Coventry Health and Life Insurance Company
PPO Schedule of Benefits

State(s) of Issue: Oklahoma
PPO Plan: OIGOC20040 25

Covered Services	Cost to Insured when Receiving Services from Participating Providers (In-Network)	Cost to Insured when Receiving Services from Non-Participating Providers (Out-of- Network) [2, 3]
Contract Year Deductible	$2,000 Individual $6,000 Family	$2,000 Individual $6,000 Family
Coinsurance For All Eligible Expenses (unless otherwise noted)	Deductible Plus 20% Coinsurance	Deductible Plus 40% Coinsurance
Contract Year Out-of-Pocket Maximum Only Includes Coinsurance	$4,000 Individual $12,000 Family	$8,000 Individual $24,000 Family
Combined Lifetime Benefit Maximum	$2,000,000	
Primary Care Physician (PCP) Services[1]		
▪ Physician Office Visit	$25 Copayment	Deductible Plus 40% Coinsurance
▪ Physician Office Surgery	$25 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 Services[1]		
▪ Physician Office Visit	$40 Copayment	Deductible Plus 40% Coinsurance

Covered Services	Cost to Insured when Receiving Services from Participating Providers (In-Network)	Cost to Insured when Receiving Services from Non-Participating Providers (Out-of- Network) [2, 3]
▪ Physician Office Surgery	$40 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	No Member Responsibility	No Member Responsibility
▪ Well Baby and Child Care	Same as Physician Office Visit[1]	Deductible Plus 40% Coinsurance
▪ Annual Prostate Screening - High Risk or Symptomatic (Age 40+) and All Males (Age 50+)	Same as Physician Office Visit[1]	Deductible Plus 40% Coinsurance
▪ Routine Health Screening	Same as Physician Office Visit[1]	Deductible Plus 40% Coinsurance
	Routine Health Screenings Covered up to a Contract Year Benefit Maximum of $300	
Immunizations ▪ Pediatric (through 18 years of age)	No Member Responsibility	No Member Responsibility
▪ Adult	$0 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

Covered Services	Cost to Insured when Receiving Services from Participating Providers (In-Network)	Cost to Insured when Receiving Services from Non-Participating Providers (Out-of- Network) [2, 3]
Outpatient Laboratory Services	Deductible Plus 20% Coinsurance	Deductible Plus 40% Coinsurance
Outpatient Surgery and Scopes Includes related Professional Charges • Performed in Hospital • Performed in Ambulatory Surgery Center	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 and Services (Not Listed Elsewhere) Includes related Professional Charges ▪ Performed in Hospital ▪ Performed in Other Outpatient Setting	Deductible Plus 20% Coinsurance	Deductible Plus 40% Coinsurance
Emergency Services ▪ Emergency Room (Copayment waived if admitted) ▪ Related Professional Fees	$125 Copayment and 20% Coinsurance for Facility Charges 20% Coinsurance	$125 Copayment and 20% Coinsurance for Facility Charges 20% Coinsurance
Ambulance/Emergency Transportation (Ground or Air)	Deductible Plus 20% Coinsurance	Deductible Plus 20% Coinsurance
Urgent Care	$75 Copayment	$75 Copayment
Outpatient Short Term Therapy ▪ Physical Therapy ▪ Occupational Therapy ▪ Speech Therapy	Deductible Plus 20% Coinsurance *Limited to 20 visits per Therapy per Contract Year Maximum*	Deductible Plus 40% Coinsurance
Spinal Manipulation	Same as Physician Office Visit[1] *Limited to 26 visits per Contract Year Benefit Maximum*	Deductible Plus 40% Coinsurance
Rehabilitation		

Covered Services	Cost to Insured when Receiving Services from Participating Providers (In-Network)	Cost to Insured when Receiving Services from Non-Participating Providers (Out-of- Network) [2, 3]
▪ Inpatient	Deductible Plus 20% Coinsurance	Deductible Plus 40% Coinsurance
	Limited to 20 days per Contract Year Benefit Maximum	
▪ Partial Day Programs (4 hours or greater)	Deductible Plus 20% Coinsurance	Deductible Plus 40% Coinsurance
	Limited to 20 visits per Contract Year Benefit Maximum	
▪ Outpatient (Pulmonary, Cardiac)	Deductible Plus 20% Coinsurance	Deductible Plus 40% Coinsurance
	Limited to 36 visits per Condition Benefit Maximum	
Home Health Care	Deductible Plus 20% Coinsurance	Deductible Plus 40% Coinsurance
Skilled Nursing Facility	Deductible Plus 20% Coinsurance	Deductible Plus 40% Coinsurance
	Limited to 60 days per Contract Year Benefit Maximum	
Hospice Care ▪ Inpatient ▪ Outpatient	Deductible Plus 20% Coinsurance	Deductible Plus 40% Coinsurance
	Inpatient Limited to 15 days per Contract Year Benefit Maximum	
Durable Medical Equipment	Deductible Plus 20% Coinsurance	Deductible Plus 40% Coinsurance
	Limited to $3,000 per Contract Year Benefit Maximum	
Prosthetics, Orthotics & Braces	Deductible Plus 20% Coinsurance	Deductible Plus 40% Coinsurance
	Limited to $3,000 per Contract Year Benefit Maximum	
Organ Transplant	See Appropriate Benefits	See Appropriate Benefits
	Limited to $500,000 Lifetime Benefit Maximum	

Covered Services	Cost to Insured when Receiving Services from Participating Providers (In-Network)	Cost to Insured when Receiving Services from Non-Participating Providers (Out-of- Network) [2, 3]
Injectable Medications (Not listed elsewhere)	Deductible Plus 20% Coinsurance See Prescription Drug Rider for Self-Injectable Medications	Deductible Plus 40% Coinsurance See Prescription Drug Rider for Self-Injectable Medications
Outpatient Dialysis	Deductible Plus 20% Coinsurance	Deductible Plus 40% Coinsurance
Nutritional Evaluation & Diabetes Management/Self-Training	$0 Copayment	Deductible Plus 40% Coinsurance
Mental Illness, Nervous & Mental Disorders and Alcohol or Chemical Dependency Treatment	*See Mental Illness Rider for Details* *Limits May Apply*	*See Mental Illness Rider for Details* *Limits May Apply*
Prescription Drugs	*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. When receiving services from non-participating providers, payment for Covered Services is limited to the lesser of the billed charge of the Out-of-Network rate less applicable Copayment, Coinsurance and/or Deductibles. Please refer to the Individual Policy for additional details.

3. In order to receive the maximum benefits for services requiring prior authorization, you must participate in Our Utilization Management Program as outlined in your Individual Policy. ***Failure to do so may result in a $200 reduction in benefits for that particular service.***