

## CoventryOne® \$20 Copay POS Plans

	\$20 / \$500		\$20 / \$1,000	
	In-Network	Out-of-Network	In-Network	Out-of-Network
<b>Lifetime Max</b> (per Member)	\$6,000,000		\$6,000,000	
<b>Deductible</b> (per benefit year) - Maximum 3 per family	\$500	\$1,000	\$1,000	\$2,000
<b>Coinsurance</b> Plan Pays	70%	60%	70%	60%
<b>Out-of-Pocket Max</b> (per benefit year) - Maximum 3 per family	\$2,500	None	\$2,500	None
<b>Medical benefits shown with copays are not subject to the deductible. Coinsurance percentages are effective after the deductible has been met unless specifically noted.</b>				
<b>PCP Visits</b> (General Physician, Family Practitioner, Pediatrician or Internist) • Office Visits • X-ray and Lab when performed in office • Immunizations	\$20	60%	\$20	60%
<b>Specialist Visits</b> • X-ray and Lab when performed in office • Allergy Testing and Treatment	\$55	60%	\$55	60%
<b>Preventive Screenings</b> for Adults and Children - PCP & Specialist	\$20	Not Covered	\$20	Not Covered
<b>Convenience Care Clinic</b>	\$20	60%	\$20	60%
<b>Mammograms (No deductible when received in-network)</b>	100%	60%	100%	60%
<b>Emergency Services</b> (Copay waived if admitted to hospital)	\$150	\$150	\$150	\$150
<b>Urgent Care</b>	\$55	\$55	\$55	\$55
<b>Ambulance</b>	\$150	\$150	\$150	\$150
<b>Inpatient Hospital</b>	70%	60%	70%	60%
<b>Outpatient Hospital / Facility</b> • X-Ray, Lab, Diagnostic Services • MRI, CAT & PET Scans, Other Nuclear Med • Surgery, Anesthesia • Chemotherapy, Radiation Treatment	70%	60%	70%	60%
<b>Maternity</b>	Not Covered	Not Covered	Not Covered	Not Covered
<b>Short Term Therapies</b> (No visit limit) • Physical, Speech, Occupational and Respiratory Therapies • Cardiac and Pulmonary Rehabilitation	70%	60%	70%	60%
<b>Chiropractic Services</b> (24 Visits per benefit year)	\$10	Not Covered	\$10	Not Covered
<b>DME, Prosthetics, Orthoses</b> (\$2,500 Max per benefit year)	70%	Not Covered	70%	Not Covered
<b>Transplants</b>	70%	Not Covered	70%	Not Covered
<b>Home Health Care</b> (30 Days per benefit year)	70%	60%	70%	60%
<b>Skilled Nursing Facility</b> (30 Days per benefit year)	70%	60%	70%	60%
<b>Hospice</b>	70%	60%	70%	60%
<b>RX</b> • Tier 1 - Preferred Generic ( <b>No Deductible</b> ) • Tier 2 - Preferred Formulary Brand ( <b>Deductible</b> ) • Tier 3 - Non Preferred Brand and a few Non Preferred Generic ( <b>Deductible</b> ) • Tier 4 - Self-Administered Injectable Drugs ( <b>Deductible</b> ) • Rx deductible must be satisfied before copay applies on Tiers 2, 3, & 4 • Retail must be obtained from Participating Pharmacies only (except for Emergency), and Mail Order must be obtained from Caremark • To determine the specific cost of your medication, please refer to the Drug Formulary	RETAIL: \$10 MAIL ORDER*: \$10	RETAIL: \$10 MAIL ORDER*: \$10	RETAIL: \$10 MAIL ORDER*: \$10	RETAIL: \$10 MAIL ORDER*: \$10
	\$35 \$50 \$100	\$70 \$150 Not Covered	\$35 \$50 \$100	\$70 \$150 Not Covered
	\$100 Deductible		\$250 Deductible	
		*93 DAY SUPPLY		*93 DAY SUPPLY
<b>Dental</b> • One preventive cleaning every six months • Diagnostic & restorative services, orthodontic & emergency care • All care must be received as an established patient of a DeltaCare provider	\$20 Various Copays	Not Covered Not Covered	\$20 Various Copays	Not Covered Not Covered
<b>Vision Exam</b> (every 12 months) • Exam must be received from Avesis provider	\$15	Not Covered	\$15	Not Covered

All medical benefits subject to benefit year deductible unless specifically noted with a copay. Benefit limitations are a combination of in-network and out-of-network benefits. Deductibles and copays do not apply to out-of-pocket maximum.

