

**COVENTRY HEALTH CARE OF DELAWARE, INC.
 QUALIFIED HIGH DEDUCTIBLE HEALTH PLAN (QHDHP)
 \$1200 DEDUCTIBLE OPEN ACCESS HSA
 (Maryland)**

The benefits outlined in this Schedule are in addition to the benefits offered under Coventry Health Care of Delaware, Inc. Small Employer Health Plan and Standard Package Cost Sharing for Maryland Small Employers. The benefits described herein are chosen at the Small Employer's option for an additional Premium to provide lower cost sharing for Members.

Deductible*\$1,200/Individual
 \$2,400/Family
 (Except for covered Well Child Visits and Adult Preventive Care Services described below, there is a combined annual deductible for all Covered services, including prescription drugs).

Out-of-Pocket Limit**\$2,400/Individual
 \$4,800/Family
 (Includes deductible, coinsurance and copayments.)

COVERED SERVICES **COPAYMENT/COINSURANCE**

Primary Care Services \$20 copayment

Specialty Care Services \$30 copayment

Adult Preventive Care Services.....\$15 copayment
 (Not subject to the deductible. Eligible expenses include routine physical examinations, routine gynecological examinations, pap smears, routine mammograms, and prostate screening).

Well Child Visits \$10 copayment
 (Not subject to the deductible. Includes all visits for children 0-24 months of age and visits that include immunizations for children older than 24 months-13 years of age)

Inpatient Hospitalization \$250 copayment per admission

Physician Inpatient Hospital Visits... \$20 copayment

Outpatient Laboratory Services \$30 copayment or 50% of the cost
 of the service, whichever is less

Outpatient Diagnostic Services \$30 copayment or 50% of the cost
 of the service, whichever is less

Outpatient Surgery \$30 copayment

Outpatient Rehabilitative Services

(up to 30 visits for each service per condition per Contract Year) \$30 copayment

Habilitative Services

(for children up to age 19 with a congenital or genetic birth defect)..... \$30 copayment

Chiropractic Services

(up to 20 visits per condition per Contract Year). \$30 copayment

Durable Medical Equipment \$0 copayment

Hospice \$0 copayment

Home Health Care \$0 copayment

Outpatient Mental Health and Substance Abuse Services 30% coinsurance
(Medication Management visits are not counted towards Outpatient Mental Health Visits)

Inpatient Mental Health and Substance Abuse Services

(2 days of partial hospitalization maybe substituted for 1 day of inpatient hospital care)

- Inpatient Hospital Care and Residential Crisis Services
(up to 60 days per Contract Year)..... \$250 copayment per admission
- Physician Inpatient Services \$20 copayment

Infertility Services

- After diagnosis of Infertility has been confirmed50% coinsurance

Skilled Nursing Facility Services

(up to 100 days per Contract Year)..... \$30 copayment per day

Prescription Drugs

All prescriptions are subject to the same deductible as all other medical services:

- Generic Drugs.....Deductible applies then, \$0 copayment per Prescription or refill (\$0 copayment per prescription or refill for a 90 consecutive day supply for Maintenance Drugs).
- Preferred Drugs (brand name drugs).....Deductible applies then, \$25 copayment per Prescription or refill (\$50 copayment per prescription or refill for 90 consecutive day supply for Maintenance Drugs).
- Non-Preferred Drugs (brand name drugs)....Deductible applies then, \$50 copayment per Prescription or refill (\$100 copayment per prescription or refill for 90 consecutive day supply for Maintenance Drugs).

- Self Administered injectable (other than insulin).....Copay is 50% of the allowable charge not to exceed \$75, after the Deductible.

Allowable charge means charges for Prescription Drugs dispensed at a Participating Pharmacy that are equal to:

- the contracted rate or the rate the Health Plan has agreed to pay.

If member chooses a brand name drug when a generic is available, the member will pay the difference in price; between the price of the brand name and the generic in addition to the copay. The member is responsible for the lesser of the copayment or the cost of the prescription.

Emergency Services

- Urgent Care Center..... \$30 copayment
- Hospital Emergency Room (waived if admitted) \$100 copayment
- Emergency Ambulance..... \$0 copayment

* **Deductible:** The individual Deductible is a limit on the amount You must pay before you receive benefits. The family Deductible is the limit on the total amount Members of the same family covered under this Agreement must pay before receiving benefits.

** **Out-of-Pocket Limit:** Article 1.6 of the Membership Agreement is amended to read as follows:

The individual Out-of-Pocket Limit is the dollar amount a Member will have to pay out of his or her pocket in a contract year. When a Member has reached the individual Out-of-Pocket Limit, benefits for Covered Services are covered at the rate of 100% for the rest of that contract year.

The family Out-of-Pocket Limit is the dollar amount members of the same family will have to pay out of pocket in a contract year. The out-of-pocket limit for all covered services, including prescription drugs, child wellness, and immunization services, shall be subject to the annual out-of-pocket maximum. When a family has reached the family Out-of-Pocket Limit, benefits for Covered Services are covered at the rate of 100% for the rest of that contract year for all family members.

The Out-of-Pocket Limit includes the deductible, coinsurance and copayments.