



Coventry Health Care of Delaware, Inc. Schedule of Benefits

This Schedule of Benefits is part of your Certificate of Coverage (“COC”), Covered Services, and Exclusions, but does not replace it. Many words are defined elsewhere in the COC, and other limitations or exclusions may be listed in other sections of your COC. Reading this Schedule by itself could give you an inaccurate impression of the terms of your coverage. This Schedule must be read with the rest of your COC, Covered Services, and Exclusions. Prior authorization may be required for specific services.

BENEFIT CATEGORIES AND COST-SHARING

MD Select Bronze HMO QHD 2000

Benefit	Member pays
	Participating Provider
Contract Year Deductible	Individual: \$2,000 Family: \$4,000
Coinsurance	0%
Out-of-Pocket Maximum <i>(Includes member-paid deductible, coinsurance, and copayments)</i>	Individual: \$4,000 Family: \$8,000
PREVENTION / WELLNESS	
Preventive Care/Screening/Immunization/Mammogram	No Charge
AMBULATORY SERVICES	
Office Visit	
Primary Care Physician (PCP)	Deductible then \$20 Copay per visit
Specialist	Deductible then \$50 Copay per visit
Surgery	
PCP's Office	Deductible
Specialist's Office	Deductible
Free-Standing Facility	Deductible then \$250 Copay per visit
Outpatient Facility	Deductible then \$250 Copay per visit
Outpatient Physician Services	Deductible then \$250 Copay per visit
Home Health Care / Hospice	Deductible
Skilled Nursing Facility	Deductible then \$250 Copay per admission Limit 100 days per contract year
EMERGENCY CARE	
Convenience Care	Deductible then \$30 Copay per visit
Urgent Care	Deductible then \$75 Copay per visit
Emergency Room Care <i>(waived if admitted)</i>	Deductible then \$250 Copay per visit
Emergency Advanced Imaging / High Tech Radiology	Deductible
Emergency Transportation/ Ambulance	Deductible
<i>(Coventry Health Care must be notified within 48 hours of initial emergency treatment)</i>	
HOSPITALIZATION	
Inpatient Services	Deductible then \$250 Copay per admission
Inpatient Physician and Surgical Services	Deductible

MATERNITY AND NEWBORN CARE

Prenatal Office visits	No Charge
Physician Charges, Prenatal, Postnatal, Ultrasound, Delivery	Deductible
Outpatient Ultrasound	Deductible
All Inpatient Services / Facility Charges	Deductible then \$250 Copay per admission

MENTAL HEALTH / SUBSTANCE ABUSE DISORDER SERVICES INCLUDING BEHAVIORAL HEALTH MANAGEMENT

PCP's Office	Deductible then \$20 Copay per visit
Specialist's Office	Deductible then \$50 Copay per visit
Outpatient / Partial Hospitalization	Deductible
Inpatient	Deductible then \$250 Copay per admission

REHABILITATIVE AND HABILITATIVE SERVICES

Outpatient Rehabilitation Services (Occupational, Speech, Physical Therapy – age 19 and above)	Deductible then \$50 Copay per visit
	Limit 30 outpatient therapy visits per condition per contract year
Habilitation Services (covered members birth to age 19)	Deductible then \$50 Copay per visit
Durable Medical Equipment (including hair prosthesis)	Deductible
Hearing Aids	Deductible
	Covered minors under age 18; one hearing aid per each impaired ear every 36 months

LAB SERVICES

Lab / Radiology	
PCP's Office	Deductible
Specialist's Office	Deductible then \$50 Copay per visit
Outpatient	Deductible then \$50 Copay per visit
Diagnostic Mammogram	
PCP's Office	Deductible then \$50 Copay per visit
Specialist's Office	Deductible then \$50 Copay per visit
Free-Standing Facility	Deductible then \$50 Copay per visit
Outpatient	Deductible then \$50 Copay per visit
Advanced Imaging / High Tech Radiology	
PCP's Office	Deductible then \$250 Copay per visit
Specialist's Office	Deductible then \$250 Copay per visit
Free-Standing Facility	Deductible then \$250 Copay per visit
Outpatient	Deductible then \$250 Copay per visit