All plans are subject to a twelve (12) month waiting period for pre-existing conditions except when a condition is disclosed on the application at the time of medical underwriting and the policy is approved. Preexisting condition means the existence of symptoms which would cause an ordinarily prudent person to seek diagnosis, care, or treatment, or a condition for which medical advice or treatment was recommended by or received from a provider of health care services, within 12 months preceding the effective date of coverage of the insured.

An optional Mental Health Rider is available with POS Plans shown above. If this Rider is purchased, it must be taken by all family members applying for coverage on the same application. Each member is charged an additional monthly premium. All care must be coordinated through Coventry's mental health and substance abuse vendor. Refer to your broker for more details.

This summary is a partial description of coverage and does not detail all benefits, limitations and exclusions. Please consult the Member Contract, Schedule of Benefits, and applicable Riders to determine the exact terms, conditions and scope of coverage. Ask your broker for a DeltaCare dental provider list created specifically for the CoventryOne product.

## CoventryOne® \$20 Copay POS Plans

	\$20 / \$2,000		\$20 / \$3,000		\$20 / \$4,000		\$20 / \$5,000		\$20 / \$10,000	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
<b>Lifetime Max</b> (per Member)	\$6,000,000		\$6,000,000		\$6,000,000		\$6,000,000		\$6,000,000	
<b>Deductible</b> (per benefit year) - Maximum 3 per family	\$2,000	\$4,000	\$3,000	\$6,000	\$4,000	\$8,000	\$5,000	\$10,000	\$10,000	\$20,000
<b>Coinsurance</b>	70%	60%	70%	60%	70%	60%	70%	60%	70%	60%
<b>Out-of-Pocket Max</b> (per benefit year) - Maximum 3 per family	\$2,500	None	\$2,500	None	\$2,500	None	\$2,500	None	\$2,500	None
<b>Medical benefits shown with copays are not subject to the deductible. Coinsurance percentages are effective after the deductible has been met unless specifically noted.</b>										
<b>PCP Visits</b> (General Physician, Family Practitioner, Pediatrician or Internist) • Office Visits • X-ray and Lab when performed in office • Immunizations	\$20	60%	\$20	60%	\$20	60%	\$20	60%	\$20	60%
<b>Specialist Visits</b> • X-ray and Lab when performed in office • Allergy Testing and Treatment	\$55	60%	\$55	60%	\$55	60%	\$55	60%	\$55	60%
<b>Preventive Screenings</b> for Adults and Children - PCP & Specialist	\$20	Not Covered	\$20	Not Covered	\$20	Not Covered	\$20	Not Covered	\$20	Not Covered
<b>Convenience Care Clinic</b>	\$20	60%	\$20	60%	\$20	60%	\$20	60%	\$20	60%
<b>Mammograms (No deductible when received in-network)</b>	100%	60%	100%	60%	100%	60%	100%	60%	100%	60%
<b>Emergency Services</b> (Copay waived if admitted to hospital)	\$150	\$150	\$150	\$150	\$150	\$150	\$150	\$150	\$150	\$150
<b>Urgent Care</b>	\$55	\$55	\$55	\$55	\$55	\$55	\$55	\$55	\$55	\$55
<b>Ambulance</b>	\$150	\$150	\$150	\$150	\$150	\$150	\$150	\$150	\$150	\$150
