SCHEDULE OF MEDICAL BENEFITS
Option 1

Annual Deductibles:	Annual Out-Of-Pocket Maximums: (Excludes Deductible)
$300 Individual	$ 700 Individual
$600 Family	$1,400 Family

Lifetime Benefit Maximum:
(Includes All Other Maximums)
$2,000,000 Individual

You must receive services only from health care providers participating in the network or benefits will not be covered by the plan. Expenses for non-network providers will only be considered as specified in the NOTES or Additional Limitations And Explanations sections of this schedule.

The following schedule summarizes coinsurance amounts paid by the plan, benefit maximums and additional explanation needed for your benefits. The plan's payment will be reduced if you do not follow the procedures outlined in the Health Care Management Services section of this plan. Please refer to the text for additional plan provisions which may affect your benefits.

Benefit Description	Annual Deductible	Network Plan Pays	Non-Network Plan Pays	Additional Limitations And Explanations
Physician Office Visits	NO	100%	Not Covered	You must pay the first $25 per visit to a primary care provider or the first $35 per visit to a specialist. Your co-pay applies to the office visit only. Only one co-pay is required per provider per date of service. For maternity visits, you are only required to pay the co-pay at the initial visit. Benefits include all non-surgical* services performed during the visit and billed by the physician/physician's office, including services and supplies for the administration of injectable medications, excluding the cost of the medication. Infusion therapy will be considered for the initial visit only. Subsequent infusion drugs and all injectable medications must be obtained through Caremark Specialty Services by calling (Caremark Connect) 1-800-237-2767 before receiving additional infusion and injectable drugs. The cost for administration of injectable medications, and services and supplies for the administration of infusion drugs, will be included with the office visit. For purposes of this plan, a primary care physician (PCP) may be a general or family practitioner, an internist, an obstetrician/ gynecologist or a pediatrician.
Allergy Treatment:				You must pay the first $25 per visit to a primary care provider or the first $35 per visit to a specialist, in addition to your coinsurance. Your co-pay applies to the office visit for testing and treatment only. Only one co-pay is required per provider per date of service.
Testing/Treatment	NO	95%	Not Covered	
Injections/Serum	YES	95%	Not Covered	

Benefit Description	Annual Deductible	Network Plan Pays	Non-Network Plan Pays	Additional Limitations And Explanations
Rabies Shots Administered By A Local Health Department	**NO**	**100%**	**100%**	**You must pay the first $25 per visit. You must pay for the shot at the time of service and submit a claim to the plan for reimbursement. You will be reimbursed the cost of the shot, less your co-pay. See the "Filing A Claim For Payment Of Benefits" section of this plan for additional information.**
Routine And Wellness Benefits	**NO**	**100%**	**Not Covered**	**You must pay the first $25 per visit to a primary care provider or the first $35 per visit to a specialist. Your co-pay applies to the office visit only. Only one co-pay is required per provider per date of service. Benefits include:** **· physicals for covered individuals age 2 and over, limited to 1 per year;** **· well-child checkups, limited to 8 visits from birth to 26 months of age;** **· all related x-rays and laboratory services (e.g. cholesterol screenings, TSH and resting EKGs);** **· PAP tests, including gynecological exams, limited to 1 per year;** **· PSA tests, limited to 1 per year for covered males age 50 and over;** **· digital rectal exams, limited to 1 per year for covered males age 40 and over;** **· occult blood tests, limited to 1 per year;** **· sigmoidoscopy, for individuals age 50 and over, limited to 1 every 5 years;** **· colonoscopy in lieu of sigmoidoscopy, limited to 1 colonoscopy for individuals age 50 through 59 and 1 colonoscopy every 5 years for individuals age 60 and over; and** **· flu and pneumonia shots, vaccinations, inoculations and immunizations.** **PAP tests and well-child checkups are subject to the PCP co-pay only. The age limit for PSA tests, digital rectal exams, colonoscopies and sigmoidoscopies will be waived if you have any family history of cancer, as documented by your practitioner.**
Routine Mammograms	**NO**	**100%**	**Not Covered**	**Limited to 1 per year for covered females age 40 and over. The age limit will be waived if you have any family history of cancer, as documented by your practitioner.**
Routine Vision And Hearing Exams	**NO**	**95%**	**Not Covered**	**You must pay the first $25 per visit, in addition to your coinsurance. Only one co-pay is required per provider per date of service. Limited to 1 each every 2 years.**

