



Coventry Health and Life Insurance Company

Individual Policy PPO Schedule of Benefits

State(s) of Issue: Missouri

PPO Plan: MI08C05020 20

Covered Services	Cost to Member when Receiving Services from Participating Providers (In-Network) ²	Cost to Member when Receiving Services from Non-Participating Providers (Out-of-Network) ²
Annual Plan Deductible	\$500 Individual \$1,500 Family	\$500 Individual \$1,500 Family
Coinsurance For All Eligible Expenses (unless otherwise noted)	Deductible Plus 20% Coinsurance	Deductible Plus 40% Coinsurance
Out-of-Pocket Maximum Only Includes coinsurance	\$2,000 Individual \$6,000 Family	\$4,000 Individual \$12,000 Family
Combined Lifetime Benefit Maximum	\$2,000,000	
Primary Care Physician (PCP) Services¹		
▪ Physician Office Visit	\$20 Copayment	Deductible Plus 40% Coinsurance
▪ Physician Office Surgery	\$20 Copayment	Deductible Plus 40% Coinsurance
▪ Allergy Injections	\$0 Copayment	Deductible Plus 40% Coinsurance
▪ Allergy Testing	Deductible Plus 20% Coinsurance	Deductible Plus 40% Coinsurance
Specialty Physician Services¹		
▪ Physician Office Visit	\$35 Copayment	Deductible Plus 40% Coinsurance
▪ Physician Office Surgery	\$35 Copayment	Deductible Plus 40% Coinsurance
▪ Allergy Injections	\$0 Copayment	Deductible Plus 40% Coinsurance
▪ Allergy Testing	Deductible Plus 20% Coinsurance	Deductible Plus 40% Coinsurance
Preventive Care		
▪ Annual Well Woman Exam	Same as Physician Office Visit ¹	Deductible Plus 40% Coinsurance
▪ Mammograms (Routine Screening and Diagnostic)	\$0 Copayment	Deductible Plus 40% Coinsurance

Covered Services	Cost to Member when Receiving Services from Participating Providers (In-Network) ²	Cost to Member when Receiving Services from Non-Participating Providers (Out-of-Network) ²
<ul style="list-style-type: none"> Bone Density 	Same as Physician Office Visit ¹	Deductible Plus 40% Coinsurance
<ul style="list-style-type: none"> Well Baby and Child Care 	Same as Physician Office Visit ¹	Deductible Plus 40% Coinsurance
<ul style="list-style-type: none"> Annual Prostate Screening - High Risk or Symptomatic (Age 40+) and All Males (Age 50+) 	Same as Physician Office Visit ¹	Deductible Plus 40% Coinsurance
<ul style="list-style-type: none"> Routine Health Screening 	Same as Physician Office Visit ¹	Deductible Plus 40% Coinsurance <i>Limited up to \$300 per Member per Calendar Year Benefit Maximum</i>
Immunizations <ul style="list-style-type: none"> Pediatric (up to age 72 months) Covered Adult Immunizations 	No Copayment	No Copayment Deductible Plus 40% Coinsurance
Hospital Inpatient Services Services include semi-private hospital room & board, physician and surgeon services, lab, x-ray and other facility and ancillary charges.	Deductible Plus 20% Coinsurance	Deductible Plus 40% Coinsurance
Outpatient Surgery and Scopes Includes related Professional Charges <ul style="list-style-type: none"> Performed in Hospital Performed in Ambulatory Surgery Center 	Deductible Plus 20% Coinsurance	Deductible Plus 40% Coinsurance Deductible Plus 40% Coinsurance
Outpatient Laboratory Services <i>Human Leukocyte Antigen testing limited to \$75 per Calendar Year Benefit Maximum</i>	Deductible Plus 20% Coinsurance	Deductible Plus 40% Coinsurance
Outpatient X-rays Includes related Professional Charges	Deductible Plus 20% Coinsurance	Deductible Plus 40% Coinsurance
Outpatient Diagnostic Testing, Imaging, and Services (Not Listed Elsewhere) <ul style="list-style-type: none"> Performed in Hospital Performed in Other Outpatient Setting Includes related Professional Charges	Deductible Plus 20% Coinsurance	Deductible Plus 40% Coinsurance Deductible Plus 40% Coinsurance

