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 Atlanta, GA 30339
 1-800-395-2545

HMO \$20-\$40 \$500/100%
SCHEDULE OF BENEFITS

BENEFITS	MEMBER PAYS
Primary Care Physician (PCP) Services * Office Visits * Prenatal/Postnatal Physician Services Care (one time Copayment) * Well Child Care/Newborn Care * Immunizations * Preventative Health Screenings <i>Physician services are limited to one Copayment per Member per provider per date of service. Copayment applies to every visit to the office.</i>	\$20 Copayment
Specialist Physician Services * Office Visits * Prenatal/Postnatal Physician Services Care (one time Copayment) * Allergy Testing & Treatment <i>Physician services are limited to one Copayment per Member per provider per date of service. Copayment applies to every visit to the office.</i>	\$40 Copayment
Inpatient Hospital Care * Unlimited Hospital Days (Semi-Private) * Private Room When Medically Necessary * Medication & Drugs/Therapies * Professional Services * X-Ray/Laboratory/Blood Administration * Intensive/Coronary Care * Maternity Care	Deductible
Diagnostic/Outpatient Services At Hospital & Free Standing Facility * X-Ray/Laboratory * Diagnostic Services * Ambulatory Surgery * MRI, CAT and PET Scans	Deductible
	Deductible + \$100 Copayment
Short Term Therapies (per Benefit Year) * Physical – 20 visits * Speech – 20 visits * Occupational – 20 visits * Pulmonary Rehabilitation – 30 visits * Cardiac Rehabilitation – 30 visits * Chiropractic – 6 visits <i>Therapies are intended to restore normal function following illness/injury. Speech therapy is not covered for developmental delay. All therapies must receive prior</i>	\$40 Copayment
Family Planning * Elective Sterilization (Copayment in addition to facility Copayment if applicable) * Diagnostic Infertility Testing Services Only	Deductible + \$100 Copayment
	Deductible + \$40 Copayment
Injectables – Self Administered * Must be obtained from contracted vendor * Prior authorization required	10% Coinsurance

BENEFITS	MEMBER PAYS
Skilled Nursing Facility * Facility, supplies & equipment authorized in lieu of acute care hospitalization within Service * 60 days per Benefit Year	Deductible
Home Health Care * Authorized in lieu of acute care hospitalization within the Service Area * 60 visits per Benefit Year	Deductible
Hospice * Authorized in lieu of acute care hospitalization within the Service Area	Deductible
Mental Health Services * Outpatient visits – 20 sessions * Inpatient benefits according to Rider	\$40 Copayment
Durable Medical Equipment/Prosthetics and Orthosis * Authorized durable medical equipment * Authorized prosthetic devices * Specific orthosis covered <i>Dependent on benefit coverage and authorization requirements</i>	Deductible + 10% Coinsurance
Transplant Services * Services provided at approved Transplant Centers * Not all In Network facilities are approved for transplant	Determined by Location of Service
Urgent Care Services * At a Physician's Office * Urgent Care Facility	\$20 Copayment
	\$40 Copayment
Emergency Care Services * At a Hospital Emergency Room (waived if admitted) * Ambulance <i>Coventry Health Care must be notified within 48 hours of initial treatment in an emergency. Emergency Care is subject to prudent layperson review.</i>	\$150 Copayment
	\$150 Copayment
Deductible (per Benefit Year)	Individual: \$500
	Family: \$1,500
Out-of-Pocket Maximum (per Benefit Year)	\$3,000 Individual / \$9,000 Family
Maximum Lifetime Benefit (per Member)	Unlimited

This Schedule of Benefits is part of your Certificate of Coverage but does not replace it. Many words are defined elsewhere in the Certificate, and other limitations or exclusions may be listed in other sections of your Certificate. Reading this Schedule by itself could give you an inaccurate impression of the terms of your coverage. This Schedule must be read with the rest of your Certificate. A complete list of covered services, exclusions, and limitations can be found in your Certificate of Coverage. Prior authorization may be required for specific services.

- * Primary Care Physician (PCP) services not required
- * Direct access to all In Network providers
- * Direct access to In Network OB/GYN, Dermatologist and Ophthalmologist (disease and injury only)
- * Deductibles and Copayments do not apply to Out-of-Pocket Maximum

Exclusions and Limitations:
 Services not covered include, but are not limited to: services that are not medically necessary; personal or convenience items; custodial care; cosmetic services and surgery; over-the-counter drugs, medications/supplies not requiring a prescription; experimental procedures and treatments; and food and food supplements. Please refer to your Certificate of Coverage.