Benefit Description	Annual Deductible	Network Plan Pays	Non-Network Plan Pays	Additional Limitations And Explanations
Obesity-Related Office Visits	**NO**	**100%**	**Not Covered**	**You must pay the first $25 per visit to a primary care provider or the first $35 per visit to a specialist. Only one co-pay is required per provider per date of service. Limited to 4 visits per year. Expenses for related diagnostic x-rays and laboratory services will be considered as specified on this schedule.**
Home Health Care	**YES**	**95%**	**95%**	**Limited to 120 visits per year. To help reduce your out-of-pocket costs, you should notify Coventry Health Care by calling Member Services prior to receiving any home health care benefits.**
Outpatient Private-Duty Nursing Care	**YES**	**95%**	**95%**	**Limited to 70 visits per year. To help reduce your out-of-pocket costs, you should notify Coventry Health Care by calling Member Services prior to receiving any private-duty nursing care.**
Chiropractic Services	**NO**	**100%**	**Not Covered**	**You must pay the first $35 per visit. Limited to 20 visits per year.**
Outpatient Therapy Services	**NO**	**100%**	**Not Covered**	**You must pay the first $35 per visit. Benefits include physical, occupational and speech therapies. Services will be reviewed for medical necessity after the 12th visit for physical therapy or after the initial consultation for speech and occupational therapy. You should contact Coventry Health Care prior to continuing a treatment plan.**
Acupuncture	**NO**	**100%**	**100%**	**You must pay the first $35 per visit. Limited to 10 visits per year, including the initial consultation.**
Biofeedback	**NO**	**100%**	**100%**	**You must pay the first $35 per visit. Limited to 10 visits per year, including the initial consultation. Expenses for related labs or x-rays will be considered as All Other Covered Medical Expenses.**
Dental Services Due To Accidental Injury	**YES**	**95%**	**95%**	**$5,000 individual maximum per accident. Treatment must begin within 90 days of the injury. Benefits include practitioner and facility expenses, replacement of teeth and any related x-rays. An accidental injury does not include teeth cracked or broken due to biting or chewing.**

Benefit Description	Annual Deductible	Network Plan Pays	Non-Network Plan Pays	Additional Limitations And Explanations
Lab Savings Program	**NO**	**100%**	**Not Covered**	**You can use this voluntary program for covered lab tests. Show your plan ID card and ask your physician to send your lab order to Quest Diagnostics. Note: This benefit applies to eligible expenses for lab tests only. Related expenses for services provided by a physician (i.e. charges for an office visit or blood draw) are subject to applicable co-payments and coinsurance. See the Health Care Management Services section of this plan for details. Expenses for lab tests not performed by Quest will be considered as specified on this schedule.**
Diagnostic Testing/ X-Ray And Laboratory Services	**YES**	**95%**	**95%**	**Benefits include non-routine services including, but not limited to, diagnostic charges for x-rays and laboratory services, pre-admission testing, genetic testing/screenings associated with amniocentesis and ultrasounds. The plan's payment for MRI, MRA, CT Scans and PET Scans will be reduced by $400 if you do not follow the procedures required by the health care management services program. This penalty does not apply to the out-of-pocket maximum.**
Routine Pregnancy-Related Ultrasounds	**YES**	**95%**	**Not Covered**	**Limited to 2 per pregnancy. Additional ultrasounds may be authorized if you follow the required review procedures outlined in the Health Care Management Services section of this plan.**
Urgent Care Services	**NO**	**100%**	**Not Covered**	**You must pay the first $100 per visit. Please see your regular physician or practitioner for routine care. Contact Coventry Health Care if you need assistance with locating network providers.**
Emergency Room Services	**NO**	**95%**	**95%**	**You must pay the first $200 per emergency room visit, in addition to your coinsurance. Your $200 co-pay applies to the facility only and will be waived if you are admitted.** **Benefits include:** **· physician and facility services; and** **· 1 follow-up visit from a non-network provider, not subject to reduction for usual and customary charges.** **Non-emergency use of the emergency room is not covered. Please see your regular physician or practitioner for non-emergency or routine care.**
Ambulance Services	**YES**	**95%**	**95%**	

Benefit Description	Annual Deductible	Network Plan Pays	Non-Network Plan Pays	Additional Limitations And Explanations
Inpatient Physician Services	**YES**	**95%**	**Not Covered**	**Benefits include inpatient physician services such as inpatient visits, surgeon and assistant surgeon services.**
Inpatient Hospital Services	**YES**	**95%**	**Not Covered**	**A non-network hospital may be covered when admission is due to a medical emergency as outlined in the NOTES section. Benefits include, but are not limited to, administration of injectable medications, including the cost of the medication; infusion therapy; room and board expenses; and miscellaneous hospital services. The plan's payment for hospital expenses will be reduced by $400 if you do not follow the procedures required by the health care management services program. This penalty does not apply to the out-of-pocket maximum.**
Outpatient Surgery	**YES**	**95%**	**Not Covered**	**You are encouraged to notify Coventry Health Care by calling Member Services prior to scheduling any outpatient surgery. Upon request, Coventry Health Care will provide a pre-determination of benefits which will give you a description of which services are covered by the plan. This pre-determination of benefits is not a guarantee of payment by the plan, but is a tool to help you plan for your own expenses.**
Treatment Of TMJ	**YES**	**95%**	**Not Covered**	**$2,000 individual lifetime maximum. Benefits include surgical and non-surgical treatment.**
Treatment Of Infertility: **Office Visits** **Other Expenses**	 **NO** **YES**	 **100%** **95%**	 **Not Covered** **Not Covered**	**$15,000 individual lifetime maximum. You must pay the first $35 per office visit. Benefits include: surgical and non-surgical treatments, including, but not limited to, supplies and devices necessary for treatment; tests; and surgical and non-surgical impregnation procedures. For non-covered females, surrogate expenses are covered for tests and impregnation (actual or attempted). Surrogate expenses after a successful impregnation (e.g., physician office visits, delivery charges) are not covered. Fertility medications are excluded, but may be available through your prescription drug plan.**
Skilled Nursing Facility	**YES**	**95%**	**95%**	**Limited to 60 days per year. To help reduce your out-of-pocket costs, you should notify Coventry Health Care by calling Member Services prior to your admission.**
Hospice Facility	**YES**	**95%**	**95%**	**Limited to 30 days per lifetime. To help reduce your out-of-pocket costs, you should notify Coventry Health Care by calling Member Services prior to receiving any hospice care.**

