

## Shared Choice PPO \$2000 with Coventry Fund \$250

DEDUCTIBLES AND MAXIMUMS	Participating MEMBER RESPONSIBILITY	Non-Participating MEMBER RESPONSIBILITY
<b>Annual Deductible</b> Individual / Family	\$2,000 / \$6,000	\$4,000 / \$12,000
<b>Out-of-Pocket Maximum</b> (copays, deductibles and coinsurance) Individual / Family	none / none	\$10,000 / \$30,000
<b>COVENTRY FUND (participating provider expenses only)</b>		
<b>Coventry Fund Balance</b> per contract year: Individual/Family	\$250/\$750	
<b>Maximum Rollover:</b> Individual/Family	\$250/\$750	Not Applicable
<b>Coventry Fund Maximum:</b> Individual/Family	\$500/\$1,500	
OUTPATIENT SERVICES	Participating MEMBER RESPONSIBILITY	Non-Participating MEMBER RESPONSIBILITY
<b>Physician Services (for illness or injury)</b> Level One Visits (PCP, OB/GYN, Dermatologists, Chiropractors) Level Two Visits (all other office visits)	\$20 Copay \$40 Copay (after annual deductible)	30% Eligible Charges (after annual deductible) 30% Eligible Charges (after annual deductible)
<b>Preventive Services*</b> Gynecological Exam (PCP/SCP) Well Child Visit Adult Physical Visit Preventive Pediatric Immunizations Hearing Exams (under age 18) Routine Mammograms	\$20 Copay \$20 Copay \$20 Copay 0% 0% 0%	30% Eligible Charges (after annual deductible) 30% Eligible Charges (after annual deductible) 30% Eligible Charges (after annual deductible) 30% Eligible Charges (after annual deductible) 30% Eligible Charges (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 \$1,000 per contract year)	\$20 Copay	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)	\$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) Physician and Surgeon Fees Surgery Lab and X-ray services All Medically Necessary Ancillary Services Anesthesia Administration of Blood Blood Products Therapy Services (Chemotherapy & Radiation Therapy)	0% (after annual deductible) 0% (after annual deductible) 0% (after annual deductible) 0% (after annual deductible) 0% (after annual deductible) 0% (after annual deductible) 0% (after annual deductible) 0% (after annual deductible) 0% (after annual deductible)	30% Eligible Charges (after annual deductible) 30% Eligible Charges (after annual deductible) 30% Eligible Charges (after annual deductible) 30% Eligible Charges (after annual deductible) 30% Eligible Charges (after annual deductible) 30% Eligible Charges (after annual deductible) 30% Eligible Charges (after annual deductible) 30% Eligible Charges (after annual deductible) 30% Eligible Charges (after annual deductible)
MATERNITY SERVICES	Participating MEMBER RESPONSIBILITY	Non-Participating MEMBER RESPONSIBILITY
<b>Pregnancy Care</b> (PCP/SCP)	\$20 Copay (copay for the first office visit only)	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>	0% (after annual deductible)	\$300 one time deductible then coinsurance applies 30% Eligible Charges (after annual deductible)
<b>Tubal Ligation/Vasectomy</b>	0% (after annual deductible)	\$2,400 combined benefit maximum 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>Tier 1 = \$10 Tier 2 = \$35 (after annual deductible) Tier 3 = \$60 (after annual deductible)</b>	<b>COVERED ONLY AT PARTICIPATING PHARMACIES</b>
EMERGENCY CARE	Participating MEMBER RESPONSIBILITY	Non-Participating MEMBER RESPONSIBILITY
<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)	30% Eligible Charges (after annual deductible)
		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	<i>(Mental health services must be preauthorized)</i>	
	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
Physician Services (Outpatient)	<i>30 days per contract year 90 day lifetime benefit maximum</i>	
	\$40 Copay (after annual deductible)	30% Eligible Charges (after annual deductible)
<b>Serious Mental Health:</b> Inpatient	<i>30 days per contract year</i>	
	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
Physician Services (Outpatient)	<i>60 outpatient visits maximum per contract year</i>	
	\$40 Copay (after annual deductible)	30% Eligible Charges (after annual deductible)
<b>Substance Abuse:</b> Inpatient Detoxification	<i>7 days maximum per admission 4 admission benefit maximum</i>	
	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
Inpatient Rehabilitation	<i>30 days maximum per contract year 90 days benefit maximum</i>	
	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
Transitional Partial Hospitalization	<i>60 visits per contract year 120 visits per benefit maximum</i>	
	0% (after annual 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)</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>	<i>\$20,000 combined benefit maximum</i>	
	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
<b>Hospice Care</b>	<i>120 visits per contract year 120 visits combined per contract year</i>	
	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
<b>Skilled Nursing Facility</b>	<i>60 visits per contract year; \$60 maximum allowable charge per visit</i>	
	0% (after annual deductible)	30% 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)	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>	\$5,000,000	
<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.	
<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 19; extended to 25 for full-time Student.</i> <b>COVENTRY FUND:</b> When you received Benefits from a Participating Health Care Provider or Covered Prescription Drugs, you can use the money in your Fund to cover your portion of the cost. Your financial responsibilities are listed in your Schedule of Benefits. If you are not enrolled in your Group's benefit plan at the beginning of the Contract Year, or in the event you are rehired within the Contract Year, the beginning balance in your Fund account will be pro-rated to reflect the amount of the Contract Year during which you will be enrolled. Pro-rating is calculated on a monthly basis. If you have a family status change during the year, your Fund balance will be pro-rated based on the new status. Your Fund Rollover balance, if any, will not be adjusted for a family status change. Your Fund's Maximum Rollover limits the Fund balance you can carry from one contract year to the next contract year.		
*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. <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 \$150 per calendar year per member.		