



BENEFITS	PPO PLAN D-100	
	In-Panel	Out-of-Panel
Lifetime Maximum	Unlimited	Unlimited
Annual Deductible (person/ family)	\$1,000/\$2,000	\$2,000/\$4,000
Primary Physician Office Visit Copay (Family Practitioner, Internist, Pediatrics, Ob-Gyn)	\$25	80% of UCR after ded.
Specialist Office Visit Copay (Excluding Mental Illness, Substance Abuse, Surgery or Pregnancy)	\$40	
Coinsurance	100% after ded.	80% of UCR after ded.
Annual Out-of-Pocket	\$0/person	\$3,000/person
Coinsurance Limit	\$0/family	\$6,000/family
Copay for Hospital Inpatient Admission	\$0	\$100
Hospital Emergency Room Visit (Access Fee waived with Admission)	\$100 Access Fee 100% after ded.	\$100 Access Fee 100% after ded.
Substance Abuse	90 day inpatient 120 outpatient visits	90 day inpatient 120 outpatient visits
COVERED SERVICES		
Preventive Care: Routine adult physical exams* and Well Child Care	100%	Not Covered
Immunizations	100%	100%
Mammograms	100%	Not Covered
Inpatient Facility Care	100% after ded.	80% of UCR after ded. & \$100 Copay/admission
Outpatient or Ambulatory Surgery	100% after ded.	80% of UCR after ded.
Maternity	100% after ded.	80% of UCR after ded.
Skilled Nursing Facility	100% after ded.	80% of UCR after ded. and \$100 Copay/admission
Home Health Care	100% after ded.	80% of UCR after ded.
Hospice Care for Individuals expected to live less than 6 months	100% after ded.	80% of UCR after ded.
Rehabilitation Service (Occupational, physical and speech therapies)	100% after ded.	80% of UCR after ded.
Other Services (incl. diagnostic, x-ray & lab) Manipulative Therapy * Infertility (Initial office visit & blood work only)	100% after ded.	80% of UCR after ded.
Mental Health (calendar year)	80% after ded. 30 days - inpatient 30 visits – outpatient	60% UCR after ded. and \$100 Copay 30 days - inpatient 30 visits - outpatient
Substance Abuse (calendar year) (lifetime max 120 visits)	80% after ded. 30 days - inpatient 30 visits – outpatient	60% UCR after ded. and \$100 Copay 30 days - inpatient 30 visits - outpatient
Prescription Plan (Mandatory Generic Plan)	\$ 100 Deductible - Coinsurance –N/A Retail Co-Pay: \$20 generic - \$35 Preferred Brand - \$60 non-preferred Supply limit: - 30 day retail / 90 day mail (double copay)	

* Manipulative Therapy: 20 Visits per year for subluxations demonstrable by x-ray. This is a summary of principal provisions of the Agreement between your group and ICHP as regulated by PA Insurance laws. The Member Certificate of Insurance should be consulted to determine the governing provisions. Includes 1 vision exam every 2 years.

RATES STARTING AT:	
SINGLE	\$278.07
2-PARTY	\$656.76
FAMILY	\$704.86

Rates are illustrative only. Final rates are subject to medical

Underwritten by: **ICHP**
Inter-County
Hospitalization Plan, Inc.
Health Plan, Inc.
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