Benefit Description	Annual Deductible	Network Plan Pays	Non-Network Plan Pays	Additional Limitations And Explanations
Home Hospice	**YES**	**95%**	**95%**	**$5,000 individual lifetime maximum. To help reduce your out-of-pocket costs, you should notify Coventry Health Care by calling Member Services prior to receiving any hospice care.**
Inpatient Mental/ Nervous And Substance Abuse Treatment	**YES**	**95%**	**50%**	**Limited to 60 combined network and non-network days per year. Non-network days are limited to 30 per year. The plan's payment for hospital expenses will be reduced by $400 if you do not follow the procedures required by the health care management services program. This penalty does not apply to the out-of-pocket maximum.**
Outpatient Mental/ Nervous And Substance Abuse Treatment:				**You must pay the first $35 per visit to a network provider. Limited to 30 combined network and non-network visits per year. Non-network visits are limited to 15 visits per year and $50 individual per visit maximum benefit. You are encouraged to notify Coventry Health Care prior to receiving any services. However, you must notify Coventry Health Care prior to receiving your 4th visit to verify medical necessity. Benefits will be denied if you do not follow the prior notification requirements of the plan.**
Network	**NO**	**100%**	**---**	
Non-Network	**YES**	**---**	**50%**	
Alternate Mental/ Nervous And Substance Abuse Treatment	**YES**	**95%**	**50%**	**Subject to the inpatient mental/nervous and substance abuse treatment maximums (2 partial days = 1 inpatient day). Benefits include partial hospitalization, intensive outpatient treatment and residential treatment facilities. The plan's payment will be reduced by $400 if you do not follow the procedures required by the health care management services program. This penalty does not apply to the out-of-pocket maximum.**
Durable Medical Equipment/ Prosthetics	**YES**	**95%**	**95%**	**Examples of durable medical equipment include wheelchairs, hospital beds, walkers, oxygen equipment, insulin infusion pumps and artificial limbs. To help reduce your out-of-pocket costs, you should notify Coventry Health Care by calling Member Services prior to ordering, renting or purchasing any durable medical equipment or prosthetics. You are strongly encouraged to notify Coventry Health Care prior to renting or purchasing a TENS unit of $500 or more.**
Wigs And Artificial Hairpieces	**YES**	**95%**	**95%**	**$300 individual lifetime maximum. Limited to replacement of hair loss due to medical treatment, e.g., radiation therapy or chemotherapy.**

Benefit Description	Annual Deductible	Network Plan Pays	Non-Network Plan Pays	Additional Limitations And Explanations
All Other Covered Medical Expenses	**YES**	**95%**	**Not Covered**	**Benefits are provided for expenses listed in the Covered Medical Expenses section of this plan. See pages 21-27.**

Member Services/Health Care Management Services toll free number: 1-800-272-8931

NOTES: **The word lifetime refers to the period of time you or your eligible dependents participate in this plan or any other plan sponsored by Caremark Rx, Inc.**

Required Outpatient Review: Some outpatient services, whether performed in a physician's office or hospital/facility setting, require prior certification or your plan benefits may be reduced. For a list of these services, see Prior Notification Requirements in the Health Care Management Services section of this plan. The plan's payment will be reduced by $400 if you do not follow the procedures required by the health care management services program. This penalty does not apply to the out-of-pocket maximum.

Usual And Customary Charges: Covered non-network expenses considered at the network level of benefits are subject to reduction for usual and customary charges.

No Choice Of Provider – REAP Ancillary Providers: If you receive treatment from a network provider or facility, related charges for non-network emergency room physicians, anesthesiology, x-rays and laboratory services will be considered at the network level of benefits, not subject to reduction for usual and customary charges. (For all other ancillary providers, refer to the "No Choice Of Provider – Other Ancillary Providers" note on this schedule.) Any follow-up care from a non-network provider will be denied, except as specified under Emergency Room Services.

No Choice Of Provider – Other Ancillary Providers: If you receive treatment from a network provider or facility, expenses for services received from a non-network ancillary provider (for example, an assistant surgeon or inpatient physician) may be covered at the network level of benefits less 10% (e.g., 95% less 10% = 85%), not subject to reduction for usual and customary charges. This does not include emergency room physicians, anesthesiology, x-rays and laboratory services (see separate provision in NOTES for REAP Ancillary Providers.) To qualify, you must file an appeal within the required timeframe outlined in the "How To Appeal A Denial Of Benefits Or Clinical Non-Certification" section of this document. Any follow-up care from a non-network provider will be denied.

