

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	\$1,200	\$2,400
Family (aggregate)	\$2,400	\$4,800
<b>Out-of-Pocket Maximum</b> (includes copays, deductibles and coinsurance)		
Individual	\$5,000	Unlimited
Family (aggregate)	\$10,000	Unlimited
<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% (after annual deductible)	50% Eligible Charges (after annual deductible)
Specialist Visit (SCP)	20% (after annual deductible)	50% Eligible Charges (after annual deductible)
<b>Preventive Services*</b>		
Gynecological Exam (PCP/SCP)	20%	50% Eligible Charges (after annual deductible)
Well Child Visit (UP TO AGE 9, NO DEDUCTIBLE)	20%	50% Eligible Charges
Adult Physical Visit	20%	50% Eligible Charges (after annual deductible)
Routine Pediatric Immunizations	20%	50% Eligible Charges
Hearing Exams (under age 10)	20% (after annual deductible)	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 included)</b>	20% (after annual deductible)	50% Eligible Charges (after annual deductible)
<b>Chiropractic Care</b>	Not Covered	Not Covered
<b>Outpatient Surgery</b>	20% (after annual deductible)	50% Eligible Charges (after annual deductible)
<b>Lab Services</b>	20% (after annual deductible)	50% Eligible Charges (after annual deductible)
<b>Diagnostic X-ray</b>	20% (after annual deductible)	50% Eligible Charges (after annual deductible)
<b>Radiology</b> (CAT, MRI, Ultrasound)	20% (after annual deductible)	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)	20% (after annual deductible)	50% Eligible Charges (after annual deductible)
Physician and Surgeon Fees	20% (after annual deductible)	50% Eligible Charges (after annual deductible)
Surgery	20% (after annual deductible)	50% Eligible Charges (after annual deductible)
Lab and X-ray services	20% (after annual deductible)	50% Eligible Charges (after annual deductible)
All Medically Necessary Ancillary Services	20% (after annual deductible)	50% Eligible Charges (after annual deductible)
Anesthesia	20% (after annual deductible)	50% Eligible Charges (after annual deductible)
Administration of Blood	20% (after annual deductible)	50% Eligible Charges (after annual deductible)
Blood Products	20% (after annual deductible)	50% Eligible Charges (after annual deductible)
Therapy Services (Chemotherapy & Radiation Therapy)	20% (after annual deductible)	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.)	\$10 Generic Copay/\$30 Brand Copay/\$50 Non-Formulary Copay (after annual deductible)	
<b>EMERGENCY CARE</b>	<b>Participating MEMBER RESPONSIBILITY</b>	<b>Non-Participating MEMBER RESPONSIBILITY</b>
Emergency Room Services	20% (after annual deductible)	
<b>REHABILITATION SERVICES</b>	<b>Participating MEMBER RESPONSIBILITY</b>	<b>Non-Participating MEMBER RESPONSIBILITY</b>
<b>Occupational, Speech, Physical Therapy</b>	20% (after annual deductible)	50% Eligible Charges (after annual deductible)
	<i>45 inpatient days per contract year 24 outpatient visits per contract year</i>	

MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES	Participating MEMBER RESPONSIBILITY	Non-Participating MEMBER RESPONSIBILITY
<b>General Mental Illness:</b>	Not Covered	
Inpatient	Not Covered	
Physician Services (Outpatient)	10 visits per contract year	
<b>Biologically Based Mental Illness:</b>		
Inpatient	20% (after annual deductible)	50% Eligible Charges (after annual deductible)
Physician Services (Outpatient)	20% (after annual deductible)	50% Eligible Charges (after annual deductible)
<b>Substance Abuse:</b>		
Inpatient Detoxification	20% (after annual deductible)	50% Eligible Charges (after annual deductible)
	7 days per admission 4 admissions benefit maximum	
Inpatient Rehabilitation	20% (after annual deductible)	50% Eligible Charges (after annual deductible)
	30 days per contract year 90 days benefit maximum	
Outpatient Visits and Transitional Partial Hospitalization	20% (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
<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% (after annual deductible)	50% Eligible Charges (after annual deductible)
	\$2,000 lifetime maximum	
<b>Corrective Appliances</b>	50% (after annual deductible)	50% Eligible Charges (after annual deductible)
	\$2,000 lifetime maximum	
<b>Home Health Care Services</b>	20% (after annual deductible)	50% Eligible Charges (after annual deductible)
	120 visits per contract year	
<b>Hospice Care</b>	20% (after annual deductible)	50% Eligible Charges (after annual deductible)
	\$7,500 lifetime maximum	
<b>Skilled Nursing Facility</b>	20% (after annual deductible)	50% Eligible Charges (after annual deductible)
	50 days per contract year	
<b>Dental Services</b>		
Emergency treatment of dental injury	20% (after annual deductible)	50% Eligible Charges (after annual deductible)
Removal of Third Molars	20% (after annual deductible)	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>	Participating: \$4,000,000/Non-Participating: \$500,000	
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> Dependent Coverage Age Limit is up to 25. *If your Schedule of Benefits indicates that you have a Qualified High Deductible Health Plan, you must consult your group benefit documents for a specific description and the terms and conditions of your coverage for these benefits. Also, some covered services that you receive during a preventive service office visit may not qualify as preventive services under the group contract and, consequently, will be subject to applicable deductibles. In order to be exempt from applicable deductibles, preventive services must qualify as preventive services under the group contract and Section 223 of the Internal Revenue Code. **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
<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).