Covered Services	Cost to Member when Receiving Services from Participating Providers (In-Network) ²	Cost to Member when Receiving Services from Non-Participating Providers (Out-of- Network) ²
Emergency Services <ul style="list-style-type: none"> ▪ Emergency Room Copayment and Coinsurance waived if admitted	\$100 Copayment and 20% Coinsurance for Facility Charges	\$100 Copayment and 20% Coinsurance for Facility Charges
<ul style="list-style-type: none"> ▪ Related Professional Fees 	20% Coinsurance for Related Professional Fees	20% Coinsurance for Related Professional Fees
Ambulance/Emergency Transportation (Ground or Air)	Deductible Plus 20% Coinsurance	Deductible Plus 20% Coinsurance
Urgent Care	\$50 Copayment	\$50 Copayment
Outpatient Short Term Therapy <ul style="list-style-type: none"> ▪ Physical Therapy ▪ Occupational Therapy ▪ Speech Therapy 	Deductible Plus 20% Coinsurance <i>Limit of 20 visits per therapy per Calendar Year Benefit Maximum</i>	Deductible Plus 40% Coinsurance
Spinal Manipulation	Same as Physician Office Visit ¹ <i>Limit of 26 visits per Calendar Year Benefit Maximum</i>	Deductible Plus 40% Coinsurance
Rehabilitation <ul style="list-style-type: none"> ▪ Inpatient 	Deductible Plus 20% Coinsurance <i>Limit of 20 days per Calendar Year Benefit Maximum</i>	Deductible Plus 40% Coinsurance
<ul style="list-style-type: none"> ▪ Partial Day Programs (4 hours or greater) 	Deductible Plus 20% Coinsurance <i>Limit of 20 visits per Calendar Year Benefit Maximum</i>	Deductible Plus 40% Coinsurance
<ul style="list-style-type: none"> ▪ Outpatient (Pulmonary, Cardiac) 	Deductible Plus 20% Coinsurance <i>Limit of 36 visits per Calendar Year Benefit Maximum</i>	Deductible Plus 40% Coinsurance
Home Health Care	Deductible Plus 20% Coinsurance	Deductible Plus 40% Coinsurance
Skilled Nursing Facility	Deductible Plus 20% Coinsurance <i>Limit of 60 days per Calendar Year Benefit Maximum</i>	Deductible Plus 40% Coinsurance

Covered Services	Cost to Member when Receiving Services from Participating Providers (In-Network) ²	Cost to Member when Receiving Services from Non-Participating Providers (Out-of-Network) ²
Hospice Care <ul style="list-style-type: none"> ▪ Inpatient ▪ Outpatient 	Deductible Plus 20% Coinsurance <i>Limit of 15 days per Calendar Year Benefit Maximum</i>	Deductible Plus 40% Coinsurance
Durable Medical Equipment	Deductible Plus 20% Coinsurance <i>Limit of \$3,000 per Calendar Year Benefit Maximum</i>	Deductible Plus 40% Coinsurance
Prosthetics & Braces	Deductible Plus 20% Coinsurance <i>Limit of \$3,000 per Calendar Year Benefit Maximum</i>	Deductible Plus 40% Coinsurance
Organ Transplant	See Appropriate Benefits <i>Limited to \$500,000 Lifetime Benefit Maximum</i>	Not Covered
Outpatient Dialysis	Deductible Plus 20% Coinsurance	Deductible Plus 40% Coinsurance
Nutritional Evaluation & Diabetes Management/Self-Training	0% Coinsurance	Deductible Plus 40% Coinsurance
Mental Illness, Nervous & Mental Disorders and Alcohol or Chemical Dependency Treatment	Inpatient: Same as Hospital Inpatient Services Outpatient: Same as Specialist Office Visit <i>See Mental Health and Chemical Dependency Rider for Details</i> <i>Limits may apply</i>	Inpatient: Same as Hospital Inpatient Services Outpatient: Same as Specialist Office Visit <i>See Mental Health and Chemical Dependency Rider for Details</i> <i>Limits may apply</i>
Prescription Drug	<i>See Prescription Drug Rider for Details</i>	<i>See Prescription Drug Rider for Details</i>

Please Note: Maximum Benefit Limits do not guarantee that all services will be approved to the Maximum number allowed under this plan. Payments that are on a percentage basis will be applied to the contracted allowed amount reimbursed to the provider, if applicable.

1. Primary Care Physicians (PCP) generally include those physicians who practice in the specialties of Family Practice, Internal Medicine, General Practice, or Pediatrics. If you are not sure if a physician is a PCP, please contact the Customer Service Number on the back of your ID card. If you receive this service from a Primary Care Physician (PCP), your PCP payment will apply. If you receive these services from a Specialist, your Specialist payment will apply.
2. In order to receive the maximum benefits for services requiring prior authorization, you must participate in Our Utilization Management Program as outline in your Evidence of Coverage. **Failure to do so may result in a 20% reduction in benefits for that particular service.**

**Formula & Low Protein Modified Foods for PKU & Amino Acid Disease are limited to \$5,000 per Calendar Year Benefit Maximum.*