HealthAmerica
A Coventry Health Care Plan

HealthAmerica Small Business Solutions

PPO Products for Central and Western Pennsylvania

Effective 7/1/2011

	Plan Name	Participating Providers: Primary Care Physician & Specialist Office Visit	Preventive Care Copay	Medical Injectable	Urgent Care/ Emergency Room Copay (after deductible)	Deductible Single (3x)	Coinsurance (after deductible)	Inpatient Copay Per Admission	Outpatient Surgery Copay	Outpatient Diagnostic X-Ray Copay	Major Radiology Copay	Out-of-Pocket Max. Single (3x)	Non-participating Providers: Deductible Single (3x)	Coinsurance (after deductible)	Out-of-Pocket Max. Single (3x)
Choice	Choice PPO $1250†	Level 1 $20; Level 2 ded/$40	$0	ded/0%	$40/$125	$1,250	0%	ded/0%	ded/0%	ded/0%	ded/$125	None	$2,500	30%	$10,000
	Choice PPO $2000†	Level 1 $20; Level 2 ded/$40	$0	ded/0%	$40/$125	$2,000	0%	ded/0%	ded/0%	ded/0%	ded/$125	None	$4,000	30%	$10,000
	Choice PPO $4000†	Level 1 $20; Level 2 ded/$40	$0	ded/0%	$40/$125	$4,000	0%	ded/0%	ded/0%	ded/0%	ded/$125	None	$8,000	30%	$10,000

Level 1 providers: internists, family doctors, pediatricians, OB/Gyns, dermatologists and chiropractors. **Level 2 providers:** all others.

		Primary Care Physician & Specialist Office Visit	Preventive Care Copay	Medical Injectable	Urgent Care/ Emergency Room Copay	Deductible Single*	Coinsurance (after deductible)	Inpatient Copay Per Admission	Outpatient Surgery Copay	Outpatient Diagnostic X-Ray Copay	Major Radiology Copay	Out-of-Pocket Max. Single*	Deductible Single*	Coinsurance (after deductible)	Out-of-Pocket Max. Single*
Premier	Premier PPO $5$10	$5/$10	$0	$75	$10/$150	$0	0%	$0	$0	$0	$125	None	$500	20%	$3,000
	Premier PPO $10$10	$10/$10	$0	$75	$10/$150	$0	0%	$0	$0	$0	$125	None	$500	30%	$3,000
	Premier PPO $15$30	$15/$30	$0	$75	$30/$150	$0	0%	$0	$0	$0	$125	None	$750	30%	$3,000
	Premier PPO $20$40	$20/$40	$0	$75	$40/$150	$0	0%	$500	$0	$0	$125	None	$500	30%	$3,000
	Premier PPO $250	$15/$30	$0	ded/0%	$30/$125	$250	0%	ded/0%	ded/0%	ded/0%	ded/0%	None	$500	30%	$3,000
	Premier PPO $500	$15/$30	$0	ded/0%	$30/$125	$500	0%	ded/0%	ded/0%	ded/0%	ded/0%	None	$1,000	30%	$3,000
	Premier PPO $750	$15/$30	$0	ded/0%	$30/$125	$750	0%	ded/0%	ded/0%	ded/0%	ded/0%	None	$1,500	30%	$3,000
	Premier PPO $1000	$15/$30	$0	ded/0%	$30/$125	$1,000	0%	ded/0%	ded/0%	ded/0%	ded/0%	None	$2,000	30%	$3,000
	Premier PPO $1250	$15/$30	$0	ded/0%	$30/$125	$1,250	0%	ded/0%	ded/0%	ded/0%	ded/0%	None	$2,500	40%	$5,000
	Premier PPO $1500	$20/$40	$0	ded/0%	$40/$125	$1,500	0%	ded/0%	ded/0%	ded/0%	ded/0%	None	$3,000	40%	$5,000
	Premier PPO $2000	$20/$40	$0	ded/0%	$40/$125	$2,000	0%	ded/0%	ded/0%	ded/0%	ded/0%	None	$4,000	40%	$5,000
	Premier PPO $3000	$20/$40	$0	ded/0%	$40/$125	$3,000	0%	ded/0%	ded/0%	ded/0%	ded/0%	None	$5,000	40%	$7,000
	Premier PPO $5000	$20/$40	$0	ded/0%	$40/$125	$5,000	0%	ded/0%	ded/0%	ded/0%	ded/0%	None	$7,500	40%	$9,000
Premier 1x	Premier PPO $2500 1x	$20/$40	$0	ded/0%	$40/$125	$2500 1x	0%	ded/0%	ded/0%	ded/0%	ded/0%	None	$5,000 1x	20%	$10,000 1x
	Premier PPO $3250 1x	$20/$40	$0	ded/0%	$40/$125	$3250 1x	0%	ded/0%	ded/0%	ded/0%	ded/0%	None	$5,000 1x	20%	$10,000 1x
	Premier PPO $4000 1x	$25/$50	$0	ded/0%	$50/$125	$4000 1x	0%	ded/0%	ded/0%	ded/0%	ded/0%	None	$6,000 1x	20%	$5,000 1x
	Premier PPO $5000 1x	$20/$40	$0	ded/0%	$40/$125	$5000 1x	0%	ded/0%	ded/0%	ded/0%	ded/0%	None	$7,500 1x	20%	$10,000 1x
	Premier PPO $6000 1x	$20/$40	$0	ded/0%	$40/$125	$6000 1x	0%	ded/0%	ded/0%	ded/0%	ded/0%	None	$8,500 1x	20%	$10,000 1x
	Premier PPO $7500 1x	$25/$50	$0	ded/0%	$50/$125	$7,500 1x	0%	ded/0%	ded/0%	ded/0%	ded/0%	None	$10,000 1x	20%	$5,000 1x
	Premier PPO $10000 1x	$25/$50	$0	ded/0%	$50/$125	$10,000 1x	0%	ded/0%	ded/0%	ded/0%	ded/0%	None	$12,000 1x	20%	$5,000 1x

		Participating Providers											Non-participating Providers		
		Primary Care Physician & Specialist Office Visit	Preventive Care Copay	Medical Injectable	Urgent Care/ Emergency Room Copay	Deductible Single*	Coinsurance (after deductible)	Inpatient Copay Per Admission	Outpatient Surgery Copay	Outpatient Diagnostic X-Ray Copay	Major Radiology Copay	Out-of-Pocket Max. Single*	Deductible Single*	Coinsurance (after deductible)	Out-of-Pocket Max. Single*
Classic	Classic PPO $250	$15/$30	$0	ded/10%	$30/$125	$250	10%	ded/10%	ded/10%	ded/10%	ded/10%	$1,500	$750	30%	$3,000
	Classic PPO $500	$15/$30	$0	ded/10%	$30/$125	$500	10%	ded/10%	ded/10%	ded/10%	ded/10%	$1,500	$1,000	30%	$3,000
	Classic PPO $1000	$15/$30	$0	ded/10%	$30/$125	$1,000	10%	ded/10%	ded/10%	ded/10%	ded/10%	$1,500	$2,000	30%	$3,000
Value	Value PPO $250	$20/$40	$0	ded/20%	$40/$125	$250	20%	ded/20%	ded/20%	ded/20%	ded/20%	$2,500	$750	40%	$3,000
	Value PPO $500	$20/$40	$0	ded/20%	$40/$125	$500	20%	ded/20%	ded/20%	ded/20%	ded/20%	$2,500	$1,000	40%	$3,000
	Value PPO $1000	$20/$40	$0	ded/20%	$40/$125	$1,000	20%	ded/20%	ded/20%	ded/20%	ded/20%	$2,500	$2,000	40%	$3,000
	Value PPO $1500	$20/$40	$0	ded/20%	$40/$125	$1,500	20%	ded/20%	ded/20%	ded/20%	ded/20%	$2,500	$3,000	40%	$5,000
	Value PPO $2000	$20/$40	$0	ded/20%	$40/$125	$2,000	20%	ded/20%	ded/20%	ded/20%	ded/20%	$2,500	$4,000	40%	$5,000
HSA Compatible**	FlexChoice QHDHP PPO $1250††	$15/$25	$0	ded/0%	ded $25/ded $125	$1,250	0%	ded/0%	ded/0%	ded/0%	ded/0%	$3,000	$2,500	20%	$10,000
	FlexChoice QHDHP PPO $1250 II††	$0	$0	ded/0%	ded 0%/ded $125	$1,250	0%	ded/0%	ded/0%	ded/0%	ded/0%	$3,000	$2,500	20%	$10,000
	FlexChoice QHDHP PPO $2500††	$0	$0	ded/0%	ded 0%/ded $125	$2,500	0%	ded/0%	ded/0%	ded/0%	ded/0%	$4,000	$5,000	30%	$10,000
	FlexChoice QHDHP Value PPO $1250††	$20/$40	$0	ded/20%	ded $40/ded 20%	$1,250	20%	ded/20%	ded/20%	ded/20%	ded/20%	$5,000	$2,500	40%	$10,000
	FlexChioce QHDHP Value PPO $2500††	$20/$40	$0	ded/20%	ded $40/ded 20%	$2,500	20%	ded/20%	ded/20%	ded/20%	ded/20%	$5,000	$5,000	40%	$10,000
	FlexChoice QHDHP Value PPO $3750††	$20/$40	$0	ded/20%	ded $40/ded 20%	$3,750	20%	ded/20%	ded/20%	ded/20%	ded/20%	$5,000	$7,500	40%	$10,000
HSA 1x	FlexChoice QHDHP PPO $2500 1x††	$15/$25	$0	ded/0%	ded $25/ded $125	$2,500 1x	0%	ded/0%	ded/0%	ded/0%	ded/0%	$4,000 1x	$5,000 1x	20%	$10,000 1x
	FlexChoice QHDHP PPO $5000 1x††	$0	$0	ded/0%	ded/0%; ded/$125	$5,000 1x	0%	ded/0%	ded/0%	ded/0%	ded/0%	$5,950 1x	$5,000 1x	30%	$10,000 1x

Notes Regarding All Plans

*** Unless otherwise indicated, family deductible is 2x the single deductible. Family OOP max is 2x the single OOP max.**

** 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.

*** Lifetime maximum is unlimited.

† Choice plans include Rx plan Tier 1A $3 – Tier 1 $10 – Tier 2 ded/$35 – Tier 3 ded/$60.

†† Qualified plans include Rx plan $3/$10/$20/$45 and/or Rx plan $3/$10/$35/$60.

Provided for demonstration purposes only. Actual benefits, cost sharing provisions, limitations and exclusions are set forth in the Certificate of Insurance issued to members. **Non-covered 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; and 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, non-skilled nursing care, and disposable medical supplies.

Pennsylvania in-area PPO and CCPPO (POS) products are underwritten by HealthAmerica Pennsylvania, Inc. (d.b.a HealthAmerica). All indemnity products, out-of-area PPO products, HealthAmerica*One* 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 Health Care 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 any questions call us at 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.

Prescription Drug Plan – Retail

Rx Plans Available	Tier 1A	Tier 1	Tier 2	Tier 3
$3/$10/$20/$45	$3	$10	$20	$45
$3/$10/$25/$50	$3	$10	$25	$50
$3/$10/$35/$60	$3	$10	$35	$60
$3/$15/$30/$55	$3	$15	$30	$55
$3/$15/$35/$60	$3	$15	$35	$60
$3/$20/$40/$70	$3	$20	$40	$70
Mail Order	2	2	2.5	3

Note: Mandatory generics required for all prescription drug plans.

Prescription Drug Tier Level Descriptions

Tier 1A: Includes common antibiotics, pain relievers, acid reducers, anti-depressants, blood pressure and cholesterol lowering drugs, and more.

Tier 1: Includes more generic and a few selected OTC (over-the-counter) drugs.

Tier 2: Formulary brand-name drugs.

Tier 3: Nonformulary brand-name, and a few nonformulary generic drugs. These drugs may have a lower cost alternative on Tier 1 or Tier 2.

Mail Order: Through the convenience of mail order, customers can receive their prescription drugs that fall under any tier at a 90-day supply.

*Lifestyle Drug Discount for certain non-covered prescription medications: smoking cessation, weight loss, vitamins and fertility drugs. Automatically taken at the pharmacy when ID card is used to fill a prescription.

HEALTHAMERICA
A Coventry Health Care Plan

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

Choice PPO $1250

DEDUCTIBLES AND MAXIMUMS	Participating MEMBER RESPONSIBILITY	Non-Participating MEMBER RESPONSIBILITY
Annual Deductible		
Individual	$1,250	$2,500
Family	$3,750	$7,500
Out-of-Pocket Maximum (includes copays, deductibles and coinsurance)		
Individual	None	$10,000
Family	None	$30,000
OUTPATIENT SERVICES	**Participating MEMBER RESPONSIBILITY**	**Non-Participating MEMBER RESPONSIBILITY**
Physician Services (for illness or injury)		
Level One Visits (PCP, OBGYN, Dermatologists, Chiropractors)	$20 Copay	30% Eligible Charges (after annual deductible)
Level Two Visits (all other office visits)	$40 Copay (after annual deductible)	30% Eligible Charges (after annual deductible)
Preventive Services*		
Gynecological Exam (PCP/SCP)	$0 Copay	30% Eligible Charges (after annual deductible)
Well Child Visit	$0 Copay	30% Eligible Charges (after annual deductible)
Adult Physical Visit	$0 Copay	30% Eligible Charges (after annual deductible)
Preventive Pediatric Immunizations	0%	30% Eligible Charges
Hearing Exams (under age 18)	0%	30% Eligible Charges (after annual deductible)
Routine Mammograms	0%	30% Eligible Charges (after annual deductible)
Routine Colonscopies***	0%	30% Eligible Charges (after annual deductible)
Allergy Testing & Allergy Serum	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
Chiropractic Care		
Maximum 20 visits per contract year	$20 Copay	30% Eligible Charges (after annual deductible)
Outpatient Surgery	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
Lab Services	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
Diagnostic X-ray	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
Radiology (CAT, MRI, Ultrasound)	$125 (after annual deductible)	30% Eligible Charges (after annual deductible)
HOSPITAL SERVICES	**Participating MEMBER RESPONSIBILITY**	**Non-Participating MEMBER RESPONSIBILITY**
Hospital Care		
Semi-private room (private room if medically necessary)	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
Physician and Surgeon Fees	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
Surgery	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
Lab and X-ray services	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
All Medically Necessary Ancillary Services	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
Anesthesia	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
Administration of Blood	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
Blood Products	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
Therapy Services (Chemotherapy & Radiation Therapy)	0% (after annual deductible)	30% 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 Copay	30% Eligible Charges (after annual deductible)
Delivery	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
FAMILY PLANNING	**Participating MEMBER RESPONSIBILITY**	**Non-Participating MEMBER RESPONSIBILITY**
	$300 one time deductible then coinsurance applies	
Infertility Counseling/Testing/Services	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
Tubal Ligation/Vasectomy	$2400 combined benefit maximum	
PRESCRIPTION DRUGS	**Participating MEMBER RESPONSIBILITY**	**Non-Participating MEMBER RESPONSIBILITY**
(Includes oral contraceptives & managed formulary. Mandatory generic substitution may apply)	**$10 generic / $35 brand (after ded) / $60 non-formulary (after ded)**	
EMERGENCY CARE	**Participating MEMBER RESPONSIBILITY**	**Non-Participating MEMBER RESPONSIBILITY**
Urgent Care Center	$40 Copay (after annual deductible)	
Emergency Room Services	$125 Copay (after annual deductible) ER Copay waived if admitted	
REHABILITATION SERVICES	**Participating MEMBER RESPONSIBILITY**	**Non-Participating MEMBER RESPONSIBILITY**
Occupational, Speech, Physical Therapy	0% (after annual deductible)	30% 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	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
	30 days per contract year *90 day lifetime benefit maximum*	
Physician Services (Outpatient)	$40 Copay (after annual deductible)	30% Eligible Charges (after annual deductible)
	20 outpatient visits maximum per contract year	
Serious Mental Health: Inpatient	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
	30 days per contract year	
Physician Services (Outpatient)	$40 Copay (after annual deductible)	30% Eligible Charges (after annual deductible)
	60 outpatient visits maximum per contract year	
Substance Abuse: Inpatient Detoxification	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
	7 days maximum per admission *4 admission benefit maximum*	
Inpatient Rehabilitation	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
	30 days maximum per contract year *90 days benefit maximum*	
Transitional Partial Hospitalization	0% (after annual deductible)	30% 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.	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
Corrective Appliances	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
Home Health Care Services	0% (after annual deductible) *120 visits per contract year*	30% Eligible Charges (after annual deductible) *60 visits per contract year*
	120 visits combined per contract year	
Hospice Care	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
Skilled Nursing Facility	0% (after annual deductible) *100 inpatient days per contract year*	30% 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	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
Removal of Third Molars	0% (after annual deductible)	30% 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 $150 per calendar year per member.*

