

## Premier PPO \$20\$40

DEDUCTIBLES AND MAXIMUMS	Participating MEMBER RESPONSIBILITY	Non-Participating MEMBER RESPONSIBILITY
<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
OUTPATIENT SERVICES	Participating MEMBER RESPONSIBILITY	Non-Participating MEMBER RESPONSIBILITY
<b>Physician Services (for illness or injury)</b>	<b>(office visit NOT subject to deductible)</b>	
Primary Care Visit (PCP)	\$20 Copay	30% Eligible Charges (after annual deductible)
Specialist Visit (SCP)	\$40 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)	<b>\$75 Copay</b>	<b>30% Eligible Charges (after annual deductible)</b>
<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	\$40 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)
HOSPITAL SERVICES	Participating MEMBER RESPONSIBILITY	Non-Participating MEMBER RESPONSIBILITY
<b>Hospital Care</b>		
Semi-private room (private room if medically necessary)	\$500 per admission	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)
MATERNITY SERVICES	Participating MEMBER RESPONSIBILITY	Non-Participating MEMBER RESPONSIBILITY
<b>Pregnancy Care</b> (PCP/SCP) (copay for the first office visit only)	\$20/\$40 Copay	30% Eligible Charges (after annual deductible)
<b>Delivery</b>	\$500 per admission	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%	30% Eligible Charges (after annual deductible)
		\$2,400 combined benefit maximum
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	\$40 Copay	
Emergency Room Services (not subject to deductible)	0% after \$150 Copay (ER Copay waived if admitted)	
REHABILITATION SERVICES	Participating MEMBER RESPONSIBILITY	Non-Participating MEMBER RESPONSIBILITY
<b>Occupational, Speech, Physical Therapy</b>	0%	30% Eligible Charges (after annual deductible)
	\$500 per admission	
	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	\$500 per admission	30% Eligible Charges (after annual deductible)
	<i>30 days per contract year/90 day lifetime benefit maximum</i>	
Physician Services (Outpatient)	\$40 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 per admission	30% Eligible Charges (after annual deductible)
	<i>30 days per contract year/90 day lifetime benefit maximum</i>	
Physician Services (Outpatient)	\$40 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 per admission	30% Eligible Charges (after annual deductible)
	<i>7 days maximum per admission/4 admission benefit maximum</i>	
Inpatient Rehabilitation	\$500 per admission	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>	\$500 per admission	30% Eligible Charges (after annual deductible)
<b>Skilled Nursing Facility</b>	\$500 per admission	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	
<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>		