

# CoventryOne® \$35 Copay POS Plans

	\$35/\$1,000		\$35/\$2,500		\$35/\$5,000	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
<b>Lifetime Max</b>	\$ 7,000,000		\$ 7,000,000		\$ 7,000,000	
<b>Deductible</b> (per benefit year) - Maximum 2 per family	\$1,000	\$2,000	\$2,500	\$5,000	\$5,000	\$10,000
<b>Coinsurance</b> Plan Pays	70%	50%	70%	50%	70%	50%
<b>Out-of-Pocket Max</b> (per benefit year) - Maximum 2 per family	\$5,000	None	\$5,000	None	\$5,000	None
<b>PCP Visits</b> (General Physician, Family Practitioner, Pediatrician, or Internist) · Office Visits · Includes lab when performed in office · Immunizations	\$35	50%	\$35	50%	\$35	50%
<b>Specialist Visits</b> · Includes lab when performed in office · Allergy Testing and Treatment	First 2 Visits: \$50 3+: \$50 After Ded.	50%	First 2 Visits: \$50 3+: \$50 After Ded.	50%	First 2 Visits: \$50 3+: \$50 After Ded.	50%
<b>X-Ray</b> (in office) - <b>PCP &amp; Specialist</b>	70%	50%	70%	50%	70%	50%
<b>Preventive Screenings</b> for Adults and Children - PCP & Specialist	\$35	50%	\$35	50%	\$35	50%
<b>Convenience Clinic Care</b> (ex. MinuteClinic)	\$35	50%	\$35	50%	\$35	50%
<b>Mammograms</b> (No deductible when received in-network)	100%	50%	100%	50%	100%	50%
<b>Urgent Care</b>	\$75	\$75	\$75	\$75	\$75	\$75
<b>Emergency Services</b> (Copay waived if admitted to hospital)	\$250	\$250	\$250	\$250	\$250	\$250
<b>Ambulance</b>	70%	50%	70%	50%	70%	50%
<b>Inpatient Hospital Care</b>	70%	50%	70%	50%	70%	50%
<b>Outpatient Hospital/Facility</b> · X-Ray, Lab, Diagnostic Services · MRI, CAT & PET Scans, Other Nuclear Med- Surgery, Anesthesia · Chemotherapy, Radiation Treatment	70%	50%	70%	50%	70%	50%
<b>Maternity</b>	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
<b>Short Term Therapies</b> · Physical, Speech and Occupational Therapies (24 Visits per benefit year) · Respiratory Therapy (30 visits per benefit year) · Cardiac and Pulmonary Rehabilitation (30 Visits per benefit year)	70%	50%	70%	50%	70%	50%
<b>Chiropractic Services</b> (12 Visits per benefit year)	\$10	Not Covered	\$10	Not Covered	\$10	Not Covered
<b>DME, Prosthetics &amp; Orthotics</b> - (Combined \$2500 Max per benefit year)	70%	50%	70%	50%	70%	50%
<b>Transplants</b>	70%	Not Covered	70%	Not Covered	70%	Not Covered
<b>Home Health Care</b> (30 Visits per benefit year)	70%	50%	70%	50%	70%	50%
<b>Skilled Nursing Facility</b> (30 Days per benefit year)	70%	50%	70%	50%	70%	50%
<b>Hospice</b>	70%	50%	70%	50%	70%	50%
<b>RX</b>	RETAIL:	MAIL ORDER*:	RETAIL:	MAIL ORDER*:	RETAIL:	MAIL ORDER*:
· Tier 1 - Preferred Generic (No Deductible)	\$10	\$10	\$10	\$10	\$10	\$10
· Tier 2 - Preferred Formulary Brand (Deductible)	\$30	\$60	\$30	\$60	\$30	\$60
· Tier 3 - Non Preferred Brand and a few Non Preferred Generic (Deductible)	\$60	\$180	\$60	\$180	\$60	\$180
· Tier 4 - Self-Administered Injectable Drugs (Deductible)	\$100	Not Covered	\$100	Not Covered	\$100	Not Covered
· RX deductible must be satisfied before copay applies on Tiers 2, 3, & 4	\$1,000 Deductible		\$1,000 Deductible		\$1,000 Deductible	
· Retail must be obtained from Participating Pharmacies only (except for Emergency), and Mail Order must be obtained from Caremark®	*93-Day Supply		*93-Day Supply		*93-Day Supply	
· To determine the specific cost of your medication, please refer to the Drug Formulary						
<b>Vision Exam</b> (every 12 months) · Exam must be received from Avesis provider	\$15	Not Covered	\$15	Not Covered	\$15	Not Covered