HEALTHAMERICA
A Coventry Health Care Plan

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

Choice PPO $2000

DEDUCTIBLES AND MAXIMUMS	Participating MEMBER RESPONSIBILITY	Non-Participating MEMBER RESPONSIBILITY
Annual Deductible		
Individual	$2,000	$4,000
Family	$6,000	$12,000
Out-of-Pocket Maximum (includes copays, deductibles and coinsurance)		
Individual	None	$10,000
Family	None	$30,000
OUTPATIENT SERVICES	**Participating MEMBER RESPONSIBILITY**	**Non-Participating MEMBER RESPONSIBILITY**
Physician Services (for illness or injury)		
Level One Visits (PCP, OBGYN, Dermatologists, Chiropractors)	$20 Copay	30% Eligible Charges (after annual deductible)
Level Two Visits (all other office visits)	$40 Copay (after annual deductible)	30% Eligible Charges (after annual deductible)
Preventive Services*		
Gynecological Exam (PCP/SCP)	$0 Copay	30% Eligible Charges (after annual deductible)
Well Child Visit	$0 Copay	30% Eligible Charges (after annual deductible)
Adult Physical Visit	$0 Copay	30% Eligible Charges (after annual deductible)
Preventive Pediatric Immunizations	0%	30% Eligible Charges
Hearing Exams (under age 18)	0%	30% Eligible Charges (after annual deductible)
Routine Mammograms	0%	30% Eligible Charges (after annual deductible)
Routine Colonoscopies***	0%	30% Eligible Charges (after annual deductible)
Allergy Testing & Allergy Serum	0%	30% Eligible Charges (after annual deductible)
Chiropractic Care		
Maximum 20 visits per contract year	$20 Copay	30% Eligible Charges (after annual deductible)
Outpatient Surgery	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
Lab Services	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
Diagnostic X-ray	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
Radiology (CAT, MRI, Ultrasound)	$125 (after annual deductible)	30% Eligible Charges (after annual deductible)
HOSPITAL SERVICES	**Participating MEMBER RESPONSIBILITY**	**Non-Participating MEMBER RESPONSIBILITY**
Hospital Care		
Semi-private room (private room if medically necessary)	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
Physician and Surgeon Fees	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
Surgery	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
Lab and X-ray services	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
All Medically Necessary Ancillary Services	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
Anesthesia	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
Administration of Blood	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
Blood Products	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
Therapy Services (Chemotherapy & Radiation Therapy)	0% (after annual deductible)	30% 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 Copay	30% Eligible Charges (after annual deductible)
Delivery	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
FAMILY PLANNING	**Participating MEMBER RESPONSIBILITY**	**Non-Participating MEMBER RESPONSIBILITY**
	$300 one time deductible then coinsurance applies	
Infertility Counseling/Testing/Services	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
Tubal Ligation/Vasectomy	$2,400 combined benefit maximum	
PRESCRIPTION DRUGS	**Participating MEMBER RESPONSIBILITY**	**Non-Participating MEMBER RESPONSIBILITY**
(Includes oral contraceptives & managed formulary. Mandatory generic substitution may apply)	**$10 generic / $35 brand (after ded) / $60 non-formulary (after ded)**	
EMERGENCY CARE	**Participating MEMBER RESPONSIBILITY**	**Non-Participating MEMBER RESPONSIBILITY**
Urgent Care Center	$40 Copay (after annual deductible)	
Emergency Room Services	$125 Copay (after annual deductible) ER Copay waived if admitted	
REHABILITATION SERVICES	**Participating MEMBER RESPONSIBILITY**	**Non-Participating MEMBER RESPONSIBILITY**
Occupational, Speech, Physical Therapy	0% (after annual deductible)	30% 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	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
	30 days per contract year *90 day lifetime benefit maximum*	
Physician Services (Outpatient)	$40 Copay (after annual deductible)	30% Eligible Charges (after annual deductible)
	20 outpatient visits maximum per contract year	
Serious Mental Health: Inpatient	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
	30 days per contract year	
Physician Services (Outpatient)	$40 Copay (after annual deductible)	30% Eligible Charges (after annual deductible)
	60 outpatient visits maximum per contract year	
Substance Abuse: Inpatient Detoxification	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
	7 days maximum per admission *4 admission benefit maximum*	
Inpatient Rehabilitation	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
	30 days maximum per contract year *90 days benefit maximum*	
Transitional Partial Hospitalization	0% (after annual deductible)	30% 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.	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
Corrective Appliances	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
Home Health Care Services	0% (after annual deductible) *120 visits per contract year*	30% Eligible Charges (after annual deductible) *60 visits per contract year*
	120 visits combined per contract year	
Hospice Care	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
Skilled Nursing Facility	0% (after annual deductible) *100 inpatient days per contract year*	30% 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	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
Removal of Third Molars	0% (after annual deductible)	30% 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

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LIFETIME MAXIMUM Unlimited

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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.

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***Reimbursement for Weight Management programs is limited to $150 per calendar year per member.*

HEALTHAMERICA
A Coventry Health Care Plan

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

Choice PPO $4000

DEDUCTIBLES AND MAXIMUMS	Participating MEMBER RESPONSIBILITY	Non-Participating MEMBER RESPONSIBILITY
Annual Deductible		
Individual	$4,000	$8,000
Family	$12,000	$24,000
Out-of-Pocket Maximum (includes copays, deductibles and coinsurance)		
Individual	None	$10,000
Family	None	$30,000
OUTPATIENT SERVICES	**Participating MEMBER RESPONSIBILITY**	**Non-Participating MEMBER RESPONSIBILITY**
Physician Services (for illness or injury)		
Level One Visits (PCP, OBGYN, Dermatologists, Chiropractors)	$20 Copay	30% Eligible Charges (after annual deductible)
Level Two Visits (all other office visits)	$40 Copay (after annual deductible)	30% Eligible Charges (after annual deductible)
Preventive Services*		
Gynecological Exam (PCP/SCP)	$0 Copay	30% Eligible Charges (after annual deductible)
Well Child Visit	$0 Copay	30% Eligible Charges (after annual deductible)
Adult Physical Visit	$0 Copay	30% Eligible Charges (after annual deductible)
Preventive Pediatric Immunizations	0%	30% Eligible Charges
Hearing Exams (under age 18)	0%	30% Eligible Charges (after annual deductible)
Routine Mammograms	0%	30% Eligible Charges (after annual deductible)
Routine Colonoscopies***	0%	30% Eligible Charges (after annual deductible)
Allergy Testing & Allergy Serum	0%	30% Eligible Charges (after annual deductible)
Chiropractic Care		
Maximum 20 visits per contract year	$20 Copay	30% Eligible Charges (after annual deductible)
Outpatient Surgery	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
Lab Services	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
Diagnostic X-ray	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
Radiology (CAT, MRI, Ultrasound)	$125 (after annual deductible)	30% Eligible Charges (after annual deductible)
HOSPITAL SERVICES	**Participating MEMBER RESPONSIBILITY**	**Non-Participating MEMBER RESPONSIBILITY**
Hospital Care		
Semi-private room (private room if medically necessary)	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
Physician and Surgeon Fees	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
Surgery	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
Lab and X-ray services	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
All Medically Necessary Ancillary Services	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
Anesthesia	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
Administration of Blood	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
Blood Products	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
Therapy Services (Chemotherapy & Radiation Therapy)	0% (after annual deductible)	30% 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 Copay	30% Eligible Charges (after annual deductible)
Delivery	0% (after annual deductible)	30% 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	0% (after annual deductible)	30% 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)	**$10 generic / $35 brand (after ded) / $60 non-formulary (after ded)**	
EMERGENCY CARE	**Participating MEMBER RESPONSIBILITY**	**Non-Participating MEMBER RESPONSIBILITY**
Urgent Care Center	$40 Copay (after annual deductible)	
Emergency Room Services	$125 Copay (after annual deductible) ER Copay waived if admitted	
REHABILITATION SERVICES	**Participating MEMBER RESPONSIBILITY**	**Non-Participating MEMBER RESPONSIBILITY**
Occupational, Speech, Physical Therapy	0% (after annual deductible)	30% 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	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
	30 days per contract year *90 day lifetime benefit maximum*	
Physician Services (Outpatient)	$40 Copay (after annual deductible)	30% Eligible Charges (after annual deductible)
	20 outpatient visits maximum per contract year	
Serious Mental Health: Inpatient	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
	30 days per contract year	
Physician Services (Outpatient)	$40 Copay (after annual deductible)	30% Eligible Charges (after annual deductible)
	60 outpatient visits maximum per contract year	
Substance Abuse: Inpatient Detoxification	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
	7 days maximum per admission *4 admission benefit maximum*	
Inpatient Rehabilitation	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
	30 days maximum per contract year *90 days benefit maximum*	
Transitional Partial Hospitalization	0% (after annual deductible)	30% 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.	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
Corrective Appliances	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
Home Health Care Services	0% (after annual deductible) *120 visits per contract year*	30% Eligible Charges (after annual deductible) *60 visits per contract year*
	120 visits combined per contract year	
Hospice Care	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
Skilled Nursing Facility	0% (after annual deductible) *100 inpatient days per contract year*	30% 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	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
Removal of Third Molars	0% (after annual deductible)	30% 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

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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.

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***Reimbursement for Weight Management programs is limited to $150 per calendar year per member.*

HEALTHAMERICA
A Coventry Health Care Plan

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

Premier PPO $5$10

DEDUCTIBLES AND MAXIMUMS	Participating MEMBER RESPONSIBILITY	Non-Participating MEMBER RESPONSIBILITY
Annual Deductible (Inpatient and Infertility deductibles apply separately from annual deductible)		
Individual	None	$500
Family (aggregate)	None	$1,000
Out-of-Pocket Maximum (excludes deductibles and copays)		
Individual	None	$3,000
Family (aggregate)	None	$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)	$5 Copay	20% Eligible Charges (after annual deductible)
Specialist Visit (SCP)	$10 Copay	20% Eligible Charges (after annual deductible)
Preventive Services*	**(office visit NOT subject to deductible)**	
Gynecological Exam (PCP/SCP)	$0 Copay	20% Eligible Charges (after annual deductible)
Well Child Visit	$0 Copay	20% Eligible Charges (after annual deductible)
Adult Physical Visit	$0 Copay	20% Eligible Charges (after annual deductible)
Routine Pediatric Immunizations	0%	20% Eligible Charges
Hearing Exams (under age 18)	0%	20% Eligible Charges (after annual deductible)
Routine Mammograms	0%	20% Eligible Charges (after annual deductible)
Routine Colonoscopies***	0%	20% Eligible Charges (after annual deductible)
Medical Injectable (Therapies including but not limited to: Remicade, Tysabri, Amevive, Boniva, Reclast)	$75 Copay	20% Eligible Charges (after annual deductible)
Allergy Testing & Allergy Serum	0%	20% Eligible Charges (after annual deductible)
Chiropractic Care (x-rays are subject to deductible) Maximum 20 visits per contract year	$10 Copay	20% Eligible Charges (after annual deductible)
Outpatient Surgery	0%	20% Eligible Charges (after annual deductible)
Lab Services	0%	20% Eligible Charges (after annual deductible)
Diagnostic X-ray	0%	20% Eligible Charges (after annual deductible)
Radiology (CAT, MRI, Ultrasound, PET)	$125 Copay	20% Eligible Charges (after annual deductible)
HOSPITAL SERVICES	**Participating MEMBER RESPONSIBILITY**	**Non-Participating MEMBER RESPONSIBILITY**
Hospital Care		
Semi-private room (private room if medically necessary)	0%	20% Eligible Charges (after annual deductible)
Physician and Surgeon Fees	0%	20% Eligible Charges (after annual deductible)
Surgery	0%	20% Eligible Charges (after annual deductible)
Lab and X-ray services	0%	20% Eligible Charges (after annual deductible)
All Medically Necessary Ancillary Services	0%	20% Eligible Charges (after annual deductible)
Anesthesia	0%	20% Eligible Charges (after annual deductible)
Administration of Blood	0%	20% Eligible Charges (after annual deductible)
Blood Products	0%	20% Eligible Charges (after annual deductible)
Therapy Services (Chemotherapy & Radiation Therapy)	0%	20% 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)	$5/$10 Copay	20% Eligible Charges (after annual deductible)
Delivery	0%	20% 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	0%	20% 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	$10 Copay	
Emergency Room Services (not subject to deductible)	0% after $150 Copay (ER Copay waived if admitted)	
REHABILITATION SERVICES	**Participating MEMBER RESPONSIBILITY**	**Non-Participating MEMBER RESPONSIBILITY**
Occupational, Speech, Physical Therapy	0%	20% 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	0%	20% Eligible Charges (after annual deductible)
	30 days per contract year *90 day lifetime benefit maximum*	
Physician Services (Outpatient)	$10 Copay per visit	20% Eligible Charges (after annual deductible)
	20 outpatient visits maximum per contract year	
Serious Mental Health: Inpatient	0%	20% Eligible Charges (after annual deductible)
	30 days per contract year	
Physician Services (Outpatient)	$10 Copay per visit	20% Eligible Charges (after annual deductible)
	60 outpatient visits maximum per contract year	
Substance Abuse: Inpatient Detoxification	0%	20% Eligible Charges (after annual deductible)
	7 days maximum per admission *4 admission benefit maximum*	
Inpatient Rehabilitation	0%	20% Eligible Charges (after annual deductible)
	30 days maximum per contract year *90 days benefit maximum*	
Transitional Partial Hospitalization	0%	20% 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.	0%	20% Eligible Charges (after annual deductible)
Corrective Appliances	0%	20% Eligible Charges (after annual deductible)
Home Health Care Services	0% *120 visits per contract year*	20% Eligible Charges (after annual deductible) *60 visits per contract year*
	120 visits combined per contract year	
Hospice Care	0%	20% Eligible Charges (after annual deductible)
Skilled Nursing Facility	0% *100 inpatient days per contract year*	20% 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	0%	20% Eligible Charges (after annual deductible)
Removal of Third Molars	0%	20% 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.
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HEALTHAMERICA
A Coventry Health Care Plan

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

Premier PPO $10$10

DEDUCTIBLES AND MAXIMUMS	Participating MEMBER RESPONSIBILITY	Non-Participating MEMBER RESPONSIBILITY
Annual Deductible (Inpatient and Infertility deductibles apply separately from annual deductible)		
Individual	None	$500
Family (aggregate)	None	$1,000
Out-of-Pocket Maximum (excludes deductibles and copays)		
Individual	None	$3,000
Family (aggregate)	None	$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)	$10 Copay	30% Eligible Charges (after annual deductible)
Specialist Visit (SCP)	$10 Copay	30% Eligible Charges (after annual deductible)
Preventive Services*	**(office visit NOT subject to deductible)**	
Gynecological Exam (PCP/SCP)	$0 Copay	30% Eligible Charges (after annual deductible)
Well Child Visit	$0 Copay	30% Eligible Charges (after annual deductible)
Adult Physical Visit	$0 Copay	30% Eligible Charges (after annual deductible)
Routine Pediatric Immunizations	0%	30% Eligible Charges
Hearing Exams (under age 18)	0%	30% Eligible Charges (after annual deductible)
Routine Mammograms	0%	30% Eligible Charges (after annual deductible)
Routine Colonoscopies***	0%	30% Eligible Charges (after annual deductible)
Medical Injectable (Therapies including but not limited to: Remicade, Tysabri, Amevive, Boniva, Reclast)	$75 Copay	30% Eligible Charges (after annual deductible)
Allergy Testing & Allergy Serum	0%	30% Eligible Charges (after annual deductible)
Chiropractic Care (x-rays are subject to deductible) Maximum 20 visits per contract year	$10 Copay	30% Eligible Charges (after annual deductible)
Outpatient Surgery	0%	30% Eligible Charges (after annual deductible)
Lab Services	0%	30% Eligible Charges (after annual deductible)
Diagnostic X-ray	0%	30% Eligible Charges (after annual deductible)
Radiology (CAT, MRI, Ultrasound, PET)	$125 Copay	30% Eligible Charges (after annual deductible)
HOSPITAL SERVICES	**Participating MEMBER RESPONSIBILITY**	**Non-Participating MEMBER RESPONSIBILITY**
Hospital Care		
Semi-private room (private room if medically necessary)	0%	30% Eligible Charges (after annual deductible)
Physician and Surgeon Fees	0%	30% Eligible Charges (after annual deductible)
Surgery	0%	30% Eligible Charges (after annual deductible)
Lab and X-ray services	0%	30% Eligible Charges (after annual deductible)
All Medically Necessary Ancillary Services	0%	30% Eligible Charges (after annual deductible)
Anesthesia	0%	30% Eligible Charges (after annual deductible)
Administration of Blood	0%	30% Eligible Charges (after annual deductible)
Blood Products	0%	30% Eligible Charges (after annual deductible)
Therapy Services (Chemotherapy & Radiation Therapy)	0%	30% 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)	$10 Copay	30% Eligible Charges (after annual deductible)
Delivery	0%	30% 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	0%	30% 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	$10 Copay	
Emergency Room Services (not subject to deductible)	0% after $150 Copay (ER Copay waived if admitted)	
REHABILITATION SERVICES	**Participating MEMBER RESPONSIBILITY**	**Non-Participating MEMBER RESPONSIBILITY**
Occupational, Speech, Physical Therapy	0%	30% 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	0%	30% Eligible Charges (after annual deductible)
	30 days per contract year *90 day lifetime benefit maximum*	
Physician Services (Outpatient)	$10 Copay per visit	30% Eligible Charges (after annual deductible)
	20 outpatient visits maximum per contract year	
Serious Mental Health: Inpatient	0%	30% Eligible Charges (after annual deductible)
	30 days per contract year	
Physician Services (Outpatient)	$10 Copay per visit	30% Eligible Charges (after annual deductible)
	60 outpatient visits maximum per contract year	
Substance Abuse: Inpatient Detoxification	0%	30% Eligible Charges (after annual deductible)
	7 days maximum per admission *4 admission benefit maximum*	
Inpatient Rehabilitation	0%	30% Eligible Charges (after annual deductible)
	30 days maximum per contract year *90 days benefit maximum*	
Transitional Partial Hospitalization	0%	30% 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.	0%	30% Eligible Charges (after annual deductible)
Corrective Appliances	0%	30% Eligible Charges (after annual deductible)
Home Health Care Services	0% *120 visits per contract year*	30% Eligible Charges (after annual deductible) *60 visits per contract year*
	120 visits combined per contract year	
Hospice Care	0%	30% Eligible Charges (after annual deductible)
Skilled Nursing Facility	0% *100 inpatient days per contract year*	30% 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	0%	30% Eligible Charges (after annual deductible)
Removal of Third Molars	0%	30% 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 $150 per calendar year per member.*