Emergency Admission To A Network Hospital: If you are admitted to a network hospital due to a medical emergency, all related facility and physician expenses will be considered at the in-network level of benefits. You or your authorized representative must contact Coventry Health Care by calling the toll-free number within 48 hours (2 calendar days) of admission. When you call, Health Care Management Services will help identify appropriate network providers, if necessary.

Emergency Admission To A Non-Network Hospital: If you are admitted to a non-network hospital due to a medical emergency, all related facility and physician expenses will be considered at the in-network level of benefits until the plan notifies you or your health care provider that it considers your condition to be stable. Once your condition has stabilized, Health Care Management Services will help identify an appropriate network provider and arrange for a safe and timely transfer. Reasonable transportation expenses related to such transfer will be covered by the plan. However, if you choose not to transfer to a network hospital, expenses will be denied starting the day after your condition has stabilized. You or your authorized representative must contact Coventry Health Care by calling the toll-free number within 48 hours (2 calendar days) of admission.

<u>Network Specialists Not Available</u>: If you live within the network service area and you need specialty care that is not available from a network provider within 30 miles of your home address, you may receive treatment from a non-network specialty provider and have your benefits paid at the in-network level. To qualify, you must call Coventry Health Care's toll-free number prior to receiving any care. After your approval to receive care from a non-network specialist, you must call every 6 months to continue care with that provider. If you do not call, benefits will be denied.

<u>Network Providers Not Available While Traveling On Vacation</u>: If you are traveling on vacation, and no network providers are available within 30 miles of your location, you may utilize a non-network provider and have your benefits paid at the in-network level. To qualify, you must call Coventry Health Care's toll-free number prior to receiving any care. If you do not call, benefits will be denied.

<u>Transition Of Benefits</u>: If prior to your enrollment in this plan, you were receiving on-going medical care for pregnancy in the second or third trimester; cardiac rehabilitation; physical, occupational or speech therapy; radiation therapy or chemotherapy; mental/nervous or substance abuse treatment; or post-surgical care for surgery performed prior to the date your benefits became effective, expenses for related services will be considered at the in-network level of benefits for the first 90 days from your effective date of coverage for medical care, or through delivery and post-partum care for pregnancy (limited to initial hospital confinement for newborns). To qualify for these transition benefits, you must call Coventry Health Care at the toll-free number before continuing to receive services. Please refer to the Health Care Management Services section of this plan for additional information. If you are currently in a course of treatment for a condition not listed above, but think you may be eligible for transition benefits, call Coventry Health Care at 1-800-272-8931. If you do not call, benefits will be denied.

* **A surgical procedure is any operative or diagnostic procedure performed in the treatment of an injury or illness by instrument or cutting procedure through any natural body opening or incision (e.g., the removal of skin cancer, moles or lesions).**

SCHEDULE OF MEDICAL BENEFITS
Option 2

Annual Deductibles:	**Annual Out-Of-Pocket Maximums:**
$300 Individual	**(Excludes Deductible)**
$600 Family	**$1,250 Individual**
	$2,500 Family

Lifetime Benefit Maximum:
(Includes All Other Maximums)
$2,000,000 Individual

You must receive services only from health care providers participating in the network or benefits will not be covered by the plan. Expenses for non-network providers will only be considered as specified in the NOTES or Additional Limitations And Explanations sections of this schedule.

The following schedule summarizes coinsurance amounts paid by the plan, benefit maximums and additional explanation needed for your benefits. The plan's payment will be reduced if you do not follow the procedures outlined in the Health Care Management Services section of this plan. Please refer to the text for additional plan provisions which may affect your benefits.

Benefit Description	Annual Deductible	Network Plan Pays	Non-Network Plan Pays	Additional Limitations And Explanations
Physician Office Visits	NO	100%	Not Covered	You must pay the first $20 per visit to a primary care provider or the first $35 per visit to a specialist. Your co-pay applies to the office visit only. Only one co-pay is required per provider per date of service. For maternity visits, you are only required to pay the co-pay at the initial visit. Benefits include all non-surgical* services performed during the visit and billed by the physician/physician's office, including services and supplies for the administration of injectable medications, excluding the cost of the medication. Infusion therapy will be considered for the initial visit only. Subsequent infusion drugs and all injectable medications must be obtained through Caremark Specialty Services by calling (Caremark Connect) 1-800-237-2767 before receiving additional infusion and injectable drugs. The cost for administration of injectable medications, and services and supplies for the administration of infusion drugs, will be included with the office visit. For purposes of this plan, a primary care physician (PCP) may be a general or family practitioner, an internist, an obstetrician/ gynecologist or a pediatrician.
Allergy Treatment: Testing/Treatment Injections/Serum	 NO YES	 90% 90%	 Not Covered Not Covered	You must pay the first $20 per visit to a primary care provider or the first $35 per visit to a specialist, in addition to your coinsurance. Your co-pay applies to the office visit for testing and treatment only. Only one co-pay is required per provider per date of service.

