

CoventryOne® \$20 Copay POS Plans

	\$20 / \$500		\$20 / \$1,000	
	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	\$500	\$1,000	\$1,000	\$2,000
Coinsurance Plan Pays	70%	60%	70%	60%
Out-of-Pocket Max (per benefit year) - Maximum 3 per family	\$2,500	None	\$2,500	None
Medical benefits shown with copays are not subject to the deductible. Coinsurance percentages are effective after the deductible has been met unless specifically noted.				
PCP Visits (General Physician, Family Practitioner, Pediatrician or Internist) • Office Visits • X-ray and Lab when performed in office • Immunizations	\$20	60%	\$20	60%
Specialist Visits • X-ray and Lab when performed in office • Allergy Testing and Treatment	\$55	60%	\$55	60%
Preventive Screenings for Adults and Children - PCP & Specialist	\$20	Not Covered	\$20	Not Covered
Convenience Care Clinic	\$20	60%	\$20	60%
Mammograms (No deductible when received in-network)	100%	60%	100%	60%
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	70%	60%	70%	60%
Outpatient Hospital / Facility • X-Ray, Lab, Diagnostic Services • MRI, CAT & PET Scans, Other Nuclear Med • Surgery, Anesthesia • Chemotherapy, Radiation Treatment	70%	60%	70%	60%
Maternity	Not Covered	Not Covered	Not Covered	Not Covered
Short Term Therapies (No visit limit) • Physical, Speech, Occupational and Respiratory Therapies • Cardiac and Pulmonary Rehabilitation	70%	60%	70%	60%
Chiropractic Services (24 Visits per benefit year)	\$10	Not Covered	\$10	Not Covered
DME, Prosthetics, Orthoses (\$2,500 Max per benefit year)	70%	Not Covered	70%	Not Covered
Transplants	70%	Not Covered	70%	Not Covered
Home Health Care (30 Days per benefit year)	70%	60%	70%	60%
Skilled Nursing Facility (30 Days per benefit year)	70%	60%	70%	60%
Hospice	70%	60%	70%	60%
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 MAIL ORDER*: \$35 \$50 \$100 \$100 Deductible	MAIL ORDER*: \$10 \$70 \$150 Not Covered *93 DAY SUPPLY	RETAIL: \$10 MAIL ORDER*: \$35 \$50 \$100 \$250 Deductible	MAIL ORDER*: \$10 \$70 \$150 Not Covered *93 DAY SUPPLY
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

All medical benefits subject to benefit year deductible unless specifically noted with a copay. 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.

CHCGA_10102008

CoventryOne® \$20 Copay POS Plans

	\$20 / \$2,000		\$20 / \$3,000		\$20 / \$4,000		\$20 / \$5,000		\$20 / \$10,000	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
	\$6,000,000		\$6,000,000		\$6,000,000		\$6,000,000		\$6,000,000	
	\$2,000	\$4,000	\$3,000	\$6,000	\$4,000	\$8,000	\$5,000	\$10,000	\$10,000	\$20,000
	70%	60%	70%	60%	70%	60%	70%	60%	70%	60%
	\$2,500	None	\$2,500	None	\$2,500	None	\$2,500	None	\$2,500	None
Medical benefits shown with copays are not subject to the deductible. Coinsurance percentages are effective after the deductible has been met unless specifically noted.										
	\$20	60%	\$20	60%	\$20	60%	\$20	60%	\$20	60%
	\$55	60%	\$55	60%	\$55	60%	\$55	60%	\$55	60%
	\$20	Not Covered	\$20	Not Covered	\$20	Not Covered	\$20	Not Covered	\$20	Not Covered
	\$20	60%	\$20	60%	\$20	60%	\$20	60%	\$20	60%
	100%	60%	100%	60%	100%	60%	100%	60%	100%	60%
	\$150	\$150	\$150	\$150	\$150	\$150	\$150	\$150	\$150	\$150
	\$55	\$55	\$55	\$55	\$55	\$55	\$55	\$55	\$55	\$55
	\$150	\$150	\$150	\$150	\$150	\$150	\$150	\$150	\$150	\$150
	70%	60%	70%	60%	70%	60%	70%	60%	70%	60%
	70%	60%	70%	60%	70%	60%	70%	60%	70%	60%
	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
	70%	60%	70%	60%	70%	60%	70%	60%	70%	60%
	\$10	Not Covered	\$10	Not Covered	\$10	Not Covered	\$10	Not Covered	\$10	Not Covered
	70%	Not Covered	70%	Not Covered	70%	Not Covered	70%	Not Covered	70%	Not Covered
	70%	Not Covered	70%	Not Covered	70%	Not Covered	70%	Not Covered	70%	Not Covered
	70%	60%	70%	60%	70%	60%	70%	60%	70%	60%
	70%	60%	70%	60%	70%	60%	70%	60%	70%	60%
	70%	60%	70%	60%	70%	60%	70%	60%	70%	60%
	RETAIL: \$10 MAIL ORDER*: \$35 \$50 \$100 \$250 Deductible	MAIL ORDER*: \$10 \$70 \$150 Not Covered *93 DAY SUPPLY	RETAIL: \$10 MAIL ORDER*: \$35 \$50 \$100 \$250 Deductible	MAIL ORDER*: \$10 \$70 \$150 Not Covered *93 DAY SUPPLY	RETAIL: \$10 MAIL ORDER*: \$35 \$50 \$100 \$250 Deductible	MAIL ORDER*: \$10 \$70 \$150 Not Covered *93 DAY SUPPLY	RETAIL: \$10 MAIL ORDER*: \$35 \$50 \$100 \$500 Deductible	MAIL ORDER*: \$10 \$70 \$150 Not Covered *93 DAY SUPPLY	RETAIL: \$10 MAIL ORDER*: \$35 \$50 \$100 \$500 Deductible	MAIL ORDER*: \$10 \$70 \$150 Not Covered *93 DAY SUPPLY
	\$20 Various Copays	Not Covered Not Covered	\$20 Various Copays	Not Covered Not Covered	\$20 Various Copays	Not Covered Not Covered	\$20 Various Copays	Not Covered Not Covered	\$20 Various Copays	Not Covered Not Covered
	\$15	Not Covered	\$15	Not Covered	\$15	Not Covered	\$15	Not Covered	\$15	Not Covered

