



**Copay 100% \$0**

Preferred Provider Organization  
 Underwritten by Coventry Health and Life Insurance Company  
 (d.b.a. HealthAmerica)

<b>DEDUCTIBLES AND MAXIMUMS</b>	<b>Participating MEMBER RESPONSIBILITY</b>	<b>Non-Participating MEMBER RESPONSIBILITY</b>
<b>Annual Deductible</b>		
Individual	None	\$5,000
Family (aggregate)	None	\$10,000
<b>Out-of-Pocket Maximum</b> (includes coinsurance and copays, except for prescription drug copays)		
Individual	Unlimited	\$5,000
Family (aggregate)	Unlimited	\$10,000
<b>OUTPATIENT SERVICES</b>	<b>Participating MEMBER RESPONSIBILITY</b>	<b>Non-Participating MEMBER RESPONSIBILITY</b>
<b>Physician Services (for illness or injury)</b>		
Primary Care Visit (PCP)	\$20 Copay	50% Eligible Charges (after annual deductible)
Specialist Visit (SCP)	\$40 Copay	50% Eligible Charges (after annual deductible)
<b>Preventive Services</b>		
Gynecological Exam (PCP/SCP)	\$20/\$40 Copay	50% Eligible Charges (after annual deductible)
Well Child Visit (up to age 9, no deductible)	\$20 Copay	50% Eligible Charges
Adult Physical Visit	\$20 Copay	50% Eligible Charges (after annual deductible)
Routine Pediatric Immunizations	0%	50% Eligible Charges
Hearing Exams (under age 10)	0%	50% Eligible Charges (after annual deductible)
Routine Mammograms ( <i>Reimbursement limited to 130% of Medicare</i> )	\$30 Copay	<b>\$30 Copay</b>
<b>Allergy Testing &amp; Injections (Serum is NOT covered)</b>	0%	50% Eligible Charges (after annual deductible)
<b>Chiropractic Care</b> (x-rays are subject to deductible) <i>10 visit maximum per contract year</i>	\$40 Copay	50% Eligible Charges (after annual deductible)
<b>Outpatient Surgery</b>	\$200 Copay	50% Eligible Charges (after annual deductible)
<b>Lab Services</b>	0%	50% Eligible Charges (after annual deductible)
<b>Diagnostic X-ray</b>	\$40	50% Eligible Charges (after annual deductible)
<b>Radiology</b> (CAT, MRI, Ultrasound)	\$200	50% Eligible Charges (after annual deductible)
<b>HOSPITAL SERVICES</b>	<b>Participating MEMBER RESPONSIBILITY</b>	<b>Non-Participating MEMBER RESPONSIBILITY</b>
<b>Hospital Care</b>		
Semi-private room (private room if medically necessary)	\$200/day; 5 day maximum	
Physician and Surgeon Fees	0%	50% Eligible Charges (after annual deductible)
Surgery	0%	50% Eligible Charges (after annual deductible)
Lab and X-ray services	0%	50% Eligible Charges (after annual deductible)
All Medically Necessary Ancillary Services	0%	50% Eligible Charges (after annual deductible)
Anesthesia	0%	50% Eligible Charges (after annual deductible)
Administration of Blood	0%	50% Eligible Charges (after annual deductible)
Blood Products	0%	50% Eligible Charges (after annual deductible)
Therapy Services (Chemotherapy & Radiation Therapy)	0%	50% Eligible Charges (after annual deductible)
<b>MATERNITY SERVICES</b>	<b>Participating MEMBER RESPONSIBILITY</b>	<b>Non-Participating MEMBER RESPONSIBILITY</b>
Pregnancy Care & Delivery	Not Covered (except for complications)	
<b>FAMILY PLANNING</b>	<b>Participating MEMBER RESPONSIBILITY</b>	<b>Non-Participating MEMBER RESPONSIBILITY</b>
<b>Infertility Counseling/Testing/Services</b>	Not Covered	
<b>Tubal Ligation/Vasectomy</b>	Not Covered	
<b>PRESCRIPTION DRUGS</b>	<b>Participating MEMBER RESPONSIBILITY</b>	<b>Non-Participating MEMBER RESPONSIBILITY</b>
(Includes oral contraceptives & managed formulary. Mandatory generic substitution may apply.)	\$100 single/\$300 family deductible (deductible applies to Tier 2 and Tier 3 only) \$15 Tier 1 Copay (Generic)/\$25 Tier 2 Copay (Brand Name)/\$50 Tier 3 Copay (Non-Formulary)	
<b>EMERGENCY CARE</b>	<b>Participating MEMBER RESPONSIBILITY</b>	<b>Non-Participating MEMBER RESPONSIBILITY</b>
Emergency Room Services	\$200 Copay (waived if admitted and then inpatient copay applies)	
<b>REHABILITATION SERVICES</b>	<b>Participating MEMBER RESPONSIBILITY</b>	<b>Non-Participating MEMBER RESPONSIBILITY</b>
<b>Occupational, Speech, Physical Therapy</b>	0%	50% Eligible Charges (after annual deductible)
	\$200/day; 5 day maximum	
	45 inpatient days per contract year	
	24 outpatient visits per contract year	

MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES		Participating MEMBER RESPONSIBILITY	Non-Participating MEMBER RESPONSIBILITY
<b>General Mental Illness and Substance Abuse:</b>			
Inpatient		Not Covered	
Physician Services (Outpatient)		0% 10 visits per contract year	
<b>Biologically Based Mental Illness:</b>			
Inpatient		0% \$200/day; 5 day maximum	50% Eligible Charges (after annual deductible)
Physician Services (Outpatient)		\$40 Copay	50% Eligible Charges (after annual deductible)
<b>Alcoholism (other chemical dependency is not covered)</b>			
Inpatient		Up to \$550 in Eligible Charges per contract year	
Outpatient		\$200/day; 5 day maximum	
Transitional Care		0%	
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.		50%	50% Eligible Charges (after annual deductible)
<b>Corrective Appliances</b>		50%	50% Eligible Charges (after annual deductible)
<b>Home Health Care Services</b>		0%	50% Eligible Charges (after annual deductible)
<b>Hospice Care</b>		0%	50% Eligible Charges (after annual deductible)
<b>Skilled Nursing Facility</b>		0%	50% Eligible Charges (after annual deductible)
<b>Dental Services</b>			
Emergency treatment of dental injury		0%	50% Eligible Charges (after annual deductible)
Removal of Third Molars		0%	50% Eligible Charges (after annual deductible)
<b>Vision Services</b>	<b>Vision One Eyecare Program®:</b> Receive immediate savings on all eye care 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
<b>Penalty (By Patient)</b>		None	\$0
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, the member may be responsible for an additional financial penalty stated above or, if the service is not medically necessary, 100% of the cost of the services.			
<b>LIFETIME MAXIMUM</b>		\$5,000,000	
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 866.874.2624 in Central/Eastern Pennsylvania, and 866.874.2624 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 up to 25.</i>			
<i>**Reimbursement for Weight Management programs is limited to \$150 per calendar year per member.</i>			



## Dental

**Choice. Simplicity. Affordability.**



Visit any licensed dentist in or out of the national network. Coverage is focused on prevention with little or no cost for oral evaluation and basic diagnostics.

	In Network	Out of Network**	Benefit Guidelines
<b>Preventive &amp; Diagnostic</b>			
Periodic Oral Evaluation (120)	100%	100%**	One per year
Comprehensive Oral Evaluation (150)	100%	100%**	One evaluation w/ new dentist
Bitewing X-rays (272)	100%	100%**	Once per 12 months; one set
Cleaning (Prophylaxis)—Adult (1110)	100%	100%**	One per year
Cleaning (Prophylaxis)—Child (1120)	100%	100%**	One per year
<b>Plan Description</b>			
Deductible	\$0	\$0	
Annual Maximum	\$250	\$250	
Reimbursement	MAC*	MAC*	
Waiting Periods	No	No	

Find a network provider at [www.cvtydental.com](http://www.cvtydental.com)

**Questions? Call Customer Service at 1-866-690-4910**

**Notes:** Procedures not listed are excluded from coverage under your insurance benefit; however, network providers may offer you a discounted price on noncovered services.

\*Maximum allowable charge for network providers accepting our fees.

\*\*Non-network providers are reimbursed at the maximum allowable charge and may charge members the difference between the billed amount and the reimbursed amount.

The in- and out-of-network maximums are combined.

This brochure is not a contract. It is intended solely to provide you with a general overview of our health insurance products. Complete details of benefits, terms, and exclusions that apply to your health care coverage are governed by the group contract between Coventry Health and Life Insurance Company and the HealthAmerica Ohio Insurance Trust and the Trust Participation Agreement between you and HealthAmerica. HealthAmericaOne is offered through the HealthAmerica Ohio Insurance Trust. HealthAmericaOne products are underwritten by Coventry Health and Life Insurance Company (d.b.a. HealthAmerica).