

		IN AREA PLANS									NONPARTICIPATING PROVIDERS		
Plan Type	CHOICE PLANS	Office Visit PCP/Specialist Copay	Deductible Single*	Coinsurance (after deductible)	Emergency Room Copay	Outpatient Surgery Copay	Outpatient Diagnostic X-ray Copay	Major Radiology Copay	Inpatient Copay Per Admission	Out-of-Pocket Maximum Single*	Deductible Single*	Coinsurance (after deductible)	Out-of-Pocket Maximum Single*
Choice	Choice PPO \$1,250	Level 1 \$20 Level 2 ded/\$40	\$1,250	0%	ded /\$125	ded /0%	ded /0%	ded /\$125	ded /0%	None	\$2,500	30%	\$10,000
	Choice PPO \$2,000	Level 1 \$20 Level 2 ded/\$40	\$2,000	0%	ded /\$125	ded /0%	ded /0%	ded /\$125	ded /0%	None	\$4,000	30%	\$10,000
	Choice PPO \$4,000	Level 1 \$20 Level 2 ded/\$40	\$4,000	0%	ded /\$125	ded /0%	ded /0%	ded /\$125	ded /0%	None	\$8,000	30%	\$10,000
For all Plan Rx benefits, all Tier 1 prescriptions are \$10 Copay. All Tier 2 & 3 prescriptions are \$35 & \$60 respectively after deductible. <sup>1</sup> Level 1 providers are: internists, family doctors, pediatricians, OB/GYNs, Dermatologist, Chiropractors. Level 2 providers: All Others. Family deductible is 3X single deductible.													
Plan Type	PLAN NAME	Office Visit PCP/Specialist Copay	Deductible Single*	Coinsurance (after deductible)	Emergency Room Copay	Outpatient Surgery Copay	Outpatient Diagnostic X-ray Copay	Outpatient Major Radiology Copay	Inpatient Copay Per Admission	Out-of-Pocket Maximum Single*	Deductible Single*	Coinsurance (after deductible)	Out-of-Pocket Maximum Single*
Saver	PPO Saver 100/90/70	Level 1 \$0 Level 2 10% after ded	\$1,000	0% <sup>1</sup> /10%	ded /10%	ded /10%	0% <sup>1</sup> /10%	ded /10%	ded /10%	\$2,000	\$2,000	30%	\$4,000
	PPO Saver 100/80/60	Level 1 \$0 Level 2 20% after ded	\$1,000	0% <sup>1</sup> /20%	ded /20%	ded /20%	0% <sup>1</sup> /20%	ded /20%	ded /20%	\$2,000	\$2,000	40%	\$4,000
<sup>1</sup> Level 1 providers are: internists, family doctors, pediatricians, OB/GYNs, Dermatologist, Chiropractors. Level 2 providers: All Others. Routine labs and x-rays for preventive services are paid at Level 1, exempt from deductible.													
Premier	Premier PPO \$5\$10	\$5/\$10	\$0	0%	\$150	\$0	\$0	\$125	None	None	\$500	20%	\$3,000
	Premier PPO \$10\$10	\$10/\$10	\$0	0%	\$150	\$0	\$0	\$125	None	None	\$500	30%	\$3,000
	Premier PPO \$15\$30	\$15/\$30	\$0	0%	\$150	\$0	\$0	\$125	None	None	\$750	30%	\$3,000
	Premier PPO \$20\$40	\$20/\$40	\$0	0%	\$150	\$0	\$0	\$125	\$500	None	\$500	30%	\$3,000
	Premier PPO \$250	\$15/\$30	\$250	0%	\$125	ded/100%	\$0	\$0	None	None	\$500	30%	\$3,000
	Premier PPO \$500	\$15/\$30	\$500	0%	\$125	ded/100%	\$0	\$0	None	None	\$1,000	30%	\$3,000
	Premier PPO \$750	\$15/\$30	\$750	0%	\$125	ded/100%	\$0	\$0	None	None	\$1,500	30%	\$3,000
	Premier PPO \$1,000	\$15/\$30	\$1,000	0%	\$125	ded/100%	\$0	\$0	None	None	\$2,000	30%	\$3,000
	Premier PPO \$1,250	\$15/\$30	\$1,250	0%	\$125	ded/100%	\$0	\$0	None	None	\$2,500	40%	\$5,000
	Premier PPO \$1,500	\$20/\$40	\$1,500	0%	\$125	ded/100%	\$0	\$0	None	None	\$3,000	40%	\$5,000
	Premier PPO \$2,000	\$20/\$40	\$2,000	0%	\$125	ded/100%	\$0	\$0	None	None	\$4,000	40%	\$5,000
	Premier PPO \$2,500 1x	\$20/\$40	\$2,500 1x	0%	\$125	ded/100%	\$0	\$0	None	None	\$5,000 1x	20%	\$10,000 1x
	Premier PPO \$3,000	\$20/\$40	\$3,000	0%	\$125	ded/100%	\$0	\$0	None	None	\$5,000	40%	\$7,000
Premier PPO \$5,000	\$20/\$40	\$5,000	0%	\$125	ded/100%	\$0	\$0	None	None	\$7,500	40%	\$9,000	
Built for tough times: Indicates popular cost-savings plans.													

