

## Description of Coverage (Face Sheet)

This is a summary of your benefits. See your Evidence of Coverage for more detailed information.



Group:  
 Effective Date:  
 Medical Package: **PPO Value Option 78**  
 Rx Package: **Rx Option 3**  
 Mental Health Package: **Mental Health Option 1**  
 Chiropractic Package: **Chiropractic Option 500**  
 Network: **PersonalCare Diamond PPO**  
 TMJ Package: **TMJ N/A**  
 ER Copayment Package: **ER Coinsurance**  
 Physician Copay Diff: **10 Phys Copay Diff**  
 Copay Inclusivity: **Standard Office Copay**  
 Benefit Year: **Contract Year**

BASICS		Maximums, Deductibles, and Limitations	
Annual Medical Deductible	In-Network	Out-of-Network	
Individual	\$500	\$1,000	
Family	\$1,000	\$2,000	
	Deductibles must be met before coverage begins. Once 2 family members meet their Contract Year deductible, family deductible is met. Routine immunizations, allergy testing and treatment, wellness care, and evaluation and management services provided in-network are not included on your deductible.		
Out-of-Pocket Maximum	In-Network	Out-of-Network	
Individual	\$2,500	\$3,500	
Family	\$5,000	\$7,000	
	Does not include annual medical deductible, non-serious mental health, substance abuse charges, evaluation and management copayments, prescription drugs, and maximum allowable charges.		
Lifetime Maximum	\$5,000,000		
Prior Authorization Requirements	Certain services require prior authorization. Call (800) 431-1211 to prior authorize. Failure to prior authorize will result in the assessment of an additional charge equal to 10 percent of the maximum allowable charge.		
Maximum Allowable Charge	Except for emergency services, charges by out-of-network providers in excess of maximum allowable charge will not be covered.		
Annual Pharmacy Deductible per Individual	None		
Annual Pharmacy Maximum	None		

IN THE HOSPITAL	Description	You Pay In-Network	You Pay Out-of-Network
Hospital Care	Hospital services are covered when prior authorized by PersonalCare. PersonalCare should be notified of emergency admissions within 48 hours.	\$0 per admission 20% after copayment	\$500 per admission 40% after copayment
Number of Days of Inpatient Care	Unlimited number of medical/surgical stays, subject to medical necessity.	See Hospital Care	See Hospital Care
Room and Board	Coverage is provided for semi-private room and board or specialty unit, when medically necessary.	See Hospital Care	See Hospital Care
Medications	Coverage is included under Hospital Care. Take-home drugs dispensed to you prior to your release are not covered. You may have benefits as outlined in a prescription drug rider, if applicable.	See Hospital Care	See Hospital Care
Other Miscellaneous Charges	Coverage is included under Hospital Care. Personal comfort or convenience items are not covered.	See Hospital Care	See Hospital Care
Physician Services			
Primary Care	Evaluation and Management Services (when your primary doctor visits you in the hospital).	\$20 per visit	40%
Specialist Other Than Listed in Medical Services	Evaluation and Management Services (when a specialist visits you in the hospital).	\$30 per visit	40%
Procedures, diagnostics, & therapeutics	Includes x-ray examinations, laboratory tests, therapeutics and pathology services are covered.	20%	40%

IN THE DOCTOR'S OFFICE	Description	You Pay In-Network	You Pay Out-of-Network
Primary Physician	Evaluation and Management Services	\$20 per visit	40%
Specialist Other Than Listed in Medical Services	Evaluation and Management Services	\$30 per visit	40%
Procedures, Diagnostics and Therapeutic Services	Includes x-ray examinations, laboratory tests, therapeutic injections, therapeutics and pathology services. Certain services require prior authorization. See Precertification section for more information.	20%	40%

Routine Physical Exams	Includes well-child care up to age 2 and an annual school physical or exam and services listed in our published preventive care guidelines.	See applicable primary or specialist coinsurance and/or copayment.	
Routine Immunizations	See Evidence of Coverage for further information.	\$0	40%
Allergy Treatment and Testing	See Evidence of Coverage for further information.	See office visit, hospital, and outpatient services sections for applicable coinsurance and/or copayment.	
Wellness Care	According to our published preventive care guidelines.	See office visit, hospital, and outpatient services sections for applicable coinsurance and/or copayment.	

