

Preferred Provider Organization underwritten by  
HealthAssurance Pennsylvania, Inc.

<b>DEDUCTIBLES AND MAXIMUMS</b>	<b>Participating MEMBER RESPONSIBILITY</b>	<b>Participating MEMBER RESPONSIBILITY</b>
<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
<b>OUTPATIENT SERVICES</b>	<b>Participating MEMBER RESPONSIBILITY</b>	<b>Participating MEMBER RESPONSIBILITY</b>
<b>Physician Services (for illness or injury)</b>		
Primary Care Visit (PCP)	0% (after annual deductible)	30% R&C (after annual deductible)
Specialist Visit (SCP)	0% (after annual deductible)	30% R&C (after annual deductible)
<b>Preventive Services*</b>		
Gynecological Exam (PCP/SCP)	0%	30% R&C (after annual deductible)
Well Child Visit	0%	30% R&C (after annual deductible)
Adult Physical Visit	0%	30% R&C (after annual deductible)
Preventive Pediatric Immunizations	0%	30% R&C
Preventive Adult Immunizations	0%	30% R & C (after annual deductible)
Hearing Exams (under age 18)	0%	30% R&C (after annual deductible)
Routine Mammograms	0%	30% R&C (after annual deductible)
<b>Allergy Testing &amp; Allergy Serum</b>	0% (after annual deductible)	30% R&C (after annual deductible)
<b>Chiropractic Care</b>		
Maximum \$1,000 per contract year	0% (after annual deductible)	30% R&C (after annual deductible)
<b>Outpatient Surgery</b>	0% (after annual deductible)	30% R&C (after annual deductible)
<b>Lab Services</b>	0% (after annual deductible)	30% R&C (after annual deductible)
<b>Diagnostic X-ray</b>	0% (after annual deductible)	30% R&C (after annual deductible)
<b>Radiology (CAT, MRI, Ultrasound)</b>	0% (after annual deductible)	30% R&C (after annual deductible)
<b>HOSPITAL SERVICES</b>	<b>Participating MEMBER RESPONSIBILITY</b>	<b>Participating MEMBER RESPONSIBILITY</b>
<b>Hospital Care</b>		
Semi-private room (private room if medically necessary)	0% (after annual deductible)	30% R&C (after annual deductible)
Physician and Surgeon Fees	0% (after annual deductible)	30% R&C (after annual deductible)
Surgery	0% (after annual deductible)	30% R&C (after annual deductible)
Lab and X-ray services	0% (after annual deductible)	30% R&C (after annual deductible)
All Medically Necessary Ancillary Services	0% (after annual deductible)	30% R&C (after annual deductible)
Anesthesia	0% (after annual deductible)	30% R&C (after annual deductible)
Administration of Blood	0% (after annual deductible)	30% R&C (after annual deductible)
Blood Products	0% (after annual deductible)	30% R&C (after annual deductible)
Therapy Services (Chemotherapy & Radiation Therapy)	0% (after annual deductible)	30% R&C (after annual deductible)
<b>MATERNITY SERVICES</b>	<b>Participating MEMBER RESPONSIBILITY</b>	<b>Participating MEMBER RESPONSIBILITY</b>
<b>Pregnancy Care (PCP/SCP)</b>	0% (after annual deductible)	30% R&C (after annual deductible)
<b>Delivery</b>	0% (after annual deductible)	30% R&C (after annual deductible)
<b>FAMILY PLANNING</b>	<b>Participating MEMBER RESPONSIBILITY</b>	<b>Participating MEMBER RESPONSIBILITY</b>
<b>Infertility Counseling/Testing/Services</b>	0% (after annual deductible)	30% R&C (after annual deductible)
<b>Tubal Ligation/Vasectomy</b>	0% (after annual deductible)	30% R&C (after annual deductible)
<i>\$2,400 combined benefit maximum</i>		
<b>PRESCRIPTION DRUGS</b>	<b>Participating MEMBER RESPONSIBILITY</b>	<b>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.</b> <b>Quantity limits still apply.</b> <b>VARIOUS RIDERS AVAILABLE</b> <b>COVERED ONLY AT PARTICIPATING PHARMACIES (after annual deductible)</b>	
<b>EMERGENCY CARE</b>	<b>Participating MEMBER RESPONSIBILITY</b>	<b>Participating MEMBER RESPONSIBILITY</b>
<b>Emergency Room Services</b>	\$100 Copay (after annual deductible) ER copay waived if admitted	
<b>REHABILITATION SERVICES</b>	<b>Participating MEMBER RESPONSIBILITY</b>	<b>Participating MEMBER RESPONSIBILITY</b>
<b>Occupational, Speech, Physical Therapy</b>	0% (after annual deductible)	30% R&C (after annual deductible)
<i>45 inpatient days per contract year 30 outpatient visits per contract year</i>		

