

Summary of Benefits

Preferred Healthcare System

The Plan offers you the choice of two levels of health care benefits each time you need medical services. Providers will need to pre-certify inpatient and tertiary care referrals through Preferred Healthcare System, Inc. at 1-800-422-8929.

For More Information

This managed care plan may not cover all your health care expenses. Please read your Certificate of Coverage carefully for complete information about benefits and exclusions. If you have any claims questions, please call CoreSource at _800-222-1958 X2430_____.

Covered Services	Participating Provider	Non-Participating Provider
Annual Deductible		
Individual	None	\$300
Family	None	\$600
Annual Out-of-Pocket Maximum		
Individual	None	\$2,000
Family	None	\$4,000
Coinsurance	100%	80% after deductible ¹
Lifetime Maximum	\$5,000,000	\$5,000,000
Primary Care Physician Required	No	No
Pre-existing Condition Limitations	None	None
Pre-certification Requirements	Provider Responsibility	Member Responsibility - Required for select services, \$150 financial penalty per incident for failure to comply
Foreign Travel Immunization	Covered @ 100%	80% after deductible ¹
Hearing Aid	\$250 Allowance	\$250 Allowance
Preventive Care		
Adult		
Routine Physical Exam	100% after \$10 copayment/visit	Not covered
Pediatric		
Routine Physical Exam	100% after \$10 copayment/visit	Not covered
Pediatric Immunization	100%	80% (deductibles does not apply) ¹
Well-Baby Visits	100% after \$10 copayment/visit	Not covered
Physician Services		
Physician Office Visit (for illness or injury)	100% after \$10 copayment/visit	80% after deductible ¹
Women's Care		
Routine Gynecologic Exam, Pap Test, Mammogram (based on age guidelines), Maternity Care, Diagnostic Tests, and Surgical Services	100% \$10 Copayment applies to gynecologic exam only	80% after deductible ¹ Routine gynecologic exam, Pap test, and mammogram not subject to deductible.
Hospital Services		
Medical/Surgical Services	100% after:	
Inpatient Medical and Surgical Care,	Inpatient: \$25 copay	80% after deductible ¹
Outpatient Surgeon's Fees, Anesthesia	Outpatient: \$10 copay	80% after deductible ¹
Emergency Room Services		
If admitted, please call Preferred Healthcare Systems, Inc. within 24 hours or as soon as possible.	100% after \$25 copayment/visit (waived if admitted)	100% after \$25 copayment/visit (waived if admitted)
Diagnostic Services		
X-ray, Lab, and Other Tests	100%	80% after deductible ¹
Rehabilitation Therapy Services		
Physical, Speech, and Occupational	100% after \$10 copayment/visit	80% after deductible ¹

Limited to the greater of: 60 consecutive days of coverage OR 25 visits per condition, per Benefit Period, for all therapies combined, subject to ongoing substantial improvement.

Medical Therapy Services		
Chemotherapy, Radiation, Infusion Therapy, Dialysis	100%	80% after deductible ¹
Other Medical Services		
Skilled Nursing Facility	100%	80% after deductible ¹
	Limit of 100 days per Benefit Period	
Home Health Care	100%	80% after deductible ¹
Hospice Care	100%	80% after deductible ¹
Therapeutic Manipulation	100% after \$25 copayment for first visit then \$10 copayment/visit	80% after deductible ¹
	Limit of 25 visits per Benefit Period	
Podiatric Care	100% after \$25 copayment/visit	80% after deductible ¹
Allergy Testing and Serum	100%	80% after deductible ¹
Durable Medical Equipment and Corrective Appliances	100%	80% after deductible ¹
Behavioral Health		
Mental Health		
Inpatient ²	100%	80% after deductible ¹
	Limit 30 days per Benefit Period, Lifetime Maximum of 90 days (30 inpatient days may be exchanged on a 1:2 basis to secure up to a maximum of 60 transitional partial hospitalization days)	
Outpatient ²	100% after \$10 copayment/visit	50% after deductible ¹
	Limit 20 visits per Benefit Period	
Chemical Dependency Treatment	100%	50% after deductible ¹
Inpatient Detoxification	7 days/admission, Lifetime Maximum of 4 admissions	
Inpatient Rehabilitation	30 days per Benefit Period, Lifetime Maximum 90 days	
Outpatient Rehabilitation	60 visits per Benefit Period, Lifetime Maximum 120 visits	
Prescription Drug Coverage		
Retail Prescription Drug Prescriptions must be dispensed by a participating pharmacy.	\$10 copayment generic 10% of retail price with min \$20 copayment maximum \$100 preferred brand 10% of retail price with min \$40 copayment maximum \$100 non-preferred Mandatory Generic ³ 30-day maximum retail supply Annual Deductible \$50 Brand	
Mail Order Prescription Drug Use of an initial 30-day supply is required for all new prescriptions before a 90-day mail-order supply may be requested.	\$20 copayment generic \$40 copayment preferred brand \$80 copayment non-preferred brand 90-day maximum mail-order supply	
Other		

Notes

¹ If care is out-of-network, benefits are paid at a lower level after your annual deductible is met. If you go to an out-of-network provider, you also may have to pay the difference between the provider's charge and the payment (reasonable and customary amount).

² Pennsylvania Act 150 mandates 30 inpatient days per Benefit Period (no lifetime maximum) and 60 outpatient visits per Benefit Period for certain diagnoses based on Medical Necessity and Appropriateness.

³ If you choose to purchase a brand-name drug instead of the generic equivalent, you must pay the brand-name copayment as well as the retail price difference between the brand and generic drug.