HEALTHAMERICA
A Coventry Health Care Plan

Preferred Provider Organization
Underwritten by HealthAssurance Pennsylvania, Inc.
(d.b.a. HealthAmerica)

Value PPO $500

DEDUCTIBLES AND MAXIMUMS	Participating MEMBER RESPONSIBILITY	Non-Participating MEMBER RESPONSIBILITY
Annual Deductible (Inpatient and Infertility deductibles apply separately from annual deductible)		
Individual	$500	$1,000
Family (aggregate)	$1,000	$2,000
Out-of-Pocket Maximum (excludes deductibles and copays)		
Individual	$2,500	$3,000
Family (aggregate)	$5,000	$6,000
OUTPATIENT SERVICES	**Participating MEMBER RESPONSIBILITY**	**Non-Participating MEMBER RESPONSIBILITY**
Physician Services (for illness or injury)	**(office visit NOT subject to deductible)**	
Primary Care Visit (PCP)	$20 Copay	40% Eligible Charges (after annual deductible)
Specialist Visit (SCP)	$40 Copay	40% Eligible Charges (after annual deductible)
Preventive Services*	**(office visit NOT subject to deductible)**	
Gynecological Exam (PCP/SCP)	$0 Copay	40% Eligible Charges (after annual deductible)
Well Child Visit	$0 Copay	40% Eligible Charges (after annual deductible)
Adult Physical Visit	$0 Copay	40% Eligible Charges (after annual deductible)
Routine Pediatric Immunizations	0%	40% Eligible Charges
Hearing Exams (under age 18)	0%	40% Eligible Charges (after annual deductible)
Routine Mammograms	0%	40% Eligible Charges (after annual deductible)
Routine Colonoscopies***	0%	40% Eligible Charges (after annual deductible)
Allergy Testing & Allergy Serum	20% (after annual deductible)	40% Eligible Charges (after annual deductible)
Chiropractic Care (x-rays are subject to deductible) Maximum 20 visits per contract year	$40 Copay (not subject to annual deductible)	40% Eligible Charges (after annual deductible)
Outpatient Surgery	20% (after annual deductible)	40% Eligible Charges (after annual deductible)
Lab Services	20% (after annual deductible)	40% Eligible Charges (after annual deductible)
Diagnostic X-ray	20% (after annual deductible)	40% Eligible Charges (after annual deductible)
Radiology (CAT, MRI, Ultrasound, PET)	20% (after annual deductible)	40% 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)	40% Eligible Charges (after annual deductible)
Physician and Surgeon Fees	20% (after annual deductible)	40% Eligible Charges (after annual deductible)
Surgery	20% (after annual deductible)	40% Eligible Charges (after annual deductible)
Lab and X-ray services	20% (after annual deductible)	40% Eligible Charges (after annual deductible)
All Medically Necessary Ancillary Services	20% (after annual deductible)	40% Eligible Charges (after annual deductible)
Anesthesia	20% (after annual deductible)	40% Eligible Charges (after annual deductible)
Administration of Blood	20% (after annual deductible)	40% Eligible Charges (after annual deductible)
Blood Products	20% (after annual deductible)	40% Eligible Charges (after annual deductible)
Therapy Services (Chemotherapy & Radiation Therapy)	20% (after annual deductible)	40% Eligible Charges (after annual deductible)
MATERNITY SERVICES	**Participating MEMBER RESPONSIBILITY**	**Non-Participating MEMBER RESPONSIBILITY**
Pregnancy Care (PCP/SCP) (copay for the first office visit only)	$20/$40 Copay (not subject to annual deductible)	40% Eligible Charges (after annual deductible)
Delivery	20% (after annual deductible)	40% Eligible Charges (after annual deductible)
FAMILY PLANNING	**Participating MEMBER RESPONSIBILITY**	**Non-Participating MEMBER RESPONSIBILITY**
Infertility Counseling/Testing/Services	$300 One Time Deductible Then Coinsurance Applies	
Tubal Ligation/Vasectomy	20% (after annual deductible)	40% Eligible Charges (after annual deductible)
	$2,400 combined benefit maximum	
PRESCRIPTION DRUGS	**Participating MEMBER RESPONSIBILITY**	**Non-Participating MEMBER RESPONSIBILITY**
(Includes oral contraceptives & managed formulary. Mandatory generic substitution may apply)	**Refer to the RX Select formulary to identify which drugs do not require authorization. Quantity limits still apply.** **VARIOUS RIDERS AVAILABLE** **COVERED ONLY AT PARTICIPATING PHARMACIES**	
EMERGENCY CARE	**Participating MEMBER RESPONSIBILITY**	**Non-Participating MEMBER RESPONSIBILITY**
Urgent Care Center	$40 Copay	
Emergency Room Services (not subject to deductible)	0% after $125 Copay (ER Copay waived if admitted)	
REHABILITATION SERVICES	**Participating MEMBER RESPONSIBILITY**	**Non-Participating MEMBER RESPONSIBILITY**
Occupational, Speech, Physical Therapy	20% (after annual deductible)	40% Eligible Charges (after annual deductible)
	45 inpatient days per contract year *30 outpatient visits per contract year*	

MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES	Participating MEMBER RESPONSIBILITY	Non-Participating MEMBER RESPONSIBILITY
General Mental Health:	(Mental health services must be preauthorized)	
Inpatient	20% (after annual deductible)	40% Eligible Charges (after annual deductible)
	30 days per contract year *90 day lifetime benefit maximum*	
Physician Services (Outpatient)	$40 Copay per visit	40% Eligible Charges (after annual deductible)
	20 outpatient visits maximum per contract year	
Serious Mental Health: Inpatient	20% (after annual deductible)	40% Eligible Charges (after annual deductible)
	30 days per contract year *90 day lifetime benefit maximum*	
Physician Services (Outpatient)	$40 Copay per visit	40% Eligible Charges (after annual deductible)
	60 outpatient visits maximum per contract year	
Substance Abuse: Inpatient Detoxification	20% (after annual deductible)	40% Eligible Charges (after annual deductible)
	7 days maximum per admission *4 admission benefit maximum*	
Inpatient Rehabilitation	20% (after annual deductible)	40% Eligible Charges (after annual deductible)
	30 days maximum per contract year *90 days benefit maximum*	
Transitional Partial Hospitalization	20% (after annual deductible)	40% Eligible Charges (after annual deductible)
	60 visits per contract year *120 visits per benefit maximum*	

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.	20% (after annual deductible)	40% Eligible Charges (after annual deductible)
Corrective Appliances	20% (after annual deductible)	40% Eligible Charges (after annual deductible)
Home Health Care Services	20% (after annual deductible) *120 visits per contract year*	40% Eligible Charges (after annual deductible) *60 visits per contract year*
	120 visits combined per contract year	
Hospice Care	20% (after annual deductible)	40% Eligible Charges (after annual deductible)
Skilled Nursing Facility	20% (after annual deductible) *100 inpatient days per contract year*	40% Eligible Charges (after annual deductible) *50 inpatient days per contract year*
	100 days combined maximum per contract year	
Dental Services		
Emergency treatment of dental injury	20% (after annual deductible)	40% Eligible Charges (after annual deductible)
Removal of Third Molars	20% (after annual deductible)	40% 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	

Autism Spectrum Disorders are covered pursuant to state mandates for groups with 51 or more employees.
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 800.788.8445 in Central/Eastern Pennsylvania, and 800.735.4404 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 26
*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.
*** The physician must bill the claim with a preventive diagnosis code in order to apply under preventive benefits coverage.
This document neither affirmatively nor negatively amends, extends, or alters the terms of or the coverage afforded by policy referenced herein
***Reimbursement for Weight Management programs is limited to $350 per calendar year per member.*