HEALTHAMERICA
A Coventry Health Care Plan

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

Premier PPO $15$30

DEDUCTIBLES AND MAXIMUMS	Participating MEMBER RESPONSIBILITY	Non-Participating MEMBER RESPONSIBILITY
Annual Deductible (Inpatient and Infertility deductibles apply separately from annual deductible)		
Individual	None	$750
Family (aggregate)	None	$1,500
Out-of-Pocket Maximum (excludes deductibles and copays)		
Individual	None	$3,000
Family (aggregate)	None	$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)	$15 Copay	30% Eligible Charges (after annual deductible)
Specialist Visit (SCP)	$30 Copay	30% Eligible Charges (after annual deductible)
Preventive Services*	**(office visit NOT subject to deductible)**	
Gynecological Exam (PCP/SCP)	$0 Copay	30% Eligible Charges (after annual deductible)
Well Child Visit	$0 Copay	30% Eligible Charges (after annual deductible)
Adult Physical Visit	$0 Copay	30% Eligible Charges (after annual deductible)
Routine Pediatric Immunizations	0%	30% Eligible Charges
Hearing Exams (under age 18)	0%	30% Eligible Charges (after annual deductible)
Routine Mammograms	0%	30% Eligible Charges (after annual deductible)
Routine Colonoscopies***	0%	30% Eligible Charges (after annual deductible)
Medical Injectable (Therapies including but not limited to: Remicade, Tysabri, Amevive, Boniva, Reclast)	$75 Copay	30% Eligible Charges (after annual deductible)
Allergy Testing & Allergy Serum	0%	30% Eligible Charges (after annual deductible)
Chiropractic Care (x-rays are subject to deductible) Maximum 20 visits per contract year	$30 Copay	30% Eligible Charges (after annual deductible)
Outpatient Surgery	0%	30% Eligible Charges (after annual deductible)
Lab Services	0%	30% Eligible Charges (after annual deductible)
Diagnostic X-ray	0%	30% Eligible Charges (after annual deductible)
Radiology (CAT, MRI, Ultrasound, PET)	$125 Copay	30% Eligible Charges (after annual deductible)
HOSPITAL SERVICES	**Participating MEMBER RESPONSIBILITY**	**Non-Participating MEMBER RESPONSIBILITY**
Hospital Care		
Semi-private room (private room if medically necessary)	0%	30% Eligible Charges (after annual deductible)
Physician and Surgeon Fees	0%	30% Eligible Charges (after annual deductible)
Surgery	0%	30% Eligible Charges (after annual deductible)
Lab and X-ray services	0%	30% Eligible Charges (after annual deductible)
All Medically Necessary Ancillary Services	0%	30% Eligible Charges (after annual deductible)
Anesthesia	0%	30% Eligible Charges (after annual deductible)
Administration of Blood	0%	30% Eligible Charges (after annual deductible)
Blood Products	0%	30% Eligible Charges (after annual deductible)
Therapy Services (Chemotherapy & Radiation Therapy)	0%	30% 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)	$15/$30 Copay	30% Eligible Charges (after annual deductible)
Delivery	0%	30% 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	0%	30% 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	$30 Copay	
Emergency Room Services (not subject to deductible)	0% after $150 Copay (ER Copay waived if admitted)	
REHABILITATION SERVICES	**Participating MEMBER RESPONSIBILITY**	**Non-Participating MEMBER RESPONSIBILITY**
Occupational, Speech, Physical Therapy	0%	30% 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	0%	30% Eligible Charges (after annual deductible)
	30 days per contract year *90 day lifetime benefit maximum*	
Physician Services (Outpatient)	$30 Copay per visit	30% Eligible Charges (after annual deductible)
	20 outpatient visits maximum per contract year	
Serious Mental Health: Inpatient	0%	30% Eligible Charges (after annual deductible)
	30 days per contract year	
Physician Services (Outpatient)	$30 Copay per visit	30% Eligible Charges (after annual deductible)
	60 outpatient visits maximum per contract year	
Substance Abuse: Inpatient Detoxification	0%	30% Eligible Charges (after annual deductible)
	7 days maximum per admission *4 admission benefit maximum*	
Inpatient Rehabilitation	0%	30% Eligible Charges (after annual deductible)
	30 days maximum per contract year *90 days benefit maximum*	
Transitional Partial Hospitalization	0%	30% 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.	0%	30% Eligible Charges (after annual deductible)
Corrective Appliances	0%	30% Eligible Charges (after annual deductible)
Home Health Care Services	0% *120 visits per contract year*	30% Eligible Charges (after annual deductible) *60 visits per contract year*
	120 visits combined per contract year	
Hospice Care	0%	30% Eligible Charges (after annual deductible)
Skilled Nursing Facility	0% *100 inpatient days per contract year*	30% 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	0%	30% Eligible Charges (after annual deductible)
Removal of Third Molars	0%	30% 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.

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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 $150 per calendar year per member.

HEALTHAMERICA
A Coventry Health Care Plan

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

Premier PPO $20$40

DEDUCTIBLES AND MAXIMUMS	Participating MEMBER RESPONSIBILITY	Non-Participating MEMBER RESPONSIBILITY
Annual Deductible (Inpatient and Infertility deductibles apply separately from annual deductible)		
Individual	None	$500
Family (aggregate)	None	$1,000
Out-of-Pocket Maximum (excludes deductibles and copays)		
Individual	None	$3,000
Family (aggregate)	None	$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	30% Eligible Charges (after annual deductible)
Specialist Visit (SCP)	$40 Copay	30% Eligible Charges (after annual deductible)
Preventive Services*	**(office visit NOT subject to deductible)**	
Gynecological Exam (PCP/SCP)	$0 Copay	30% Eligible Charges (after annual deductible)
Well Child Visit	$0 Copay	30% Eligible Charges (after annual deductible)
Adult Physical Visit	$0 Copay	30% Eligible Charges (after annual deductible)
Routine Pediatric Immunizations	0%	30% Eligible Charges
Hearing Exams (under age 18)	0%	30% Eligible Charges (after annual deductible)
Routine Mammograms	0%	30% Eligible Charges (after annual deductible)
Routine Colonoscopies***	0%	30% Eligible Charges (after annual deductible)
Medical Injectable (Therapies including but not limited to: Remicade, Tysabri, Amevive, Boniva, Reclast)	**$75 Copay**	**30% Eligible Charges (after annual deductible)**
Allergy Testing & Allergy Serum	0%	30% Eligible Charges (after annual deductible)
Chiropractic Care (x-rays are subject to deductible) Maximum 20 visits per contract year	$40 Copay	30% Eligible Charges (after annual deductible)
Outpatient Surgery	0%	30% Eligible Charges (after annual deductible)
Lab Services	0%	30% Eligible Charges (after annual deductible)
Diagnostic X-ray	0%	30% Eligible Charges (after annual deductible)
Radiology (CAT, MRI, Ultrasound, PET)	$125 Copay	30% Eligible Charges (after annual deductible)
HOSPITAL SERVICES	**Participating MEMBER RESPONSIBILITY**	**Non-Participating MEMBER RESPONSIBILITY**
Hospital Care	$500 per admission	
Semi-private room (private room if medically necessary)	0%	30% Eligible Charges (after annual deductible)
Physician and Surgeon Fees	0%	30% Eligible Charges (after annual deductible)
Surgery	0%	30% Eligible Charges (after annual deductible)
Lab and X-ray services	0%	30% Eligible Charges (after annual deductible)
All Medically Necessary Ancillary Services	0%	30% Eligible Charges (after annual deductible)
Anesthesia	0%	30% Eligible Charges (after annual deductible)
Administration of Blood	0%	30% Eligible Charges (after annual deductible)
Blood Products	0%	30% Eligible Charges (after annual deductible)
Therapy Services (Chemotherapy & Radiation Therapy)	0%	30% 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	30% Eligible Charges (after annual deductible)
Delivery	0% $500 per admission	30% 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	0%	30% 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)	**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 $150 Copay (ER Copay waived if admitted)	
REHABILITATION SERVICES	**Participating MEMBER RESPONSIBILITY**	**Non-Participating MEMBER RESPONSIBILITY**
Occupational, Speech, Physical Therapy	0% $500 per admission	30% 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	0% $500 per admission	30% Eligible Charges (after annual deductible)
	30 days per contract year/90 day lifetime benefit maximum	
Physician Services (Outpatient)	$40 Copay per visit	30% Eligible Charges (after annual deductible)
	20 outpatient visits maximum per contract year	
Serious Mental Health: Inpatient	0% $500 per admission	30% Eligible Charges (after annual deductible)
	30 days per contract year	
Physician Services (Outpatient)	$40 Copay per visit	30% Eligible Charges (after annual deductible)
	60 outpatient visits maximum per contract year	
Substance Abuse: Inpatient Detoxification	0% $500 per admission	30% Eligible Charges (after annual deductible)
	7 days maximum per admission/4 admission benefit maximum	
Inpatient Rehabilitation	0% $500 per admission	30% Eligible Charges (after annual deductible)
	30 days maximum per contract year/90 days benefit maximum	
Transitional Partial Hospitalization	0%	30% 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.	0%	30% Eligible Charges (after annual deductible)
Corrective Appliances	0%	30% Eligible Charges (after annual deductible)
Home Health Care Services	0% *120 visits per contract year*	30% Eligible Charges (after annual deductible) *60 visits per contract year*
	120 visits combined per contract year	
Hospice Care	0%	30% Eligible Charges (after annual deductible)
Skilled Nursing Facility	0% $500 per admission *100 inpatient days per contract year*	30% 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	0%	30% Eligible Charges (after annual deductible)
Removal of Third Molars	0%	30% 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

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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.

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***Reimbursement for Weight Management programs is limited to $150 per calendar year per member.*

HEALTHAMERICA
A Coventry Health Care Plan

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

Premier PPO $250

DEDUCTIBLES AND MAXIMUMS	Participating MEMBER RESPONSIBILITY	Non-Participating MEMBER RESPONSIBILITY
Annual Deductible (Inpatient and Infertility deductibles apply separately from annual deductible)		
Individual	$250	$500
Family (aggregate)	$500	$1,000
Out-of-Pocket Maximum (excludes deductibles and copays)		
Individual	None	$3,000
Family (aggregate)	None	$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)	$15 Copay	30% Eligible Charges (after annual deductible)
Specialist Visit (SCP)	$30 Copay	30% Eligible Charges (after annual deductible)
Preventive Services*	**(office visit NOT subject to deductible)**	
Gynecological Exam (PCP/SCP)	$0 Copay	30% Eligible Charges (after annual deductible)
Well Child Visit	$0 Copay	30% Eligible Charges (after annual deductible)
Adult Physical Visit	$0 Copay	30% Eligible Charges (after annual deductible)
Routine Pediatric Immunizations	0%	30% Eligible Charges
Hearing Exams (under age 18)	0%	30% Eligible Charges (after annual deductible)
Routine Mammograms	0%	30% Eligible Charges (after annual deductible)
Routine Colonoscopies***	0%	30% Eligible Charges (after annual deductible)
Allergy Testing & Allergy Serum	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
Chiropractic Care (x-rays are subject to deductible) Maximum 20 visits per contract year	$30 Copay (not subject to annual deductible)	30% Eligible Charges (after annual deductible)
Outpatient Surgery	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
Lab Services	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
Diagnostic X-ray	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
Radiology (CAT, MRI, Ultrasound, PET)	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
HOSPITAL SERVICES	**Participating MEMBER RESPONSIBILITY**	**Non-Participating MEMBER RESPONSIBILITY**
Hospital Care		
Semi-private room (private room if medically necessary)	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
Physician and Surgeon Fees	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
Surgery	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
Lab and X-ray services	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
All Medically Necessary Ancillary Services	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
Anesthesia	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
Administration of Blood	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
Blood Products	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
Therapy Services (Chemotherapy & Radiation Therapy)	0% (after annual deductible)	30% 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)	$15/$30 Copay (not subject to annual deductible)	30% Eligible Charges (after annual deductible)
Delivery	0% (after annual deductible)	30% 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	0% (after annual deductible)	30% 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	$30 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	0% (after annual deductible)	30% 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	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
	30 days per contract year *90 day lifetime benefit maximum*	
Physician Services (Outpatient)	$30 Copay per visit	30% Eligible Charges (after annual deductible)
	20 outpatient visits maximum per contract year	
Serious Mental Health: Inpatient	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
	30 days per contract year	
Physician Services (Outpatient)	$30 Copay per visit	30% Eligible Charges (after annual deductible)
	60 outpatient visits maximum per contract year	
Substance Abuse: Inpatient Detoxification	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
	7 days maximum per admission *4 admission benefit maximum*	
Inpatient Rehabilitation	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
	30 days maximum per contract year *90 days benefit maximum*	
Transitional Partial Hospitalization	0% (after annual deductible)	30% 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.	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
Corrective Appliances	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
Home Health Care Services	0% (after annual deductible) *120 visits per contract year*	30% Eligible Charges (after annual deductible) *60 visits per contract year*
	120 visits combined per contract year	
Hospice Care	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
Skilled Nursing Facility	0% (after annual deductible) *100 inpatient days per contract year*	30% 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	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
Removal of Third Molars	0% (after annual deductible)	30% 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.

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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 $150 per calendar year per member.*

HEALTHAMERICA
A Coventry Health Care Plan

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

Premier 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	None	$3,000
Family (aggregate)	None	$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)	$15 Copay	30% Eligible Charges (after annual deductible)
Specialist Visit (SCP)	$30 Copay	30% Eligible Charges (after annual deductible)
Preventive Services*	**(office visit NOT subject to deductible)**	
Gynecological Exam (PCP/SCP)	$0 Copay	30% Eligible Charges (after annual deductible)
Well Child Visit	$0 Copay	30% Eligible Charges (after annual deductible)
Adult Physical Visit	$0 Copay	30% Eligible Charges (after annual deductible)
Routine Pediatric Immunizations	0%	30% Eligible Charges
Hearing Exams (under age 18)	0%	30% Eligible Charges (after annual deductible)
Routine Mammograms	0%	30% Eligible Charges (after annual deductible)
Routine Colonoscopies***	0%	30% Eligible Charges (after annual deductible)
Allergy Testing & Allergy Serum	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
Chiropractic Care (x-rays are subject to deductible) Maximum 20 visits per contract year	$30 Copay (not subject to annual deductible)	30% Eligible Charges (after annual deductible)
Outpatient Surgery	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
Lab Services	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
Diagnostic X-ray	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
Radiology (CAT, MRI, Ultrasound, PET)	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
HOSPITAL SERVICES	**Participating MEMBER RESPONSIBILITY**	**Non-Participating MEMBER RESPONSIBILITY**
Hospital Care		
Semi-private room (private room if medically necessary)	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
Physician and Surgeon Fees	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
Surgery	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
Lab and X-ray services	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
All Medically Necessary Ancillary Services	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
Anesthesia	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
Administration of Blood	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
Blood Products	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
Therapy Services (Chemotherapy & Radiation Therapy)	0% (after annual deductible)	30% 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)	$15/$30 Copay (not subject to annual deductible)	30% Eligible Charges (after annual deductible)
Delivery	0% (after annual deductible)	30% 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	0% (after annual deductible)	30% 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	$30 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	0% (after annual deductible)	30% 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	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
	30 days per contract year *90 day lifetime benefit maximum*	
Physician Services (Outpatient)	$30 Copay per visit	30% Eligible Charges (after annual deductible)
	20 outpatient visits maximum per contract year	
Serious Mental Health: Inpatient	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
	30 days per contract year	
Physician Services (Outpatient)	$30 Copay per visit	30% Eligible Charges (after annual deductible)
	60 outpatient visits maximum per contract year	
Substance Abuse: Inpatient Detoxification	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
	7 days maximum per admission *4 admission benefit maximum*	
Inpatient Rehabilitation	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
	30 days maximum per contract year *90 days benefit maximum*	
Transitional Partial Hospitalization	0% (after annual deductible)	30% 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.	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
Corrective Appliances	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
Home Health Care Services	0% (after annual deductible) *120 visits per contract year*	30% Eligible Charges (after annual deductible) *60 visits per contract year*
	120 visits combined per contract year	
Hospice Care	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
Skilled Nursing Facility	0% (after annual deductible) *100 inpatient days per contract year*	30% 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	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
Removal of Third Molars	0% (after annual deductible)	30% 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.

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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.

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***Reimbursement for Weight Management programs is limited to $150 per calendar year per member.*

HEALTHAMERICA
A Coventry Health Care Plan

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

Premier PPO $750

DEDUCTIBLES AND MAXIMUMS	Participating MEMBER RESPONSIBILITY	Non-Participating MEMBER RESPONSIBILITY
Annual Deductible (Inpatient and infertility deductibles apply separately from annual deductible)		
Individual	$750	$1,500
Family (aggregate)	$1,500	$3,000
Out-of-Pocket Maximum (excludes deductibles and copays)		
Individual	None	$3,000
Family (aggregate)	None	$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)	$15 Copay	30% Eligible Charges (after annual deductible)
Specialist Visit (SCP)	$30 Copay	30% Eligible Charges (after annual deductible)
Preventive Services*	**(office visit NOT subject to deductible)**	
Gynecological Exam (PCP/SCP)	$0 Copay	30% Eligible Charges (after annual deductible)
Well Child Visit	$0 Copay	30% Eligible Charges (after annual deductible)
Adult Physical Visit	$0 Copay	30% Eligible Charges (after annual deductible)
Routine Pediatric Immunizations	0%	30% Eligible Charges
Hearing Exams (under age 18)	0%	30% Eligible Charges (after annual deductible)
Routine Mammograms	0%	30% Eligible Charges (after annual deductible)
Routine Colonoscopy ***	0%	30% Eligible Charges (after annual deductible)
Allergy Testing & Allergy Serum	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
Chiropractic Care (x-rays are subject to deductible) Maximum 20 visits per contract year	$30 Copay (not subject to annual deductible)	30% Eligible Charges (after annual deductible)
Outpatient Surgery	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
Lab Services	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
Diagnostic X-ray	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
Radiology (CAT, MRI, Ultrasound, PET)	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
HOSPITAL SERVICES	**Participating MEMBER RESPONSIBILITY**	**Non-Participating MEMBER RESPONSIBILITY**
Hospital Care		
Semi-private room (private room if medically necessary)	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
Physician and Surgeon Fees	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
Surgery	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
Lab and X-ray services	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
All Medically Necessary Ancillary Services	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
Anesthesia	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
Administration of Blood	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
Blood Products	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
Therapy Services (Chemotherapy & Radiation Therapy)	0% (after annual deductible)	30% 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)	$15/$30 Copay (not subject to annual deductible)	30% Eligible Charges (after annual deductible)
Delivery	0% (after annual deductible)	30% 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	0% (after annual deductible)	30% 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	$30 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	0% (after annual deductible)	30% 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	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
	30 days per contract year *90 day lifetime benefit maximum*	
Physician Services (Outpatient)	$30 Copay per visit	30% Eligible Charges (after annual deductible)
	20 outpatient visits maximum per contract year	
Serious Mental Health: Inpatient	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
	30 days per contract year	
Physician Services (Outpatient)	$30 Copay per visit	30% Eligible Charges (after annual deductible)
	60 outpatient visits maximum per contract year	
Substance Abuse: Inpatient Detoxification	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
	7 days maximum per admission *4 admission benefit maximum*	
Inpatient Rehabilitation	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
	30 days maximum per contract year *90 days benefit maximum*	
Transitional Partial Hospitalization	0% (after annual deductible)	30% 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.	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
Corrective Appliances	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
Home Health Care Services	0% (after annual deductible) *120 visits per contract year*	30% Eligible Charges (after annual deductible) *60 visits per contract year*
	120 visits combined per contract year	
Hospice Care	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
Skilled Nursing Facility	0% (after annual deductible) *100 inpatient days per contract year*	30% 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	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
Removal of Third Molars	0% (after annual deductible)	30% 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

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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.

