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
Surgery	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
Lab and X-ray services	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
All Medically Necessary Ancillary Services	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
Anesthesia	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
Administration of Blood	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
Blood Products	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
Therapy Services (Chemotherapy & Radiation Therapy)	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
MATERNITY SERVICES	Participating MEMBER RESPONSIBILITY	Non-Participating MEMBER RESPONSIBILITY
<b>Pregnancy Care</b> (PCP/SCP) (copay for the first office visit only)	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
<b>Delivery</b>	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
FAMILY PLANNING	Participating MEMBER RESPONSIBILITY	Non-Participating MEMBER RESPONSIBILITY
<b>Infertility Counseling/Testing/Services</b>	(\$2,400 combined benefit maximum for infertility)	
<b>Tubal Ligation/Vasectomy</b>	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
PRESCRIPTION DRUGS	Participating MEMBER RESPONSIBILITY	Non-Participating MEMBER RESPONSIBILITY
(Includes oral contraceptives & managed formulary. Mandatory generic substitution may apply)	<b>Refer to the RX Select formulary to identify which drugs do not require authorization.</b> <b>Quantity limits still apply.</b> <b>VARIOUS RIDERS AVAILABLE</b> <b>COVERED ONLY AT PARTICIPATING PHARMACIES (after annual deductible)</b>	
EMERGENCY CARE	Participating MEMBER RESPONSIBILITY	Non-Participating MEMBER RESPONSIBILITY
Urgent Care Center	\$50 Copay (after annual deductible)	
Emergency Room Services	\$150 Copay (after annual deductible) ER Copay waived if admitted	
REHABILITATION SERVICES	Participating MEMBER RESPONSIBILITY	Non-Participating MEMBER RESPONSIBILITY
<b>Occupational, Speech, Physical Therapy</b>	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
	45 inpatient days per contract year 30 outpatient visits per contract year	

MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES	Participating MEMBER RESPONSIBILITY		Non-Participating MEMBER RESPONSIBILITY	
<i>(Mental health services must be preauthorized)</i>				
General Mental Health: Inpatient	0% (after annual deductible)		30% Eligible Charges (after annual deductible)	
	<i>30 days per contract year 90 day lifetime benefit maximum</i>			
Physician Services (Outpatient)	0% (after annual deductible)		30% Eligible Charges (after annual deductible)	
	<i>20 outpatient visits maximum per contract year</i>			
Serious Mental Health: Inpatient	0% (after annual deductible)		30% Eligible Charges (after annual deductible)	
	<i>30 days per contract year 90 day lifetime benefit maximum</i>			
Physician Services (Outpatient)	0% (after annual deductible)		30% Eligible Charges (after annual deductible)	
	<i>60 outpatient visits maximum per contract year</i>			
Substance Abuse: Inpatient Detoxification	0% (after annual deductible)		30% Eligible Charges (after annual deductible)	
	<i>7 days maximum per admission 4 admission benefit maximum</i>			
Inpatient Rehabilitation	0% (after annual deductible)		30% Eligible Charges (after annual deductible)	
	<i>30 days maximum per contract year 90 days benefit maximum</i>			
Transitional Partial Hospitalization	0% (after annual deductible)		30% Eligible Charges (after annual deductible)	
	<i>60 visits per contract year 120 visits per benefit maximum</i>			
OTHER BENEFITS	Participating MEMBER RESPONSIBILITY		Non-Participating MEMBER RESPONSIBILITY	
Claim Forms Required	No		Yes	
Durable Medical Equipment (DME) / Corrective Appliances - Limited to once every 2 years for irreparable damage and/or normal wear.	0% (after annual deductible)		50% Eligible Charges (after annual deductible)	
Home Health Care Services	0% (after annual deductible)		30% Eligible Charges (after annual deductible)	
	<i>120 visits per contract year 60 visits per contract year 120 visits combined per contract year</i>			
Hospice Care	0% (after annual deductible)		30% Eligible Charges (after annual deductible)	
Skilled Nursing Facility	0% (after annual deductible)		30% Eligible Charges (after annual deductible)	
	<i>100 inpatient days per contract year 50 inpatient days per contract year 100 days combined maximum per contract year</i>			
Dental Services Emergency treatment of dental injury Removal of Third Molars	0% (after annual deductible)		30% Eligible Charges (after annual deductible)	
	0% (after annual deductible)		30% Eligible Charges (after annual deductible)	
Vision Services	Vision One Eyecare Program®: Receive immediate savings on all eyecare needs--discounts on frames, lenses, disposable contacts, and even LASIK surgery--at participating providers through the EyeMed Vision Care network.			
