



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

**CoventryOne<sup>SM</sup>**  
**QHD INDIVIDUAL POS PLAN**  
**\$3,000/\$5,500**

BENEFITS	MEMBER PAYS	
	In-Network	Out-of-Network
Lifetime Maximum	\$6,000,000	
Deductible (per Benefit Year)	\$3,000 Individual \$5,500 Family	\$6,000 Individual \$11,000 Family
Out-of-Pocket Maximum (per Benefit Year)	\$3,000 Individual \$5,500 Family	\$6,000 Individual \$11,000 Family
Medical Benefits shown with copays are not subject to deductible		
Primary Care Physician (PCP) and Specialists Visits * Office visits * X-ray and Lab when performed in office * Immunizations * Allergy Testing and Treatment	Ded	40%
Preventive Screenings for Adults and Children - PCP & Specialist *Not subject to plan deductible	\$20	Not Covered
Mammograms	Plan pays 100%	Not Covered
Emergency Care Services	Ded	Ded
Urgent Care	Ded	Ded
Ambulance * When Medically Necessary	Ded	Ded
Inpatient Hospital Care	Ded	40%
Outpatient Hospital / Facility, Including: * X-Ray, Lab, Diagnostic Services * MRI, CAT & PET Scans, Other Nuclear Med * Surgery, Anesthesia, Etc. * Chemotherapy and Radiation Treatment	Ded	40%
Short Term Therapies * No Visit Limits * Physical, Speech, Occupational and Respiratory Therapies * Cardiac and Pulmonary Rehabilitation	Ded	40%
Chiropractic Services	Not Covered	Not Covered
DME, Prosthetics and Orthoses * Limited to \$2,500 Annual Max, All Combined	Ded	Not Covered
Transplants	Ded	Not Covered
Home Health Care * Limited to 30 days, IN and OON Combined	Ded	40%
Skilled Nursing Facility * Limited to 30 days, IN and OON Combined	Ded	40%
Hospice	Ded	40%
RX - Subject to plan deductible * 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 * 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	RETAIL: Ded Ded Ded Ded	MAIL ORDER: Ded Ded Ded Not Covered
Dental - Not subject to plan deductible * Preventative Cleanings for Adults and Children, 1 each six month period * Diagnostic, Routine & Preventive services * Emergency care * Restorative services; Crowns and jackets * Orthodontic care * Plan Deductible does not apply * All care must be received from DeltaCare provider	\$20 Copay Various Copays	Not Covered Not Covered
Vision - Not subject to plan deductible * Plan Deductible does not apply * 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.

# Coventry Health Care of Georgia, Inc.

## CoventryONE<sup>SM</sup>

### Summary of Exclusions and Limitations

It is important for You to understand that certain medical services are not covered by Coventry (these are called “exclusions”). A summary is provided here. **This represents a partial list. Please see the Individual Member Contract for a complete list.**

Coventry does not cover:

- Acupuncture, biofeedback, hypnotherapy, naturopathy, and sleep therapy
- Chiropractic manipulation of the spine (unless covered by a Rider)
- Cosmetic services and surgeries
- Custodial care
- Dental care (unless covered by a Rider)
- Durable medical equipment, other than that specified as covered
- Experimental or Investigational procedures and treatments
- External prosthetic devices, other than those specified as covered
- Eyeglasses and contact lenses, except for the first pair of eyeglasses or contacts prescribed as a result of cataract surgery
- Gastric bypass surgeries
- Hearing, educational, and psychological testing and therapy, including hearing aids and cochlear implants
- Immunizations for work or travel
- Infertility treatment
- Long-term therapies and rehabilitation
- Maternity care, delivery of newborns, and prenatal, postnatal and postpartum care (except that complications of pregnancy are covered)
- Mental health or substance-related disorders (unless covered by a Rider)
- Non-Emergency services in an emergency facility
- Nutritional counseling, food and food supplements and services related to weight gain or loss
- Outpatient prescription drugs (unless covered by a Rider)
- Radial keratotomy and laser eye surgery for the correction of eyesight
- Routine foot care
- Services that are not Medically Necessary
- Sex-change surgery
- Sexual dysfunction diagnosis, care, and treatment
- Surrogate parenting
- War related sickness or injury, or services or care for military services connected disabilities and conditions