HealthAmericaOne.
A Coventry Health Care Plan

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

Copay 100% $0 $20$40

DEDUCTIBLES AND MAXIMUMS	Participating MEMBER RESPONSIBILITY	Non-Participating MEMBER RESPONSIBILITY
Annual Deductible		
Individual	None	$5,000
Family (aggregate)	None	$10,000
Out-of-Pocket Maximum (includes deductible and coinsurance)		
Individual	Unlimited	$5,000
Family (aggregate)	Unlimited	$10,000
OUTPATIENT SERVICES	**Participating MEMBER RESPONSIBILITY**	**Non-Participating MEMBER RESPONSIBILITY**
Physician Services (for illness or injury)		
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		
Gynecological Exam (PCP/SCP)	$0 Copay	50% Eligible Charges (after annual deductible)
Well Child Visit (up to age 9, no deductible)	$0 Copay	50% Eligible Charges
Adult Physical Visit	$0 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 *(Reimbursement limited to 130% of Medicare)*	$0 Copay	***$30 Copay***
Allergy Testing & Injections (Serum is NOT covered)	0%	50% Eligible Charges (after annual deductible)
Chiropractic Care (x-rays are subject to deductible) *10 visit maximum per contract year*	$40 Copay	50% Eligible Charges (after annual deductible)
Outpatient Surgery	$350 Copay	50% Eligible Charges (after annual deductible)
Lab Services	0%	50% Eligible Charges (after annual deductible)
Diagnostic X-ray	$40	50% Eligible Charges (after annual deductible)
Radiology (CAT, MRI, Ultrasound)	$200 Copay	50% Eligible Charges (after annual deductible)
HOSPITAL SERVICES	**Participating MEMBER RESPONSIBILITY**	**Non-Participating MEMBER RESPONSIBILITY**
Hospital Care	$350/day; 5 day maximum (per admission)	
Semi-private room (private room if medically necessary)	0%	50% Eligible Charges (after annual deductible)
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)
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	50% Eligible Charges (after annual deductible)
Prenatal Visits	$40 Copay (first visit only) not subject to deductible	50% Eligible Charges (after annual deductible)
Other maternity services (includes diagnostic tests, delivery and other physician services)	0% (after annual deductible)	50% Eligible Charges (after annual deductible)
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)/$35 Tier 2 Copay (Brand Name)/$60 Tier 3 Copay (Non-Formulary)	
EMERGENCY CARE	**Participating MEMBER RESPONSIBILITY**	**Non-Participating MEMBER RESPONSIBILITY**
Emergency Room Services	$200 Copay (waived if admitted and then inpatient copay applies)	
REHABILITATION SERVICES	**Participating MEMBER RESPONSIBILITY**	**Non-Participating MEMBER RESPONSIBILITY**
Occupational, Speech, Physical Therapy	0% $350/day; 5 day maximum	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)	*$40 copay (10 visits per contract year)*	
Biologically Based Mental Illness:		
Inpatient	0% $350/day; 5 day maximum	50% Eligible Charges (after annual deductible)
Physician Services (Outpatient)	$40 Copay	50% Eligible Charges (after annual deductible)
Substance Abuse: Inpatient Detoxification	0%	50% Eligible Charges (after annual deductible)
	7 days per admission *4 admissions benefit maximum*	
Inpatient Rehabilitation	0%	50% Eligible Charges (after annual deductible)
	30 days per contract year *90 days benefit maximum*	
Outpatient Visits and Transitional Partial Hospitalization	0%	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%	50% Eligible Charges (after annual deductible)
Corrective Appliances	50%	50% Eligible Charges (after annual deductible)
Home Health Care Services	0%	50% Eligible Charges (after annual deductible)
	120 visits per contract year	
Hospice Care	0%	50% Eligible Charges (after annual deductible)
Skilled Nursing Facility	0% $350/day; 5 day maximum	50% Eligible Charges (after annual deductible)
	50 days per contract year	
Dental Services		
Emergency treatment of dental injury	0%	50% Eligible Charges (after annual deductible)
Removal of Third Molars	0%	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.**

	By Physician	By Patient
PRECERTIFICATION REQUIREMENT		
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 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.**

Dependent Coverage Age Limit is up to 26

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

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Dental

Choice. Simplicity. Affordability.

The following basic, preventive, & diagnostic services are covered at any licensed dentist.

	In Network	Out of Network**	Benefit Guidelines
Preventive & Diagnostic (covered procedure code)			
Periodic Oral Evaluation (0120)	100%	100%**	One per year
Comprehensive Oral Evaluation (0150)	100%	100%**	One evaluation w/ new dentist
Bitewing X-rays (0272)	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
Basic Services			
Amalgam Filling (2140, 2150, 2160)	100%	100%**	One per year
Resin-based Filling (2330,2331, 2332)	100%	100%**	One per year
Plan Description			
Deductible	$0	$0	
Annual Maximum	$300	$300	
Reimbursement	MAC*	MAC*	
Waiting Periods	No	No	

Find a network provider at *www.cvtydental.com*

Questions? Call Customer Service at 1-866-690-4910
or visit us on the web at *www.HealthAmericaOne.com*

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.