Health Education	Members receive reimbursement of the cost of approved wellness programs offered through local hospitals and organizations.**			
PRECERTIFICATION REQUIREMENT	By Physician		By Patient	
When using a nonparticipating provider, the member must obtain precertification of nonemergency hospital and other facility (e.g., skilled nursing facilities, rehabilitation facilities, drug and alcohol treatment facilities) admissions, outpatient surgery and certain other services as stated in the Group Contract. If these services or admissions are not precertified and the service is not medically necessary, the member may be responsible for 100% of the cost of the services.				
LIFETIME MAXIMUM	Unlimited			
<p><b>Autism Spectrum Disorders are covered pursuant to state mandates for groups with 51 or more employees.</b>  This is not a contract. It is intended solely to provide you with an overview of the plan. Complete details of benefits, terms and exclusions are governed by your Group Contract. <b>This managed care plan may not cover all your health care expenses. Read your contract carefully to determine which health care services are covered. If you have questions call us at 800.788.8445 in Central/Eastern Pennsylvania, and 800.735.4404 in Western Pennsylvania and Ohio.</b>  Benefits are administered on a contract year basis. Coinsurance is based on Eligible Charges as defined in your Certificate of Insurance. For non-participating providers, Eligible Charges are based on the lesser of the provider's billed charges or our Out-of-Network Rate, which is defined in your Certificate of Insurance. <b>In addition to your copay or coinsurance, you are responsible for paying nonparticipating providers the difference between our out-of-network rate and their actual charge for nonemergency services. Your out-of-pocket costs for nonemergency care from nonparticipating providers may be substantial.</b>  <i>Dependent Coverage Age Limit is 26</i>  *If your Schedule of Benefits indicates that you have a Qualified High Deductible Health Plan., you must consult your group benefit documents for a specific description and the terms and conditions of your coverage for these benefits. Also, some covered services that you receive during a preventive service office visit may not qualify as preventive services under the group contract and, consequently, will be subject to applicable deductibles. In order to be exempt from applicable deductibles, preventive services must qualify as preventive services under the group contract and Section 223 of the Internal Revenue Code.  This document neither affirmatively nor negatively amends, extends, or alters the terms of or the coverage afforded by policy referenced herein.  **Reimbursement for Weight Management programs is limited to \$350 per calendar year per member.</p>				

DEDUCTIBLES AND MAXIMUMS	Participating MEMBER RESPONSIBILITY	Non-Participating MEMBER RESPONSIBILITY
<b>Annual Deductible</b>		
Individual	\$4,000	\$5,000
Family	\$4,000	\$5,000
The individual deductible applies when the Subscriber has an employee only policy. For policies that include the Subscriber and one or more dependents, the family deductible must be met before any family member begins to receive the benefits listed below, including prescription drug benefits covered under the prescription drug rider (except preventive services).		