Benefit Description	Annual Deductible	Network Plan Pays	Non-Network Plan Pays	Additional Limitations And Explanations
Rabies Shots Administered By A Local Health Department	**NO**	**100%**	**100%**	**You must pay the first $20 per visit. You must pay for the shot at the time of service and submit a claim to the plan for reimbursement. You will be reimbursed the cost of the shot, less your co-pay. See the "Filing A Claim For Payment Of Benefits" section of this plan for additional information.**
Routine And Wellness Benefits	**NO**	**100%**	**Not Covered**	**You must pay the first $20 per visit to a primary care provider or the first $35 per visit to a specialist. Your co-pay applies to the office visit only. Only one co-pay is required per provider per date of service. Benefits include:** **· physicals for covered individuals age 2 and over, limited to 1 per year;** **· well-child checkups, limited to 8 visits from birth to 26 months of age;** **· all related x-rays and laboratory services (e.g. cholesterol screenings, TSH and resting EKGs);** **· PAP tests, including gynecological exams, limited to 1 per year;** **· PSA tests, limited to 1 per year for covered males age 50 and over;** **· digital rectal exams, limited to 1 per year for covered males age 40 and over;** **· occult blood tests, limited to 1 per year;** **· sigmoidoscopy, for individuals age 50 and over, limited to 1 every 5 years;** **· colonoscopy in lieu of sigmoidoscopy, limited to 1 colonoscopy for individuals age 50 through 59 and 1 colonoscopy every 5 years for individuals age 60 and over; and** **· flu and pneumonia shots, vaccinations, inoculations and immunizations.** **PAP tests and well-child checkups are subject to the PCP co-pay only. The age limit for PSA tests, digital rectal exams, colonoscopies and sigmoidoscopies will be waived if you have any family history of cancer, as documented by your practitioner.**
Routine Mammograms	**NO**	**100%**	**Not Covered**	**Limited to 1 per year for covered females age 40 and over. The age limit will be waived if you have any family history of cancer, as documented by your practitioner.**
Routine Vision And Hearing Exams	**NO**	**90%**	**Not Covered**	**You must pay the first $20 per visit, in addition to your coinsurance. Only one co-pay is required per provider per date of service. Limited to 1 each every 2 years.**

Benefit Description	Annual Deductible	Network Plan Pays	Non-Network Plan Pays	Additional Limitations And Explanations
Obesity-Related Office Visits	**NO**	**100%**	**Not Covered**	**You must pay the first $20 per visit to a primary care provider or the first $35 per visit to a specialist. Only one co-pay is required per provider per date of service. Limited to 4 visits per year. Expenses for related diagnostic x-rays and laboratory services will be considered as specified on this schedule.**
Home Health Care	**YES**	**90%**	**90%**	**Limited to 120 visits per year. To help reduce your out-of-pocket costs, you should notify Coventry Health Care by calling Member Services prior to receiving any home health care benefits.**
Outpatient Private-Duty Nursing Care	**YES**	**90%**	**90%**	**Limited to 70 visits per year. To help reduce your out-of-pocket costs, you should notify Coventry Health Care by calling Member Services prior to receiving any private-duty nursing care.**
Chiropractic Services	**NO**	**100%**	**Not Covered**	**You must pay the first $35 per visit. Limited to 20 visits per year.**
Outpatient Therapy Services	**NO**	**100%**	**Not Covered**	**You must pay the first $35 per visit. Benefits include physical, occupational and speech therapies. Services will be reviewed for medical necessity after the 12th visit for physical therapy or after the initial consultation for speech and occupational therapy. You should contact Coventry Health Care prior to continuing a treatment plan.**
Acupuncture	**NO**	**100%**	**100%**	**You must pay the first $35 per visit. Limited to 10 visits per year, including the initial consultation.**
Biofeedback	**NO**	**100%**	**100%**	**You must pay the first $35 per visit. Limited to 10 visits per year, including the initial consultation. Expenses for related labs or x-rays will be considered as All Other Covered Medical Expenses.**
Dental Services Due To Accidental Injury	**YES**	**90%**	**90%**	**$5,000 individual maximum per accident. Treatment must begin within 90 days of the injury. Benefits include practitioner and facility expenses, replacement of teeth and any related x-rays. An accidental injury does not include teeth cracked or broken due to biting or chewing.**

