



**Coventry Health and Life Insurance Company**  
**PPO Schedule of Benefits**

**State(s) of Issue:** Oklahoma

**PPO Plan:** OIQ08A25025 30

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) <sup>2,3</sup>
<b>Contract Year Deductible</b>	\$2,500 Individual \$5,000 Family	\$2,500 Individual \$5,000 Family
<b>Coinsurance For All Eligible Expenses</b> (unless otherwise noted)	Deductible Plus 0% Coinsurance	Deductible Plus 20% Coinsurance
<b>Contract Year Out-of-Pocket Maximum</b> Only Includes Coinsurance	\$2,500 Individual \$5,000 Family	\$5,000 Individual \$10,000 Family
<b>Combined Lifetime Benefit Maximum</b>	\$2,000,000	
<b>Primary Care Physician (PCP) Services<sup>1</sup></b> <ul style="list-style-type: none"> <li>▪ Physician Office Visit</li> <li>▪ Physician Office Surgery</li> <li>▪ Allergy Injections</li> <li>▪ Allergy Testing</li> </ul>	Deductible Plus 0% Coinsurance  Deductible Plus 0% Coinsurance  Deductible Plus 0% Coinsurance  Deductible Plus 0% Coinsurance	Deductible Plus 20% Coinsurance  Deductible Plus 20% Coinsurance  Deductible Plus 20% Coinsurance  Deductible Plus 20% Coinsurance
<b>Specialty Physician Services<sup>1</sup></b> <ul style="list-style-type: none"> <li>▪ Physician Office Visit</li> <li>▪ Physician Office Surgery</li> </ul>	Deductible Plus 0% Coinsurance  Deductible Plus 0% Coinsurance	Deductible Plus 20% Coinsurance  Deductible Plus 20% 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) <sup>2,3</sup>
<ul style="list-style-type: none"> <li>▪ Allergy Injections</li> <li>▪ Allergy Testing</li> </ul>	<p style="text-align: center;">Deductible Plus 0% Coinsurance</p> <p style="text-align: center;">Deductible Plus 0% Coinsurance</p>	<p style="text-align: center;">Deductible Plus 20% Coinsurance</p> <p style="text-align: center;">Deductible Plus 20% Coinsurance</p>
<p><b>Preventive Care</b></p> <ul style="list-style-type: none"> <li>▪ Annual Well Woman Exam</li> <li>▪ Mammograms - Routine Screening and Diagnostic</li> <li>▪ Well Baby and Child Care</li> <li>▪ Annual Prostate Screening - High Risk or Symptomatic (Age 40+) and All Males (Age 50+)</li> <li>▪ Routine Health Screening</li> </ul>	<p style="text-align: center;">\$30 Copayment</p> <p style="text-align: center;">No Member Responsibility</p> <p style="text-align: center;">\$30 Copayment</p> <p style="text-align: center;">\$30 Copayment</p> <p style="text-align: center;">\$30 Copayment</p> <p style="text-align: center;"><i>Routine Health Screenings Covered up to a Contract Year Benefit Maximum of \$300</i></p>	<p style="text-align: center;">Deductible Plus 20% Coinsurance</p> <p style="text-align: center;">No Member Responsibility</p> <p style="text-align: center;">Deductible Plus 20% Coinsurance</p> <p style="text-align: center;">Deductible Plus 20% Coinsurance</p> <p style="text-align: center;">Deductible Plus 20% Coinsurance</p>
<p><b>Immunizations</b></p> <ul style="list-style-type: none"> <li>▪ Pediatric (through 18 years of age)</li> <li>▪ Adult</li> </ul>	<p style="text-align: center;">No Member Responsibility</p> <p style="text-align: center;">\$0 Copayment</p>	<p style="text-align: center;">No Member Responsibility</p> <p style="text-align: center;">Deductible Plus 20% Coinsurance</p>
<p><b>Hospital Inpatient Services</b> Services include semi-private hospital room &amp; board, physician and surgeon services, lab, x-ray and other facility and ancillary charges.</p>	<p style="text-align: center;">Deductible Plus 0% Coinsurance</p>	<p style="text-align: center;">Deductible Plus 20% Coinsurance</p>
<p><b>Outpatient Laboratory Services</b></p>	<p style="text-align: center;">Deductible Plus 0% Coinsurance</p>	<p style="text-align: center;">Deductible Plus 20% Coinsurance</p>