<b>Out-of-Pocket Maximum (includes copays, deductibles and coinsurance)</b>		
Individual	\$5,000	\$10,000
Family	\$5,000	\$10,000
OUTPATIENT SERVICES	Participating MEMBER RESPONSIBILITY	Non-Participating MEMBER RESPONSIBILITY
<b>Physician Services (for illness or injury)</b>		
Primary Care Visit (PCP)	\$20 Copay (after annual deductible)	20% Eligible Charges (after annual deductible)
Specialist Visit (SCP)	\$40 Copay (after annual deductible)	20% Eligible Charges (after annual deductible)
<b>Preventive Services*</b>		
Gynecological Exam (PCP/SCP)	\$0 Copay	20% Eligible Charges (after annual deductible)
Well Child Visit	\$0 Copay	20% Eligible Charges (after annual deductible)
Adult Physical Visit	\$0 Copay	20% Eligible Charges (after annual deductible)
Preventive Pediatric Immunizations	0%	20% Eligible Charges
Preventive Adult Immunizations	0%	20% Eligible Charges (after annual deductible)
Hearing Exams (under age 18)	0%	20% Eligible Charges (after annual deductible)
Routine Mammograms	0%	20% Eligible Charges (after annual deductible)
<b>Allergy Testing &amp; Allergy Serum</b>	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
<b>Chiropractic Care</b>		
Maximum 20 visits per contract year	\$40 Copay (after annual deductible)	20% Eligible Charges (after annual deductible)
<b>Outpatient Surgery</b>	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
<b>Lab Services</b>	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
<b>Diagnostic X-ray</b>	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
<b>Radiology (CAT, MRI, Ultrasound)</b>	\$150 Copay (after annual deductible)	20% Eligible Charges (after annual deductible)
HOSPITAL SERVICES	Participating MEMBER RESPONSIBILITY	Non-Participating MEMBER RESPONSIBILITY
<b>Hospital Care</b>		
Semi-private room (private room if medically necessary)	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Physician and Surgeon Fees	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Surgery	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Lab and X-ray services	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
All Medically Necessary Ancillary Services	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Anesthesia	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Administration of Blood	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Blood Products	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Therapy Services (Chemotherapy & Radiation Therapy)	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
MATERNITY SERVICES	Participating MEMBER RESPONSIBILITY	Non-Participating MEMBER RESPONSIBILITY
<b>Pregnancy Care (PCP/SCP)</b> (copay for the first office visit only)	\$20/\$40 Copay (after annual deductible)	20% Eligible Charges (after annual deductible)
<b>Delivery</b>	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
FAMILY PLANNING	Participating MEMBER RESPONSIBILITY	Non-Participating MEMBER RESPONSIBILITY
<b>Infertility Counseling/Testing/Services</b>	(\$2,400 combined benefit maximum for infertility)	
<b>Tubal Ligation/Vasectomy</b>	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
PRESCRIPTION DRUGS	Participating MEMBER RESPONSIBILITY	Non-Participating MEMBER RESPONSIBILITY
(Includes oral contraceptives & managed formulary. Mandatory generic substitution may apply)	<b>Refer to the RX Select formulary to identify which drugs do not require authorization.</b> <b>Quantity limits still apply.</b> <b>VARIOUS RIDERS AVAILABLE</b> <b>COVERED ONLY AT PARTICIPATING PHARMACIES (after annual deductible)</b>	
EMERGENCY CARE	Participating MEMBER RESPONSIBILITY	Non-Participating MEMBER RESPONSIBILITY
Urgent Care Center	\$50 Copay (after annual deductible)	
Emergency Room Services	\$150 Copay (after annual deductible) ER Copay waived if admitted	
REHABILITATION SERVICES	Participating MEMBER RESPONSIBILITY	Non-Participating MEMBER RESPONSIBILITY
<b>Occupational, Speech, Physical Therapy</b>	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
	<i>45 inpatient days per contract year</i> <i>30 outpatient visits per contract year</i>	

<b>MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES</b>		<b>Participating MEMBER RESPONSIBILITY</b>	<b>Non-Participating MEMBER RESPONSIBILITY</b>
<b>General Mental Health:</b>		<i>(Mental health services must be preauthorized)</i>	
Inpatient		0% (after annual deductible)	20% Eligible Charges (after annual deductible)
		<i>30 days per contract year 90 day lifetime benefit maximum</i>	
Physician Services (Outpatient)		\$40 Copay (after annual deductible)	20% Eligible Charges (after annual deductible)
		<i>20 outpatient visits maximum per contract year</i>	
<b>Serious Mental Health:</b>			
Inpatient		0% (after annual deductible)	20% Eligible Charges (after annual deductible)
		<i>30 days per contract year 90 day lifetime benefit maximum</i>	
Physician Services (Outpatient)		\$40 Copay (after annual deductible)	20% Eligible Charges (after annual deductible)