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***Reimbursement for Weight Management programs is limited to $150 per calendar year per member.*

HEALTHAMERICA
A Coventry Health Care Plan

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

Premier PPO $1000

DEDUCTIBLES AND MAXIMUMS	Participating MEMBER RESPONSIBILITY	Non-Participating MEMBER RESPONSIBILITY
Annual Deductible (Inpatient and Infertility deductibles apply separately from annual deductible)		
Individual	$1,000	$2,000
Family (aggregate)	$2,000	$4,000
Out-of-Pocket Maximum (excludes deductibles and copays)		
Individual	None	$3,000
Family (aggregate)	None	$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)	$15 Copay	30% Eligible Charges (after annual deductible)
Specialist Visit (SCP)	$30 Copay	30% Eligible Charges (after annual deductible)
Preventive Services*	**(office visit NOT subject to deductible)**	
Gynecological Exam (PCP/SCP)	$0 Copay	30% Eligible Charges (after annual deductible)
Well Child Visit	$0 Copay	30% Eligible Charges (after annual deductible)
Adult Physical Visit	$0 Copay	30% Eligible Charges (after annual deductible)
Routine Pediatric Immunizations	0%	30% Eligible Charges
Hearing Exams (under age 18)	0%	30% Eligible Charges (after annual deductible)
Routine Mammograms	0%	30% Eligible Charges (after annual deductible)
Routine Colonoscopies***	0%	30% Eligible Charges (after annual deductible)
Allergy Testing & Allergy Serum	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
Chiropractic Care (x-rays are subject to deductible) Maximum 20 visits per contract year	$30 Copay (not subject to annual deductible)	30% Eligible Charges (after annual deductible)
Outpatient Surgery	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
Lab Services	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
Diagnostic X-ray	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
Radiology (CAT, MRI, Ultrasound, PET)	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
HOSPITAL SERVICES	**Participating MEMBER RESPONSIBILITY**	**Non-Participating MEMBER RESPONSIBILITY**
Hospital Care		
Semi-private room (private room if medically necessary)	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
Physician and Surgeon Fees	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
Surgery	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
Lab and X-ray services	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
All Medically Necessary Ancillary Services	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
Anesthesia	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
Administration of Blood	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
Blood Products	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
Therapy Services (Chemotherapy & Radiation Therapy)	0% (after annual deductible)	30% 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)	$15/$30 Copay (not subject to annual deductible)	30% Eligible Charges (after annual deductible)
Delivery	0% (after annual deductible)	30% 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	0% (after annual deductible)	30% 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	$30 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	0% (after annual deductible)	30% 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	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
	30 days per contract year *90 day lifetime benefit maximum*	
Physician Services (Outpatient)	$30 Copay per visit	30% Eligible Charges (after annual deductible)
	20 outpatient visits maximum per contract year	
Serious Mental Health: Inpatient	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
	30 days per contract year	
Physician Services (Outpatient)	$30 Copay per visit	30% Eligible Charges (after annual deductible)
	60 outpatient visits maximum per contract year	
Substance Abuse: Inpatient Detoxification	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
	7 days maximum per admission *4 admission benefit maximum*	
Inpatient Rehabilitation	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
	30 days maximum per contract year *90 days benefit maximum*	
Transitional Partial Hospitalization	0% (after annual deductible)	30% 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.	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
Corrective Appliances	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
Home Health Care Services	0% (after annual deductible) *120 visits per contract year*	30% Eligible Charges (after annual deductible) *60 visits per contract year*
	120 visits combined per contract year	
Hospice Care	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
Skilled Nursing Facility	0% (after annual deductible) *100 inpatient days per contract year*	30% 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	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
Removal of Third Molars	0% (after annual deductible)	30% 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.

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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 $150 per calendar year per member.*

HEALTHAMERICA
A Coventry Health Care Plan

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

Premier PPO $1250

DEDUCTIBLES AND MAXIMUMS	Participating MEMBER RESPONSIBILITY	Non-Participating MEMBER RESPONSIBILITY
Annual Deductible (Inpatient and Infertility deductibles apply separately from annual deductible)		
Individual	$1,250	$2,500
Family (aggregate)	$2,500	$5,000
Out-of-Pocket Maximum (excludes deductibles and copays)		
Individual	None	$5,000
Family (aggregate)	None	$10,000
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)	$15 Copay	40% Eligible Charges (after annual deductible)
Specialist Visit (SCP)	$30 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	0% (after annual deductible)	40% Eligible Charges (after annual deductible)
Chiropractic Care (x-rays are subject to deductible) Maximum 20 visits per contract year	$30 Copay (not subject to annual deductible)	40% Eligible Charges (after annual deductible)
Outpatient Surgery	0% (after annual deductible)	40% Eligible Charges (after annual deductible)
Lab Services	0% (after annual deductible)	40% Eligible Charges (after annual deductible)
Diagnostic X-ray	0% (after annual deductible)	40% Eligible Charges (after annual deductible)
Radiology (CAT, MRI, Ultrasound, PET)	0% (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)	0% (after annual deductible)	40% Eligible Charges (after annual deductible)
Physician and Surgeon Fees	0% (after annual deductible)	40% Eligible Charges (after annual deductible)
Surgery	0% (after annual deductible)	40% Eligible Charges (after annual deductible)
Lab and X-ray services	0% (after annual deductible)	40% Eligible Charges (after annual deductible)
All Medically Necessary Ancillary Services	0% (after annual deductible)	40% Eligible Charges (after annual deductible)
Anesthesia	0% (after annual deductible)	40% Eligible Charges (after annual deductible)
Administration of Blood	0% (after annual deductible)	40% Eligible Charges (after annual deductible)
Blood Products	0% (after annual deductible)	40% Eligible Charges (after annual deductible)
Therapy Services (Chemotherapy & Radiation Therapy)	0% (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)	$15/$30 Copay (not subject to annual deductible)	40% Eligible Charges (after annual deductible)
Delivery	0% (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	0% (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	$30 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	0% (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	0% (after annual deductible)	40% Eligible Charges (after annual deductible)
	30 days per contract year *90 day lifetime benefit maximum*	
Physician Services (Outpatient)	$30 Copay per visit	40% Eligible Charges (after annual deductible)
	20 outpatient visits maximum per contract year	
Serious Mental Health: **Inpatient**	0% (after annual deductible)	40% Eligible Charges (after annual deductible)
	30 days per contract year	
Physician Services (Outpatient)	$30 Copay per visit	40% Eligible Charges (after annual deductible)
	60 outpatient visits maximum per contract year	
Substance Abuse: Inpatient Detoxification	0% (after annual deductible)	40% Eligible Charges (after annual deductible)
	7 days maximum per admission *4 admission benefit maximum*	
Inpatient Rehabilitation	0% (after annual deductible)	40% Eligible Charges (after annual deductible)
	30 days maximum per contract year *90 days benefit maximum*	
Transitional Partial Hospitalization	0% (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.	0% (after annual deductible)	40% Eligible Charges (after annual deductible)
Corrective Appliances	0% (after annual deductible)	40% Eligible Charges (after annual deductible)
Home Health Care Services	0% (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	0% (after annual deductible)	40% Eligible Charges (after annual deductible)
Skilled Nursing Facility	0% (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	0% (after annual deductible)	40% Eligible Charges (after annual deductible)
Removal of Third Molars	0% (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

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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.

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***Reimbursement for Weight Management programs is limited to $150 per calendar year per member.*

HEALTHAMERICA
A Coventry Health Care Plan

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

Premier PPO $1500

DEDUCTIBLES AND MAXIMUMS	Participating MEMBER RESPONSIBILITY	Non-Participating MEMBER RESPONSIBILITY
Annual Deductible (Inpatient and Infertility deductibles apply separately from annual deductible)		
Individual	$1,500	$3,000
Family (aggregate)	$3,000	$6,000
Out-of-Pocket Maximum (excludes deductibles and copays)		
Individual	None	$5,000
Family (aggregate)	None	$10,000
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	0% (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	0% (after annual deductible)	40% Eligible Charges (after annual deductible)
Lab Services	0% (after annual deductible)	40% Eligible Charges (after annual deductible)
Diagnostic X-ray	0% (after annual deductible)	40% Eligible Charges (after annual deductible)
Radiology (CAT, MRI, Ultrasound, PET)	0% (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)	0% (after annual deductible)	40% Eligible Charges (after annual deductible)
Physician and Surgeon Fees	0% (after annual deductible)	40% Eligible Charges (after annual deductible)
Surgery	0% (after annual deductible)	40% Eligible Charges (after annual deductible)
Lab and X-ray services	0% (after annual deductible)	40% Eligible Charges (after annual deductible)
All Medically Necessary Ancillary Services	0% (after annual deductible)	40% Eligible Charges (after annual deductible)
Anesthesia	0% (after annual deductible)	40% Eligible Charges (after annual deductible)
Administration of Blood	0% (after annual deductible)	40% Eligible Charges (after annual deductible)
Blood Products	0% (after annual deductible)	40% Eligible Charges (after annual deductible)
Therapy Services (Chemotherapy & Radiation Therapy)	0% (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	0% (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	0% (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	0% (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	0% (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	0% (after annual deductible)	40% Eligible Charges (after annual deductible)
	30 days per contract year	
Physician Services (Outpatient)	$40 Copay per visit	40% Eligible Charges (after annual deductible)
	60 outpatient visits maximum per contract year	
Substance Abuse: Inpatient Detoxification	0% (after annual deductible)	40% Eligible Charges (after annual deductible)
	7 days maximum per admission *4 admission benefit maximum*	
Inpatient Rehabilitation	0% (after annual deductible)	40% Eligible Charges (after annual deductible)
	30 days maximum per contract year *90 days benefit maximum*	
Transitional Partial Hospitalization	0% (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.	0% (after annual deductible)	40% Eligible Charges (after annual deductible)
Corrective Appliances	0% (after annual deductible)	40% Eligible Charges (after annual deductible)
Home Health Care Services	0% (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	0% (after annual deductible)	40% Eligible Charges (after annual deductible)
Skilled Nursing Facility	0% (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	0% (after annual deductible)	40% Eligible Charges (after annual deductible)
Removal of Third Molars	0% (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

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LIFETIME MAXIMUM Unlimited

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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.

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HEALTHAMERICA
A Coventry Health Care Plan

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

Premier PPO $2000

DEDUCTIBLES AND MAXIMUMS	Participating MEMBER RESPONSIBILITY	Non-Participating MEMBER RESPONSIBILITY
Annual Deductible (Inpatient and Infertility deductibles apply separately from annual deductible)		
Individual	$2,000	$4,000
Family (aggregate)	$4,000	$8,000
Out-of-Pocket Maximum (excludes deductibles and copays)		
Individual	None	$5,000
Family (aggregate)	None	$10,000
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	0% (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	0% (after annual deductible)	40% Eligible Charges (after annual deductible)
Lab Services	0% (after annual deductible)	40% Eligible Charges (after annual deductible)
Diagnostic X-ray	0% (after annual deductible)	40% Eligible Charges (after annual deductible)
Radiology (CAT, MRI, Ultrasound, PET)	0% (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)	0% (after annual deductible)	40% Eligible Charges (after annual deductible)
Physician and Surgeon Fees	0% (after annual deductible)	40% Eligible Charges (after annual deductible)
Surgery	0% (after annual deductible)	40% Eligible Charges (after annual deductible)
Lab and X-ray services	0% (after annual deductible)	40% Eligible Charges (after annual deductible)
All Medically Necessary Ancillary Services	0% (after annual deductible)	40% Eligible Charges (after annual deductible)
Anesthesia	0% (after annual deductible)	40% Eligible Charges (after annual deductible)
Administration of Blood	0% (after annual deductible)	40% Eligible Charges (after annual deductible)
Blood Products	0% (after annual deductible)	40% Eligible Charges (after annual deductible)
Therapy Services (Chemotherapy & Radiation Therapy)	0% (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	0% (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	0% (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	0% (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	0% (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	0% (after annual deductible)	40% Eligible Charges (after annual deductible)
	30 days per contract year	
Physician Services (Outpatient)	$40 Copay per visit	40% Eligible Charges (after annual deductible)
	60 outpatient visits maximum per contract year	
Substance Abuse: Inpatient Detoxification	0% (after annual deductible)	40% Eligible Charges (after annual deductible)
	7 days maximum per admission *4 admission benefit maximum*	
Inpatient Rehabilitation	0% (after annual deductible)	40% Eligible Charges (after annual deductible)
	30 days maximum per contract year *90 days benefit maximum*	
Transitional Partial Hospitalization	0% (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.	0% (after annual deductible)	40% Eligible Charges (after annual deductible)
Corrective Appliances	0% (after annual deductible)	40% Eligible Charges (after annual deductible)
Home Health Care Services	0% (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	0% (after annual deductible)	40% Eligible Charges (after annual deductible)
Skilled Nursing Facility	0% (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	0% (after annual deductible)	40% Eligible Charges (after annual deductible)
Removal of Third Molars	0% (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.

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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 $150 per calendar year per member.*

HEALTHAMERICA
A Coventry Health Care Plan

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

Premier PPO $3000

DEDUCTIBLES AND MAXIMUMS	Participating MEMBER RESPONSIBILITY	Non-Participating MEMBER RESPONSIBILITY
Annual Deductible (Inpatient and Infertility deductibles apply separately from annual deductible)		
Individual	$3,000	$5,000
Family (aggregate)	$6,000	$10,000
Out-of-Pocket Maximum (excludes deductibles and copays)		
Individual	None	$7,000
Family (aggregate)	None	$14,000
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	0% (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	0% (after annual deductible)	40% Eligible Charges (after annual deductible)
Lab Services	0% (after annual deductible)	40% Eligible Charges (after annual deductible)
Diagnostic X-ray	0% (after annual deductible)	40% Eligible Charges (after annual deductible)
Radiology (CAT, MRI, Ultrasound, PET)	0% (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)	0% (after annual deductible)	40% Eligible Charges (after annual deductible)
Physician and Surgeon Fees	0% (after annual deductible)	40% Eligible Charges (after annual deductible)
Surgery	0% (after annual deductible)	40% Eligible Charges (after annual deductible)
Lab and X-ray services	0% (after annual deductible)	40% Eligible Charges (after annual deductible)
All Medically Necessary Ancillary Services	0% (after annual deductible)	40% Eligible Charges (after annual deductible)
Anesthesia	0% (after annual deductible)	40% Eligible Charges (after annual deductible)
Administration of Blood	0% (after annual deductible)	40% Eligible Charges (after annual deductible)
Blood Products	0% (after annual deductible)	40% Eligible Charges (after annual deductible)
Therapy Services (Chemotherapy & Radiation Therapy)	0% (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	0% (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	0% (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	0% (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	0% (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	0% (after annual deductible)	40% Eligible Charges (after annual deductible)
	30 days per contract year	
Physician Services (Outpatient)	$40 Copay per visit	40% Eligible Charges (after annual deductible)
	60 outpatient visits maximum per contract year	
Substance Abuse: Inpatient Detoxification	0% (after annual deductible)	40% Eligible Charges (after annual deductible)
	7 days maximum per admission *4 admission benefit maximum*	
Inpatient Rehabilitation	0% (after annual deductible)	40% Eligible Charges (after annual deductible)
	30 days maximum per contract year *90 days benefit maximum*	
Transitional Partial Hospitalization	0% (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.	0% (after annual deductible)	40% Eligible Charges (after annual deductible)
Corrective Appliances	0% (after annual deductible)	40% Eligible Charges (after annual deductible)
Home Health Care Services	0% (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	0% (after annual deductible)	40% Eligible Charges (after annual deductible)
Skilled Nursing Facility	0% (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	0% (after annual deductible)	40% Eligible Charges (after annual deductible)
Removal of Third Molars	0% (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.

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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.

