COVENTRY HEALTH AND LIFE INSURANCE COMPANY

(Maryland)
2751 Centerville Road, Suite 400
Wilmington, DE 19808-1627

PPO SCHEDULE OF BENEFITS
100/80; $100 Combined Deductible

This Schedule is part of Your Certificate of Insurance but does not replace it. Many words are defined elsewhere in the Certificate and other limitations or exclusions may be listed in other sections of Your Certificate. Reading this Schedule by itself could give You an inaccurate impression of the terms of Your Coverage. This Schedule must be read with the rest of Your Certificate of Coverage. A complete list of Covered Services, Exclusions and Limitations can be found in Your Certificate of Insurance.

Benefits and Services	**In-Network When You Use Preferred Providers (PPO)**	**Out-of-Network When You Use Non-Preferred Providers (Non-PPO)**
Calendar Year Deductible (For PPO and Non-PPO combined)	$100 per individual $200 per family	
Calendar Year Out-of-Pocket Limit (For PPO and Non-PPO combined)	$1,500 per individual $3,000 per family	
Lifetime Maximum	None	
Physician Services		
• Well Child Visits for children through 17 years (includes immunizations for children from age 24 months through 13 years)	No deductible; $10 copay per visit	No deductible; $10 copay per visit
• Well Adult Visits – Physical, Preventive Services, Annual GYN Exam and Pap Smear, and Prostate Cancer Screening	No deductible; $20 copay per visit	Deductible, then greater of $20 copay or 20%, but not greater than the charges
• All Other Office Visits, Consultations, Allergy Tests and Treatment, Surgeon's Services, Nutritional Counseling, and Diabetes Treatment	Deductible, then $20 copay per visit	Deductible, then greater of $20 copay or 20%, but not greater than the charges
Maternity (Prenatal and postnatal care, delivery, semi-private room.)	Deductible, then covered in full	Deductible, then 20%
Emergency and Urgent Care		
• Emergency Room (copay is applied to Deductible and Out-of-Pocket Limit or waived if admitted)	Deductible, $35 copay, then 20%	Deductible, $35 copay, then 20%
• Urgent Care Center	Deductible, then 20%	Deductible, then 20%
• Ambulance	Deductible, then 20%	Deductible, then 20%

Benefits and Services	In-Network When You Use Preferred Providers (PPO)	Out-of-Network When You Use Non-Preferred Providers (Non-PPO)
Outpatient Facility Services		
• Outpatient Hospital Unit, freestanding surgical center or other outpatient facility	Deductible, then $20 copay per visit	Deductible, then 20%
• Outpatient Laboratory and X-ray	No deductible; $10 copay per visit	Deductible, then 20%
• Specialized Imaging (CT, PET, DEXA, MRA and MRI scan)	Deductible, then 20%	Deductible, then 40%
• Mammogram	No deductible; $10 copay per visit	Deductible, then 20%
Inpatient Hospital Services (Semi-private room, operating room, intensive and coronary care unit; physician and surgeon services; lab, x-ray, and other ancillary services.)	Deductible, then covered in full	Deductible, then 20%
Voluntary Family Planning		
• Outpatient Family Planning Services	Deductible, then $20 copay per visit	Deductible, then greater of $20 copay or 20%, but not greater than the charges
• Outpatient Elective Sterilization	Deductible, then $20 copay per visit	Deductible, then greater of $20 copay or 20%, but not greater than the charges
• Inpatient Elective Sterilization	Deductible, then covered in full	Deductible, then 20%
• Infertility Services (after confirmed diagnosis)	Deductible, then 50%	Deductible, then 50%
Skilled Nursing Facility (limit of 100 days per calendar year)	Deductible, then Covered in full	Deductible, then 20%
Home Health Care (Copayment, coinsurance and deductible are waived for newborn visits.)	Deductible, then $20 copay per visit	Deductible, then greater of $20 copay or 20%, but not greater than the charges
Hospice Care	Deductible, then $20 copay per visit	Deductible, then greater of $20 copay or 20%, but not greater than the charges
Durable Medical Equipment (Prosthetic Devices and Durable Medical Equipment including hearing aids for children up to age 18 with limit of $1,400 per hearing aid per ear in a 36-month period)	Deductible, then $20 copay per item	Deductible, then 40%

Benefits and Services	In-Network When You Use Preferred Providers (PPO)	Out-of-Network When You Use Non-Preferred Providers (Non-PPO)
Therapy		
• Physical, Occupational and Speech Therapy (limit of 30 visits per condition per calendar year)	Deductible, then $20 copay per visit	Deductible, then 50%
• Habilitative services (for children up to and including age 19 with congenital or genetic birth defect)	Deductible, then $20 copay per visit	Deductible, then 50%
Chiropractic Care (limit of 20 visits per condition per year)	Deductible, then $20 copay per visit	Deductible, then 50%
Mental Health/Alcohol or Drug Abuse Services (Combined)		
• Inpatient Services (limit of 60 days per calendar year)	20%	Deductible, then 40%
• Partial Hospitalization (2 days may be substituted for 1 inpatient day)	20%	Deductible, then 40%
• Outpatient Services	30%	Deductible, then 50%

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.

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Officer
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