Benefit Description	Annual Deductible	Network Plan Pays	Non-Network Plan Pays	Additional Limitations And Explanations
Lab Savings Program	**NO**	**100%**	**Not Covered**	**You can use this voluntary program for covered lab tests. Show your plan ID card and ask your physician to send your lab order to Quest Diagnostics. Note: This benefit applies to eligible expenses for lab tests only. Related expenses for services provided by a physician (i.e. charges for an office visit or blood draw) are subject to applicable co-payments and coinsurance. See the Health Care Management Services section of this plan for details. Expenses for lab tests not performed by Quest will be considered as specified on this schedule.**
Diagnostic Testing/ X-Ray And Laboratory Services	**YES**	**90%**	**90%**	**Benefits include non-routine services including, but not limited to, diagnostic charges for x-rays and laboratory services, pre-admission testing, genetic testing/screenings associated with amniocentesis and ultrasounds. The plan's payment for MRI, MRA, CT Scans and PET Scans will be reduced by $400 if you do not follow the procedures required by the health care management services program. This penalty does not apply to the out-of-pocket maximum.**
Routine Pregnancy-Related Ultrasounds	**YES**	**90%**	**Not Covered**	**Limited to 2 per pregnancy. Additional ultrasounds may be authorized if you follow the required review procedures outlined in the Health Care Management Services section of this plan.**
Urgent Care Services	**NO**	**100%**	**Not Covered**	**You must pay the first $50 per visit. Please see your regular physician or practitioner for routine care. Contact Coventry Health Care if you need assistance with locating network providers.**
Emergency Room Services	**NO**	**90%**	**90%**	**You must pay the first $100 per emergency room visit, in addition to your coinsurance. Your $100 co-pay applies to the facility only and will be waived if you are admitted. Benefits include:** **· physician and facility services; and** **· 1 follow-up visit from a non-network provider, not subject to reduction for usual and customary charges.** **Non-emergency use of the emergency room is not covered. Please see your regular physician or practitioner for non-emergency or routine care.**
Ambulance Services	**YES**	**90%**	**90%**	

Benefit Description	Annual Deductible	Network Plan Pays	Non-Network Plan Pays	Additional Limitations And Explanations
Inpatient Physician Services	**YES**	**90%**	**Not Covered**	**Benefits include inpatient physician services such as inpatient visits, surgeon and assistant surgeon services.**
Inpatient Hospital Services	**YES**	**90%**	**Not Covered**	**You must pay the first $150 per admission, in addition to your deductible and coinsurance. A non-network hospital may be covered when admission is due to a medical emergency as outlined in the NOTES section. Benefits include, but are not limited to, administration of injectable medications, including the cost of the medication; infusion therapy; room and board expenses; and miscellaneous hospital services. The plan's payment for hospital expenses will be reduced by $400 if you do not follow the procedures required by the health care management services program. This penalty does not apply to the out-of-pocket maximum.**
Outpatient Surgery	**YES**	**90%**	**Not Covered**	**You are encouraged to notify Coventry Health Care by calling Member Services prior to scheduling any outpatient surgery. Upon request, Coventry Health Care will provide a pre-determination of benefits which will give you a description of which services are covered by the plan. This pre-determination of benefits is not a guarantee of payment by the plan, but is a tool to help you plan for your own expenses.**
Treatment Of TMJ	**YES**	**90%**	**Not Covered**	**$2,000 individual lifetime maximum. Benefits include surgical and non-surgical treatment.**
Treatment Of Infertility: **Office Visits** **Other Expenses**	 **NO** **YES**	 **100%** **90%**	 **Not Covered** **Not Covered**	**$15,000 individual lifetime maximum. You must pay the first $35 per office visit. Benefits include: surgical and non-surgical treatments, including, but not limited to, supplies and devices necessary for treatment; tests; and surgical and non-surgical impregnation procedures. For non-covered females, surrogate expenses are covered for tests and impregnation (actual or attempted). Surrogate expenses after a successful impregnation (e.g., physician office visits, delivery charges) are not covered. Fertility medications are excluded, but may be available through your prescription drug plan.**
Skilled Nursing Facility	**YES**	**90%**	**90%**	**Limited to 60 days per year. To help reduce your out-of-pocket costs, you should notify Coventry Health Care by calling Member Services prior to your admission.**

Benefit Description	Annual Deductible	Network Plan Pays	Non-Network Plan Pays	Additional Limitations And Explanations
Hospice Facility	**YES**	**90%**	**90%**	**Limited to 30 days per lifetime. To help reduce your out-of-pocket costs, you should notify Coventry Health Care by calling Member Services prior to receiving any hospice care.**
Home Hospice	**YES**	**90%**	**90%**	**$5,000 individual lifetime maximum. To help reduce your out-of-pocket costs, you should notify Coventry Health Care by calling Member Services prior to receiving any hospice care.**
Inpatient Mental/ Nervous And Substance Abuse Treatment	**YES**	**90%**	**50%**	**You must pay the first $150 per admission, in addition to your deductible and coinsurance. Limited to 60 combined network and non-network days per year. Non-network days are limited to 30 per year. The plan's payment for hospital expenses will be reduced by $400 if you do not follow the procedures required by the health care management services program. This penalty does not apply to the out-of-pocket maximum.**
Outpatient Mental/ Nervous And Substance Abuse Treatment:				**You must pay the first $35 per visit to a network provider. Limited to 30 combined network and non-network visits per year. Non-network visits are limited to 15 visits per year and $50 individual per visit maximum benefit. You are encouraged to notify Coventry Health Care prior to receiving any services. However, you must notify Coventry Health Care prior to receiving your 4th visit to verify medical necessity. Benefits will be denied if you do not follow the prior notification requirements of the plan.**
Network	**NO**	**100%**	**---**	
Non-Network	**YES**	**---**	**50%**	
Alternate Mental/ Nervous And Substance Abuse Treatment	**YES**	**90%**	**50%**	**Subject to the inpatient mental/nervous and substance abuse treatment maximums (2 partial days = 1 inpatient day). Benefits include partial hospitalization, intensive outpatient treatment and residential treatment facilities. The plan's payment will be reduced by $400 if you do not follow the procedures required by the health care management services program. This penalty does not apply to the out-of-pocket maximum.**
Durable Medical Equipment/ Prosthetics	**YES**	**90%**	**90%**	**Examples of durable medical equipment include wheelchairs, hospital beds, walkers, oxygen equipment, insulin infusion pumps and artificial limbs. To help reduce your out-of-pocket costs, you should notify Coventry Health Care by calling Member Services prior to ordering, renting or purchasing any durable medical equipment or prosthetics. You are strongly encouraged to notify Coventry Health Care prior to renting or purchasing a TENS unit of $500 or more.**