Benefit year deductible must be satisfied before coinsurance applies. Medical benefits noted with a copay are not subject to deductible unless noted. 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.

# CoventryOne® \$35 Copay POS Plans

	\$35/\$7,500 Basic		\$35/\$10,000 Basic		
	In-Network	Out-of-Network	In-Network	Out-of-Network	
<b>Lifetime Max</b>	\$ 7,000,000		\$ 7,000,000		
<b>Deductible</b> (per benefit year) - Maximum 2 per family	\$7,500	\$15,000	\$10,000	\$20,000	
<b>Coinsurance</b>	Plan Pays	70%	50%	70%	50%
<b>Out-of-Pocket Max</b> (per benefit year) - Maximum 2 per family	\$5,000	None	\$10,000	None	
<b>PCP Visits</b> (General Physician, Family Practitioner, Pediatrician, or Internist) · Office Visits · Includes lab when performed in office · Immunizations	\$35	50%	\$35	50%	
<b>Specialist Visits</b> · Includes lab when performed in office · Allergy Testing and Treatment	After deductible: \$50	50%	After deductible: \$50	50%	
<b>X-Ray</b> (in office) - <b>PCP &amp; Specialist</b>	70%	50%	70%	50%	
<b>Preventive Screenings</b> for Adults and Children - PCP & Specialist	\$35	50%	\$35	50%	
<b>Convenience Clinic Care</b> (ex. MinuteClinic)	\$35	50%	\$35	50%	
<b>Mammograms</b> (No deductible when received in-network)	100%	50%	100%	50%	
<b>Urgent Care</b>	\$75	\$75	\$75	\$75	
<b>Emergency Services</b> (Copay waived if admitted to hospital)	\$500	\$500	\$500	\$500	
<b>Ambulance</b>	70%	50%	70%	50%	
<b>Inpatient Hospital Care</b>	70%	50%	70%	50%	
<b>Outpatient Hospital/Facility</b> · X-Ray, Lab, Diagnostic Services · MRI, CAT & PET Scans, Other Nuclear Med- Surgery, Anesthesia · Chemotherapy, Radiation Treatment	70%	50%	70%	50%	
<b>Maternity</b>	Not Covered	Not Covered	Not Covered	Not Covered	
<b>Short Term Therapies</b> · Physical, Speech and Occupational Therapies (24 Visits per benefit year) · Respiratory Therapy (30 visits per benefit year) · Cardiac and Pulmonary Rehabilitation (30 Visits per benefit year)	70%	50%	70%	50%	
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<b>Hospice</b>	70%	50%	70%	50%	
<b>RX</b>	RETAIL:	MAIL ORDER*:	RETAIL:	MAIL ORDER*:	
· Tier 1 - Preferred Generic (No Deductible)	\$10	\$10	\$10	\$10	
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· Tier 4 - Self-Administered Injectable Drugs (Deductible)	\$100	Not Covered	\$100	Not Covered	
· RX deductible must be satisfied before copay applies on Tiers 2, 3, & 4	\$2,000 Deductible		\$2,000 Deductible		
· Retail must be obtained from Participating Pharmacies only (except for Emergency), and Mail Order must be obtained from Caremark"	*93-Day Supply		*93-Day Supply		
· To determine the specific cost of your medication, please refer to the Drug Formulary					
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