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		Office Visit PCP/Specialist Copay	Deductible Single*	Coinsurance (after deductible)	Emergency Room Copay	Outpatient Surgery Copay	Outpatient Diagnostic X-ray Copay	Outpatient Major Radiology Copay	Inpatient Copay Per Admission	Out-of-Pocket Maximum Single*	Deductible Single*	Coinsurance (after deductible)	Out-of-Pocket Maximum Single*
Classic	Classic PPO \$15/\$30	\$15/\$30	\$0	10%	\$125/0%	10%	10%	\$125	10% (after ded)	\$500	\$750	30%	\$3,000
	Classic PPO \$250	\$15/\$30	\$250	10%	\$125/0%	10%	10%	10%	10% (after ded)	\$1,500	\$750	30%	\$3,000
	Classic PPO \$500	\$15/\$30	\$500	10%	\$125/0%	10%	10%	10%	10% (after ded)	\$1,500	\$1,000	30%	\$3,000
	Classic PPO \$1,000	\$15/\$30	\$1,000	10%	\$125/0%	10%	10%	10%	10% (after ded)	\$1,500	\$2,000	30%	\$3,000
Value	Value PPO \$20/\$40	\$20/\$40	\$0	20%	\$125/0%	20%	20%	\$125	20% (after ded)	\$2,500	\$750	40%	\$3,000
	Value PPO \$250	\$20/\$40	\$250	20%	\$125/0%	20%	20%	20%	20% (after ded)	\$2,500	\$750	40%	\$3,000
	Value PPO \$500	\$20/\$40	\$500	20%	\$125/0%	20%	20%	20%	20% (after ded)	\$2,500	\$1,000	40%	\$3,000
	Value PPO \$750	\$20/\$40	\$750	20%	\$125/0%	20%	20%	20%	20% (after ded)	\$2,500	\$1,500	40%	\$3,000
	Value PPO \$1,000	\$20/\$40	\$1,000	20%	\$125/0%	20%	20%	20%	20% (after ded)	\$2,500	\$2,000	40%	\$3,000
	Value PPO \$1,500	\$20/\$40	\$1,500	20%	\$125/0%	20%	20%	20%	20% (after ded)	\$2,500	\$3,000	40%	\$5,000
	Value PPO \$2,000	\$20/\$40	\$2,000	20%	\$125/0%	20%	20%	20%	20% (after ded)	\$2,500	\$4,000	40%	\$5,000
HSA- Compatible**	FlexChoice QHDHP PPO \$1,250	\$15/\$25	\$1,250	0%	\$125	\$0	\$0	\$0	\$0	\$3,000	\$2,500	20%	\$10,000
	FlexChoice QHDHP PPO \$1,250 II	0%	\$1,250	0%	\$125	\$0	\$0	\$0	\$0	\$3,000	\$2,500	20%	\$10,000
	FlexChoice QHDHP PPO \$2,500	0%	\$2,500	0%	\$125	\$0	\$0	\$0	\$0	\$4,000	\$5,000	30%	\$10,000
	FlexChoice QHDHP PPO \$2,500 1x	\$15/\$25	\$2,500 1x	0%	\$125	\$0	\$0	\$0	\$0	\$4,000 1x	\$5,000 1x	20%	\$10,000 1x
	FlexChoice Value PPO \$1,250	\$20/\$40	\$1,250	20%	20% (after ded)	20%	20%	20%	20%	\$5,000	\$2,500	40%	\$10,000
	FlexChoice Value PPO \$2,500	\$20/\$40	\$2,500	20%	20% (after ded)	20%	20%	20%	20%	\$5,000	\$5,000	40%	\$10,000
	FlexChoice Value PPO \$3,750	\$20/\$40	\$3,750	20%	20% (after ded)	20%	20%	20%	20%	\$5,000	\$7,500	40%	\$10,000

*\*Unless otherwise indicated, family deductible is two times the single deductible. Family OOP max is two times the single OOP max. Lifetime maximum on all plans is \$5,000,000.*

*\*\*Deductible at the participating provider level may not apply to qualified preventive services; see your schedule of benefits to determine if deductibles are waived for qualified preventive services.*

Provided for demonstration purposes only. Actual benefits, cost sharing provisions, limitations, and exclusions are set forth in the certificate of insurance issued to members. Noncovered Services: The following are some, but not all, of the services not covered: Services not medically necessary or authorized in advance for payment in accordance with HealthAmerica policies and procedures. Services available through government or school programs or covered by workers' compensation, personal comfort or convenience items, surgery or other treatments primarily cosmetic in nature, surgical procedures to reverse elective sterilization or for sex transformation, experimental procedures or treatments, hearing aids, dental services, nonskilled nursing care, and disposable medical supplies. The Restricted Provider Arrangement (RPA) excludes coverage for nonemergency services provided at certain facilities. Except for authorized radiation therapy and emergency services, all services, including facility and physician charges, are not covered at the following University of Pittsburgh Medical Center (UPMC) facilities or their affiliated clinics: UPMC Shadyside, Eye and Ear Hospital, UPMC Montefiore, UPMC Presbyterian. Benefits are administered on a contract-year basis.

Pennsylvania in-area PPO and CCPPO (POS) products are underwritten by HealthAssurance Pennsylvania, Inc. (d.b.a. HealthAmerica). All indemnity products, out-of-area PPO products, HealthAmericaOne products, and Ohio in-area PPO products are underwritten by Coventry Health and Life Insurance Company (d.b.a. HealthAmerica). HMO products are underwritten by HealthAmerica Pennsylvania, Inc. Self-funded PPO, POS and indemnity plans are administered by Coventry Healthcare Management Corporation (d.b.a. HealthAmerica). Self-funded HMO plans are administered by HealthAmerica Pennsylvania, Inc.

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 1-866-522-3886.

This brochure is not a contract. It is intended solely to provide you with an overview of the plan and you should not rely on it when trying to determine whether a service, etc. is covered under your health benefit plan. Complete details of benefits, terms, and exclusions are set forth in the group contract.