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***Reimbursement for Weight Management programs is limited to $150 per calendar year per member.*

HEALTHAMERICA
A Coventry Health Care Plan

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

Premier PPO $5000

DEDUCTIBLES AND MAXIMUMS	Participating MEMBER RESPONSIBILITY	Non-Participating MEMBER RESPONSIBILITY
Annual Deductible (Inpatient and Infertility deductibles apply separately from annual deductible)		
Individual	$5,000	$7,500
Family (aggregate)	$10,000	$15,000
Out-of-Pocket Maximum (excludes deductibles and copays)		
Individual	None	$9,000
Family (aggregate)	None	$18,000
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	0% (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	0% (after annual deductible)	40% Eligible Charges (after annual deductible)
Lab Services	0% (after annual deductible)	40% Eligible Charges (after annual deductible)
Diagnostic X-ray	0% (after annual deductible)	40% Eligible Charges (after annual deductible)
Radiology (CAT, MRI, Ultrasound, PET)	0% (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)	0% (after annual deductible)	40% Eligible Charges (after annual deductible)
Physician and Surgeon Fees	0% (after annual deductible)	40% Eligible Charges (after annual deductible)
Surgery	0% (after annual deductible)	40% Eligible Charges (after annual deductible)
Lab and X-ray services	0% (after annual deductible)	40% Eligible Charges (after annual deductible)
All Medically Necessary Ancillary Services	0% (after annual deductible)	40% Eligible Charges (after annual deductible)
Anesthesia	0% (after annual deductible)	40% Eligible Charges (after annual deductible)
Administration of Blood	0% (after annual deductible)	40% Eligible Charges (after annual deductible)
Blood Products	0% (after annual deductible)	40% Eligible Charges (after annual deductible)
Therapy Services (Chemotherapy & Radiation Therapy)	0% (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	0% (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	0% (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	0% (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	0% (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	0% (after annual deductible)	40% Eligible Charges (after annual deductible)
	30 days per contract year	
Physician Services (Outpatient)	$40 Copay per visit	40% Eligible Charges (after annual deductible)
	60 outpatient visits maximum per contract year	
Substance Abuse: Inpatient Detoxification	0% (after annual deductible)	40% Eligible Charges (after annual deductible)
	7 days maximum per admission *4 admission benefit maximum*	
Inpatient Rehabilitation	0% (after annual deductible)	40% Eligible Charges (after annual deductible)
	30 days maximum per contract year *90 days benefit maximum*	
Transitional Partial Hospitalization	0% (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.	0% (after annual deductible)	40% Eligible Charges (after annual deductible)
Corrective Appliances	0% (after annual deductible)	40% Eligible Charges (after annual deductible)
Home Health Care Services	0% (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	0% (after annual deductible)	40% Eligible Charges (after annual deductible)
Skilled Nursing Facility	0% (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	0% (after annual deductible)	40% Eligible Charges (after annual deductible)
Removal of Third Molars	0% (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.

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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.

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***Reimbursement for Weight Management programs is limited to $150 per calendar year per member.*

HEALTHAMERICA
A Coventry Health Care Plan

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

Premier PPO $2500 1x

DEDUCTIBLES AND MAXIMUMS	Participating MEMBER RESPONSIBILITY	Non-Participating MEMBER RESPONSIBILITY
Annual Deductible (Inpatient and Infertility deductibles apply separately from annual deductible)		
Individual	$2,500	$5,000
Family	$2,500	$5,000
Out-of-Pocket Maximum (excludes deductibles and copays)		
Individual	None	$10,000
Family (aggregate)	None	$10,000
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	20% Eligible Charges (after annual deductible)
Specialist Visit (SCP)	$40	20% Eligible Charges (after annual deductible)
Preventive Services*	(office visit NOT subject to deductible)	
Gynecological Exam (PCP/SCP)	$0 Copay	20% Eligible Charges (after annual deductible)
Well Child Visit	$0 Copay	20% Eligible Charges (after annual deductible)
Adult Physical Visit	$0 Copay	20% Eligible Charges (after annual deductible)
Routine Pediatric Immunizations	0%	20% Eligible Charges
Hearing Exams (under age 18)	0%	20% Eligible Charges (after annual deductible)
Routine Mammograms	0%	20% Eligible Charges (after annual deductible)
Routine Colonoscopies***	0%	20% Eligible Charges (after annual deductible)
Allergy Testing & Allergy Serum	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Chiropractic Care (x-rays are subject to deductible) Maximum 20 visits per contract year	$40 (not subject to annual deductible)	20% Eligible Charges (after annual deductible)
Outpatient Surgery	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Lab Services	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Diagnostic X-ray	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Radiology (CAT, MRI, Ultrasound. PET)	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
HOSPITAL SERVICES	**Participating MEMBER RESPONSIBILITY**	**Non-Participating MEMBER RESPONSIBILITY**
Hospital Care	0% (after annual deductible)	
Semi-private room (private room if medically necessary)	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Physician and Surgeon Fees	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Surgery	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Lab and X-ray services	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
All Medically Necessary Ancillary Services	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Anesthesia	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Administration of Blood	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Blood Products	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Therapy Services (Chemotherapy & Radiation Therapy)	0% (after annual deductible)	20% 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 (not subject to annual deductible)	20% Eligible Charges (after annual deductible)
Delivery	0% (after annual deductible)	20% 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	0% (after annual deductible)	20% 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	0% (after annual deductible)	20% 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	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
	30 days per contract year *90 day lifetime benefit maximum*	
Physician Services (Outpatient)	$40 Copay per visit	20% Eligible Charges (after annual deductible)
	20 outpatient visits maximum per contract year	
Serious Mental Health: Inpatient	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
	30 days per contract year	
Physician Services (Outpatient)	$40 Copay per visit	20% Eligible Charges (after annual deductible)
	60 outpatient visits maximum per contract year	
Substance Abuse: Inpatient Detoxification	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
	7 days maximum per admission *4 admission benefit maximum*	
Inpatient Rehabilitation	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
	30 days maximum per contract year *90 days benefit maximum*	
Transitional Partial Hospitalization	0% (after annual deductible)	20% 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.	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Corrective Appliances	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Home Health Care Services	0% (after annual deductible) *120 visits per contract year*	20% Eligible Charges (after annual deductible) *60 visits per contract year*
	120 visits combined per contract year	
Hospice Care	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Skilled Nursing Facility	0% (after annual deductible) *100 inpatient days per contract year*	20% 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	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Removal of Third Molars	0% (after annual deductible)	20% 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.

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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 $150 per calendar year per member.*

HEALTHAMERICA
A Coventry Health Care Plan

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

Premier PPO $3250 1x

DEDUCTIBLES AND MAXIMUMS	Participating MEMBER RESPONSIBILITY	Non-Participating MEMBER RESPONSIBILITY
Annual Deductible (Inpatient and Infertility deductibles apply separately from annual deductible)		
Individual	$3,250	$5,000
Family	$3,250	$5,000
Out-of-Pocket Maximum (excludes deductibles and copays)		
Individual	None	$10,000
Family (aggregate)	None	$10,000
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	20% Eligible Charges (after annual deductible)
Specialist Visit (SCP)	$40	20% Eligible Charges (after annual deductible)
Preventive Services*	(office visit NOT subject to deductible)	
Gynecological Exam (PCP/SCP)	$0 Copay	20% Eligible Charges (after annual deductible)
Well Child Visit	$0 Copay	20% Eligible Charges (after annual deductible)
Adult Physical Visit	$0 Copay	20% Eligible Charges (after annual deductible)
Routine Pediatric Immunizations	0%	20% Eligible Charges
Hearing Exams (under age 18)	0%	20% Eligible Charges (after annual deductible)
Routine Mammograms	0%	20% Eligible Charges (after annual deductible)
Routine Colonoscopies***	0%	20% Eligible Charges (after annual deductible)
Allergy Testing & Allergy Serum	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Chiropractic Care (x-rays are subject to deductible) Maximum 20 visits per contract year	$40 (not subject to annual deductible)	20% Eligible Charges (after annual deductible)
Outpatient Surgery	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Lab Services	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Diagnostic X-ray	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Radiology (CAT, MRI, Ultrasound. PET)	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
HOSPITAL SERVICES	**Participating MEMBER RESPONSIBILITY**	**Non-Participating MEMBER RESPONSIBILITY**
Hospital Care		
Semi-private room (private room if medically necessary)	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Physician and Surgeon Fees	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Surgery	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Lab and X-ray services	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
All Medically Necessary Ancillary Services	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Anesthesia	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Administration of Blood	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Blood Products	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Therapy Services (Chemotherapy & Radiation Therapy)	0% (after annual deductible)	20% 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 (not subject to annual deductible)	20% Eligible Charges (after annual deductible)
Delivery	0% (after annual deductible)	20% 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	0% (after annual deductible)	20% 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	0% (after annual deductible)	20% 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	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
	30 days per contract year *90 day lifetime benefit maximum*	
Physician Services (Outpatient)	$40 Copay per visit	20% Eligible Charges (after annual deductible)
	20 outpatient visits maximum per contract year	
Serious Mental Health: Inpatient	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
	30 days per contract year *90 day lifetime benefit maximum*	
Physician Services (Outpatient)	$40 Copay per visit	20% Eligible Charges (after annual deductible)
	60 outpatient visits maximum per contract year	
Substance Abuse: Inpatient Detoxification	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
	7 days maximum per admission *4 admission benefit maximum*	
Inpatient Rehabilitation	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
	30 days maximum per contract year *90 days benefit maximum*	
Transitional Partial Hospitalization	0% (after annual deductible)	20% 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.	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Corrective Appliances	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Home Health Care Services	0% (after annual deductible) *120 visits per contract year*	20% Eligible Charges (after annual deductible) *60 visits per contract year*
	120 visits combined per contract year	
Hospice Care	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Skilled Nursing Facility	0% (after annual deductible) *100 inpatient days per contract year*	20% 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	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Removal of Third Molars	0% (after annual deductible)	20% 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

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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.

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

HEALTHAMERICA
A Coventry Health Care Plan

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

Premier PPO $4,000 1x

DEDUCTIBLES AND MAXIMUMS	Participating MEMBER RESPONSIBILITY	Non-Participating MEMBER RESPONSIBILITY
Annual Deductible (Inpatient and Infertility deductibles apply separately from annual deductible)		
Individual	$4,000	$6,000
Family	$4,000	$6,000
Out-of-Pocket Maximum (excludes deductibles and copays)		
Individual	None	$5,000
Family (aggregate)	None	$5,000
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)	$25	20% Eligible Charges (after annual deductible)
Specialist Visit (SCP)	$50	20% Eligible Charges (after annual deductible)
Preventive Services*	(office visit NOT subject to deductible)	
Gynecological Exam (PCP/SCP)	$0 Copay	20% Eligible Charges (after annual deductible)
Well Child Visit	$0 Copay	20% Eligible Charges (after annual deductible)
Adult Physical Visit	$0 Copay	20% Eligible Charges (after annual deductible)
Routine Pediatric Immunizations	0%	20% Eligible Charges
Hearing Exams (under age 18)	0%	20% Eligible Charges (after annual deductible)
Routine Mammograms	0%	20% Eligible Charges (after annual deductible)
Routine Colonoscopies***	0%	20% Eligible Charges (after annual deductible)
Allergy Testing & Allergy Serum	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Chiropractic Care (x-rays are subject to deductible) Maximum 20 visits per contract year	$50 (not subject to annual deductible)	20% Eligible Charges (after annual deductible)
Outpatient Surgery	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Lab Services	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Diagnostic X-ray	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Radiology (CAT, MRI, Ultrasound. PET)	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
HOSPITAL SERVICES	**Participating MEMBER RESPONSIBILITY**	**Non-Participating MEMBER RESPONSIBILITY**
Hospital Care	0% (after annual deductible)	
Semi-private room (private room if medically necessary)	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Physician and Surgeon Fees	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Surgery	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Lab and X-ray services	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
All Medically Necessary Ancillary Services	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Anesthesia	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Administration of Blood	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Blood Products	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Therapy Services (Chemotherapy & Radiation Therapy)	0% (after annual deductible)	20% 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)	$25/$50 (not subject to annual deductible)	20% Eligible Charges (after annual deductible)
Delivery	0% (after annual deductible)	20% 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	0% (after annual deductible)	20% 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	$50 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	0% (after annual deductible)	20% 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	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
	30 days per contract year *90 day lifetime benefit maximum*	
Physician Services (Outpatient)	$50 Copay per visit	20% Eligible Charges (after annual deductible)
	20 outpatient visits maximum per contract year	
Serious Mental Health: Inpatient	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
	30 days per contract year	
Physician Services (Outpatient)	$50 Copay per visit	20% Eligible Charges (after annual deductible)
	60 outpatient visits maximum per contract year	
Substance Abuse: Inpatient Detoxification	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
	7 days maximum per admission *4 admission benefit maximum*	
Inpatient Rehabilitation	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
	30 days maximum per contract year *90 days benefit maximum*	
Transitional Partial Hospitalization	0% (after annual deductible)	20% 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.	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Corrective Appliances	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Home Health Care Services	0% (after annual deductible) *120 visits per contract year*	20% Eligible Charges (after annual deductible) *60 visits per contract year*
	120 visits combined per contract year	
Hospice Care	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Skilled Nursing Facility	0% (after annual deductible) *100 inpatient days per contract year*	20% 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	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Removal of Third Molars	0% (after annual deductible)	20% 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

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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 $150 per calendar year per member.*

HEALTHAMERICA
A Coventry Health Care Plan

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

Premier PPO $5,000 1x

DEDUCTIBLES AND MAXIMUMS	Participating MEMBER RESPONSIBILITY	Non-Participating MEMBER RESPONSIBILITY
Annual Deductible (Inpatient and Infertility deductibles apply separately from annual deductible)		
Individual	$5,000	$7,500
Family	$5,000	$7,500
Out-of-Pocket Maximum (excludes deductibles and copays)		
Individual	None	$10,000
Family (aggregate)	None	$10,000
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	20% Eligible Charges (after annual deductible)
Specialist Visit (SCP)	$40	20% Eligible Charges (after annual deductible)
Preventive Services*	(office visit NOT subject to deductible)	
Gynecological Exam (PCP/SCP)	$0 Copay	20% Eligible Charges (after annual deductible)
Well Child Visit	$0 Copay	20% Eligible Charges (after annual deductible)
Adult Physical Visit	$0 Copay	20% Eligible Charges (after annual deductible)
Routine Pediatric Immunizations	0%	20% Eligible Charges
Hearing Exams (under age 18)	0%	20% Eligible Charges (after annual deductible)
Routine Mammograms	0%	20% Eligible Charges (after annual deductible)
Routine Colonoscopies***	0%	20% Eligible Charges (after annual deductible)
Allergy Testing & Allergy Serum	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Chiropractic Care (x-rays are subject to deductible) Maximum 20 visits per contract year	$40 (not subject to annual deductible)	20% Eligible Charges (after annual deductible)
Outpatient Surgery	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Lab Services	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Diagnostic X-ray	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Radiology (CAT, MRI, Ultrasound. PET)	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
HOSPITAL SERVICES	**Participating MEMBER RESPONSIBILITY**	**Non-Participating MEMBER RESPONSIBILITY**
Hospital Care		
Semi-private room (private room if medically necessary)	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Physician and Surgeon Fees	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Surgery	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Lab and X-ray services	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
All Medically Necessary Ancillary Services	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Anesthesia	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Administration of Blood	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Blood Products	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Therapy Services (Chemotherapy & Radiation Therapy)	0% (after annual deductible)	20% 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 (not subject to annual deductible)	20% Eligible Charges (after annual deductible)
Delivery	0% (after annual deductible)	20% 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	0% (after annual deductible)	20% 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.** **MULTIPLE 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	0% (after annual deductible)	20% 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	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
	30 days per contract year *90 day lifetime benefit maximum*	
Physician Services (Outpatient)	$40 Copay per visit	20% Eligible Charges (after annual deductible)
	20 outpatient visits maximum per contract year	
Serious Mental Health: Inpatient	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
	30 days per contract year *90 day lifetime benefit maximum*	
Physician Services (Outpatient)	$40 Copay per visit	20% Eligible Charges (after annual deductible)
	60 visit maximum per contract year	
Substance Abuse: Inpatient Detoxification	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
	7 days maximum per admission *4 admission benefit maximum*	
Inpatient Rehabilitation	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
	30 days per contract year *90 day lifetime benefit maximum*	
Transitional Partial Hospitalization	0% (after annual deductible)	20% 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.	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Corrective Appliances	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Home Health Care Services	0% (after annual deductible) *120 visits per contract year*	20% Eligible Charges (after annual deductible) *60 visits per contract year*
	120 visits combined per contract year	
Hospice Care	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Skilled Nursing Facility	0% (after annual deductible) *100 inpatient days per contract year*	20% 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	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Removal of Third Molars	0% (after annual deductible)	20% 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.

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

HEALTHAMERICA
A Coventry Health Care Plan

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

Premier PPO $6,000 1x

DEDUCTIBLES AND MAXIMUMS	Participating MEMBER RESPONSIBILITY	Non-Participating MEMBER RESPONSIBILITY
Annual Deductible (Inpatient and Infertility deductibles apply separately from annual deductible)		
Individual	$6,000	$8,500
Family	$6,000	$8,500
Out-of-Pocket Maximum (excludes deductibles and copays)		
Individual	None	$10,000
Family (aggregate)	None	$10,000
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	20% Eligible Charges (after annual deductible)
Specialist Visit (SCP)	$40	20% Eligible Charges (after annual deductible)
Preventive Services*	(office visit NOT subject to deductible)	
Gynecological Exam (PCP/SCP)	$0 Copay	20% Eligible Charges (after annual deductible)
Well Child Visit	$0 Copay	20% Eligible Charges (after annual deductible)
Adult Physical Visit	$0 Copay	20% Eligible Charges (after annual deductible)
Routine Pediatric Immunizations	0%	20% Eligible Charges
Hearing Exams (under age 18)	0%	20% Eligible Charges (after annual deductible)
Routine Mammograms	0%	20% Eligible Charges (after annual deductible)
Routine Colonoscopies***	0%	20% Eligible Charges (after annual deductible)
Allergy Testing & Allergy Serum	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Chiropractic Care (x-rays are subject to deductible) Maximum 20 visits per contract year	$40 (not subject to annual deductible)	20% Eligible Charges (after annual deductible)
Outpatient Surgery	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Lab Services	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Diagnostic X-ray	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Radiology (CAT, MRI, Ultrasound. PET)	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
HOSPITAL SERVICES	**Participating MEMBER RESPONSIBILITY**	**Non-Participating MEMBER RESPONSIBILITY**
Hospital Care		
Semi-private room (private room if medically necessary)	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Physician and Surgeon Fees	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Surgery	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Lab and X-ray services	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
All Medically Necessary Ancillary Services	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Anesthesia	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Administration of Blood	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Blood Products	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Therapy Services (Chemotherapy & Radiation Therapy)	0% (after annual deductible)	20% 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 (not subject to annual deductible)	20% Eligible Charges (after annual deductible)
Delivery	0% (after annual deductible)	20% 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	0% (after annual deductible)	20% 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.** **MULTIPLE 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	0% (after annual deductible)	20% 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	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
	30 days per contract year *90 day lifetime benefit maximum*	
Physician Services (Outpatient)	$40 Copay per visit	20% Eligible Charges (after annual deductible)
	20 outpatient visits maximum per contract year	
Serious Mental Health: Inpatient	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
	30 days per contract year *90 day lifetime benefit maximum*	
Physician Services (Outpatient)	$40 Copay per visit	20% Eligible Charges (after annual deductible)
	60 outpatient visits maximum per contract year	
Substance Abuse: Inpatient Detoxification	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
	7 days maximum per admission *4 admission benefit maximum*	
Inpatient Rehabilitation	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
	30 days per contract year *90 day lifetime benefit maximum*	
Transitional Partial Hospitalization	0% (after annual deductible)	20% 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.	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Corrective Appliances	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Home Health Care Services	0% (after annual deductible) *120 visits per contract year*	20% Eligible Charges (after annual deductible) *60 visits per contract year*
	120 visits combined per contract year	
Hospice Care	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Skilled Nursing Facility	0% (after annual deductible) *100 inpatient days per contract year*	20% 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	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Removal of Third Molars	0% (after annual deductible)	20% 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

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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.

