



Coventry Health and Life Insurance Company
PPO Schedule of Benefits

State(s) of Issue: Oklahoma

PPO Plan: OI08C30050 30

Covered Services	Cost to Insured when Receiving Services from Participating Providers (In-Network)	Cost to Insured when Receiving Services from Non-Participating Providers (Out-of-Network) ^{2,3}
Contract Year Deductible	\$3,000 Individual \$9,000 Family	\$3,000 Individual \$9,000 Family
Coinsurance For All Eligible Expenses (unless otherwise noted)	Deductible Plus 20% Coinsurance	Deductible Plus 40% Coinsurance
Contract Year Out-of-Pocket Maximum Only Includes Coinsurance	\$5,000 Individual \$15,000 Family	\$10,000 Individual \$30,000 Family
Combined Lifetime Benefit Maximum	\$2,000,000	
Primary Care Physician (PCP) Services¹		
▪ Physician Office Visit	\$30 Copayment	Deductible Plus 40% Coinsurance
▪ Physician Office Surgery	\$30 Copayment	Deductible Plus 40% Coinsurance
▪ Allergy Injections	\$0 Copayment	Deductible Plus 40% Coinsurance
▪ Allergy Testing	Deductible Plus 20% Coinsurance	Deductible Plus 40% Coinsurance
Specialty Physician Services¹		
▪ Physician Office Visit	\$45 Copayment	Deductible Plus 40% Coinsurance
▪ Physician Office Surgery	\$45 Copayment	Deductible Plus 40% Coinsurance

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<ul style="list-style-type: none"> ▪ Allergy Injections ▪ Allergy Testing 	<p style="text-align: center;">\$0 Copayment</p> <p style="text-align: center;">Deductible Plus 20% Coinsurance</p>	<p style="text-align: center;">Deductible Plus 40% Coinsurance</p> <p style="text-align: center;">Deductible Plus 40% Coinsurance</p>
<p>Preventive Care</p> <ul style="list-style-type: none"> ▪ Annual Well Woman Exam ▪ Mammograms - Routine Screening and Diagnostic ▪ Well Baby and Child Care ▪ Annual Prostate Screening - High Risk or Symptomatic (Age 40+) and All Males (Age 50+) ▪ Routine Health Screening 	<p style="text-align: center;">Same as Physician Office Visit¹</p> <p style="text-align: center;">No Member Responsibility</p> <p style="text-align: center;">Same as Physician Office Visit¹</p> <p style="text-align: center;">Same as Physician Office Visit¹</p> <p style="text-align: center;">Same as Physician Office Visit¹</p> <p style="text-align: center;"><i>Routine Health Screenings Covered up to a Contract Year Benefit Maximum of \$300</i></p>	<p style="text-align: center;">Deductible Plus 40% Coinsurance</p> <p style="text-align: center;">No Member Responsibility</p> <p style="text-align: center;">Deductible Plus 40% Coinsurance</p> <p style="text-align: center;">Deductible Plus 40% Coinsurance</p> <p style="text-align: center;">Deductible Plus 40% Coinsurance</p>
<p>Immunizations</p> <ul style="list-style-type: none"> ▪ Pediatric (through 18 years of age) ▪ Adult 	<p style="text-align: center;">No Member Responsibility</p> <p style="text-align: center;">\$0 Copayment</p>	<p style="text-align: center;">No Member Responsibility</p> <p style="text-align: center;">Deductible Plus 40% Coinsurance</p>
<p>Hospital Inpatient Services Services include semi-private hospital room & board, physician and surgeon services, lab, x-ray and other facility and ancillary charges.</p>	<p style="text-align: center;">Deductible Plus 20% Coinsurance</p>	<p style="text-align: center;">Deductible Plus 40% Coinsurance</p>
<p>Outpatient Laboratory Services</p>	<p style="text-align: center;">Deductible Plus 20% Coinsurance</p>	<p style="text-align: center;">Deductible Plus 40% Coinsurance</p>

