



CoventryOne<sup>SM</sup> is an individual product underwritten by Coventry Health Care of Georgia, Inc.

**CoventryONE<sup>SM</sup>  
INDIVIDUAL POS PLAN  
\$20/\$10,000**

BENEFITS	MEMBER PAYS	
	In-Network	Out-of-Network
<b>Lifetime Maximum</b>	\$6,000,000	
<b>Deductible (per Benefit Year) - 3 maximum per family</b>	\$10,000	\$20,000
<b>Out-of-Pocket Maximum (per Benefit Year) - 3 maximum per family</b>	\$2,500	None
<b>Medical Benefits shown with copays are not subject to deductible</b>		
<b>Primary Care Physician (PCP) Visits</b> * Office visits * X-ray and Lab when performed in office * Immunizations	\$20	40%
<b>Specialist Visits</b> * X-ray and Lab when performed in office * Allergy Testing and Treatment	\$55	40%
<b>Preventive Screenings for Adults and Children - PCP &amp; Specialist</b>	\$20	Not Covered
<b>Mammograms</b>	Plan pays 100%	Not Covered
<b>Emergency Care Services</b> * Copayment is waived if admitted	\$150	\$150
<b>Urgent Care</b>	\$55	\$55
<b>Ambulance</b> * When Medically Necessary	\$150	150
<b>Inpatient Hospital Care</b>	30%	40%
<b>Outpatient Hospital / Facility, Including:</b> * X-Ray, Lab, Diagnostic Services * MRI, CAT & PET Scans, Other Nuclear Med * Surgery, Anesthesia, Etc. * Chemotherapy and Radiation Treatment	30%	40%
<b>Short Term Therapies</b> * No Visit Limits * Physical, Speech, Occupational and Respiratory Therapies * Cardiac and Pulmonary Rehabilitation	30%	40%
<b>Chiropractic Services</b> * Limited to 24 Visits	\$10 Copay	Not Covered
<b>DME, Prosthetics and Orthoses</b> * Limited to \$2,500 Annual Max, All Combined	30%	Not Covered
<b>Transplants</b>	30%	Not Covered
<b>Home Health Care</b> * Limited to 30 days, IN and OON Combined	30%	40%
<b>Skilled Nursing Facility</b> * Limited to 30 days, IN and OON Combined	30%	40%
<b>Hospice</b>	30%	40%
<b>RX</b>  * Tier 1 - Preferred Generic - No Deductible * Tier 2 - Preferred Formulary Brand * Tier 3 - Non Preferred Brand and a few Non Preferred Generic * Tier 4 - Self-Administered Injectable Drugs * RX Deductible applies to Tier 2, Tier 3, & Tier 4 and must be satisfied before copays apply * Retail must be obtained from Participating Pharmacies only (Except for Emergency) * Mail Order must be obtained from Caremark and Participating Pharmacies that offer Mail Order * To determine the specific cost of your medication, please refer to the Preferred Drug List	\$500 Deductible - Does Not Apply to Tier 1 RETAIL: MAIL ORDER: \$10 Copay \$10 Copay \$35 Copay \$70 Copay \$50 Copay \$150 Copay \$100 Copay Not Covered	
<b>Dental - Not subject to plan deductible</b> * Preventative Cleanings for Adults and Children, 1 each six month period * Diagnostic, Routine & Preventive services * Emergency care * Restorative services * Crowns and jackets * Orthodontic care * All care must be received from DeltaCare provider	\$20 Copay Various Copays	Not Covered Not Covered
<b>Vision - Not subject to plan deductible</b> * One Exam every 12 months * Exam must be received from Avesis provider	\$15 Copay	Not Covered

All medical benefits subject to benefit year deductible unless specifically noted with copay. 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. A pre-existing condition is a condition for which medical advice, diagnosis, care, treatment, or prescribed drug was recommended or received within the 12-month period prior to your effective date of coverage.

This summary is a partial description of coverage and does not detail all benefits, limitations, and exclusions. Please consult the Member Contract and Schedule of Benefits to determine the exact terms, conditions, and scope of coverage.