



Par Pro Flex
Inpatient 1st Dollar



PPO Benefit	Participating Provider
Lifetime Maximum	\$2,000,000
Hospital	Inpatient
	100%
	Outpatient
	80% after deductible
Surgical	80% after deductible
Supplemental Accident	100% of 1st \$300 per accident
Primary Physician Office Visit (Family Practitioner, Internists, Pediatrics)	\$15 co-pay
Specialist Office Visit (Excluding Mental Illness, Substance Abuse, Surgery or Pregnancy)	\$25 co-pay
Prescription Drug Card Includes Oral Contraceptives	Standard Option: <input type="checkbox"/> \$10 generic/\$20 brand (Available with ALL Plans) Formulary Options: <input type="checkbox"/> \$15 generic/\$25 brand/\$50 non-preferred <input type="checkbox"/> \$100 deductible, then <input type="checkbox"/> \$15 generic/\$25 brand/\$50 non-preferred *(Available ONLY with the \$100 & \$250 Deductible Plans with a \$5,000 Coinsurance Level)
Immunizations, Pap Smear, Mammography, OB/GYN exam	Pennsylvania State Mandated Benefits
Well Baby Care, Routine Physical Exam, Diagnostic Services	\$100 annual individual maximum
Mental Illness (\$25,000 Lifetime Maximum)	Inpatient
	** 80% UCR for the 1st 30 days in a calendar year
	Outpatient
	50% (30 treatments maximum per calendar year)
Substance Abuse (First and Subsequent Course of Treatment)	Inpatient
	Treated as any other illness 80% for first 30 days in calendar year; 50% thereafter
	Outpatient
	50%

Note 1: After coinsurance level has been met, plan pays 100% of eligible expenses until lifetime maximum has been reached.
Note 2: Subscribers are responsible to pay non-participating providers for charges, which exceed Inter-County's UCR allowance.
Note 3: Participating Providers accept ICHP's contractual allowance as payment in full for covered services (with no balance billing). Subscribers are responsible to pay any applicable deductible and coinsurance amounts. Inter-County bases its contractual payment on Usual, Customary and Reasonable fees (UCR). Even if your Participating Provider charges more than the UCR for a covered service, you cannot be billed for the excess.
Note 4: All co-pays or prescription annual deductible do not apply to major medical deductible or out-of-pocket maximum.

PLAN OPTIONS	Deductibles (2 per family)	Coinsurance Percentages	Coinsurance Levels (2 per family)	Coinsurance Total Amounts	Out-of-Pocket Maximums
	\$100	80/20%	\$2,000	\$400	\$500
	*\$100	80/20%	\$5,000	\$1,000	\$1,100
	\$250	80/20%	\$2,500	\$500	\$750
	*\$250	80/20%	\$5,000	\$1,000	\$1,250
	\$300	80/20%	\$3,500	\$700	\$1,000
	\$500	80/20%	\$5,000	\$1,000	\$1,500

Note: This plan summary provides plan highlights only. Specific plan provisions are governed by the Master Group Contract between Inter-County and Insurance Services Industry Trust (ISIT).