

Coventry Health Care of Florida, Inc.

SCHEDULE OF BENEFITS

Enhanced Focused Deductible Open Access Plan EFDOA Option 9 City of Hialeah

Referrals are not required for Covered Services*

This Schedule of Benefits is not a complete summary or explanation of the Covered Services. Please review the Certificate of Coverage for an exact description of the Covered Services, limitations and exclusions and other terms and conditions of coverage.

Copayment Maximums (per calendar year)

Individual	\$1,500
Family	\$4,500

Annual Deductibles (per calendar year)

Hospital Deductible**	\$1,500
Pharmacy Deductible	\$0

Benefit Maximums (Coventry will pay)

Lifetime Maximum Individual Benefit	Unlimited
Pharmacy Maximum (per calendar year)	Unlimited, (copays are included in Lifetime Maximum Individual Benefit)

BENEFITS

MEMBER RESPONSIBILITY

Outpatient Physician Services

Primary Care Physician Office Visits	\$15 copay
Specialist Physician Office Visits	\$30 copay

Office visit includes routine lab tests, diagnostic procedures and radiology, hearing and vision screening in physician's office, and outpatient surgery in the physician's office.

Wellness Care No copay
(Wellness/Preventive care includes physical exams, eye exams, health education and counseling, immunizations, well-woman care, including Pap smears and well-child care to age 16 including immunizations.)

Well-child Care to age 16 including immunizations No copay

Maternity Prenatal/ Postnatal Care

- in a Physician's office One-time \$20 copay
- in a Sub-Specialty office \$20 copay

Non-Surgical Spine and Back Services

Limitation: 20 visits per calendar year

Same as office visit copay

Second Medical and Surgical Opinion

- by Participating Physician Same as office visit copay
- by Non-Participating Physician 40% of Allowed Amount

Inpatient Hospital/Physician Services**

Inpatient Hospital Facility Services (Facility services include semi-private room & board, general nursing services, use of intensive care and specialty care units, x-rays, diagnostics/labs, operating and recovery rooms and prescription medications dispensed while confined.)	\$200 copay per day for the first 5 days per admission
Inpatient Rehabilitative Services Limitation: 30 days per calendar year	No additional copay
In-Hospital Maternity Care	No additional copay
Inpatient Neonatal Intensive Care Unit (NICU) (admission and subsequent inpatient care)	\$200 copay per day for the first 5 days per admission
Inpatient Physician Services (Physician Services include surgeon and assistant surgeon, anesthesiologist, specialists' consultations and other physician visits while confined.)	Included in Hospital copay

Outpatient Services

Outpatient Diagnostic Services	
• at Hospital**	\$60 copay
• at an Ambulatory Surgical Center	\$20 copay
• at an Outpatient Diagnostic Center	\$20 copay
• in a Physician's office	No additional copay
Outpatient Surgery (including physician and facility services)	
• at Hospital**	\$200 copay
• at Ambulatory Surgical Center	\$100 copay
• at an Outpatient Diagnostic Center	\$20 copay
• in a Physician's office	No additional copay
Outpatient Endoscopic Procedures (Colonoscopy, Endoscopy, Sigmoidoscopy)	
• at Hospital**	\$200 copay
• at Ambulatory Surgical Center	\$100 copay
• at an Outpatient Diagnostic Center	\$100 copay
• in a Physician's office	No additional copay
Outpatient Physical, Speech, and Occupational Therapy Limitation: 60 visits per calendar year, combined for all therapy types	
• at Hospital**	\$20 copay
• at Freestanding Facility	\$20 copay
Outpatient Cardiac and Respiratory Therapy	
• at Hospital**	\$20 copay
• at Freestanding Facility	\$20 copay
Outpatient Radiation and Chemotherapy	
• at Hospital**	\$20 copay
• at Freestanding Facility	\$20 copay
Routine Mammography (based on established guidelines)	No copay
Outpatient Dialysis	
• at Hospital**	\$20 copay per treatment
• at Freestanding Facility	\$20 copay per treatment

Skilled Nursing, Home Health and Hospice Care Services

Skilled Nursing Care Limitation: 30 days per calendar year	\$25 copay per day for the first 5 days per admission
Home Health Care Limitation: 60 visits per calendar year	No copay
Hospice Care Limitation: 210 days per lifetime	No copay

Emergency and Urgent Care Services

Emergency Care at Hospital Emergency Room	\$200 copay (waived if admitted)
Emergency Care at Urgent Care Facility	\$20 copay
Emergency Care at Physician's Office	Same as office visit copay
Ambulance Service to Hospital	No copay

Mental Health, Alcohol & Substance Abuse Services

Mental Health Care

Inpatient Treatment**	Same as Inpatient Hospital Services
Outpatient Treatment	\$20 copay

Alcohol and Substance Abuse Care

Inpatient Detoxification**	\$100 copay per day
Inpatient Rehabilitation Treatment**	Same as Inpatient Hospital Services
Outpatient Rehabilitation Treatment	\$20 copay

Family Planning Services

Voluntary Counseling	\$20 copay
Infertility Diagnosis	\$20 copay
Infertility Treatment	Not covered
Elective Abortion	Not covered
Elective Sterilization	
• at a Hospital**	\$200 copay
• at a Freestanding Facility	\$200 copay
Intrauterine Devices (IUD) (device, insertion, removal)	Same as office visit copay

Other Services

Durable Medical Equipment	No copay
Breast Prosthetics	No copay
Other External Orthotic and Prosthetic Devices	No copay
Insulin (subject to Pharmacy Deductible)	Applicable copay per prescription
Diabetic Supplies (subject to Pharmacy Deductible) (Includes glucose monitors, test strips, lancets, etc.)	Applicable copay per month
Hearing Aids (other than Cochlear Implants)	Not covered

Circumcision

- In a Hospital prior to postnatal discharge** No additional copay
- In a Physician's office Same as office visit copay
- In a Hospital after postnatal discharge** Same as outpatient surgery copay

Vision Care (following an operation for cataract or other diseases of the eye)

Limitation: initial prescription lenses (eye glasses or contact lenses)

- Frame and plastic single vision lenses \$29 copay
- Frame and plastic bifocal lenses (FT 25-35 or Executive lenses) \$49 copay
- Frame and plastic trifocal lenses (FT 25-35 or Executive lenses) \$59 copay
- Contact lenses \$69 copay

Other Provisions

Pre-Existing Conditions Exclusion

Late Enrollees

*PCP referrals are not required to obtain Covered Services however **certain Covered Services require Prior Authorization and approval by Coventry's Medical Management Program.** Please refer to the Certificate of Coverage for further details on Prior Authorization requirements.

**All services performed at a hospital (inpatient or outpatient) are subject to the Hospital Deductible. Services must be rendered within the Coventry network. Coventry participating physicians and providers have contracted with Coventry to provide care to our members.

This is a Schedule of Benefits only. Please refer to the Certificate of Coverage for complete details on the plan.