



Copay 80% \$500

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	\$500	\$1,000
Family (aggregate)	\$1,000	\$2,000
Out-of-Pocket Maximum (includes deductible, coinsurance and copays, except for prescription drug copays)		
Individual	\$2,500	Unlimited
Family (aggregate)	\$5,000	Unlimited
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	50% Eligible Charges (after annual deductible)
Specialist Visit (SCP)	\$40	50% Eligible Charges (after annual deductible)
Preventive Services	(office visit NOT subject to annual deductible)	
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 (<i>Reimbursement limited to 130% of Medicare</i>)	\$0 Copay	\$30 Copay
Allergy Testing & Injections (Serum is NOT covered)	20% (after annual deductible)	50% Eligible Charges (after annual deductible)
Chiropractic Care	Not Covered	Not Covered
Outpatient Surgery	20% (after annual deductible)	50% Eligible Charges (after annual deductible)
Lab Services	20% (after annual deductible)	50% Eligible Charges (after annual deductible)
Diagnostic X-ray	20% (after annual deductible)	50% Eligible Charges (after annual deductible)
Radiology (CAT, MRI, Ultrasound)	\$200 copay plus 20% (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)	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)
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 20% (after annual deductible)	
REHABILITATION SERVICES	Participating MEMBER RESPONSIBILITY	Non-Participating MEMBER RESPONSIBILITY
Occupational, Speech, Physical Therapy	20% (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)	\$40 copay (10 visits per contract year)	
Biologically Based Mental Illness:		
Inpatient	20% (after annual deductible)	50% Eligible Charges (after annual deductible)
Physician Services (Outpatient)	\$40 copay	50% Eligible Charges (after annual deductible)
Substance Abuse:		
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
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)
Corrective Appliances	50% (after annual deductible)	50% Eligible Charges (after annual deductible)
Home Health Care Services	20% (after annual deductible)	50% Eligible Charges (after annual deductible)
	120 visits per contract year	
Hospice Care	20% (after annual deductible)	50% Eligible Charges (after annual deductible)
Skilled Nursing Facility	20% (after annual deductible)	50% Eligible Charges (after annual deductible)
	50 days per contract year	
Dental Services		
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)
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
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.		