Benefit Description	Annual Deductible	Network Plan Pays	Non-Network Plan Pays	Additional Limitations And Explanations
Wigs And Artificial Hairpieces	**YES**	**90%**	**90%**	**$300 individual lifetime maximum. Limited to replacement of hair loss due to medical treatment, e.g., radiation therapy or chemotherapy.**
All Other Covered Medical Expenses	**YES**	**90%**	**Not Covered**	**Benefits are provided for expenses listed in the Covered Medical Expenses section of this plan. See pages 21-27.**

Member Services/Health Care Management Services toll free number: 1-800-272-8931

NOTES: **The word lifetime refers to the period of time you or your eligible dependents participate in this plan or any other plan sponsored by Caremark Rx, Inc.**

<u>Required Outpatient Review</u>: Some outpatient services, whether performed in a physician's office or hospital/facility setting, require prior certification or your plan benefits may be reduced. For a list of these services, see Prior Notification Requirements in the Health Care Management Services section of this plan. The plan's payment will be reduced by $400 if you do not follow the procedures required by the health care management services program. This penalty does not apply to the out-of-pocket maximum.

<u>Usual And Customary Charges</u>: Covered non-network expenses considered at the network level of benefits are subject to reduction for usual and customary charges.

<u>No Choice Of Provider – REAP Ancillary Providers</u>: If you receive treatment from a network provider or facility, related charges for non-network emergency room physicians, anesthesiology, x-rays and laboratory services will be considered at the network level of benefits, not subject to reduction for usual and customary charges. (For all other ancillary providers, refer to the "No Choice Of Provider – Other Ancillary Providers" note on this schedule.) Any follow-up care from a non-network provider will be denied, except as specified under Emergency Room Services.

<u>No Choice Of Provider – Other Ancillary Providers</u>: If you receive treatment from a network provider or facility, expenses for services received from a non-network ancillary provider (for example, an assistant surgeon or inpatient physician) may be covered at the network level of benefits less 10% (e.g., 90% less 10% = 80%), not subject to reduction for usual and customary charges. This does not include emergency room physicians, anesthesiology, x-rays and laboratory services (see separate provision in NOTES for REAP Ancillary Providers.) To qualify, you must file an appeal within the required timeframe outlined in the "How To Appeal A Denial Of Benefits Or Clinical Non-Certification" section of this document. Any follow-up care from a non-network provider will be denied.

<u>Emergency Admission To A Network Hospital</u>: If you are admitted to a network hospital due to a medical emergency, all related facility and physician expenses will be considered at the in-network level of benefits. You or your authorized representative must contact Coventry Health Care by calling the toll-free number within 48 hours (2 calendar days) of admission. When you call, Health Care Management Services will help identify appropriate network providers, if necessary.

NOTES continued:

<u>Emergency Admission To A Non-Network Hospital</u>: If you are admitted to a non-network hospital due to a medical emergency, all related facility and physician expenses will be considered at the in-network level of benefits until the plan notifies you or your health care provider that it considers your condition to be stable. Once your condition has stabilized, Health Care Management Services will help identify an appropriate network provider and arrange for a safe and timely transfer. Reasonable transportation expenses related to such transfer will be covered by the plan. However, if you choose not to transfer to a network hospital, expenses will be denied starting the day after your condition has stabilized. You or your authorized representative must contact Coventry Health Care by calling the toll-free number within 48 hours (2 calendar days) of admission.

<u>Network Specialists Not Available</u>: If you live within the network service area and you need specialty care that is not available from a network provider within 30 miles of your home address, you may receive treatment from a non-network specialty provider and have your benefits paid at the in-network level. To qualify, you must call Coventry Health Care's toll-free number prior to receiving any care. After your approval to receive care from a non-network specialist, you must call every 6 months to continue care with that provider. If you do not call, benefits will be denied.

<u>Network Providers Not Available While Traveling On Vacation</u>: If you are traveling on vacation, and no network providers are available within 30 miles of your location, you may utilize a non-network provider and have your benefits paid at the in-network level. To qualify, you must call Coventry Health Care's toll-free number prior to receiving any care. If you do not call, benefits will be denied.

