COPAY 90% $1000 $3K OOPM

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

DEDUCTIBLES AND MAXIMUMS	Participating MEMBER RESPONSIBILITY	Non-Participating MEMBER RESPONSIBILITY
Annual Deductible		
Individual	$1,000	$2,000
Family (aggregate)	$2,000	$4,000
Out-of-Pocket Maximum (includes coinsurance and copays, except for prescription drug copays)		
Individual	$3,000	$8,000
Family (aggregate)	$6,000	$16,000
OUTPATIENT SERVICES	**Participating MEMBER RESPONSIBILITY**	**Non-Participating MEMBER RESPONSIBILITY**
Physician Services (for illness or injury)	**(office visit NOT subject to annual deductible)**	
Primary Care Visit (PCP)	$20 Copay	50% Eligible Charges (after annual deductible)
Specialist Visit (SCP)	$40 Copay	50% Eligible Charges (after annual deductible)
Preventive Services	**(office visit NOT subject to annual deductible)**	
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	10%	50% Eligible Charges
Hearing Exams (under age 10)	10% (after annual deductible)	50% Eligible Charges (after annual deductible)
Routine Mammograms *(Reimbursement limited to 130% of Medicare)*	$30 Copay	***$30 Copay***
Allergy Testing & Injections (Serum is NOT covered)	10% (after annual deductible)	50% Eligible Charges (after annual deductible)
Chiropractic Care (x-rays are subject to deductible) *10 visit maximum per contract year*	$40 Copay (not subject to annual deductible)	50% Eligible Charges (after annual deductible)
Outpatient Surgery	10% (after annual deductible)	50% Eligible Charges (after annual deductible)
Lab Services	10% (after annual deductible)	50% Eligible Charges (after annual deductible)
Diagnostic X-ray	$40 (after annual deductible)	50% Eligible Charges (after annual deductible)
Radiology (CAT, MRI, Ultrasound)	$200 Copay plus 10% (after annual deductible)	50% Eligible Charges (after annual deductible)
HOSPITAL SERVICES	**Participating MEMBER RESPONSIBILITY**	**Non-Participating MEMBER RESPONSIBILITY**
Hospital Care		
Semi-private room (private room if medically necessary)	10% (after annual deductible)	50% Eligible Charges (after annual deductible)
Physician and Surgeon Fees	10% (after annual deductible)	50% Eligible Charges (after annual deductible)
Surgery	10% (after annual deductible)	50% Eligible Charges (after annual deductible)
Lab and X-ray services	10% (after annual deductible)	50% Eligible Charges (after annual deductible)
All Medically Necessary Ancillary Services	10% (after annual deductible)	50% Eligible Charges (after annual deductible)
Anesthesia	10% (after annual deductible)	50% Eligible Charges (after annual deductible)
Administration of Blood	10% (after annual deductible)	50% Eligible Charges (after annual deductible)
Blood Products	10% (after annual deductible)	50% Eligible Charges (after annual deductible)
Therapy Services (Chemotherapy & Radiation Therapy)	10% (after annual deductible)	50% Eligible Charges (after annual deductible)
MATERNITY SERVICES	**Participating MEMBER RESPONSIBILITY**	**Non-Participating MEMBER RESPONSIBILITY**
Pregnancy Care & Delivery	Not Covered (except for complications)	
FAMILY PLANNING	**Participating MEMBER RESPONSIBILITY**	**Non-Participating MEMBER RESPONSIBILITY**
Infertility Counseling/Testing/Services	Not Covered	
Tubal Ligation/Vasectomy	Not Covered	
PRESCRIPTION DRUGS	**Participating MEMBER RESPONSIBILITY**	**Non-Participating MEMBER RESPONSIBILITY**
(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)	
EMERGENCY CARE	**Participating MEMBER RESPONSIBILITY**	**Non-Participating MEMBER RESPONSIBILITY**
Emergency Room Services	$200 Copay plus 10% (after annual deductible)	
REHABILITATION SERVICES	**Participating MEMBER RESPONSIBILITY**	**Non-Participating MEMBER RESPONSIBILITY**
Occupational, Speech, Physical Therapy	10% (after annual deductible)	50% Eligible Charges (after annual deductible)
	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
General Mental Illness:		
Inpatient	Not Covered	
Physician Services (Outpatient)	*10 visits per contract year*	
Biologically Based Mental Illness:		
Inpatient	10% (after annual deductible)	50% Eligible Charges (after annual deductible)
Physician Services (Outpatient)	$40 Copay	50% Eligible Charges (after annual deductible)
Substance Abuse:		
Inpatient Detoxification	10% (after annual deductible)	50% Eligible Charges (after annual deductible)
	7 days per admission *4 admissions benefit maximum*	
Inpatient Rehabilitation	10% (after annual deductible)	50% Eligible Charges (after annual deductible)
	30 days per contract year *90 days benefit maximum*	
Outpatient Visits and Transitional Partial Hospitalization	10% (after annual deductible)	50% Eligible Charges (after annual deductible)
	60 visits per contract year *120 visits benefit maximum* *30 outpatient visits may be exchanged on a two-for-one basis for up to 15 additional non-hospital residential or inpatient treatment days*	

OTHER BENEFITS	Participating MEMBER RESPONSIBILITY	Non-Participating MEMBER RESPONSIBILITY
Claim Forms Required	**No**	**Yes**
Durable Medical Equipment (DME) – Limited to once every 2 years for irreparable damage and/or normal wear.	50% (after annual deductible)	50% Eligible Charges (after annual deductible)
	$2,000 lifetime maximum	
Corrective Appliances	50% (after annual deductible)	50% Eligible Charges (after annual deductible)
	$2,000 lifetime maximum	
Home Health Care Services	10% (after annual deductible)	50% Eligible Charges (after annual deductible)
	120 visits per contract year	
Hospice Care	10% (after annual deductible)	50% Eligible Charges (after annual deductible)
	$7,500 lifetime maximum	
Skilled Nursing Facility	10% (after annual deductible)	50% Eligible Charges (after annual deductible)
	50 days per contract year	
Dental Services		
Emergency treatment of dental injury	10% (after annual deductible)	50% Eligible Charges (after annual deductible)
Removal of Third Molars	10% (after annual deductible)	50% Eligible Charges (after annual deductible)
Vision Services	**Vision One Eyecare Program**®: 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.	
Health Education	Members receive reimbursement of the cost of approved wellness programs offered through local hospitals and organizations.**	
PRECERTIFICATION REQUIREMENT	By Physician	By Patient
Penalty (By Patient)	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.

LIFETIME MAXIMUM	$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. **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.**

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. **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.**

Dependent Coverage Age Limit is up to 25.

***Reimbursement for Weight Management programs is limited to $150 per calendar year per member.*

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
Preventive & Diagnostic			
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
Plan Description			
Deductible	$0	$0	
Annual Maximum	$250	$250	
Reimbursement	MAC*	MAC*	
Waiting Periods	No	No	

Find a network provider at *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. HealthAmerica*One* is offered through the HealthAmerica Ohio Insurance Trust. HealthAmerica*One* products are underwritten by Coventry Health and Life Insurance Company (d.b.a. HealthAmerica).

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