		<i>60 outpatient visits maximum per contract year</i>	
<b>Substance Abuse:</b>			
Inpatient Detoxification		0% (after annual deductible)	20% Eligible Charges (after annual deductible)
		<i>7 days maximum per admission 4 admission benefit maximum</i>	
Inpatient Rehabilitation		0% (after annual deductible)	20% Eligible Charges (after annual deductible)
		<i>30 days per contract year 90 day lifetime benefit maximum</i>	
Transitional Partial Hospitalization		0% (after annual deductible)	20% Eligible Charges (after annual deductible)
		<i>60 visits per contract year 120 visits per benefit maximum</i>	
<b>OTHER BENEFITS</b>		<b>Participating MEMBER RESPONSIBILITY</b>	<b>Non-Participating MEMBER RESPONSIBILITY</b>
<b>Claim Forms Required</b>		<b>No</b>	<b>Yes</b>
<b>Durable Medical Equipment (DME) / Corrective Appliances</b> - Limited to once every 2 years for irreparable damage and/or normal wear.		50% (after annual deductible)	20% Eligible Charges (after annual deductible)
<b>Home Health Care Services</b>		0% (after annual deductible) <i>120 visits per contract year</i>	20% Eligible Charges (after annual deductible) <i>60 visits per contract year</i>
		<i>120 visits combined per contract year</i>	
<b>Hospice Care</b>		0% (after annual deductible)	20% Eligible Charges (after annual deductible)
<b>Skilled Nursing Facility</b>		0% (after annual deductible) <i>100 inpatient days per contract year</i>	20% Eligible Charges (after annual deductible) <i>50 inpatient days per contract year</i>
		<i>100 days combined maximum per contract year</i>	
<b>Dental Services</b>			
Emergency treatment of dental injury		0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Removal of Third Molars		0% (after annual deductible)	20% Eligible Charges (after annual deductible)
<b>Vision Services</b>	<b>Vision One Eyecare Program®:</b> Receive immediate savings on all eyecare needs--discounts on frames, lenses, disposable contacts, and even LASIK surgery--at participating providers through the EyeMed Vision Care network.		
<b>Health Education</b>	Members receive reimbursement of the cost of approved wellness programs offered through local hospitals and organizations.**		
<b>PRECERTIFICATION REQUIREMENT</b>		By Physician	By Patient
When using a nonparticipating provider, the member must obtain precertification of nonemergency hospital and other facility (e.g., skilled nursing facilities, rehabilitation facilities, drug and alcohol treatment facilities) admissions, outpatient surgery and certain other services as stated in the Group Contract. If these services or admissions are not precertified and the service is not medically necessary, the member may be responsible for 100% of the cost of the services.			
<b>LIFETIME MAXIMUM</b>		Unlimited	
<b>Autism Spectrum Disorders are covered pursuant to state mandates for groups with 51 or more employees.</b>			
This is not a contract. It is intended solely to provide you with an overview of the plan. Complete details of benefits, terms and exclusions are governed by your Group Contract. <b>This managed care plan may not cover all your health care expenses. Read your contract carefully to determine which health care services are covered. If you have questions call us at 800.788.8445 in Central/Eastern Pennsylvania, and 800.735.4404 in Western Pennsylvania and Ohio.</b>			
Benefits are administered on a contract year basis. Coinsurance is based on Eligible Charges as defined in your Certificate of Insurance. For non-participating providers, Eligible Charges are based on the lesser of the provider's billed charges or our Out-of-Network Rate, which is defined in your Certificate of Insurance. <b>In addition to your copay or coinsurance, you are responsible for paying nonparticipating providers the difference between our out-of-network rate and their actual charge for nonemergency services. Your out-of-pocket costs for nonemergency care from nonparticipating providers may be substantial.</b>			
<i>Dependent Coverage Age Limit is 26</i>			
*If your Schedule of Benefits indicates that you have a Qualified High Deductible Health Plan, you must consult your group benefit documents for a specific description and the terms and conditions of your coverage for these benefits. Also, some covered services that you receive during a preventive service office visit may not qualify as preventive services under the group contract and, consequently, will be subject to applicable deductibles. In order to be exempt from applicable deductibles, preventive services must qualify as preventive services under the group contract and Section 223 of the Internal Revenue Code.			
This document neither affirmatively nor negatively amends, extends, or alters the terms of or the coverage afforded by policy referenced herein.			
**Reimbursement for Weight Management programs is limited to \$350 per calendar year per member.			