<b>Inpatient Hospital</b>	70%	60%	70%	60%	70%	60%	70%	60%	70%	60%
<b>Outpatient Hospital / Facility</b> • X-Ray, Lab, Diagnostic Services • MRI, CAT & PET Scans, Other Nuclear Med • Surgery, Anesthesia • Chemotherapy, Radiation Treatment	70%	60%	70%	60%	70%	60%	70%	60%	70%	60%
<b>Maternity</b>	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
<b>Short Term Therapies</b> (No visit limit) • Physical, Speech, Occupational and Respiratory Therapies • Cardiac and Pulmonary Rehabilitation	70%	60%	70%	60%	70%	60%	70%	60%	70%	60%
<b>Chiropractic Services</b> (24 Visits per benefit year)	\$10	Not Covered	\$10	Not Covered	\$10	Not Covered	\$10	Not Covered	\$10	Not Covered
<b>DME, Prosthetics, Orthoses</b> (\$2,500 Max per benefit year)	70%	Not Covered	70%	Not Covered	70%	Not Covered	70%	Not Covered	70%	Not Covered
<b>Transplants</b>	70%	Not Covered	70%	Not Covered	70%	Not Covered	70%	Not Covered	70%	Not Covered
<b>Home Health Care</b> (30 Days per benefit year)	70%	60%	70%	60%	70%	60%	70%	60%	70%	60%
<b>Skilled Nursing Facility</b> (30 Days per benefit year)	70%	60%	70%	60%	70%	60%	70%	60%	70%	60%
<b>Hospice</b>	70%	60%	70%	60%	70%	60%	70%	60%	70%	60%
<b>RX</b> • Tier 1 - Preferred Generic ( <b>No Deductible</b> ) • Tier 2 - Preferred Formulary Brand ( <b>Deductible</b> ) • Tier 3 - Non Preferred Brand and a few Non Preferred Generic ( <b>Deductible</b> ) • Tier 4 - Self-Administered Injectable Drugs ( <b>Deductible</b> ) • Rx deductible must be satisfied before copay applies on Tiers 2, 3, & 4 • Retail must be obtained from Participating Pharmacies only (except for Emergency), and Mail Order must be obtained from Caremark • To determine the specific cost of your medication, please refer to the Drug Formulary	RETAIL: \$10 MAIL ORDER*: \$10	RETAIL: \$10 MAIL ORDER*: \$10	RETAIL: \$10 MAIL ORDER*: \$10	RETAIL: \$10 MAIL ORDER*: \$10	RETAIL: \$10 MAIL ORDER*: \$10	RETAIL: \$10 MAIL ORDER*: \$10	RETAIL: \$10 MAIL ORDER*: \$10	RETAIL: \$10 MAIL ORDER*: \$10	RETAIL: \$10 MAIL ORDER*: \$10	RETAIL: \$10 MAIL ORDER*: \$10
	\$35 \$50 \$100	\$70 \$150 Not Covered	\$35 \$50 \$100	\$70 \$150 Not Covered	\$35 \$50 \$100	\$70 \$150 Not Covered	\$35 \$50 \$100	\$70 \$150 Not Covered	\$35 \$50 \$100	\$70 \$150 Not Covered
	\$100 Deductible		\$250 Deductible		\$250 Deductible		\$500 Deductible		\$500 Deductible	
		*93 DAY SUPPLY		*93 DAY SUPPLY		*93 DAY SUPPLY		*93 DAY SUPPLY		*93 DAY SUPPLY
<b>Dental</b> • One preventive cleaning every six months • Diagnostic & restorative services, orthodontic & emergency care • All care must be received as an established patient of a DeltaCare provider	\$20 Various Copays	Not Covered Not Covered	\$20 Various Copays	Not Covered Not Covered	\$20 Various Copays	Not Covered Not Covered	\$20 Various Copays	Not Covered Not Covered	\$20 Various Copays	Not Covered Not Covered
<b>Vision Exam</b> (every 12 months) • Exam must be received from Avesis provider	\$15	Not Covered	\$15	Not Covered	\$15	Not Covered	\$15	Not Covered	\$15	Not Covered

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