All medical benefits subject to benefit year deductible unless specifically noted with a copay. 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.

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CHCGA_10102008

CoventryOne® \$35 Copay POS Plans

	\$35/\$1,000		\$35/\$2,500		\$35/\$5,000	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Lifetime Max	\$ 7,000,000		\$ 7,000,000		\$ 7,000,000	
Deductible (per benefit year) - Maximum 2 per family	\$1,000	\$2,000	\$2,500	\$5,000	\$5,000	\$10,000
Coinsurance Plan Pays	70%	50%	70%	50%	70%	50%
Out-of-Pocket Max (per benefit year) - Maximum 2 per family	\$5,000	None	\$5,000	None	\$5,000	None
PCP Visits (General Physician, Family Practitioner, Pediatrician, or Internist) · Office Visits · Includes lab when performed in office · Immunizations	\$35	50%	\$35	50%	\$35	50%
Specialist Visits · Includes lab when performed in office · Allergy Testing and Treatment	First 2 Visits: \$50 3+: \$50 After Ded.	50%	First 2 Visits: \$50 3+: \$50 After Ded.	50%	First 2 Visits: \$50 3+: \$50 After Ded.	50%
X-Ray (in office) - PCP & Specialist	70%	50%	70%	50%	70%	50%
Preventive Screenings for Adults and Children - PCP & Specialist	\$35	50%	\$35	50%	\$35	50%
Convenience Clinic Care (ex. MinuteClinic)	\$35	50%	\$35	50%	\$35	50%
Mammograms (No deductible when received in-network)	100%	50%	100%	50%	100%	50%
Urgent Care	\$75	\$75	\$75	\$75	\$75	\$75
Emergency Services (Copay waived if admitted to hospital)	\$250	\$250	\$250	\$250	\$250	\$250
Ambulance	70%	50%	70%	50%	70%	50%
Inpatient Hospital Care	70%	50%	70%	50%	70%	50%
Outpatient Hospital/Facility · X-Ray, Lab, Diagnostic Services · MRI, CAT & PET Scans, Other Nuclear Med · Surgery, Anesthesia · Chemotherapy, Radiation Treatment	70%	50%	70%	50%	70%	50%
Maternity	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Short Term Therapies · Physical, Speech and Occupational Therapies (24 Visits per benefit year) · Respiratory Therapy (30 visits per benefit year) · Cardiac and Pulmonary Rehabilitation (30 Visits per benefit year)	70%	50%	70%	50%	70%	50%
Chiropractic Services (12 Visits per benefit year)	\$10	Not Covered	\$10	Not Covered	\$10	Not Covered
DME, Prosthetics & Orthotics - (Combined \$2500 Max per benefit year)	70%	50%	70%	50%	70%	50%
Transplants	70%	Not Covered	70%	Not Covered	70%	Not Covered
Home Health Care (30 Visits per benefit year)	70%	50%	70%	50%	70%	50%
Skilled Nursing Facility (30 Days per benefit year)	70%	50%	70%	50%	70%	50%
Hospice	70%	50%	70%	50%	70%	50%
RX	RETAIL:	MAIL ORDER*:	RETAIL:	MAIL ORDER*:	RETAIL:	MAIL ORDER*:
· Tier 1 - Preferred Generic (No Deductible)	\$10	\$10	\$10	\$10	\$10	\$10
· Tier 2 - Preferred Formulary Brand (Deductible)	\$35	\$70	\$35	\$70	\$35	\$70
· Tier 3 - Non Preferred Brand and a few Non Preferred Generic (Deductible)	\$50	\$150	\$50	\$150	\$50	\$150
· Tier 4 - Self-Administered Injectable Drugs (Deductible)	70%	Not Covered	70%	Not Covered	70%	Not Covered
· RX deductible must be satisfied before copay applies on Tiers 2, 3, & 4	\$1,000 Deductible		\$1,000 Deductible		\$1,000 Deductible	
· Retail must be obtained from Participating Pharmacies only (except for Emergency), and Mail Order must be obtained from Caremark*	*93-Day Supply		*93-Day Supply		*93-Day Supply	
· To determine the specific cost of your medication, please refer to the Drug Formulary						
Vision Exam (every 12 months) · Exam must be received from Avesis provider	\$15	Not Covered	\$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.