MEDICAL SERVICES		Description	You Pay In-Network	You Pay Out-of-Network
Outpatient Surgery		Covered when prior authorized by PersonalCare	20%	40%
Outpatient Observation Stays		Observation services are covered up to 24 hours when prior authorized by PersonalCare.	20%	40%
Outpatient Procedures, Diagnostics, and Therapeutic Services		Certain services may require prior authorization. See Precertification section for more information.	20%	40%
Maternity Care				
Hospital Care		A minimum of 48 hours of inpatient care following a vaginal delivery and a minimum of 96 hours of inpatient care following a delivery by cesarean section. Stays beyond these timeframes require prior authorization.	\$0 per delivery 20% after copay	\$500 per delivery 40%
Physician Care		Routine prenatal, delivery, and post-natal care.	0%	40% after copay
		Care provided by other physicians and specialists may result in assessment of additional copayments/coinsurance.	See office visit, hospital, and outpatient services sections for applicable coinsurance and/or copayment.	
Infertility Services		Infertility means the inability to conceive after one year of unprotected sexual intercourse or the inability to sustain a successful pregnancy. Covered when prior authorized by PersonalCare.	See office visit, hospital, and outpatient services sections for applicable coinsurance and/or copayment.	
Serious Mental Health		<b>Covered per benefit year:</b>		
Outpatient		When prior authorized by PersonalCare.	60 Visits	\$30 per visit
Inpatient		When prior authorized by PersonalCare.	45 Days	\$0 per admission 20% after copay
				\$500 per admission 40% after copay
Non- Serious Mental Health		Inpatient and outpatient services have a combined annual benefit limit of \$10,000.		
Outpatient		When prior authorized by PersonalCare.	\$30 per visit	40%
Inpatient		When prior authorized by PersonalCare.	\$0 per admission 20% after copay	\$500 per admission 40% after copay
Substance Abuse		<b>Covered per benefit year:</b>		
Outpatient		When prior authorized by PersonalCare.	20 Visits	\$30 per visit
Inpatient		When prior authorized by PersonalCare. Note: inpatient alcoholism treatment will be covered the same as any other sickness under this policy.	10 Days	\$0 per admission 20% after copay
				\$500 per admission 40% after copay
Outpatient Speech Therapy for Pervasive Developmental Disorders		Coverage is provided for up to 20 additional outpatient speech therapy visits for the treatment of pervasive developmental disorders.	20% per visit	40%
Rehabilitation Services				
Outpatient		Coverage is provided for up to a maximum of \$3000 per benefit year for physical, occupational and speech therapy.	20% per visit	40%
Inpatient		Coverage limited to 30 days per benefit year when prior authorized by PersonalCare.	\$0 per admission 20% after copay	\$500 per admission 40% after copay
Anesthesiologist Services		Professional fees.	30%	50%
Radiologist and Radiology Services		Professional and technical fees. Some services may require prior authorization.	20%	40%
Pathologist/Laboratory Services		Professional and technical fees. Some services may require prior authorization.	20%	40%

EMERGENCY SERVICES		Description	You Pay
Emergency Room Services		Care provided at any licensed hospital emergency room is covered at the in-network benefit level when an emergency medical condition exists.	30%
Emergency Room Physician Services		Professional fees.	30%
Emergency Transportation by Ambulance		Covered when medically necessary for land or air transport.	30%
Emergency Post-Stabilization Services		Covered when medically necessary.	See Hospital Care for applicable coinsurance and/or copayment.

OTHER MEDICAL SERVICES		Description	You Pay In-Network	You Pay Out-of-Network
Durable Medical Equipment	Standard model equipment covered when medically necessary and when prior authorized by PersonalCare.		20%	40%
Prosthetic Devices	Standard model prostheses, prosthetic appliances, and implants covered when medically necessary and when prior authorized by PersonalCare.		20%	40%
Hospice	Covered when prior authorized by PersonalCare.		20%	40%
Home Health Care	Covered Service		20%	40%
Home Infusion Services	Covered Service		20%	40%
Prescribed Injectables	Covered when prior authorized by PersonalCare.		50%	50%
Vision Care	Not covered by PersonalCare. Coverage for vision screening and refractive services may be covered by your vision plan.		Not applicable	Not applicable
Dental Services	Not covered by PersonalCare.		Not applicable	Not applicable
TMJ Services	Not covered by PersonalCare.		Not applicable	Not applicable
Skilled Nursing Facilities	Short-term, non-custodial care in a skilled nursing facility is covered up to a maximum of 120 days per benefit year when medically necessary and when prior authorized by PersonalCare.		20%	40%
Chiropractic Services	Limited to \$500 per benefit year		20%	40%
Organ Transplants	Covered when medically necessary, when prior authorized by PersonalCare, performed at a Coventry Transplant Network participating facility approved by PersonalCare, and not experimental or investigational.		\$0 per admission 20% after copay	Not covered
Non-Emergent Transportation by Ambulance	Covered Service		20%	40%
Self Administered Injectables	Covered when prior authorized by PersonalCare. Maximum Coinsurance of \$150 per prescription.		Formulary: 25%	
			Non-Formulary: 50%	
Prescription Drugs	Covered when a prescription drug rider is purchased by your group. See rider for further benefit details and limitations.		Generic: \$15	
			Formulary: \$25	
			Non-Formulary: \$50	