PEDIATRIC SERVICES – ORAL CARE

Contract Year Deductible	Deductible & Out-of-Pocket Maximum combined with medical; deductible does not apply to preventive & diagnostic services. Coverage for children under age 19
Out-of-Pocket Maximum	

Service	Type	Coverage In-Network
Preventive & Diagnostic		
Exams	I	100%
Cleanings	I	100%
X-rays	I	100%
Fluoride	I	100%

Sealants	I	100%
Space Maintainers	I	100%
Basic Restorative		
Silver Fillings	II	50%
White Fillings (front teeth)	II	50%
Temporary Fillings	II	50%
Stainless Steel Crowns	II	50%
Repair or Re-cement Crowns	II	50%
Major Restorative		
Crowns	III	50%
Replacement Crowns	III	50%
Repair or Re-cement Crowns	III	50%
Endodontics		
Root Canal Treatment	III	50%
Vital pulpotomy	III	50%
Periodontics		
Periodontal Cleaning	I	100%
Removal of diseased gum	III	50%
Reshaping of diseased gum tissue	III	50%
Prosthodontics		
Complete and Partial Dentures	III	50%
Repair / Replace Dentures	III	50%
Maxillofacial Prosthetics		
Adjust appliance	III	50%
Maintenance of a maxillofacial prosthesis	III	50%
Prosthodontics, Fixed		
Re-cement Fixed Partial Denture	III	50%
Oral and Maxillofacial Surgery		
Extractions	III	50%
Tooth Replantation	III	50%
Orthodontia	IV	50%
Adjunctive Services		
Occlusal Guards	III	50%
Palliative Treatment	I	100%
General Anesthesia	II	50%
IV Sedation	II	50%
PEDIATRIC SERVICES – VISION CARE		
Vision Screening for Children	No Charge	
	One routine eye examination per contract year	
Eye Glasses for Children	No Charge	
	One pair of standard eyeglass lenses or contact lenses per contract year; one frame per contract year	

PRESCRIPTION DRUGS

Pharmacy	Integrated Medical / Rx Deductible (Individual / Family)		
	Preferred Pharmacy	Non-Preferred Pharmacy	Mail Order / Retail 90-Day Supply
Tier 1A: Select Generic Drugs	Deductible then \$5 Copay	Deductible then \$20 Copay	Deductible then 3 times the Preferred / Non-Preferred Pharmacy Copay
Tier 1: Preferred Drugs	Deductible then \$15 Copay	Deductible then \$20 Copay	Deductible then 3 times the Preferred / Non-Preferred Pharmacy Copay
Tier 2: Preferred Brand Drugs	Deductible then \$45 Copay	Deductible then \$55 Copay	Deductible then 3 times the Preferred / Non-Preferred Pharmacy Copay
Tier 3: Non-Preferred Drugs	Deductible then \$75 Copay	Deductible then \$85 Copay	Deductible then 3 times the Preferred / Non-Preferred Pharmacy Copay
Tier 4: Preferred Specialty Medications	At a Preferred Specialty Pharmacy: Deductible then 30% Coinsurance		
Tier 5: Non-Preferred Specialty Medications	At a Preferred Specialty Pharmacy: Deductible then 40% Coinsurance		
Refer to Section 1.4 of Your Certificate of Coverage for an explanation of Your Individual and Family deductible			
OTHER COVERED SERVICES			
Acupuncture	Deductible		
Bariatric Surgery	Deductible		
Infertility Treatment	Deductible		

This is not a contract or a definitive statement of benefits. It is intended solely to provide you with an overview of the proposed plan. Complete details of benefits, terms, and exclusions are governed by your Coventry Certificate of Coverage (COC), Covered Services, and Exclusions. This managed care plan may not cover all your health care expenses. Read your benefit documents carefully to determine which health care services are covered. This document, affirmatively nor negatively amends, extends, or alters the terms of or the coverage afforded by policy reference herein. If you have questions call us toll free at 1-800-833-7423.