1100 Circle 75 Parkway, Suite 1400
Atlanta, GA 30339
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POS $20-$40 $500/100%/70%
SCHEDULE OF BENEFITS

BENEFITS	MEMBER PAYS	
	In Network	Out of Network **
Primary Care Physician (PCP) Services * Office Visits * Prenatal/Postnatal Physician Services Care (one time Copayment) * Well Child Care/Newborn Care * Immunizations * Preventative Health Screenings *Physician services are limited to one Copayment per Member per provider per date of service. Copayment applies to every visit to the office.*	$20 Copayment	Deductible + 30% Coinsurance, based on ONR *Deductible does not apply to Well Child Care*
Specialist Physician Services * Office Visits * Prenatal/Postnatal Physician Services Care (one time Copayment) * Allergy Testing & Treatment *Physician services are limited to one Copayment per Member per provider per date of service. Copayment applies to every visit to the office.*	$40 Copayment	Deductible + 30% Coinsurance, based on ONR
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	Deductible + 30% Coinsurance, based on ONR
Diagnostic/Outpatient Services At Hospital & Free Standing Facility * X-Ray/Laboratory * Diagnostic Services	Deductible	Deductible + 30% Coinsurance, based on ONR
* Ambulatory Surgery * MRI, CAT and PET Scans	Deductible + $100 Copayment	Deductible + 30% Coinsurance, based on ONR
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 *Therapies are intended to restore normal function following illness/injury. Speech therapy is not covered for developmental delay. All therapies must receive prior*	$40 Copayment	Deductible + 30% Coinsurance, based on ONR
Family Planning * Elective Sterilization *(Copayment in addition to facility Copayment if applicable)*	Deductible + $100 Copayment	Deductible + 30% Coinsurance, based on ONR
* Diagnostic Infertility Testing Services Only	$40 Copayment	Deductible + 30% Coinsurance, based on ONR
Injectables – Self Administered * Must be obtained from contracted vendor * Prior authorization required	10% Coinsurance	Deductible + 30% Coinsurance, based on ONR

BENEFITS	MEMBER PAYS	
	In Network	Out of Network **
Skilled Nursing Facility * Facility, supplies & equipment authorized in lieu of acute care hospitalization within Service * 60 days per Benefit Year * This is a combined In and Out of Network benefit	Deductible	Deductible + 30% Coinsurance, based on ONR
Home Health Care * Authorized in lieu of acute care hospitalization within the Service Area * 60 visits per Benefit Year * This is a combined In and Out of Network benefit	Deductible	Deductible + 30% Coinsurance, based on ONR
Hospice * Authorized in lieu of acute care hospitalization within the Service Area	Deductible	Deductible + 30% Coinsurance, based on ONR
Mental Health Services * Outpatient visits – 20 sessions * Inpatient benefits according to Rider	$40 Copayment	Not Covered
Durable Medical Equipment/Prosthetics and Orthosis * Authorized durable medical equipment * Authorized prosthetic devices * Specific orthosis covered *Dependent on benefit coverage and authorization requirements*	Deductible + 10% Coinsurance	Deductible + 30% Coinsurance, based on ONR
Transplant Services * Services provided at approved Transplant Centers * Not all In Network facilities are approved for transplant	Determined by Location of Service	Not Covered
Urgent Care Services * At a Physician's Office	$20 Copayment	Deductible + 30% Coinsurance, based on ONR
* Urgent Care Facility	$45 Copayment	Deductible + 30% Coinsurance, based on ONR
Emergency Care Services * At a Hospital Emergency Room (waived if admitted)	$150 Copayment	$150 Copayment
* Ambulance *Coventry Health Care must be notified within 48 hours of initial treatment in an emergency. Emergency Care is subject to prudent layperson review.*	$150 Copayment	$150 Copayment
Deductible (per Benefit Year)	Individual: $500	Individual: $500
	Family: $1,500	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 providers
Deductibles and Copayments do not apply to the Out-of-Pocket Maximum
**** NOTE: The Out-of-Network Rate (ONR) is determined by a percentage of Medicare ****

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.