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	\$35/\$7,500 Basic		\$35/\$10,000 Basic	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Lifetime Max	\$ 7,000,000		\$ 7,000,000	
Deductible (per benefit year) - Maximum 2 per family	\$7,500	\$15,000	\$10,000	\$20,000
Coinsurance Plan Pays	70%	50%	70%	50%
Out-of-Pocket Max (per benefit year) - Maximum 2 per family	\$5,000	None	\$10,000	None
PCP Visits (General Physician, Family Practitioner, Pediatrician, or Internist) · Office Visits · Includes lab when performed in office · Immunizations	\$35	50%	\$35	50%
Specialist Visits · Includes lab when performed in office · Allergy Testing and Treatment	After deductible: \$50	50%	After deductible: \$50	50%
X-Ray (in office) - PCP & Specialist	70%	50%	70%	50%
Preventive Screenings for Adults and Children - PCP & Specialist	\$35	50%	\$35	50%
Convenience Clinic Care (ex. MinuteClinic)	\$35	50%	\$35	50%
Mammograms (No deductible when received in-network)	100%	50%	100%	50%
Urgent Care	\$75	\$75	\$75	\$75
Emergency Services (Copay waived if admitted to hospital)	\$500	\$500	\$500	\$500
Ambulance	70%	50%	70%	50%
Inpatient Hospital Care	70%	50%	70%	50%
Outpatient Hospital/Facility · X-Ray, Lab, Diagnostic Services · MRI, CAT & PET Scans, Other Nuclear Med · Surgery, Anesthesia · Chemotherapy, Radiation Treatment	70%	50%	70%	50%
Maternity	Not Covered	Not Covered	Not Covered	Not Covered
Short Term Therapies · Physical, Speech and Occupational Therapies (24 Visits per benefit year) · Respiratory Therapy (30 visits per benefit year) · Cardiac and Pulmonary Rehabilitation (30 Visits per benefit year)	70%	50%	70%	50%
Chiropractic Services (12 Visits per benefit year)	\$10	Not Covered	\$10	Not Covered
DME, Prosthetics & Orthotics - (Combined \$2500 Max per benefit year)	70%	50%	70%	50%
Transplants	70%	Not Covered	70%	Not Covered
Home Health Care (30 Visits per benefit year)	70%	50%	70%	50%
Skilled Nursing Facility (30 Days per benefit year)	70%	50%	70%	50%
Hospice	70%	50%	70%	50%
RX	RETAIL:	MAIL ORDER*:	RETAIL:	MAIL ORDER*:
· Tier 1 - Preferred Generic (No Deductible)	\$10	\$10	\$10	\$10
· Tier 2 - Preferred Formulary Brand (Deductible)	\$35	\$70	\$35	\$70
· Tier 3 - Non Preferred Brand and a few Non Preferred Generic (Deductible)	\$50	\$150	\$50	\$150
· Tier 4 - Self-Administered Injectable Drugs (Deductible)	70%	Not Covered	70%	Not Covered
· RX deductible must be satisfied before copay applies on Tiers 2, 3, & 4	\$2,000 Deductible		\$2,000 Deductible	
· Retail must be obtained from Participating Pharmacies only (except for Emergency), and Mail Order must be obtained from Caremark*	*93-Day Supply		*93-Day Supply	
· To determine the specific cost of your medication, please refer to the Drug Formulary				
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.

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