Coventry Health and Life Insurance Company

Individual Policy PPO Schedule of Benefits

State(s) of Issue: Missouri
PPO Plan: MIQ08A25025 30

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	$2,500 Individual $5,000 Family	$2,500 Individual $5,000 Family
Coinsurance For All Eligible Expenses (unless otherwise noted)	Deductible Plus 0% Coinsurance	Deductible Plus 20% Coinsurance
Out-of-Pocket Maximum Includes Deductible, Copayments and Coinsurance	$2,500 Individual $5,000 Family	$5,000 Individual $10,000 Family
Combined Lifetime Benefit Maximum	$2,000,000	
Primary Care Physician (PCP) Services[1]		
▪ Physician Office Visit	Deductible Plus 0% Coinsurance	Deductible Plus 20% Coinsurance
▪ Physician Office Surgery	Deductible Plus 0% Coinsurance	Deductible Plus 20% Coinsurance
▪ Allergy Injections	Deductible Plus 0% Coinsurance	Deductible Plus 20% Coinsurance
▪ Allergy Testing	Deductible Plus 0% Coinsurance	Deductible Plus 20% Coinsurance
Specialty Physician Services[1]		
▪ Physician Office Visit	Deductible Plus 0% Coinsurance	Deductible Plus 20% Coinsurance
▪ Physician Office Surgery	Deductible Plus 0% Coinsurance	Deductible Plus 20% Coinsurance
▪ Allergy Injections	Deductible Plus 0% Coinsurance	Deductible Plus 20% Coinsurance
▪ Allergy Testing	Deductible Plus 0% Coinsurance	Deductible Plus 20% Coinsurance
Preventive Care		
▪ Annual Well Woman Exam	$30 Copayment	Deductible Plus 20% 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]
▪ Mammograms (Routine Screening and Diagnostic)	$0 Copayment	Deductible Plus 20% Coinsurance
▪ Bone Density	$30 Copayment	Deductible Plus 20% Coinsurance
▪ Well Baby and Child Care	$30 Copayment	Deductible Plus 20% Coinsurance
▪ Annual Prostate Screening - High Risk or Symptomatic (Age 40+) and All Males (Age 50+)	$30 Copayment	Deductible Plus 20% Coinsurance
▪ Routine Health Screening	$30 Copayment *Limited up to $300 per Member per Calendar Year Benefit Maximum*	Deductible Plus 20% Coinsurance
Immunizations ▪ Pediatric (up to age 72 months) ▪ Covered Adult Immunizations	 No Copayment No Copayment	 No Copayment Deductible Plus 20% 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 0% Coinsurance	Deductible Plus 20% Coinsurance
Outpatient Surgery and Scopes Includes related Professional Charges ▪ **Performed in Hospital** ▪ **Performed in Ambulatory Surgery Center**	 Deductible Plus 0% Coinsurance Deductible Plus 0% Coinsurance	 Deductible Plus 20% Coinsurance Deductible Plus 20% Coinsurance
Outpatient Laboratory Services *Human Leukocyte Antigen testing limited to $75 per Calendar Year Benefit Maximum*	Deductible Plus 0% Coinsurance	Deductible Plus 20% Coinsurance
Outpatient X-rays Includes related Professional Charges	Deductible Plus 0% Coinsurance	Deductible Plus 20% Coinsurance
Outpatient Diagnostic Testing, Imaging, and Services (Not Listed Elsewhere) ▪ Performed in Hospital ▪ Performed in Other Outpatient Setting Includes related Professional Charges	 Deductible Plus 0% Coinsurance Deductible Plus 0% Coinsurance	 Deductible Plus 20% Coinsurance Deductible Plus 20% 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 ▪ Emergency Room Copayment and Coinsurance waived if admitted	Deductible Plus 0% Coinsurance for Facility Charges	Deductible Plus 0% Coinsurance for Facility Charges
▪ Related Professional Fees	Deductible Plus 0% Coinsurance for Related Professional Fees	Deductible Plus 0% Coinsurance for Related Professional Fees
Ambulance/Emergency Transportation **(Ground or Air)**	Deductible Plus 0% Coinsurance	Deductible Plus 0% Coinsurance
Urgent Care	Deductible Plus 0% Coinsurance	Deductible Plus 0% Coinsurance
Outpatient Short Term Therapy ▪ Physical Therapy ▪ Occupational Therapy ▪ Speech Therapy	Deductible Plus 0% Coinsurance *Limit of 20 visits per therapy per Calendar Year Benefit Maximum*	Deductible Plus 20% Coinsurance
Spinal Manipulation	Deductible Plus 0% Coinsurance *Limit of 26 visits per Calendar Year Benefit Maximum*	Deductible Plus 20% Coinsurance
Rehabilitation ▪ Inpatient	Deductible Plus 0% Coinsurance *Limit of 20 days per Calendar Year Benefit Maximum*	Deductible Plus 20% Coinsurance
▪ Partial Day Programs (4 hours or greater)	Deductible Plus 0% Coinsurance *Limit of 20 visits per Calendar Year Benefit Maximum*	Deductible Plus 20% Coinsurance
▪ Outpatient (Pulmonary, Cardiac)	Deductible Plus 0% Coinsurance *Limit of 36 visits per Calendar Year Benefit Maximum*	Deductible Plus 20% Coinsurance
Home Health Care	Deductible Plus 0% Coinsurance	Deductible Plus 20% Coinsurance
Skilled Nursing Facility	Deductible Plus 0% Coinsurance *Limit of 60 days per Calendar Year Benefit Maximum*	Deductible Plus 20% 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 ▪ Inpatient	Deductible Plus 0% Coinsurance	Deductible Plus 20% Coinsurance
	Limit of 15 days per Calendar Year Benefit Maximum	
▪ Outpatient	Deductible Plus 0% Coinsurance	Deductible Plus 20% Coinsurance
Durable Medical Equipment	Deductible Plus 0% Coinsurance	Deductible Plus 20% Coinsurance
	Limit of $3,000 per Calendar Year Benefit Maximum	
Prosthetics & Braces	Deductible Plus 0% Coinsurance	Deductible Plus 20% Coinsurance
	Limit of $3,000 per Calendar Year Benefit Maximum	
Organ Transplant	See Appropriate Benefits *Limited to $500,000 Lifetime Benefit Maximum*	Not Covered
Outpatient Dialysis	Deductible Plus 0% Coinsurance	Deductible Plus 20% Coinsurance
Nutritional Evaluation & Diabetes Management/Self-Training	0% Coinsurance	Deductible Plus 20% Coinsurance
Mental Illness, Nervous & Mental Disorders and Alcohol or Chemical Dependency Treatment	**Inpatient:** Same as Hospital Inpatient Services **Outpatient:** Same as Specialist Office Visit *See Mental Health and Chemical Dependency Rider for Details* *Limits may apply*	**Inpatient:** Same as Hospital Inpatient Services **Outpatient:** Same as Specialist Office Visit *See Mental Health and Chemical Dependency Rider for Details* *Limits may apply*
Prescription Drug	*See Prescription Drug Rider for Details*	*See Prescription Drug Rider for Details*

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.*