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

HEALTHAMERICA
A Coventry Health Care Plan

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

Premier PPO $7,500 1x

DEDUCTIBLES AND MAXIMUMS	Participating MEMBER RESPONSIBILITY	Non-Participating MEMBER RESPONSIBILITY
Annual Deductible (Inpatient and Infertility deductibles apply separately from annual deductible)		
Individual	$7,500	$10,000
Family	$7,500	$10,000
Out-of-Pocket Maximum (excludes deductibles and copays)		
Individual	None	$5,000
Family (aggregate)	None	$5,000
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)	$25	20% Eligible Charges (after annual deductible)
Specialist Visit (SCP)	$50	20% Eligible Charges (after annual deductible)
Preventive Services*	(office visit NOT subject to deductible)	
Gynecological Exam (PCP/SCP)	$0 Copay	20% Eligible Charges (after annual deductible)
Well Child Visit	$0 Copay	20% Eligible Charges (after annual deductible)
Adult Physical Visit	$0 Copay	20% Eligible Charges (after annual deductible)
Routine Pediatric Immunizations	0%	20% Eligible Charges
Hearing Exams (under age 18)	0%	20% Eligible Charges (after annual deductible)
Routine Mammograms	0%	20% Eligible Charges (after annual deductible)
Routine Colonoscopies***	0%	20% Eligible Charges (after annual deductible)
Allergy Testing & Allergy Serum	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Chiropractic Care (x-rays are subject to deductible) Maximum 20 visits per contract year	$50 (not subject to annual deductible)	20% Eligible Charges (after annual deductible)
Outpatient Surgery	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Lab Services	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Diagnostic X-ray	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Radiology (CAT, MRI, Ultrasound. PET)	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
HOSPITAL SERVICES	**Participating MEMBER RESPONSIBILITY**	**Non-Participating MEMBER RESPONSIBILITY**
Hospital Care	0% (after annual deductible)	
Semi-private room (private room if medically necessary)	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Physician and Surgeon Fees	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Surgery	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Lab and X-ray services	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
All Medically Necessary Ancillary Services	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Anesthesia	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Administration of Blood	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Blood Products	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Therapy Services (Chemotherapy & Radiation Therapy)	0% (after annual deductible)	20% 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)	$25/$50 (not subject to annual deductible)	20% Eligible Charges (after annual deductible)
Delivery	0% (after annual deductible)	20% 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	0% (after annual deductible)	20% 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	$50 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	0% (after annual deductible)	20% 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	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
	30 days per contract year *90 day lifetime benefit maximum*	
Physician Services (Outpatient)	$50 Copay per visit	20% Eligible Charges (after annual deductible)
	20 outpatient visits maximum per contract year	
Serious Mental Health: Inpatient	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
	30 days per contract year	
Physician Services (Outpatient)	$50 Copay per visit	20% Eligible Charges (after annual deductible)
	60 outpatient visits maximum per contract year	
Substance Abuse: Inpatient Detoxification	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
	7 days maximum per admission *4 admission benefit maximum*	
Inpatient Rehabilitation	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
	30 days maximum per contract year *90 days benefit maximum*	
Transitional Partial Hospitalization	0% (after annual deductible)	20% 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.	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Corrective Appliances	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Home Health Care Services	0% (after annual deductible) *120 visits per contract year*	20% Eligible Charges (after annual deductible) *60 visits per contract year*
	120 visits combined per contract year	
Hospice Care	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Skilled Nursing Facility	0% (after annual deductible) *100 inpatient days per contract year*	20% 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	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Removal of Third Molars	0% (after annual deductible)	20% 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.

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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 $150 per calendar year per member.*

HEALTHAMERICA
A Coventry Health Care Plan

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

Premier PPO $10,000 1x

DEDUCTIBLES AND MAXIMUMS	Participating MEMBER RESPONSIBILITY	Non-Participating MEMBER RESPONSIBILITY
Annual Deductible (Inpatient and Infertility deductibles apply separately from annual deductible)		
Individual	$10,000	$12,000
Family	$10,000	$12,000
Out-of-Pocket Maximum (excludes deductibles and copays)		
Individual	None	$5,000
Family (aggregate)	None	$5,000
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)	$25	20% Eligible Charges (after annual deductible)
Specialist Visit (SCP)	$50	20% Eligible Charges (after annual deductible)
Preventive Services*	(office visit NOT subject to deductible)	
Gynecological Exam (PCP/SCP)	$0 Copay	20% Eligible Charges (after annual deductible)
Well Child Visit	$0 Copay	20% Eligible Charges (after annual deductible)
Adult Physical Visit	$0 Copay	20% Eligible Charges (after annual deductible)
Routine Pediatric Immunizations	0%	20% Eligible Charges
Hearing Exams (under age 18)	0%	20% Eligible Charges (after annual deductible)
Routine Mammograms	0%	20% Eligible Charges (after annual deductible)
Routine Colonoscopies***	0%	20% Eligible Charges (after annual deductible)
Allergy Testing & Allergy Serum	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Chiropractic Care (x-rays are subject to deductible) Maximum 20 visits per contract year	$50 (not subject to annual deductible)	20% Eligible Charges (after annual deductible)
Outpatient Surgery	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Lab Services	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Diagnostic X-ray	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Radiology (CAT, MRI, Ultrasound. PET)	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
HOSPITAL SERVICES	**Participating MEMBER RESPONSIBILITY**	**Non-Participating MEMBER RESPONSIBILITY**
Hospital Care	0% (after annual deductible)	
Semi-private room (private room if medically necessary)	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Physician and Surgeon Fees	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Surgery	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Lab and X-ray services	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
All Medically Necessary Ancillary Services	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Anesthesia	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Administration of Blood	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Blood Products	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Therapy Services (Chemotherapy & Radiation Therapy)	0% (after annual deductible)	20% 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)	$25/$50 (not subject to annual deductible)	20% Eligible Charges (after annual deductible)
Delivery	0% (after annual deductible)	20% 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	0% (after annual deductible)	20% 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	$50 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	0% (after annual deductible)	20% 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	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
	30 days per contract year *90 day lifetime benefit maximum*	
Physician Services (Outpatient)	$50 Copay per visit	20% Eligible Charges (after annual deductible)
	20 outpatient visits maximum per contract year	
Serious Mental Health: Inpatient	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
	30 days per contract year	
Physician Services (Outpatient)	$50 Copay per visit	20% Eligible Charges (after annual deductible)
	60 outpatient visits maximum per contract year	
Substance Abuse: Inpatient Detoxification	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
	7 days maximum per admission *4 admission benefit maximum*	
Inpatient Rehabilitation	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
	30 days maximum per contract year *90 days benefit maximum*	
Transitional Partial Hospitalization	0% (after annual deductible)	20% 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.	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Corrective Appliances	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Home Health Care Services	0% (after annual deductible) *120 visits per contract year*	20% Eligible Charges (after annual deductible) *60 visits per contract year*
	120 visits combined per contract year	
Hospice Care	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Skilled Nursing Facility	0% (after annual deductible) *100 inpatient days per contract year*	20% 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	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Removal of Third Molars	0% (after annual deductible)	20% 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.

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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.

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Reimbursement for Weight Management programs is limited to $150 per calendar year per member.

HEALTHAMERICA
A Coventry Health Care Plan

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

Classic PPO $250

DEDUCTIBLES AND MAXIMUMS	Participating MEMBER RESPONSIBILITY	Non-Participating MEMBER RESPONSIBILITY
Annual Deductible (Inpatient and Infertility deductibles apply separately from annual deductible)		
Individual	$250	$750
Family (aggregate)	$500	$1,500
Out-of-Pocket Maximum (excludes deductibles and copays)		
Individual	$1,500	$3,000
Family (aggregate)	$3,000	$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)	$15 Copay	30% Eligible Charges (after annual deductible)
Specialist Visit (SCP)	$30 Copay	30% Eligible Charges (after annual deductible)
Preventive Services*	**(office visit NOT subject to deductible)**	
Gynecological Exam (PCP/SCP)	$0 Copay	30% Eligible Charges (after annual deductible)
Well Child Visit	$0 Copay	30% Eligible Charges (after annual deductible)
Adult Physical Visit	$0 Copay	30% Eligible Charges (after annual deductible)
Routine Pediatric Immunizations	0%	30% Eligible Charges
Hearing Exams (under age 18)	0%	30% Eligible Charges (after annual deductible)
Routine Mammograms	0%	30% Eligible Charges (after annual deductible)
Routine Colonoscopies***	0%	30% Eligible Charges (after annual deductible)
Allergy Testing & Allergy Serum	10% (after annual deductible)	30% Eligible Charges (after annual deductible)
Chiropractic Care (x-rays are subject to deductible) Maximum 20 visits per contract year	$30 Copay (not subject to annual deductible)	30% Eligible Charges (after annual deductible)
Outpatient Surgery	10% (after annual deductible)	30% Eligible Charges (after annual deductible)
Lab Services	10% (after annual deductible)	30% Eligible Charges (after annual deductible)
Diagnostic X-ray	10% (after annual deductible)	30% Eligible Charges (after annual deductible)
Radiology (CAT, MRI, Ultrasound, PET)	10% (after annual deductible)	30% Eligible Charges (after annual deductible)
HOSPITAL SERVICES	**Participating MEMBER RESPONSIBILITY**	**Non-Participating MEMBER RESPONSIBILITY**
Hospital Care		
Semi-private room (private room if medically necessary)	10% (after annual deductible)	30% Eligible Charges (after annual deductible)
Physician and Surgeon Fees	10% (after annual deductible)	30% Eligible Charges (after annual deductible)
Surgery	10% (after annual deductible)	30% Eligible Charges (after annual deductible)
Lab and X-ray services	10% (after annual deductible)	30% Eligible Charges (after annual deductible)
All Medically Necessary Ancillary Services	10% (after annual deductible)	30% Eligible Charges (after annual deductible)
Anesthesia	10% (after annual deductible)	30% Eligible Charges (after annual deductible)
Administration of Blood	10% (after annual deductible)	30% Eligible Charges (after annual deductible)
Blood Products	10% (after annual deductible)	30% Eligible Charges (after annual deductible)
Therapy Services (Chemotherapy & Radiation Therapy)	10% (after annual deductible)	30% 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)	$15/$30 Copay (not subject to annual deductible)	30% Eligible Charges (after annual deductible)
Delivery	10% (after annual deductible)	30% 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	10% (after annual deductible)	30% 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)	**VARIOUS RIDERS AVAILABLE** **COVERED ONLY AT PARTICIPATING PHARMACIES**	

EMERGENCY CARE	Participating MEMBER RESPONSIBILITY	Non-Participating MEMBER RESPONSIBILITY
Urgent Care Center	$30 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	10% (after annual deductible)	30% 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	10% (after annual deductible)	30% Eligible Charges (after annual deductible)
	30 days per contract year *90 day lifetime benefit maximum*	
Physician Services (Outpatient)	$30 Copay per visit	30% Eligible Charges (after annual deductible)
	20 outpatient visits maximum per contract year	
Serious Mental Health: Inpatient	10% (after annual deductible)	30% Eligible Charges (after annual deductible)
	30 days per contract year	
Physician Services (Outpatient)	$30 Copay per visit	30% Eligible Charges (after annual deductible)
	60 outpatient visits maximum per contract year	
Substance Abuse: Inpatient Detoxification	10% (after annual deductible)	30% Eligible Charges (after annual deductible)
	7 days maximum per admission *4 admission benefit maximum*	
Inpatient Rehabilitation	10% (after annual deductible)	30% Eligible Charges (after annual deductible)
	30 days maximum per contract year *90 days benefit maximum*	
Transitional Partial Hospitalization	10% (after annual deductible)	30% 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.	10% (after annual deductible)	30% Eligible Charges (after annual deductible)
Corrective Appliances	10% (after annual deductible)	30% Eligible Charges (after annual deductible)
Home Health Care Services	10% (after annual deductible) *120 visits per contract year*	30% Eligible Charges (after annual deductible) *60 visits per contract year*
	120 visits combined per contract year	
Hospice Care	10% (after annual deductible)	30% Eligible Charges (after annual deductible)
Skilled Nursing Facility	10% (after annual deductible) *100 inpatient days per contract year*	30% 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	10% (after annual deductible)	30% Eligible Charges (after annual deductible)
Removal of Third Molars	10% (after annual deductible)	30% 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.

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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.

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***Reimbursement for Weight Management programs is limited to $150 per calendar year per member.*

HEALTHAMERICA
A Coventry Health Care Plan

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

Classic 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	$1,500	$3,000
Family (aggregate)	$3,000	$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)	$15 Copay	30% Eligible Charges (after annual deductible)
Specialist Visit (SCP)	$30 Copay	30% Eligible Charges (after annual deductible)
Preventive Services*	**(office visit NOT subject to deductible)**	
Gynecological Exam (PCP/SCP)	$0 Copay	30% Eligible Charges (after annual deductible)
Well Child Visit	$0 Copay	30% Eligible Charges (after annual deductible)
Adult Physical Visit	$0 Copay	30% Eligible Charges (after annual deductible)
Routine Pediatric Immunizations	0%	30% Eligible Charges
Hearing Exams (under age 18)	0%	30% Eligible Charges (after annual deductible)
Routine Mammograms	0%	30% Eligible Charges (after annual deductible)
Routine Colonoscopies***	0%	30% Eligible Charges (after annual deductible)
Allergy Testing & Allergy Serum	10% (after annual deductible)	30% Eligible Charges (after annual deductible)
Chiropractic Care (x-rays are subject to deductible)		
Maximum 20 visits per contract year	$30 Copay (not subject to annual deductible)	30% Eligible Charges (after annual deductible)
Outpatient Surgery	10% (after annual deductible)	30% Eligible Charges (after annual deductible)
Lab Services	10% (after annual deductible)	30% Eligible Charges (after annual deductible)
Diagnostic X-ray	10% (after annual deductible)	30% Eligible Charges (after annual deductible)
Radiology (CAT, MRI, Ultrasound, PET)	10% (after annual deductible)	30% Eligible Charges (after annual deductible)
HOSPITAL SERVICES	**Participating MEMBER RESPONSIBILITY**	**Non-Participating MEMBER RESPONSIBILITY**
Hospital Care		
Semi-private room (private room if medically necessary)	10% (after annual deductible)	30% Eligible Charges (after annual deductible)
Physician and Surgeon Fees	10% (after annual deductible)	30% Eligible Charges (after annual deductible)
Surgery	10% (after annual deductible)	30% Eligible Charges (after annual deductible)
Lab and X-ray services	10% (after annual deductible)	30% Eligible Charges (after annual deductible)
All Medically Necessary Ancillary Services	10% (after annual deductible)	30% Eligible Charges (after annual deductible)
Anesthesia	10% (after annual deductible)	30% Eligible Charges (after annual deductible)
Administration of Blood	10% (after annual deductible)	30% Eligible Charges (after annual deductible)
Blood Products	10% (after annual deductible)	30% Eligible Charges (after annual deductible)
Therapy Services (Chemotherapy & Radiation Therapy)	10% (after annual deductible)	30% 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)	$15/$30 Copay (not subject to annual deductible)	30% Eligible Charges (after annual deductible)
Delivery	10% (after annual deductible)	30% 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	10% (after annual deductible)	30% 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	$30 Copay	$30 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	10% (after annual deductible)	30% 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	10% (after annual deductible)	30% Eligible Charges (after annual deductible)
	30 days per contract year *90 day lifetime benefit maximum*	
Physician Services (Outpatient)	$30 Copay per visit	30% Eligible Charges (after annual deductible)
	20 outpatient visits maximum per contract year	
Serious Mental Health: Inpatient	10% (after annual deductible)	30% Eligible Charges (after annual deductible)
	30 days per contract year	
Physician Services (Outpatient)	$30 Copay per visit	30% Eligible Charges (after annual deductible)
	60 outpatient visits maximum per contract year	
Substance Abuse: Inpatient Detoxification	10% (after annual deductible)	30% Eligible Charges (after annual deductible)
	7 days maximum per admission *4 admission benefit maximum*	
Inpatient Rehabilitation	10% (after annual deductible)	30% Eligible Charges (after annual deductible)
	30 days maximum per contract year *90 days benefit maximum*	
Transitional Partial Hospitalization	10% (after annual deductible)	30% 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.	10% (after annual deductible)	30% Eligible Charges (after annual deductible)
Corrective Appliances	10% (after annual deductible)	30% Eligible Charges (after annual deductible)
Home Health Care Services	10% (after annual deductible) *120 visits per contract year*	30% Eligible Charges (after annual deductible) *60 visits per contract year*
	120 visits combined per contract year	
Hospice Care	10% (after annual deductible)	30% Eligible Charges (after annual deductible)
Skilled Nursing Facility	10% (after annual deductible) *100 inpatient days per contract year*	30% 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	10% (after annual deductible)	30% Eligible Charges (after annual deductible)
Removal of Third Molars	10% (after annual deductible)	30% 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.

