COVENTRY HEALTH AND LIFE INSURANCE COMPANY
2751 Centerville Road, Suite 400
Wilmington, Delaware 19808-1627

SCHEDULE OF BENEFITS

Coventry*One*[SM]

Coventry*One* is administered by Coventry Health Care of Delaware, Inc. and underwritten by Coventry Health and Life Insurance Company.

This Schedule is part of Your Policy but does not replace it. Many words are defined elsewhere in the Policy and other limitations or exclusions may be listed in other sections of your Policy. 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 Policy. A complete list of Covered Services, Exclusions and Limitations can be found in Your Policy.

Benefits and Services	When You Use Participating Providers	When You Use Non- Participating Providers
Contract Year Deductible		
Ø The total amount You are required to pay each contract year before the coverage begins paying. Each covered person must satisfy a contract year deductible, with a maximum of 2 times the Individual deductible for your family in total. There are separate Participating Provider and Non-Participating Provider contract year deductibles, and payments that count toward one does not count toward the other.	Individual: $2500 Family: $5000	Individual: $5000 Family: $10,0000
Coinsurance		
Ø Coinsurance is a percentage of Covered Services. After any required Copayments and contract year deductibles are paid, the coverage pays a share and you pay a share, up to your out-of-pocket maximum.	The coverage pays 70% and You pay 30%	The coverage pays 60% and You pay 40% Coinsurance of the Out-of-Network rate

Benefits and Services	When You Use Participating Providers	When You Use Non- Participating Providers
Annual Out-of-Pocket Maximum Ø The amount you pay annually in contract year deductibles and Coinsurance before the coverage pays 100% for most Covered Services, up to the benefit maximums. Each covered person has an out-of-pocket expense limit, with a maximum for your family in total. Ø Primary Care and Specialist Copayment amounts do not apply to the Annual Out-of-Pocket Maximum. Ø Annual Deductible and Coinsurance amounts, shall be applied to the Annual Out-of-Pocket Maximum. Ø You are responsible for Charges that exceed Our Out-of-Network Rate for Non-Participating Providers. This could result in Your having to pay a significant portion of Your claim. Balances above the Out-of-Network Rate do NOT apply to Your Out-of-Pocket Maximum.	Deductible + $2500 Coinsurance	Deductible + $2500 Coinsurance
Maximum Lifetime Benefit	$2 million / Covered Individual	$2 million/Covered Individual
Physician Services Ø Office visits, consultants, Ø Immunizations and injections, Ø Diagnostic laboratory tests, radiology services, x-rays, Ø Surgery, Ø Allergy tests and treatment.	Primary Care Services You pay $20 Copayment per visit, then the coverage pays 100% Specialty Care Services You pay $35 Copayment per visit, then the coverage pays 100%	You pay contract year Deductible and 40% Coinsurance of the Out-of-Network rate
Medical Services At A Physician's Office Ø Routine health assessment, well-child care*, childhood immunizations and injections, Ø Vision examination to determine need for refraction, Ø Hearing test, Ø Annual gynecological examination and pap smear, Ø Mammogram screenings*, Ø Prostate cancer screening for Covered Individuals over the age of fifty (50).	Primary Care Services You pay $20 Copayment per visit, then the coverage pays 100% Specialty Care Services You pay $35 Copayment	You pay contract year Deductible and 40%Coinsurance of the Out-of-Network rate.

Benefits and Services	When You Use Participating Providers	When You Use Non- Participating Providers
**Well-child care and mammography are not subject to a Deductible.*	per visit, then the coverage pays 100%	
Emergency Room Services		
Ø Coverage worldwide for Emergency Services as defined in the Policy	You pay $150 Copayment (Copayment waived if admitted)	You pay $150 Copayment (Copayment waived if admitted)
Ambulance Services	You pay contract year Deductible and Coinsurance	You pay contract year Deductible and 40% Coinsurance of the Out-of-Network rate
Urgent Care Services Ø At an Urgent Care Facility	Your Copayment $35	Your Copayment $35
Outpatient Facility Services		
Ø Services rendered at an Outpatient Hospital Unit, freestanding surgical center or other outpatient facility.	You pay contract year Deductible and Coinsurance	You pay contract year Deductible and 40% Coinsurance of the Out-of-Network rate
Inpatient Hospital Services		
Unlimited coverage provided for Ø Semi-private room, Ø Physician and surgeon services, Ø Operating rooms and related facilities, Ø Intensive and Coronary Care Units, Ø Laboratory, x-rays, diagnostic laboratory and radiology services/ procedures, Ø Medications and biologicals, Ø Anesthesia, Ø Special duty nursing as prescribed, Ø Short-term rehabilitation services, Ø Radiation therapy.	You pay contract year Deductible and Coinsurance	You pay contract year Deductible and 40% Coinsurance of the Out-of-Network rate

