

**COVENTRY HEALTH CARE OF DELAWARE, INC.
DIAMOND PLUS 2 PLAN
(Maryland)**

COVERED SERVICES	<u>IN-NETWORK MEMBER PAYS</u>	<u>OUT-OF-NETWORK MEMBER PAYS</u>
Deductible* (per Contract Year) Does not include copayments (except for emergency services) or the prescription drug deductible.	None	\$400/Individual \$800/Family
Out-of-Pocket* (per Contract Year) Does not include any copayments (except for emergency services). Includes the contract year deductible (but not the prescription drug deductible).	\$1,000/Individual \$3,000/Family	\$2,000/Individual \$4,000/Family
Lifetime Maximum Benefit	None	\$2,000,000
Primary Care Services	\$20 copayment	20% coinsurance
Specialty Care Services	\$30 copayment	20% coinsurance
Well Child Visits (Includes all visits for children 0-24 months of age and visits that include immunizations for children older than 24 months – 13 years of age)	\$10 copayment	20% coinsurance
Inpatient Hospitalization	\$250 copayment per admission	20% coinsurance
Physician Inpatient Visits	\$30 copayment	20% coinsurance
Outpatient Laboratory Services	\$40 copayment or 50% of the cost of the service, whichever is less	20% coinsurance
Outpatient Diagnostic Services	\$40 copayment or 50% of the cost of the service, whichever is less	20% coinsurance
Outpatient Surgery	\$40 copayment	20% coinsurance
Outpatient Rehabilitative Services (up to 30 visits for each service per condition per Contract Year)	\$30 copayment	50% coinsurance
Chiropractic Services (up to 20 visits per condition per Contract Year)	\$30 copayment	40% coinsurance
Durable Medical Equipment	\$0 copayment	40% coinsurance
Hospice	\$0 copayment	20% coinsurance
Home Health Care	\$0 copayment	20% coinsurance

COVERED SERVICES

Outpatient Mental Health and Substance Abuse Services

(Medication Management visits are not counted towards Outpatient Mental Health visits)

Inpatient Mental Health and Substance Abuse Services

(2 days of partial hospitalization may be substituted for 1 day of inpatient care.)

- Inpatient Hospital Care and Residential Crisis Services (up to 60 days per Contract Year)
- Physician Inpatient Services

Infertility Services

(after diagnosis of infertility has been confirmed)

Skilled Nursing Facility

(up to 100 days per Contract Year)

Emergency Services

- Urgent Care Center
- Hospital Emergency Room (waived if admitted)
- Ambulance

IN-NETWORK MEMBER PAYS

30% coinsurance

\$250 copayment per admission

\$30 copayment

50% coinsurance

\$40 copayment per day

\$40 copayment

\$100 copayment

\$0 copayment

OUT-OF-NETWORK MEMBER PAYS

40% coinsurance

40% coinsurance

20% coinsurance

50% coinsurance

20% coinsurance

\$40 copayment

\$100 copayment

\$0 copayment

* **Deductible and Out-of-Pocket Limit:**

To meet the Family Deductible and Family Out-of-Pocket Limit, two family members must each meet the Individual Deductible or Individual Out-of-Pocket Limit, with no more than the Individual amount applied to each member.

When the In-Network Out-of-Pocket is met, the Health Plan pays 100% for Covered Services received In-Network. When the Out-of-Network Out-of-Pocket is met, the Health Plan pays 100% for Covered Services received Out-of-Network. Both In-Network and Out-of-Network amounts are applied to the In-Network Out-of-Pocket Limit to determine when the In-Network Out-of-Pocket Limit is met. Likewise, both In-Network and Out-of-Network amounts are applied to the Out-of-Network Out-of-Pocket Limit to determine when the Out-of-Network Out-of-Pocket Limit is met.

COVENTRY HEALTH CARE OF DELAWARE, INC.
\$100 DEDUCTIBLE, \$0/\$25/\$50 COPAYMENT
PRESCRIPTION DRUG RIDER
(MARYLAND)

This Prescription Drug Rider is an addition to the Coventry Health Care of Delaware, Inc. (Health Plan) Small Employer Health Plan Agreement (Agreement) and Comprehensive Standard Health Care Plan for Maryland Small Employers. This Rider is chosen at the Small Employer's option, for an additional Premium, and lowers the cost sharing option to Members.

This Rider becomes effective when the Member becomes enrolled, as defined in the Agreement, and continues until it is replaced or terminated, as long as its conditions are met. The Benefits and Services referenced herein are subject to all terms, conditions, limitations and exclusions of the Agreement.

DEFINITIONS

Maintenance Drug(s). Prescription Drugs which are anticipated to be required for six (6) months or more to treat a chronic condition.

Prescribing Provider. A doctor of medicine or other health care professional who:

- is duly licensed under the laws of the jurisdiction in which Prescription Drugs are received; and
- may, in the usual course of business, legally prescribe Prescription Drugs.

Prescription Drug(s). Any medication or drug which:

- is provided for outpatient administration;
- has been approved by the Food and Drug Administration; and
- under federal or state law, is dispensed pursuant to a prescription order (legend drug). This definition includes some over-the-counter medications or disposable medical supplies (e.g., insulin and diabetic supplies). A compound substance is considered a Prescription Drug if one or more of the items compounded is a Prescription Drug.

PRESCRIPTION DRUG BENEFITS

Subject to the Limitations, Exclusions, Copayments and Ancillary Charges described below, outpatient Prescription Drugs will be covered when:

- written by a Prescribing Provider, and
- filled at a participating pharmacy, including a participating mail order pharmacy, (except for Emergency Services or out of the service area).

DEDUCTIBLE AND COPAYMENTS

Prescription Drugs

Benefits are provided for Generic Drugs as follows:

- Generic drugs \$0 copayment per prescription or refill
(\$0 copayment per prescription or refill
for a 90 consecutive day supply for
Maintenance Drugs).

After satisfying a \$100 deductible, benefits are provided for Preferred and Non-Preferred Drugs as follows:

- Preferred Drugs (brand name drugs) \$25 copayment per prescription or refill
(\$50 copayment per prescription or refill
for a 90 consecutive day supply for
Maintenance Drugs).
- Non-Preferred Drugs (brand name drugs) \$50 copayment per prescription or refill
(\$100 copayment per prescription or refill
for a 90 consecutive day supply for
Maintenance Drugs).

A \$100 deductible applies for each covered member per Contract Year for Preferred and Non-Preferred Drugs. When the deductible has been met, the \$25 Copayment for Preferred Prescription Drugs, or the \$50 Copayment for Non-Preferred Prescription drugs, or the cost of the Prescription Drug, whichever is less, must be paid each time a Prescription Drug is filled or refilled. Preferred or Non-Preferred Maintenance Drugs may be dispensed with two (2) Copayments for a 90 consecutive day supply.

Copayments and the deductible do not apply to the Member's Out-of-Pocket Limit listed on the Member's Schedule of Benefits

ANCILLARY CHARGES

If a brand name Prescription Drug is dispensed, and an equivalent generic Prescription Drug is available, the Member shall pay an Ancillary Charge in addition to the brand name Copayment. The Ancillary Charge will be due regardless of whether or not the Prescribing Provider indicates that the Pharmacy is to "Dispense as Written." The Ancillary Charge is the difference between the price of the brand name and the generic drug.

Total Member payments shall not exceed the price of the prescription drug. Ancillary Charges do not apply to the Member's Out-of-Pocket Limit listed on the Member's Schedule of Benefits.

Officer
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