HealthAmericaOne.
A Coventry Health Care Plan

Choice1 PPO $1250

Preferred Provider Organization
Underwritten by Health Assurance Pennsylvania, Inc.

DEDUCTIBLES AND MAXIMUMS	Participating MEMBER RESPONSIBILITY	Non-Participating MEMBER RESPONSIBILITY
Annual Deductible		
Individual	$1,250	$2,500
Family	$2,500	$5,000
Out-of-Pocket Maximum (includes deductible and coinsurance)		
Individual	Unlimited	$10,000
Family	Unlimited	$20,000
OUTPATIENT SERVICES	**Participating MEMBER RESPONSIBILITY**	**Non-Participating MEMBER RESPONSIBILITY**
Physician Services (for illness or injury)		
Level One Visits (PCP, OBGYN, Dermatologists, Chiropractors)	$20 Copay	30% Eligible Charges (after annual deductible)
Level Two Visits (all other office visits)	$40 Copay (after annual deductible)	30% Eligible Charges (after annual deductible)
Preventive Services*		
Gynecological Exam (PCP/SCP)	$0 Copay	30% Eligible Charges (after annual deductible)
Well Child Visit (up to age 9, no deductible)	$0 Copay	30% Eligible Charges
Adult Physical Visit	$0 Copay	30% Eligible Charges (after annual deductible)
Preventive Pediatric Immunizations	0%	30% Eligible Charges
Hearing Exams (under age 18)	0%	30% Eligible Charges (after annual deductible)
Routine Mammograms	0%	$30 Copay
Routine Colonscopies	0%	30% Eligible Charges (after annual deductible)
Allergy Testing & Injection (Serum not covered)	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
Chiropractic Care		
Maximum 20 visits per contract year	$20 Copay	30% Eligible Charges (after annual deductible)
Outpatient Surgery	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
Lab Services	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
Diagnostic X-ray	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
Radiology (CAT, MRI, Ultrasound)	$200 (after annual deductible)	30% Eligible Charges (after annual deductible)
HOSPITAL SERVICES	**Participating MEMBER RESPONSIBILITY**	**Non-Participating MEMBER RESPONSIBILITY**
Hospital Care		
Semi-private room (private room if medically necessary)	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
Physician and Surgeon Fees	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
Surgery	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
Lab and X-ray services	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
All Medically Necessary Ancillary Services	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
Anesthesia	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
Administration of Blood	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
Blood Products	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
Therapy Services (Chemotherapy & Radiation Therapy)	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
MATERNITY SERVICES	**Participating MEMBER RESPONSIBILITY**	**Non-Participating MEMBER RESPONSIBILITY**
Pregnancy Care & Delivery	9 month waiting period for **all** covered maternity svcs	
Inpatient Care Copayment (hospital services)	$2500 Copay (per admission) not subject to deductible	30% Eligible Charges (after annual deductible)
Prenatal Visits	$20 Copay (first visit only) not subject to deductible	30% Eligible Charges (after annual deductible)
Other maternity services (includes diagnostic tests, delivery and other physician services)	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
FAMILY PLANNING	**Participating MEMBER RESPONSIBILITY**	**Non-Participating MEMBER RESPONSIBILITY**
Infertility Counseling/Testing/Services **Tubal Ligation/Vasectomy**	Not Covered	
PRESCRIPTION DRUGS	**Participating MEMBER RESPONSIBILITY**	**Non-Participating MEMBER RESPONSIBILITY**
(Includes oral contraceptives & managed formulary. Mandatory generic substitution may apply)	$15 Tier 1 $35 Tier 2 (after annual deductible) $60 Tier 3 (after annual deductible) ***refer to Rx Select Formulary**	
EMERGENCY CARE	**Participating MEMBER RESPONSIBILITY**	**Non-Participating MEMBER RESPONSIBILITY**
Urgent Care Center	$40 Copay (after annual deductible)	
Emergency Room Services	$200 Copay (after annual deductible) ER Copay waived if admitted	
REHABILITATION SERVICES	**Participating MEMBER RESPONSIBILITY**	**Non-Participating MEMBER RESPONSIBILITY**
Occupational, Speech, Physical Therapy	0% (after annual deductible)	30% 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 Health: Inpatient	Not Covered	
Physician Services (Outpatient)	$40 Copay (after annual deductible)	30% Eligible Charges (after annual deductible)
	10 visits per contract year	
Biologically Based Mental Illness: Inpatient	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
Physician Services (Outpatient)	$40 Copay (after annual deductible)	30% Eligible Charges (after annual deductible)
Substance Abuse: Inpatient Detoxification	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
	7 days maximum per admission *4 admission benefit maximum*	
Inpatient Rehabilitation	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
	30 days maximum per contract year *90 days benefit maximum*	
Transitional Partial Hospitalization	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
	60 visits per contract year *120 visits per 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.	30% (after annual deductible)	30% Eligible Charges (after annual deductible)
Corrective Appliances	30% (after annual deductible)	30% Eligible Charges (after annual deductible)
Home Health Care Services	0% (after annual deductible) *120 visits combined per contract year*	30% Eligible Charges (after annual deductible)
Hospice Care	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
Skilled Nursing Facility	0% (after annual deductible) *50 days combined maximum per contract year*	30% Eligible Charges (after annual deductible)
Dental Services		
Emergency treatment of dental injury	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
Removal of Third Molars	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
Vision Services	**Vision One Eyecare Program®**: Receive immediate savings on all eyecare 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

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, and the service is not medically necessary, the member may be responsible for 100% of the cost of the services.

LIFETIME MAXIMUM Unlimited

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.**

*** Reimbursement for Weight Management programs is limited to $350 per calendar year per member.*

Dependent Coverage Age Limit is up to 26