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) <sup>2,3</sup>
<b>Outpatient Surgery and Scopes</b> Includes related Professional Charges <ul style="list-style-type: none"> <li>• Performed in Hospital</li> <li>• Performed in Ambulatory Surgery Center</li> </ul>	Deductible Plus 0% Coinsurance	Deductible Plus 20% Coinsurance
<b>Outpatient X-rays</b> Includes related Professional Charges	Deductible Plus 0% Coinsurance	Deductible Plus 20% Coinsurance
<b>Outpatient Diagnostic Testing and Services (Not Listed Elsewhere)</b> Includes related Professional Charges <ul style="list-style-type: none"> <li>▪ Performed in Hospital</li> <li>▪ Performed in Other Outpatient Setting</li> </ul>	Deductible Plus 0% Coinsurance	Deductible Plus 20% Coinsurance
<b>Emergency Services</b> <ul style="list-style-type: none"> <li>▪ Emergency Room (Copayment waived if admitted)</li> <li>▪ Related Professional Fees</li> </ul>	Deductible Plus 0% Coinsurance for Facility Charges  Deductible Plus 0% Coinsurance	Deductible Plus 0% Coinsurance for Facility Charges  Deductible Plus 0% Coinsurance
<b>Ambulance/Emergency Transportation (Ground or Air)</b>	Deductible Plus 0% Coinsurance	Deductible Plus 0% Coinsurance
<b>Urgent Care</b>	Deductible Plus 0% Coinsurance	Deductible Plus 0% Coinsurance
<b>Outpatient Short Term Therapy</b> <ul style="list-style-type: none"> <li>▪ Physical Therapy</li> <li>▪ Occupational Therapy</li> <li>▪ Speech Therapy</li> </ul>	Deductible Plus 0% Coinsurance  <i>Limited to 20 visits per Therapy per Contract Year Benefit Maximum</i>	Deductible Plus 20% Coinsurance
<b>Spinal Manipulation</b>	Deductible Plus 0% Coinsurance  <i>Limited to 26 visits per Contract Year Benefit Maximum</i>	Deductible Plus 20% 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) <sup>2,3</sup>
<b>Rehabilitation</b> <ul style="list-style-type: none"> <li>▪ Inpatient</li> </ul>	Deductible Plus 0% Coinsurance  <i>Limited to 20 days per Contract Year Benefit Maximum</i>	Deductible Plus 20% Coinsurance
<ul style="list-style-type: none"> <li>▪ Partial Day Programs (4 hours or greater)</li> </ul>	Deductible Plus 0% Coinsurance  <i>Limited to 20 visits per Contract Year Benefit Maximum</i>	Deductible Plus 20% Coinsurance
<ul style="list-style-type: none"> <li>▪ Outpatient (Pulmonary, Cardiac)</li> </ul>	Deductible Plus 0% Coinsurance  <i>Limited to 36 visits per Condition Benefit Maximum</i>	Deductible Plus 20% Coinsurance
<b>Home Health Care</b>  <b>Skilled Nursing Facility</b>	Deductible Plus 0% Coinsurance  Deductible Plus 0% Coinsurance  <i>Limited to 60 days per Contract Year Benefit Maximum</i>	Deductible Plus 20% Coinsurance  Deductible Plus 20% Coinsurance
<b>Hospice Care</b> <ul style="list-style-type: none"> <li>▪ Inpatient</li> <li>▪ Outpatient</li> </ul>	Deductible Plus 0% Coinsurance  <i>Inpatient Limited to 15 days per Contract Year Benefit Maximum</i>	Deductible Plus 20% Coinsurance
<b>Durable Medical Equipment</b>	Deductible Plus 0% Coinsurance  <i>Limited to \$3,000 per Contract Year Benefit Maximum</i>	Deductible Plus 20% Coinsurance
<b>Prosthetics, Orthotics &amp; Braces</b>	Deductible Plus 0% Coinsurance  <i>Limited to \$3,000 per Contract Year Benefit Maximum</i>	Deductible Plus 20% Coinsurance
<b>Organ Transplant</b>	See Appropriate Benefits  <i>Limited to \$500,000 Lifetime Benefit Maximum</i>	See Appropriate Benefits

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<b>Injectable Medications</b> (Not listed elsewhere)	Deductible Plus 0% Coinsurance  See Prescription Drug Rider for Self-Injectable Medications	Deductible Plus 20% Coinsurance  See Prescription Drug Rider for Self-Injectable Medications
<b>Outpatient Dialysis</b>	Deductible Plus 0% Coinsurance	Deductible Plus 20% Coinsurance
<b>Nutritional Evaluation &amp; Diabetes Management/Self-Training</b>	Deductible Plus 0% Coinsurance	Deductible Plus 20% Coinsurance
<b>Mental Illness, Nervous &amp; Mental Disorders and Alcohol or Chemical Dependency Treatment</b>	<i>See Mental Illness Rider for Details</i>  <i>Limits May Apply</i>	<i>See Mental Illness Rider for Details</i>  <i>Limits May Apply</i>
<b>Prescription Drugs</b>	<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. 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.***

