Coventry Health Care of Florida, Inc.

SCHEDULE OF BENEFITS
HMO Large Group
Focused Deductible Coinsurance Open Access - $20/$60-$3,500 Plan

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.

Out-of-Pocket, Copayment Maximums (per calendar year)

Individual	$4,500
Family 2 times the individual Out-of-Pocket amount	

Annual Deductibles (per calendar year)

Hospital Deductible*	
Individual	$3,500
Family	2 times the Individual Deductible
Pharmacy Deductible	Not applicable

Benefit Maximums (Coventry will pay)

Lifetime Maximum Individual Benefit	Unlimited
Pharmacy Maximum (per calendar year)	Unlimited

BENEFITS	MEMBER RESPONSIBILITY
Outpatient Physician Services	
Primary Care Physician Office Visits	$20 copay
Specialist Physician Office Visits	$60 copay

Office visit includes lab tests, X-rays, hearing and vision screening, outpatient surgery in the physician's office.

Adult Preventive Care	No copay

(includes annual physical exams, prostate cancer screening and colon cancer screening, eye exams, health education and counseling, immunizations, and annual well-woman exams, including Pap smears)

Child Preventive Care (includes well child and well baby exams and immunizations)	No copay
Maternity Prenatal/ Postnatal Care	
• in a Physician's office	One-time $60 copay
• in a Sub-Specialty office	$60 copay
Non-Surgical Spine and Back Services Limitation: 20 visits per [calendar, contract] 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	30% coinsurance

(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.)

Inpatient Rehabilitative Services Limitation: 30 days per calendar year	30% coinsurance
In-Hospital Maternity Care	30% coinsurance
Inpatient Neonatal Intensive Care Unit (NICU)	30% coinsurance
Inpatient Physician Services	30% coinsurance

(Physician Services include surgeon and assistant surgeon, anesthesiologist, specialists' consultations and other physician visits while confined.)

Outpatient Services

Outpatient Diagnostic Services	
• at a Hospital*	30% coinsurance
• at an Ambulatory Surgical Center	$150 copay
• at an Outpatient Diagnostic Center	$75 copay
• in a Physician's office	No additional copay
Outpatient Surgery (including physician and facility services)	
• at a Hospital*	30% coinsurance
• at an Ambulatory Surgical Center	$300 copay
• at an Outpatient Diagnostic Center	$100 copay
• in a Physician's office	No additional copay
Outpatient Endoscopic Procedures (colonoscopy, endoscopy, sigmoidoscopy)	
• at a Hospital*	30% coinsurance
• at an Ambulatory Surgical Center	$300 copay
• at an Outpatient Diagnostic Center	$300 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 a Hospital*	30% coinsurance
• at a Freestanding Facility	$60 copay
Outpatient Cardiac Therapy	
• at a Hospital*	30% coinsurance
• at a Freestanding Facility	$60 copay
Outpatient Respiratory Therapy	
• at a Hospital*	30% coinsurance
• at a Freestanding Facility	$60 copay
Outpatient Radiation and Chemotherapy	
• at a Hospital*	30% coinsurance
• at a Freestanding Facility	$60 copay
Routine Mammography (based on established guidelines)	No copay
Outpatient Dialysis	
• at a Hospital*	30% coinsurance
• at a Freestanding Facility	$60 copay per treatment

Skilled Nursing, Home Health and Hospice Care Services

Skilled Nursing Care Limitation: 30 days per calendar year	$100 copay per day for the first 1-5 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	$300 copay (waived if admitted)
Ambulance Service to Hospital	No copay
Urgent Care Facility	$60 copay

Mental Health, Alcohol & Substance Abuse Services

Mental Health Care

Inpatient Treatment*	Same as Inpatient Hospital Services
Outpatient Treatment	$60 copay

Alcohol & Substance Abuse Care

Inpatient Detoxification*	Same as Inpatient Hospital services
Inpatient Rehabilitation Treatment*	Same as Inpatient Hospital services
Outpatient Rehabilitation Treatment	$60 copay

Family Planning Services

Voluntary Counseling	$60 copay
Infertility Diagnosis	$60 copay
Infertility Treatment	Not covered
Elective Abortion	Not covered
Elective Sterilization	
• at a Hospital*	30% coinsurance
• at a Freestanding Facility	$300 copay
Intrauterine Devices (IUD) (device, insertion, removal)	Same as office visit copay

Other Services

Durable Medical Equipment	$50 copay
Breast Prosthetics	$50 copay
Other External Orthotic and Prosthetic Devices	$50 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

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*All services performed at a hospital (inpatient or outpatient) are subject to the Hospital Deductible.

** 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.

Out-of-Pocket Maximums include copayment, deductibles and coinsurance amounts.

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.