Preferred Provider Organization
Underwritten by HealthAssurance Pennsylvania, Inc.

Gold Premier PPO $25/$75		
PPO Plan	***PPO***	
Benefits	Member pays	
	Participating Providers	***Non-Participating Providers***
Annual Deductible (Deductible)	**Individual: $0**	**Individual: $5,000**
	Family: $0	**Family: $10,000**
Coinsurance (Coinsurance)	**0%**	**30%**
Out-of-Pocket Maximum	**Individual: $6,350**	**Individual: $10,000**
	Family: $12,700	**Family: $20,000**
AMBULATORY SERVICES		
Office Visit		
Primary Care Physician	**$25 Copay**	**Deductible/Coinsurance**
Specialist	**$75 Copay**	**Deductible/Coinsurance**
Chiropractic Care	**$75 Copay**	**Deductible/Coinsurance**
	Limited to 20 visits per benefit year	
Surgery		
Primary Care Physician's Office	**$250 Copay**	**Deductible/Coinsurance**
Specialist's Office	**$250 Copay**	**Deductible/Coinsurance**
Free-Standing Facility	**$250 Copay**	**Deductible/Coinsurance**
Outpatient	**$500 Copay**	**Deductible/Coinsurance**
Outpatient Facility and Physician Services	**$75 Copay**	**Deductible/Coinsurance**
Hospice (outpatient)	**$75 Copay**	**Deductible/Coinsurance**
Home Health Care	**$75 Copay**	**Deductible/Coinsurance**
	Limited to 60 visits per benefit year	
Skilled Nursing Facility	**$1000 Copay/Admit**	**Deductible/Coinsurance**
	Limited to 120 days per benefit year	
EMERGENCY CARE		
Convenience Care*/ Walk In Clinic (WIC)	**$25 Copay**	**Deductible/Coinsurance**
Urgent Care	**$75 Copay**	**$75 Copay**
Emergency Room Care	**$300 Copay**	**$300 Copay**
	Copay waived if admitted	
Emergency Advanced Imaging / High Tech Radiology	**$300 Copay**	**$300 Copay**
Emergency Transportation/ Ambulance	**$300 Copay**	**$300 Copay**

HOSPITALIZATION		
Inpatient Services	**$500 Copay / Admit**	**Deductible/Coinsurance**
Inpatient Physician and Surgical Services	**$0**	**Deductible/Coinsurance**
MATERNITY AND NEWBORN CARE		
Prenatal Office Visits	**$0**	**Deductible/Coinsurance**
Physician Charges, Prenatal, Postnatal, Ultrasound, Delivery	**$0**	**Deductible/Coinsurance**
Outpatient Ultrasound	**$75 Copay**	**Deductible/Coinsurance**
All Inpatient Services/Facility Charges	**$500 Copay / Admit**	**Deductible/Coinsurance**
MENTAL HEALTH/SUBSTANCE ABUSE DISORDER SERVICES INCLUDING BEHAVIORAL HEALTH MANAGEMENT		
Outpatient	**$75 Copay**	**Deductible/Coinsurance**
Inpatient (Includes Partial Hospitalization	**$500 Copay / Admit**	**Deductible/Coinsurance**
REHABILITATIVE AND HABILITATIVE SERVICES AND DEVICES		
Outpatient Rehabilitation Services	**$75 Copay**	**Deductible/Coinsurance**
	Benefit limits are combined between rehabilitation and habilitation services.	
	PT/OT limited to 30 combined visits per benefit year	
	ST limited to 30 visits per benefit year	
Habilitation Services	**$75 Copay**	**Deductible/Coinsurance**
	Benefit limits are combined between rehabilitation and habilitation services.	
	PT/OT limited to 30 combined visits per benefit year	
	ST limited to 30 visits per benefit year	
Durable Medical Equipment	**50% Coinsurance**	**Deductible/50%Coinsurance**
	Limited to once every 2 years for irreparable damage and/or normal wear	
LAB SERVICES		
Lab/Radiology		
Primary Care Physician's Office	**Included in Office Visit**	**Deductible/Coinsurance**
Specialist's Office	**Included in Office Visit**	**Deductible/Coinsurance**
Outpatient	**$25 Copay**	**Deductible/Coinsurance**
Diagnostic Mammogram		
Primary Care Physician's Office	**$25 Copay**	**Deductible/Coinsurance**
Specialist's Office	**$25 Copay**	**Deductible/Coinsurance**
Free-Standing Facility	**$25 Copay**	**Deductible/Coinsurance**
Outpatient	**$25 Copay**	**Deductible/Coinsurance**

Advanced Imaging / High Tech Radiology		
Primary Care Physician's Office	**$500 Copay**	**Deductible/Coinsurance**
Specialist's Office	**$500 Copay**	**Deductible/Coinsurance**
Free-Standing Facility	**$500 Copay**	**Deductible/Coinsurance**
Outpatient	**$500 Copay**	**Deductible/Coinsurance**
PREVENTION/WELLNESS		
Preventive Care/Screening/ Immunization	**$0**	**Deductible/Coinsurance**
Preventive/Screening Mammogram	*Limited to once per benefit year*	
Primary Care Physician's Office	**$0**	**Deductible/Coinsurance**
Specialist's Office	**$0**	**Deductible/Coinsurance**
Free-Standing Facility	**$0**	**Deductible/Coinsurance**
Outpatient	**$0**	**Deductible/Coinsurance**
PEDIATRIC SERVICES INCLUDING ORAL AND VISION CARE		
Pediatric Dental Care	**Type**	**Coverage In & Out**
Preventive & Diagnostic		
Exams	I	100%
Cleanings	I	100%
X-rays	I	100%
Fluoride	I	100%
Sealants	I	100%
Basic		
Space Maintainers	II	50%
Fillings	II	50%
Adjustments to Dentures	II	50%
Anesthesia	II	50%
General Services	II	50%
Major		
Crowns	III	50%
Inlays	III	50%
Onlays	III	50%
Dentures	III	50%
Bridges	III	50%
Endo	III	50%
Perio	III	50%
Oral Surgery	III	50%
Implants	III	50%
Orthodontia	IV	50%
Deductible	Deductible & OOP Max combined with medical, deductible does not apply to preventive & diagnostic services	
OOP Max		
Pediatric Vision Care		
Vision Screening for Children	One routine eye examination per year	
Eye Glasses for Children	One pair of standard eyeglass lenses or contact lenses per year; one frame every year	

PRESCRIPTION DRUGS	
Pharmacy	**No RX Deductible**
Tier 1A: Lower Cost Preferred Generic Drugs	**Retail $3 / Mail Order $9**
Tier 1: Preferred Generic Drugs	**Retail $10 / Mail Order $20**
Tier 2: Preferred Brand Drugs	**Retail $40 / Mail Order $100**
Tier 3: Non-Preferred Generic/Brand Drugs	**Retail $70 / Mail Order $210**
Tier 4: Preferred Specialty Drugs	**$150 minimum or 20% with a max of $300**
Tier 5: Non-Preferred Specialty Drugs	**40% Coinsurance**

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.

PRECERTIFICATION REQUIREMENT
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

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. 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.

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. 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.

This document neither affirmatively nor negatively amends, extends, or alters the terms of or the coverage afforded by policy referenced herein

*Convenience Care/ Walk In Clinic (WIC)
A condition that requires Convenience Care is an unexpected illness or injury that does not constitute an Emergency Medical Condition, but requires medical attention when you cannot see your family doctor right away. Convenience Care Centers are also useful for flu shots, vaccinations, and other shots