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Outpatient Surgery and Scopes Includes related Professional Charges <ul style="list-style-type: none"> • Performed in Hospital • Performed in Ambulatory Surgery Center 	Deductible Plus 20% Coinsurance	Deductible Plus 40% Coinsurance
Outpatient X-rays Includes related Professional Charges	Deductible Plus 20% Coinsurance	Deductible Plus 40% Coinsurance
Outpatient Diagnostic Testing and Services (Not Listed Elsewhere) Includes related Professional Charges <ul style="list-style-type: none"> ▪ Performed in Hospital ▪ Performed in Other Outpatient Setting 	Deductible Plus 20% Coinsurance	Deductible Plus 40% Coinsurance
Emergency Services <ul style="list-style-type: none"> ▪ Emergency Room (Copayment waived if admitted) ▪ Related Professional Fees 	\$150 Copayment Plus 20% Coinsurance for Facility Charges 20% Coinsurance	\$150 Copayment Plus 20% Coinsurance for Facility Charges 20% Coinsurance
Ambulance/Emergency Transportation (Ground or Air)	Deductible Plus 20% Coinsurance	Deductible Plus 20% Coinsurance
Urgent Care	\$100 Copayment	\$100 Copayment
Outpatient Short Term Therapy <ul style="list-style-type: none"> ▪ Physical Therapy ▪ Occupational Therapy ▪ Speech Therapy 	Deductible Plus 20% Coinsurance <i>Limited to 20 visits per Therapy per Contract Year Maximum</i>	Deductible Plus 40% Coinsurance
Spinal Manipulation	Same as Physician Office Visit ¹ <i>Limited to 26 visits per Contract Year Benefit Maximum</i>	Deductible Plus 40% Coinsurance
Rehabilitation <ul style="list-style-type: none"> ▪ Inpatient 	Deductible Plus 20% Coinsurance	Deductible Plus 40% Coinsurance

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	<i>Limited to 20 days per Contract Year Benefit Maximum</i>	
<ul style="list-style-type: none"> ▪ Partial Day Programs (4 hours or greater) 	Deductible Plus 20% Coinsurance <i>Limited to 20 visits per Contract Year Benefit Maximum</i>	Deductible Plus 40% Coinsurance
<ul style="list-style-type: none"> ▪ Outpatient (Pulmonary, Cardiac) 	Deductible Plus 20% Coinsurance <i>Limited to 36 visits per Condition Benefit Maximum</i>	Deductible Plus 40% Coinsurance
Home Health Care Skilled Nursing Facility	Deductible Plus 20% Coinsurance Deductible Plus 20% Coinsurance <i>Limited to 60 days per Contract Year Benefit Maximum</i>	Deductible Plus 40% Coinsurance Deductible Plus 40% Coinsurance
Hospice Care <ul style="list-style-type: none"> ▪ Inpatient ▪ Outpatient 	Deductible Plus 20% Coinsurance <i>Inpatient Limited to 15 days per Contract Year Benefit Maximum</i>	Deductible Plus 40% Coinsurance
Durable Medical Equipment	Deductible Plus 20% Coinsurance <i>Limited to \$3,000 per Contract Year Benefit Maximum</i>	Deductible Plus 40% Coinsurance
Prosthetics, Orthotics & Braces	Deductible Plus 20% Coinsurance <i>Limited to \$3,000 per Contract Year Benefit Maximum</i>	Deductible Plus 40% Coinsurance
Organ Transplant	See Appropriate Benefits <i>Limited to \$500,000 Lifetime Benefit Maximum</i>	See Appropriate Benefits
Injectable Medications (Not listed elsewhere)	Deductible Plus 20% Coinsurance See Prescription Drug Rider for Self-Injectable Medications	Deductible Plus 40% Coinsurance See Prescription Drug Rider for Self-Injectable Medications

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Outpatient Dialysis	Deductible Plus 20% Coinsurance	Deductible Plus 40% Coinsurance
Nutritional Evaluation & Diabetes Management/Self-Training	\$0 Copayment	Deductible Plus 40% Coinsurance
Mental Illness, Nervous & Mental Disorders and Alcohol or Chemical Dependency Treatment	<i>See Mental Illness Rider for Details</i> <i>Limits May Apply</i>	<i>See Mental Illness Rider for Details</i> <i>Limits May Apply</i>
Prescription Drugs	<i>See Prescription Drug Rider for Details</i>	<i>See Prescription Drug Rider for Details</i>

Please Note: Maximum Benefit Limits do not guarantee that all services will be approved to the Maximum number allowed under this plan. Payments that are on a percentage basis will be applied to the contracted allowed amount reimbursed to the provider, if applicable.

1. Primary Care Physicians (PCP) generally include those physicians who practice in the specialties of Family Practice, Internal Medicine, General Practice, or Pediatrics. If you are not sure if a physician is a PCP, please contact the Customer Service Number on the back of your ID card. If you receive this service from a Primary Care Physician (PCP), your PCP payment will apply. If you receive these services from a Specialist, your Specialist payment will apply.
2. When receiving services from non-participating providers, payment for Covered Services is limited to the lesser of the billed charge of the Out-of-Network rate less applicable Copayment, Coinsurance and/or Deductibles. Please refer to the Individual Policy for additional details.
3. In order to receive the maximum benefits for services requiring prior authorization, you must participate in Our Utilization Management Program as outlined in your Individual Policy. ***Failure to do so may result in a \$200 reduction in benefits for that particular service.***