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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 $150 per calendar year per member.*

HEALTHAMERICA
A Coventry Health Care Plan

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

Classic PPO $1000

DEDUCTIBLES AND MAXIMUMS	Participating MEMBER RESPONSIBILITY	Non-Participating MEMBER RESPONSIBILITY
Annual Deductible (Inpatient and Infertility deductibles apply separately from annual deductible)		
Individual	$1,000	$2,000
Family (aggregate)	$2,000	$4,000
Out-of-Pocket Maximum (excludes deductibles and copays)		
Individual	$1,500	$3,000
Family (aggregate)	$3,000	$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)	$15 Copay	30% Eligible Charges (after annual deductible)
Specialist Visit (SCP)	$30 Copay	30% Eligible Charges (after annual deductible)
Preventive Services*	**(office visit NOT subject to deductible)**	
Gynecological Exam (PCP/SCP)	$0 Copay	30% Eligible Charges (after annual deductible)
Well Child Visit	$0 Copay	30% Eligible Charges (after annual deductible)
Adult Physical Visit	$0 Copay	30% Eligible Charges (after annual deductible)
Routine Pediatric Immunizations	0%	30% Eligible Charges
Hearing Exams (under age 18)	0%	30% Eligible Charges (after annual deductible)
Routine Mammograms	0%	30% Eligible Charges (after annual deductible)
Routine Colonoscopies***	0%	30% Eligible Charges (after annual deductible)
Allergy Testing & Allergy Serum	10% (after annual deductible)	30% Eligible Charges (after annual deductible)
Chiropractic Care (x-rays are subject to deductible) Maximum 20 visits per contract year	$30 Copay (not subject to annual deductible)	30% Eligible Charges (after annual deductible)
Outpatient Surgery	10% (after annual deductible)	30% Eligible Charges (after annual deductible)
Lab Services	10% (after annual deductible)	30% Eligible Charges (after annual deductible)
Diagnostic X-ray	10% (after annual deductible)	30% Eligible Charges (after annual deductible)
Radiology (CAT, MRI, Ultrasound, PET)	10% (after annual deductible)	30% Eligible Charges (after annual deductible)
HOSPITAL SERVICES	**Participating MEMBER RESPONSIBILITY**	**Non-Participating MEMBER RESPONSIBILITY**
Hospital Care		
Semi-private room (private room if medically necessary)	10% (after annual deductible)	30% Eligible Charges (after annual deductible)
Physician and Surgeon Fees	10% (after annual deductible)	30% Eligible Charges (after annual deductible)
Surgery	10% (after annual deductible)	30% Eligible Charges (after annual deductible)
Lab and X-ray services	10% (after annual deductible)	30% Eligible Charges (after annual deductible)
All Medically Necessary Ancillary Services	10% (after annual deductible)	30% Eligible Charges (after annual deductible)
Anesthesia	10% (after annual deductible)	30% Eligible Charges (after annual deductible)
Administration of Blood	10% (after annual deductible)	30% Eligible Charges (after annual deductible)
Blood Products	10% (after annual deductible)	30% Eligible Charges (after annual deductible)
Therapy Services (Chemotherapy & Radiation Therapy)	10% (after annual deductible)	30% 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)	$15/$30 Copay (not subject to annual deductible)	30% Eligible Charges (after annual deductible)
Delivery	10% (after annual deductible)	30% 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	10% (after annual deductible)	30% 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	$30 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	10% (after annual deductible)	30% 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	10% (after annual deductible)	30% Eligible Charges (after annual deductible)
	30 days per contract year *90 day lifetime benefit maximum*	
Physician Services (Outpatient)	$30 Copay per visit	30% Eligible Charges (after annual deductible)
	20 outpatient visits maximum per contract year	
Serious Mental Health: Inpatient	10% (after annual deductible)	30% Eligible Charges (after annual deductible)
	30 days per contract year	
Physician Services (Outpatient)	$30 Copay per visit	30% Eligible Charges (after annual deductible)
	60 outpatient visits maximum per contract year	
Substance Abuse: Inpatient Detoxification	10% (after annual deductible)	30% Eligible Charges (after annual deductible)
	7 days maximum per admission *4 admission benefit maximum*	
Inpatient Rehabilitation	10% (after annual deductible)	30% Eligible Charges (after annual deductible)
	30 days maximum per contract year *90 days benefit maximum*	
Transitional Partial Hospitalization	10% (after annual deductible)	30% 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.	10% (after annual deductible)	30% Eligible Charges (after annual deductible)
Corrective Appliances	10% (after annual deductible)	30% Eligible Charges (after annual deductible)
Home Health Care Services	10% (after annual deductible) *120 visits per contract year*	30% Eligible Charges (after annual deductible) *60 visits per contract year*
	120 visits combined per contract year	
Hospice Care	10% (after annual deductible)	30% Eligible Charges (after annual deductible)
Skilled Nursing Facility	10% (after annual deductible) *100 inpatient days per contract year*	30% 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	10% (after annual deductible)	30% Eligible Charges (after annual deductible)
Removal of Third Molars	10% (after annual deductible)	30% 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

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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.

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***Reimbursement for Weight Management programs is limited to $150 per calendar year per member.*

HEALTHAMERICA
A Coventry Health Care Plan

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

Value PPO $250

DEDUCTIBLES AND MAXIMUMS	Participating MEMBER RESPONSIBILITY	Non-Participating MEMBER RESPONSIBILITY
Annual Deductible (Inpatient and Infertility deductibles apply separately from annual deductible)		
Individual	$250	$750
Family (aggregate)	$500	$1,500
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	
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

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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.

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***Reimbursement for Weight Management programs is limited to $150 per calendar year per member.*

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	
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.

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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 $150 per calendar year per member.*

HEALTHAMERICA
A Coventry Health Care Plan

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

Value PPO $1000

DEDUCTIBLES AND MAXIMUMS	Participating MEMBER RESPONSIBILITY	Non-Participating MEMBER RESPONSIBILITY
Annual Deductible (Inpatient and Infertility deductibles apply separately from annual deductible)		
Individual	$1,000	$2,000
Family (aggregate)	$2,000	$4,000
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	
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

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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.

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HEALTHAMERICA
A Coventry Health Care Plan

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

Value PPO $1500

DEDUCTIBLES AND MAXIMUMS	Participating MEMBER RESPONSIBILITY	Non-Participating MEMBER RESPONSIBILITY
Annual Deductible (Inpatient and Infertility deductibles apply separately from annual deductible)		
Individual	$1,500	$3,000
Family (aggregate)	$3,000	$6,000
Out-of-Pocket Maximum (excludes deductibles and copays)		
Individual	$2,500	$5,000
Family (aggregate)	$5,000	$10,000
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	
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

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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.

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HEALTHAMERICA
A Coventry Health Care Plan

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

Value PPO $2000

DEDUCTIBLES AND MAXIMUMS	Participating MEMBER RESPONSIBILITY	Non-Participating MEMBER RESPONSIBILITY
Annual Deductible (Inpatient and Infertility deductibles apply separately from annual deductible)		
Individual	$2,000	$4,000
Family (aggregate)	$4,000	$8,000
Out-of-Pocket Maximum (excludes deductibles and copays)		
Individual	$2,500	$5,000
Family (aggregate)	$5,000	$10,000
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	
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 $150 per calendar year per member.*

HEALTHAMERICA
A Coventry Health Care Plan

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

FlexChoice QHDHP PPO $1250

DEDUCTIBLES AND MAXIMUMS	Participating MEMBER RESPONSIBILITY	Non-Participating MEMBER RESPONSIBILITY
Annual Deductible		
Individual	$1,250	$2,500
Family	$2,500	$5,000
The individual deductible applies when the Subscriber has an employee only policy. For policies that include the Subscriber and one or more dependents, the family deductible must be met before any family member begins to receive the benefits listed below, including prescription drug benefits covered under the prescription drug rider (except preventive services).		
Out-of-Pocket Maximum (includes copays, deductibles and coinsurance)		
Individual	$3,000	$10,000
Family	$6,000	$20,000
OUTPATIENT SERVICES	**Participating MEMBER RESPONSIBILITY**	**Non-Participating MEMBER RESPONSIBILITY**
Physician Services (for illness or injury)		
Primary Care Visit (PCP)	$15 Copay (after annual deductible)	20% Eligible Charges (after annual deductible)
Specialist Visit (SCP)	$25 Copay (after annual deductible)	20% Eligible Charges (after annual deductible)
Preventive Services*		
Gynecological Exam (PCP/SCP)	$0 Copay	20% Eligible Charges (after annual deductible)
Well Child Visit	$0 Copay	20% Eligible Charges (after annual deductible)
Adult Physical Visit	$0 Copay	20% Eligible Charges (after annual deductible)
Preventive Pediatric Immunizations	0%	20% Eligible Charges
Preventive Adult Immunizations	0%	20% Eligible Charges (after annual deductible)
Hearing Exams (under age 18)	0%	20% Eligible Charges (after annual deductible)
Routine Mammograms	0%	20% Eligible Charges (after annual deductible)
Routine Colonoscopies***	0%	20% Eligible Charges (after annual deductible)
Allergy Testing & Allergy Serum	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Chiropractic Care		
Maximum 20 visits per contract year	$25 Copay (after annual deductible)	20% Eligible Charges (after annual deductible)
Outpatient Surgery	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Lab Services	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Diagnostic X-ray	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Radiology (CAT, MRI, Ultrasound, PET)	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
HOSPITAL SERVICES	**Participating MEMBER RESPONSIBILITY**	**Non-Participating MEMBER RESPONSIBILITY**
Hospital Care		
Semi-private room (private room if medically necessary)	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Physician and Surgeon Fees	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Surgery	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Lab and X-ray services	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
All Medically Necessary Ancillary Services	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Anesthesia	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Administration of Blood	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Blood Products	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Therapy Services (Chemotherapy & Radiation Therapy)	0% (after annual deductible)	20% 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)	$15/$25 Copay (after annual deductible)	20% Eligible Charges (after annual deductible)
Delivery	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
FAMILY PLANNING	**Participating MEMBER RESPONSIBILITY**	**Non-Participating MEMBER RESPONSIBILITY**
Infertility Counseling/Testing/Services	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Tubal Ligation/Vasectomy	0% (after annual deductible)	20% 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** (after annual deductible)	
EMERGENCY CARE	**Participating MEMBER RESPONSIBILITY**	**Non-Participating MEMBER RESPONSIBILITY**
Urgent Care Center	$25 Copay (after annual deductible)	
Emergency Room Services	$125 Copay (after annual deductible) ER Copay waived if admitted	
REHABILITATION SERVICES	**Participating MEMBER RESPONSIBILITY**	**Non-Participating MEMBER RESPONSIBILITY**
Occupational, Speech, Physical Therapy	0% (after annual deductible)	20% 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	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
	30 days per contract year *90 day lifetime benefit maximum*	
Physician Services (Outpatient)	$25 Copay (after annual deductible)	20% Eligible Charges (after annual deductible)
	20 outpatient visits maximum per contract year	
Serious Mental Health: Inpatient	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
	30 days per contract year *90 day lifetime benefit maximum*	
Physician Services (Outpatient)	$25 Copay (after annual deductible)	20% Eligible Charges (after annual deductible)
	60 outpatient visits maximum per contract year	
Substance Abuse: Inpatient Detoxification	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
	7 days maximum per admission *4 admission benefit maximum*	
Inpatient Rehabilitation	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
	30 days maximum per contract year *90 days benefit maximum*	
Transitional Partial Hospitalization	0% (after annual deductible)	20% 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.	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Corrective Appliances	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Home Health Care Services	0% (after annual deductible) *120 visits per contract year*	20% Eligible Charges (after annual deductible) *60 visits per contract year*
	120 visits combined per contract year	
Hospice Care	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Skilled Nursing Facility	0% (after annual deductible) *100 inpatient days per contract year*	20% 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	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Removal of Third Molars	0% (after annual deductible)	20% 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.

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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.

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***Reimbursement for Weight Management programs is limited to $150 per calendar year per member.*

HEALTHAMERICA
A Coventry Health Care Plan
Preferred Provider Organization
Underwritten by HealthAssurance Pennsylvania, Inc.
(d.b.a. HealthAmerica)

FlexChoice QHDHP PPO $1250 II

DEDUCTIBLES AND MAXIMUMS	Participating MEMBER RESPONSIBILITY	Non-Participating MEMBER RESPONSIBILITY
Annual Deductible		
Individual	$1,250	$2,500
Family	$2,500	$5,000
The individual deductible applies when the Subscriber has an employee only policy. For policies that include the Subscriber and one or more dependents, the family deductible must be met before any family member begins to receive the benefits listed below, including prescription drug benefits covered under the prescription drug rider (except preventive services).		
Out-of-Pocket Maximum (includes copays, deductibles and coinsurance)		
Individual	$3,000	$10,000
Family	$6,000	$20,000
OUTPATIENT SERVICES	**Participating MEMBER RESPONSIBILITY**	**Non-Participating MEMBER RESPONSIBILITY**
Physician Services (for illness or injury)		
Primary Care Visit (PCP)	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Specialist Visit (SCP)	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Preventive Services*		
Gynecological Exam (PCP/SCP)	0%	20% Eligible Charges (after annual deductible)
Well Child Visit	0%	20% Eligible Charges (after annual deductible)
Adult Physical Visit	0%	20% Eligible Charges (after annual deductible)
Preventive Pediatric Immunizations	0%	20% Eligible Charges
Preventive Adult Immunizations	0%	20% Eligible Charges (after annual deductible)
Hearing Exams (under age 18)	0%	20% Eligible Charges (after annual deductible)
Routine Mammograms	0%	20% Eligible Charges (after annual deductible)
Routine Colonoscopies***	0%	20% Eligible Charges (after annual deductible)
Allergy Testing & Allergy Serum	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Chiropractic Care		
Maximum 20 visits per contract year	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Outpatient Surgery	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Lab Services	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Diagnostic X-ray	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Radiology (CAT, MRI, Ultrasound, PET)	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
HOSPITAL SERVICES	**Participating MEMBER RESPONSIBILITY**	**Non-Participating MEMBER RESPONSIBILITY**
Hospital Care		
Semi-private room (private room if medically necessary)	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Physician and Surgeon Fees	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Surgery	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Lab and X-ray services	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
All Medically Necessary Ancillary Services	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Anesthesia	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Administration of Blood	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Blood Products	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Therapy Services (Chemotherapy & Radiation Therapy)	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
MATERNITY SERVICES	**Participating MEMBER RESPONSIBILITY**	**Non-Participating MEMBER RESPONSIBILITY**
Pregnancy Care (PCP/SCP)	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Delivery	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
FAMILY PLANNING	**Participating MEMBER RESPONSIBILITY**	**Non-Participating MEMBER RESPONSIBILITY**
Infertility Counseling/Testing/Services	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Tubal Ligation/Vasectomy	0% (after annual deductible)	20% 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** (after annual deductible)	
EMERGENCY CARE	**Participating MEMBER RESPONSIBILITY**	**Non-Participating MEMBER RESPONSIBILITY**
Urgent Care Center	0% (after annual deductible)	
Emergency Room Services	$125 Copay (after annual deductible) ER Copay waived if admitted	
REHABILITATION SERVICES	**Participating MEMBER RESPONSIBILITY**	**Non-Participating MEMBER RESPONSIBILITY**
Occupational, Speech, Physical Therapy	0% (after annual deductible)	20% 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	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
	30 days per contract year *90 day lifetime benefit maximum*	
Physician Services (Outpatient)	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
	20 outpatient visits maximum per contract year	
Serious Mental Health: Inpatient	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
	30 days per contract year *90 day lifetime benefit maximum*	
Physician Services (Outpatient)	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
	60 outpatient visits maximum per contract year	
Substance Abuse: Inpatient Detoxification	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
	7 days maximum per admission *4 admission benefit maximum*	
Inpatient Rehabilitation	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
	30 days maximum per contract year *90 days benefit maximum*	
Transitional Partial Hospitalization	0% (after annual deductible)	20% 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.	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Corrective Appliances	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Home Health Care Services	0% (after annual deductible) *120 visits per contract year*	20% Eligible Charges (after annual deductible) *60 visits per contract year*
	120 visits combined per contract year	
Hospice Care	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Skilled Nursing Facility	0% (after annual deductible) *100 inpatient days per contract year*	20% 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	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Removal of Third Molars	0% (after annual deductible)	20% 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

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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

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***Reimbursement for Weight Management programs is limited to $150 per calendar year per member.*