Benefits and Services	When You Use Participating Providers	When You Use Non- Participating Providers
Skilled Nursing Facility Ø In lieu of inpatient Hospital stay when recommended by a Physician and approved by Us. Coverage provided on a Semi-private basis limited to 30 days per contract year.	You pay contract year Deductible and Coinsurance	You pay contract year Deductible and 40% Coinsurance of the Out-of-Network rate
Home Health Care Ø In lieu of inpatient hospitalization *(Coinsurance, deductible and Copayment will be waived for home visit(s) following a mastectomy or removal of a testicle.)* Limit of 40 visits per contract year. *This limit does not apply to home visits following mastectomy or removal of a testicle.*	You pay contract year Deductible and Coinsurance	You pay contract year Deductible and 40% Coinsurance of the Out-of-Network rate
Hospice Care There is a 30-day limit per calendar year for inpatient Hospice Care. Ø	You pay contract year Deductible and Coinsurance	You pay contract year Deductible and 40% Coinsurance of the Out-of-Network rate
Prosthetic Devices and Durable Medical Equipment *Maximum $2,000* *Per contract year per Member.* *This $2,000 limit does not apply to: breast prosthesis, hair prosthesis, or hearing aids for minor children.*	You pay contract year Deductible and Coinsurance	You pay contract year Deductible and 40% Coinsurance of the Out-of-Network rate
Physical, Occupational and Speech Therapy Ø Up to 24 visits of Coverage per contract year, per physical, occupational or speech therapy *(this limit does not apply to habilitative services for children with a congenital or genetic birth defect, such as autism or cerebral palsy, which are needed to enhance the child's ability to function)* Ø	You pay contract year Deductible and Coinsurance	You pay contract year Deductible and 40% Coinsurance of the Out-of-Network rate
Outpatient Laboratory Services and Diagnostic Services	You pay contract year Deductible and Coinsurance	You pay contract year Deductible and 40% Coinsurance of the Out-of-Network rate
Mental Health/Alcohol or Drug Abuse Services		
Ø Inpatient and Residential Crisis Services	You pay contract year Deductible and Coinsurance	You pay contract year Deductible and 40% Coinsurance of the Out-of-Network rate

Benefits and Services	When You Use Participating Providers	When You Use Non- Participating Providers
Ø Partial Hospitalization (Maximum 60 days per contract year)	You pay contract year Deductible and Coinsurance	You pay contract year Deductible and 40% Coinsurance of the Out-of-Network rate
Ø Outpatient Services	You pay contract year Deductible and the following Coinsurance amount Visits 1-5 20% *per contract year* Visits 6-30 35% *per contract year* Visits 31+ 50% *per contract year*	You pay contract year Deductible and the following Coinsurance amount Visits 1-5 20% *per contract year* Visits 6-30 35% *per contract year* Visits 31+ 50% *per contract year*
Ø Medication Management Visit	Primary Care Services You pay a $20 Copayment per visit, then the coverage pays 100% Specialty Care Services You pay a $35 Copayment per visit, then the coverage pays 100%	You pay contract year Deductible and 40% Coinsurance of the Out-of-Network rate
Ø **Outpatient RX Drug (including Prescription Drugs for Infertility Services)**	$0 Deductible $10 Copayment per Generic $1500 maximum benefit per contract year	$0 Deductible $10 Copayment per Generic $1500 maximum benefit per contract year
Ø **Transplant Services**	You pay contract year Deductible and Coinsurance	You pay contract year Deductible and 40% Coinsurance of the Out-of-Network rate
Ø **Infertility Services**, (after confirmed diagnosis) **Infertility Services are subject to a $100,000 lifetime maximum benefit limit.**	You pay contract year Deductible and Coinsurance	You pay contract year Deductible and 40% Coinsurance of the Out-of-Network rate

Pre-Authorizations

The Participating Provider is responsible for obtaining prior authorization from Coventry Health Care of Delaware, Inc. Members are responsible for obtaining reviews if they use Non- Participating Providers. If the Member does not get the required approval, related benefits are denied. See the Policy form and any subsequent amendments for a list of services requiring Pre-Authorization.

Primary and Specialty Care Services

A listing of Primary and Specialty Care Participating Providers is located in the Coventry Health Care of Delaware, Inc. *Provider List* or on its Web site at www.chcde.com.

Your Plan pays Non-Participating Providers an Out-of-Network rate. In addition to your copay or coinsurance, you are responsible for paying Non-Participating Providers the difference between our Out-of-Network rate and their actual charge for non-emergency services.