<b>MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES</b>		
	<b>Participating MEMBER RESPONSIBILITY</b>	<b>Participating MEMBER RESPONSIBILITY</b>
<b>General Mental Health:</b>	<i>(Mental health services must be preauthorized)</i>	
<b>Inpatient</b>	0% (after annual deductible)	30% R&C (after annual deductible)
	30 days per contract year 90 day lifetime benefit maximum	
<b>Physician Services (Outpatient)</b>	0% (after annual deductible)	30% R&C (after annual deductible)
	20 outpatient visits maximum per contract year	
<b>Serious Mental Health:</b>		
<b>Inpatient</b>	0% (after annual deductible)	30% R&C (after annual deductible)
	30 days per contract year	
<b>Physician Services (Outpatient)</b>	0% (after annual deductible)	30% R&C (after annual deductible)
	60 outpatient visits maximum per contract year	
<b>Substance Abuse:</b>		
<b>Inpatient Detoxification</b>	0% (after annual deductible)	30% R&C (after annual deductible)
	7 days maximum per admission 4 admission benefit maximum	
<b>Inpatient Rehabilitation</b>	0% (after annual deductible)	30% R&C (after annual deductible)
	30 days maximum per contract year 90 days benefit maximum	
<b>Transitional Partial Hospitalization</b>	0% (after annual deductible)	30% R&C (after annual deductible)
	60 visits per contract year 120 visits per benefit maximum	
<b>OTHER BENEFITS</b>		
	<b>Participating MEMBER RESPONSIBILITY</b>	<b>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% R&C (after annual deductible)
<b>Corrective Appliances</b>	0% (after annual deductible)	30% R&C (after annual deductible)
	\$20,000 combined benefit maximum	
<b>Home Health Care Services</b>	0% (after annual deductible)	30% R&C (after annual deductible)
	120 visits per contract year	60 visits per contract year; \$60 maximum allowable charge per visit
	120 visits combined per contract year	
<b>Hospice Care</b>	0% (after annual deductible)	30% R&C (after annual deductible)
<b>Skilled Nursing Facility</b>	0% (after annual deductible)	30% R&C (after annual deductible)
	100 inpatient days per contract year	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)	30% R&C (after annual deductible)
Removal of Third Molars	0% (after annual deductible)	30% R&C (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 Cole Managed Vision 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
<b>Penalty (By Patient)</b>	None	\$300
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% of the cost of the services.		
<b>LIFETIME MAXIMUM</b>	\$2,500,000	
<b>PROVIDER RESTRICTIONS</b>	All non-Emergency Services provided at Shadyside Hospital and the following University of Pittsburgh Medical Center facilities: Eye and Ear Hospital, Falk Clinic, Montefiore Hospital, Presbyterian University Hospital, and their affiliated clinics are EXCLUDED from coverage under the Group Contract unless authorized for payment in advance by HealthAssurance. If you do not receive authorization in advance from HealthAssurance, NO COVERAGE WILL BE PROVIDED FOR NON-EMERGENCY SERVICES received at these hospitals or their clinics.	
<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>HealthAmerica and HealthAssurance pay nonparticipating providers an out-of-network rate, which is the usual rate paid to medical providers in a geographic area for a specific medical service. 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.</p> <p><i>Benefits are administered on a contract year basis.</i></p> <p><i>Coinurance is based on Eligible Charges as defined by HealthAssurance Pennsylvania, Inc. in your Certificate of Insurance</i></p> <p><i>Dependent Coverage Age Limit is 19; extended to 25 for full-time Student.</i></p> <p>*This list is a general description only, 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>**Reimbursement for Weight Management programs is limited to \$150 per calendar year per member.</p>		