



Schedule of Benefits

BENEFIT	PAYMENT	LIMITATION
Inpatient Hospital Facility Expenses	Deductible and Coinsurance	
Emergency Room Services or Urgent Care Center Services	Deductible and Coinsurance	
Skilled Nursing Facility	Deductible and Coinsurance	50 days per year
Outpatient Hospital Facility Expenses	Deductible and Coinsurance	
Office Visits – Medical both PCP, and Specialist	Deductible and Coinsurance	
Preventive Care – According to HSA Guidelines	NO Deductible, Coinsurance only	
Childhood Immunizations – up to age 21	NO Deductible, Coinsurance only	
Routine Gynecological Exam and Pap Test	NO Deductible, Coinsurance only	
Routine Mammogram	NO Deductible, Coinsurance only	
Chiropractic Care	Not a covered benefit	Not a covered benefit
Dental and Oral Surgical Services	Not a covered benefit	Not a covered benefit
Durable Medical Equipment Includes purchase, fitting, adjustment, repair, and replacement	Deductible and Coinsurance	\$7,000 Lifetime Maximum
Family Planning	Not a covered benefit	Not a covered benefit
Home Health Care	Deductible and Coinsurance	120 visits per year
Hospice	Deductible and Coinsurance	\$7,500 Lifetime Maximum
Infertility	Not a covered benefit	Not a covered benefit
Laboratory Services	Deductible and Coinsurance	
Maternity Services	Not a covered benefit except for complications	Not a covered benefit
Mental Health Services Inpatient Services Outpatient Services	Not a Covered Benefit Deductible and Coinsurance	Not a Covered Benefit 10 visits per year
Alcohol and Drug Abuse Services	Deductible and Coinsurance	According to PA Act 106
Rehabilitative Services (Physical, Speech, and Occupational Therapies)	Deductible and Coinsurance	Inpatient — 45 cumulative visits per year Outpatient — 24 cumulative visits per year

Benefits continued on back

PENNSYLVANIA

BENEFIT	PAYMENT	LIMITATION
Radiology Services	Deductible and Coinsurance	
RX Outpatient Benefit — Mandatory Generic Substitution		
Retail Purchase	\$10 Generic \$30 Brand Formulary \$50 Nonformulary	Rx Benefit is subject to deductible
Mail Order	\$20 Generic \$60 Brand Formulary \$100 Nonformulary	
Hearing Aids	Not a covered benefit	Not a covered benefit
Private Duty Nursing	Not a covered benefit	Not a covered benefit

NOTES



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 underwritten by Coventry Health and Life Insurance Company.

HealthAmerica and HealthAssurance pay nonparticipating providers an out-of-network rate. 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.**

When using a nonparticipating provider, the member must obtain or require the nonparticipating provider to obtain the 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 certificate of insurance or subscription agreement. If the nonparticipating provider fails to obtain precertification for these services or admissions, the member may be responsible for 100% of the cost of the services.