HEALTHAMERICA
A Coventry Health Care Plan

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

FlexChoice QHDHP PPO $2500

DEDUCTIBLES AND MAXIMUMS	Participating MEMBER RESPONSIBILITY	Non-Participating MEMBER RESPONSIBILITY
Annual Deductible		
Individual	$2,500	$5,000
Family	$5,000	$10,000
The individual deductible applies when the Subscriber has an employee only policy. For policies that include the Subscriber and one or more dependents, the family deductible must be met before any family member begins to receive the benefits listed below, including prescription drug benefits covered under the prescription drug rider (except preventive services).		
Out-of-Pocket Maximum (includes copays, deductibles and coinsurance)		
Individual	$4,000	$10,000
Family	$8,000	$20,000
OUTPATIENT SERVICES	**Participating MEMBER RESPONSIBILITY**	**Non-Participating MEMBER RESPONSIBILITY**
Physician Services (for illness or injury)		
Primary Care Visit (PCP)	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
Specialist Visit (SCP)	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
Preventive Services*		
Gynecological Exam (PCP/SCP)	0%	30% Eligible Charges (after annual deductible)
Well Child Visit	0%	30% Eligible Charges (after annual deductible)
Adult Physical Visit	0%	30% Eligible Charges (after annual deductible)
Preventive Pediatric Immunizations	0%	30% Eligible Charges
Preventive Adult Immunizations	0%	30% Eligible Charges (after annual deductible)
Hearing Exams (under age 18)	0%	30% Eligible Charges (after annual deductible)
Routine Mammograms	0%	30% Eligible Charges (after annual deductible)
Routine Colonoscopies***	0%	30% Eligible Charges (after annual deductible)
Allergy Testing & Allergy Serum	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
Chiropractic Care		
Maximum 20 visits per contract year	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
Outpatient Surgery	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
Lab Services	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
Diagnostic X-ray	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
Radiology (CAT, MRI, Ultrasound. PET)	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
HOSPITAL SERVICES	**Participating MEMBER RESPONSIBILITY**	**Non-Participating MEMBER RESPONSIBILITY**
Hospital Care		
Semi-private room (private room if medically necessary)	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
Physician and Surgeon Fees	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
Surgery	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
Lab and X-ray services	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
All Medically Necessary Ancillary Services	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
Anesthesia	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
Administration of Blood	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
Blood Products	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
Therapy Services (Chemotherapy & Radiation Therapy)	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
MATERNITY SERVICES	**Participating MEMBER RESPONSIBILITY**	**Non-Participating MEMBER RESPONSIBILITY**
Pregnancy Care (PCP/SCP)	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
Delivery	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
FAMILY PLANNING	**Participating MEMBER RESPONSIBILITY**	**Non-Participating MEMBER RESPONSIBILITY**
Infertility Counseling/Testing/Services	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
Tubal Ligation/Vasectomy	0% (after annual deductible)	30% 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** (after annual deductible)	
EMERGENCY CARE	**Participating MEMBER RESPONSIBILITY**	**Non-Participating MEMBER RESPONSIBILITY**
Urgent Care Center	0% (after annual deductible)	
Emergency Room Services	$125 Copay (after annual deductible) ER Copay waived if admitted	
REHABILITATION SERVICES	**Participating MEMBER RESPONSIBILITY**	**Non-Participating MEMBER RESPONSIBILITY**
Occupational, Speech, Physical Therapy	0% (after annual deductible)	30% 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	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
	30 days per contract year *90 day lifetime benefit maximum*	
Physician Services (Outpatient)	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
	20 outpatient visits maximum per contract year	
Serious Mental Health: Inpatient	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
	30 days per contract year *90 day lifetime benefit maximum*	
Physician Services (Outpatient)	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
	60 outpatient visits maximum per contract year	
Substance Abuse: Inpatient Detoxification	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
	7 days maximum per admission *4 admission benefit maximum*	
Inpatient Rehabilitation	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
	30 days maximum per contract year *90 days benefit maximum*	
Transitional Partial Hospitalization	0% (after annual deductible)	30% 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.	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
Corrective Appliances	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
Home Health Care Services	0% (after annual deductible) *120 visits per contract year*	30% Eligible Charges (after annual deductible) *60 visits per contract year*
	120 visits combined per contract year	
Hospice Care	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
Skilled Nursing Facility	0% (after annual deductible) *100 inpatient days per contract year*	30% 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	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
Removal of Third Molars	0% (after annual deductible)	30% 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 $150 per calendar year per member.*

HEALTHAMERICA
A Coventry Health Care Plan

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

FlexChoice QHDHP Value PPO $1250

DEDUCTIBLES AND MAXIMUMS	Participating MEMBER RESPONSIBILITY	Non-Participating MEMBER RESPONSIBILITY
Annual Deductible		
Individual	$1,250	$2,500
Family	$2,500	$5,000
The individual deductible applies when the Subscriber has an employee only policy. For policies that include the Subscriber and one or more dependents, the family deductible must be met before any family member begins to receive the benefits listed below, including prescription drug benefits covered under the prescription drug rider (except preventive services).		
Out-of-Pocket Maximum (includes copays, deductibles and coinsurance)		
Individual	$5,000	$10,000
Family	$10,000	$20,000
OUTPATIENT SERVICES	**Participating MEMBER RESPONSIBILITY**	**Non-Participating MEMBER RESPONSIBILITY**
Physician Services (for illness or injury)		
Primary Care Visit (PCP)	$20 Copay (after annual deductible)	40% Eligible Charges (after annual deductible)
Specialist Visit (SCP)	$40 Copay (after annual deductible)	40% Eligible Charges (after annual deductible)
Preventive Services*		
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)
Preventive Pediatric Immunizations	0%	40% Eligible Charges
Preventive Adult Immunizations	0%	40% Eligible Charges (after annual deductible)
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		
Maximum 20 visits per contract year	$40 Copay (after 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 (after 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	20% (after annual deductible)	40% Eligible Charges (after annual deductible)
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** (after annual deductible)	
EMERGENCY CARE	**Participating MEMBER RESPONSIBILITY**	**Non-Participating MEMBER RESPONSIBILITY**
Urgent Care Center	$40 Copay (after annual deductible)	
Emergency Room Services	20% (after annual deductible)	
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 (after annual deductible)	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 (after annual deductible)	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.

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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.

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***Reimbursement for Weight Management programs is limited to $150 per calendar year per member.*

HEALTHAMERICA
A Coventry Health Care Plan

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

FlexChoice QHDHP Value PPO $2500

DEDUCTIBLES AND MAXIMUMS	Participating MEMBER RESPONSIBILITY	Non-Participating MEMBER RESPONSIBILITY
Annual Deductible		
Individual	$2,500	$5,000
Family	$5,000	$10,000
The individual deductible applies when the Subscriber has an employee only policy. For policies that include the Subscriber and one or more dependents, the family deductible must be met before any family member begins to receive the benefits listed below, including prescription drug benefits covered under the prescription drug rider (except preventive services).		
Out-of-Pocket Maximum (includes copays, deductibles and coinsurance)		
Individual	$5,000	$10,000
Family	$10,000	$20,000
OUTPATIENT SERVICES	**Participating MEMBER RESPONSIBILITY**	**Non-Participating MEMBER RESPONSIBILITY**
Physician Services (for illness or injury)		
Primary Care Visit (PCP)	$20 Copay (after annual deductible)	40% Eligible Charges (after annual deductible)
Specialist Visit (SCP)	$40 Copay (after annual deductible)	40% Eligible Charges (after annual deductible)
Preventive Services*		
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)
Preventive Pediatric Immunizations	0%	40% Eligible Charges
Preventive Adult Immunizations	0%	40% Eligible Charges (after annual deductible)
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		
Maximum 20 visits per contract year	$40 Copay (after 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 (after 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	20% (after annual deductible)	40% Eligible Charges (after annual deductible)
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** (after annual deductible)	
EMERGENCY CARE	**Participating MEMBER RESPONSIBILITY**	**Non-Participating MEMBER RESPONSIBILITY**
Urgent Care Center	$40 Copay (after annual deductible)	
Emergency Room Services	20% (after annual deductible)	
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 (after annual deductible)	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 (after annual deductible)	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.

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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.

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***Reimbursement for Weight Management programs is limited to $150 per calendar year per member.*

HEALTHAMERICA
A Coventry Health Care Plan

Preferred Provider Organization
underwritten byHealthAssurance Pennsylvania, Inc.
(d.b.a. HealthAmerica)

FlexChoice QHDHP Value PPO $3750

DEDUCTIBLES AND MAXIMUMS	Participating MEMBER RESPONSIBILITY	Non-Participating MEMBER RESPONSIBILITY
Annual Deductible		
Individual	$3,750	$7,500
Family	$7,500	$15,000
The individual deductible applies when the Subscriber has an employee only policy. For policies that include the Subscriber and one or more dependents, the family deductible must be met before any family member begins to receive the benefits listed below, including prescription drug benefits covered under the prescription drug rider (except preventive services).		
Out-of-Pocket Maximum (includes copays, deductibles and coinsurance)		
Individual	$5,000	$10,000
Family	$10,000	$20,000
OUTPATIENT SERVICES	**Participating MEMBER RESPONSIBILITY**	**Non-Participating MEMBER RESPONSIBILITY**
Physician Services (for illness or injury)		
Primary Care Visit (PCP)	$20 Copay (after annual deductible)	40% Eligible Charges (after annual deductible)
Specialist Visit (SCP)	$40 Copay (after annual deductible)	40% Eligible Charges (after annual deductible)
Preventive Services*		
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)
Preventive Pediatric Immunizations	0%	40% Eligible Charges
Preventive Adult Immunizations	0%	40% Eligible Charges (after annual deductible)
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		
Maximum 20 visits per contract year	$40 Copay (after 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 (after 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	20% (after annual deductible)	40% Eligible Charges (after annual deductible)
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** (after annual deductible)	
EMERGENCY CARE	**Participating MEMBER RESPONSIBILITY**	**Non-Participating MEMBER RESPONSIBILITY**
Urgent Care Center	$40 Copay (after annual deductible)	
Emergency Room Services	20% (after annual deductible)	
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 (after annual deductible)	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 (after annual deductible)	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

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LIFETIME MAXIMUM Unlimited

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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.

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***Reimbursement for Weight Management programs is limited to $150 per calendar year per member.*

HEALTHAMERICA
A Coventry Health Care Plan

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

FlexChoice QHDHP PPO $2500 1x

DEDUCTIBLES AND MAXIMUMS	Participating MEMBER RESPONSIBILITY	Non-Participating MEMBER RESPONSIBILITY
Annual Deductible		
Individual	$2,500	$5,000
Family	$2,500	$5,000
The individual deductible applies when the Subscriber has an employee only policy. For policies that include the Subscriber and one or more dependents, the family deductible must be met before any family member begins to receive the benefits listed below, including prescription drug benefits covered under the prescription drug rider (except preventive services).		
Out-of-Pocket Maximum (includes copays, deductibles and coinsurance)		
Individual	$4,000	$10,000
Family	$4,000	$10,000
OUTPATIENT SERVICES	**Participating MEMBER RESPONSIBILITY**	**Non-Participating MEMBER RESPONSIBILITY**
Physician Services (for illness or injury)		
Primary Care Visit (PCP)	$15 (after annual deductible)	20% Eligible Charges (after annual deductible)
Specialist Visit (SCP)	$25 (after annual deductible)	20% Eligible Charges (after annual deductible)
Preventive Services*		
Gynecological Exam (PCP/SCP)	$0	20% Eligible Charges (after annual deductible)
Well Child Visit	$0	20% Eligible Charges (after annual deductible)
Adult Physical Visit	$0	20% Eligible Charges (after annual deductible)
Preventive Pediatric Immunizations	0%	20% Eligible Charges
Preventive Adult Immunizations	0%	20% Eligible Charges (after annual deductible)
Hearing Exams (under age 18)	0%	20% Eligible Charges (after annual deductible)
Routine Mammograms	0%	20% Eligible Charges (after annual deductible)
Routine Colonoscopies***	0%	20% Eligible Charges (after annual deductible)
Allergy Testing & Allergy Serum	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Chiropractic Care		
Maximum 20 visits per contract year	$25 (after annual deductible)	20% Eligible Charges (after annual deductible)
Outpatient Surgery	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Lab Services	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Diagnostic X-ray	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Radiology (CAT, MRI, Ultrasound, PET)	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
HOSPITAL SERVICES	**Participating MEMBER RESPONSIBILITY**	**Non-Participating MEMBER RESPONSIBILITY**
Hospital Care		
Semi-private room (private room if medically necessary)	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Physician and Surgeon Fees	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Surgery	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Lab and X-ray services	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
All Medically Necessary Ancillary Services	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Anesthesia	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Administration of Blood	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Blood Products	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Therapy Services (Chemotherapy & Radiation Therapy)	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
MATERNITY SERVICES	**Participating MEMBER RESPONSIBILITY**	**Non-Participating MEMBER RESPONSIBILITY**
Pregnancy Care (PCP/SCP)	$15/$25 (after annual deductible)	20% Eligible Charges (after annual deductible)
Delivery	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
FAMILY PLANNING	**Participating MEMBER RESPONSIBILITY**	**Non-Participating MEMBER RESPONSIBILITY**
Infertility Counseling/Testing/Services	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Tubal Ligation/Vasectomy	0% (after annual deductible)	20% 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** (after annual deductible)	
EMERGENCY CARE	**Participating MEMBER RESPONSIBILITY**	**Non-Participating MEMBER RESPONSIBILITY**
Urgent Care Center	$25 Copay (after annual deductible)	
Emergency Room Services	$125 Copay (after annual deductible) ER Copay waived if admitted	
REHABILITATION SERVICES	**Participating MEMBER RESPONSIBILITY**	**Non-Participating MEMBER RESPONSIBILITY**
Occupational, Speech, Physical Therapy	0% (after annual deductible)	20% 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	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
	30 days per contract year *90 day lifetime benefit maximum*	
Physician Services (Outpatient)	$25 Copay per visit (after annual deductible)	20% Eligible Charges (after annual deductible)
	20 outpatient visits maximum per contract year	
Serious Mental Health: Inpatient	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
	30 days per contract year *90 day lifetime benefit maximum*	
Physician Services (Outpatient)	$25 Copay per visit (after annual deductible)	20% Eligible Charges (after annual deductible)
	60 outpatient visits maximum per contract year	
Substance Abuse: Inpatient Detoxification	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
	7 days maximum per admission *4 admission benefit maximum*	
Inpatient Rehabilitation	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
	30 days maximum per contract year *90 days benefit maximum*	
Transitional Partial Hospitalization	0% (after annual deductible)	20% 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.	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Corrective Appliances	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Home Health Care Services	0% (after annual deductible) *120 visits per contract year*	20% Eligible Charges (after annual deductible) *60 visits per contract year*
	120 visits combined per contract year	
Hospice Care	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Skilled Nursing Facility	0% (after annual deductible) *100 inpatient days per contract year*	20% 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	0% (after annual deductible)	20% Eligible Charges (after annual deductible)
Removal of Third Molars	0% (after annual deductible)	20% 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

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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

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***Reimbursement for Weight Management programs is limited to $150 per calendar year per member.*

HEALTHAMERICA
A Coventry Health Care Plan

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

FlexChoice QHDHP PPO $5,000 1x

DEDUCTIBLES AND MAXIMUMS	Participating MEMBER RESPONSIBILITY	Non-Participating MEMBER RESPONSIBILITY
Annual Deductible		
Individual	$5,000	$5,000
Family	$5,000	$5,000
The individual deductible applies when the Subscriber has an employee only policy. For policies that include the Subscriber and one or more dependents, the family deductible must be met before any family member begins to receive the benefits listed below, including prescription drug benefits covered under the prescription drug rider (except preventive services).		
Out-of-Pocket Maximum (includes copays, deductibles and coinsurance)		
Individual	$5,950	$10,000
Family	$5,950	$10,000
OUTPATIENT SERVICES	**Participating MEMBER RESPONSIBILITY**	**Non-Participating MEMBER RESPONSIBILITY**
Physician Services (for illness or injury)		
Primary Care Visit (PCP)	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
Specialist Visit (SCP)	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
Preventive Services*		
Gynecological Exam (PCP/SCP)	0%	30% Eligible Charges (after annual deductible)
Well Child Visit	0%	30% Eligible Charges (after annual deductible)
Adult Physical Visit	0%	30% Eligible Charges (after annual deductible)
Preventive Pediatric Immunizations	0%	30% Eligible Charges
Preventive Adult Immunizations	0%	30% Eligible Charges (after annual deductible)
Hearing Exams (under age 18)	0%	30% Eligible Charges (after annual deductible)
Routine Mammograms	0%	30% Eligible Charges (after annual deductible)
Routine Colonoscopies***	0%	30% Eligible Charges (after annual deductible)
Allergy Testing & Allergy Serum	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
Chiropractic Care		
Maximum 20 visits per contract year	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
Outpatient Surgery	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
Lab Services	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
Diagnostic X-ray	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
Radiology (CAT, MRI, Ultrasound. PET)	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
HOSPITAL SERVICES	**Participating MEMBER RESPONSIBILITY**	**Non-Participating MEMBER RESPONSIBILITY**
Hospital Care		
Semi-private room (private room if medically necessary)	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
Physician and Surgeon Fees	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
Surgery	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
Lab and X-ray services	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
All Medically Necessary Ancillary Services	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
Anesthesia	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
Administration of Blood	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
Blood Products	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
Therapy Services (Chemotherapy & Radiation Therapy)	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
MATERNITY SERVICES	**Participating MEMBER RESPONSIBILITY**	**Non-Participating MEMBER RESPONSIBILITY**
Pregnancy Care (PCP/SCP)	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
Delivery	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
FAMILY PLANNING	**Participating MEMBER RESPONSIBILITY**	**Non-Participating MEMBER RESPONSIBILITY**
Infertility Counseling/Testing/Services	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
Tubal Ligation/Vasectomy	0% (after annual deductible)	30% 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** (after annual deductible)	
EMERGENCY CARE	**Participating MEMBER RESPONSIBILITY**	**Non-Participating MEMBER RESPONSIBILITY**
Urgent Care Center	0% (after annual deductible)	
Emergency Room Services	$125 Copay (after annual deductible) ER Copay waived if admitted	
REHABILITATION SERVICES	**Participating MEMBER RESPONSIBILITY**	**Non-Participating MEMBER RESPONSIBILITY**
Occupational, Speech, Physical Therapy	0% (after annual deductible)	30% 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	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
	30 days per contract year *90 day lifetime benefit maximum*	
Physician Services (Outpatient)	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
	20 outpatient visits maximum per contract year	
Serious Mental Health: Inpatient	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
	30 days per contract year *90 day lifetime benefit maximum*	
Physician Services (Outpatient)	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
	60 outpatient visits maximum per contract year	
Substance Abuse: Inpatient Detoxification	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
	7 days maximum per admission *4 admission benefit maximum*	
Inpatient Rehabilitation	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
	30 days per contract year *90 day lifetime benefit maximum*	
Transitional Partial Hospitalization	0% (after annual deductible)	30% 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.	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
Corrective Appliances	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
Home Health Care Services	0% (after annual deductible) *120 visits per contract year*	30% Eligible Charges (after annual deductible) *60 visits per contract year*
	120 visits combined per contract year	
Hospice Care	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
Skilled Nursing Facility	0% (after annual deductible) *100 inpatient days per contract year*	30% 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	0% (after annual deductible)	30% Eligible Charges (after annual deductible)
Removal of Third Molars	0% (after annual deductible)	30% 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.**	

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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.*