

CoventryOne® Fusion 100%/50% POS Plans

	\$3,000		\$5,000		
	In-Network	Out-of-Network	In-Network	Out-of-Network	
Lifetime Max (per Member)	\$6,000,000		\$6,000,000		
Deductible (per benefit year) - Maximum 3 per family	\$3,000		\$5,000		
Coinsurance	Plan Pays	100%	50%	100%	50%
Out-of-Pocket Max (per benefit year)	Plan pays 100% after deductible is met		None	Plan pays 100% after deductible is met	
Medical benefits shown with copays are not subject to the deductible (unless noted). Coinsurance percentages are effective after the deductible has been met unless specifically noted.					
Physician Services (PCP & Specialist) • Office Visits • Immunizations • X-ray and Lab when performed in office • Allergy Testing and Treatment • Convenience Care Clinic • Preventive Health Screenings	First 6 Visits: \$30 7+ Visits: \$60 After Deductible As Noted Above As Noted Above		First 6 Visits: \$20 7+ Visits: \$40 After Deductible As Noted Above As Noted Above		Not Covered Not Covered Not Covered Not Covered
Mammograms (No deductible when received in-network)	100%	50%	100%	50%	
Emergency Services (Copay waived if admitted to hospital)	\$150	\$150	\$150	\$150	
Urgent Care	\$55	\$55	\$55	\$55	
Ambulance	\$150	\$150	\$150	\$150	
Inpatient Hospital	100%	50%	100%	50%	
Outpatient Hospital / Facility • X-Ray, Lab, Diagnostic Services • Surgery, Anesthesia • Chemotherapy, Radiation Treatment	100%	50%	100%	50%	
Maternity	Not Covered		Not Covered		Not Covered
Short Term Therapies (20 visits per benefit year) • Physical, Speech, Occupational and Respiratory Therapies • Cardiac and Pulmonary Rehabilitation	100%	50%	100%	50%	
Chiropractic Services (12 Visits per benefit year)	\$10	Not Covered	\$10	Not Covered	
DME, Prosthetics, Orthoses (\$2,500 Max per benefit year)	100%	Not Covered	100%	Not Covered	
Transplants	100%	Not Covered	100%	Not Covered	
Home Health Care (30 Days per benefit year)	100%	50%	100%	50%	
Skilled Nursing Facility (30 Days per benefit year)	100%	50%	100%	50%	
Hospice	100%	50%	100%	50%	
RX • Tier 1 - Preferred Generic (No Deductible) • Tier 2 - Preferred Formulary Brand (Deductible) • Tier 3 - Non Preferred Brand and a few Non Preferred Generic (Deductible) • Tier 4 - Self-Administered Injectable Drugs (Deductible) • Rx deductible must be satisfied before copay applies on Tiers 2, 3, & 4 • Retail must be obtained from Participating Pharmacies only (except for Emergency), and Mail Order must be obtained from Caremark • To determine the specific cost of your medication, please refer to the Drug Formulary	RETAIL: \$10 \$35 \$50 70%	MAIL ORDER*: \$10 \$70 \$150 Not Covered \$2,000 Deductible	RETAIL: \$10 \$35 \$50 70%	MAIL ORDER*: \$10 \$70 \$150 Not Covered \$2,000 Deductible	
Dental • One preventive cleaning every six months • Diagnostic & restorative services, orthodontic & emergency care • All care must be received as an established patient of a DeltaCare provider	\$20 Various Copays	Not Covered Not Covered	\$20 Various Copays	Not Covered Not Covered	
Vision Exam (every 12 months) • Exam must be received from Avesis provider	\$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. Ask your broker for a DeltaCare dental provider list created specifically for the CoventryOne product.

CoventryOne® is an individual product underwritten by Coventry Health Care of Georgia, Inc.

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