<u>Transition Of Benefits</u>: If prior to your enrollment in this plan, you were receiving on-going medical care for pregnancy in the second or third trimester; cardiac rehabilitation; physical, occupational or speech therapy; radiation therapy or chemotherapy; mental/nervous or substance abuse treatment; or post-surgical care for surgery performed prior to the date your benefits became effective, expenses for related services will be considered at the in-network level of benefits for the first 90 days from your effective date of coverage for medical care, or through delivery and post-partum care for pregnancy (limited to initial hospital confinement for newborns). To qualify for these transition benefits, you must call Coventry Health Care at the toll-free number before continuing to receive services. Please refer to the Health Care Management Services section of this plan for additional information. If you are currently in a course of treatment for a condition not listed above, but think you may be eligible for transition benefits, call Coventry Health Care at 1-800-272-8931. If you do not call, benefits will be denied.

* **A surgical procedure is any operative or diagnostic procedure performed in the treatment of an injury or illness by instrument or cutting procedure through any natural body opening or incision (e.g., the removal of skin cancer, moles or lesions).**

SCHEDULE OF MEDICAL BENEFITS
Option 3

Annual Deductibles:	Annual Out-Of-Pocket Maximums:
$ 500 Individual	(Excludes Deductible)
$1,000 Family	$2,500 Individual
	$5,000 Family

Lifetime Benefit Maximum:
(Includes All Other Maximums)
$2,000,000 Individual

You must receive services only from health care providers participating in the network or benefits will not be covered by the plan. Expenses for non-network providers will only be considered as specified in the NOTES or Additional Limitations And Explanations sections of this schedule.

The following schedule summarizes coinsurance amounts paid by the plan, benefit maximums and additional explanation needed for your benefits. The plan's payment will be reduced if you do not follow the procedures outlined in the Health Care Management Services section of this plan. Please refer to the text for additional plan provisions which may affect your benefits.

Benefit Description	Annual Deductible	Network Plan Pays	Non-Network Plan Pays	Additional Limitations And Explanations
Physician Office Visits	NO	100%	Not Covered	You must pay the first $20 per visit to a primary care provider or the first $35 per visit to a specialist. Your co-pay applies to the office visit only. Only one co-pay is required per provider per date of service. For maternity visits, you are only required to pay the co-pay at the initial visit. Benefits include all non-surgical* services performed during the visit and billed by the physician/ physician's office, including services and supplies for the administration of injectable medications, excluding the cost of the medication. Infusion therapy will be considered for the initial visit only. Subsequent infusion drugs and all injectable medications must be obtained through Caremark Specialty Services by calling (Caremark Connect) 1-800-237-2767 before receiving additional infusion and injectable drugs. The cost for administration of injectable medications, and services and supplies for the administration of infusion drugs, will be included with the office visit. For purposes of this plan, a primary care physician (PCP) may be a general or family practitioner, an internist, an obstetrician/ gynecologist or a pediatrician.
Allergy Treatment:				You must pay the first $20 per visit to a primary care provider or the first $35 per visit to a specialist, in addition to your coinsurance. Your co-pay applies to the office visit for testing and treatment only. Only one co-pay is required per provider per date of service.
Testing/Treatment	NO	80%	Not Covered	
Injections/Serum	YES	80%	Not Covered	

Benefit Description	Annual Deductible	Network Plan Pays	Non-Network Plan Pays	Additional Limitations And Explanations
Rabies Shots Administered By A Local Health Department	**NO**	**100%**	**100%**	**You must pay the first $20 per visit. You must pay for the shot at the time of service and submit a claim to the plan for reimbursement. You will be reimbursed the cost of the shot, less your co-pay. See the "Filing A Claim For Payment Of Benefits" section of this plan for additional information.**
Routine And Wellness Benefits	**NO**	**100%**	**Not Covered**	**You must pay the first $20 per visit to a primary care provider or the first $35 per visit to a specialist. Your co-pay applies to the office visit only. Only one co-pay is required per provider per date of service. Benefits include:** · **physicals for covered individuals age 2 and over, limited to 1 per year;** · **well-child checkups, limited to 8 visits from birth to 26 months of age;** · **all related x-rays and laboratory services (e.g. cholesterol screenings, TSH and resting EKGs);** · **PAP tests, including gynecological exams, limited to 1 per year;** · **PSA tests, limited to 1 per year for covered males age 50 and over;** · **digital rectal exams, limited to 1 per year for covered males age 40 and over;** · **occult blood tests, limited to 1 per year;** · **sigmoidoscopy, for individuals age 50 and over, limited to 1 every 5 years;** · **colonoscopy in lieu of sigmoidoscopy, limited to 1 colonoscopy for individuals age 50 through 59 and 1 colonoscopy every 5 years for individuals age 60 and over; and** · **flu and pneumonia shots, vaccinations, inoculations and immunizations.** **PAP tests and well-child checkups are subject to the PCP co-pay only. The age limit for PSA tests, digital rectal exams, colonoscopies and sigmoidoscopies will be waived if you have any family history of cancer, as documented by your practitioner.**
Routine Mammograms	**NO**	**100%**	**Not Covered**	**Limited to 1 per year for covered females age 40 and over. The age limit will be waived if you have any family history of cancer, as documented by your practitioner.**
Routine Vision And Hearing Exams	**NO**	**80%**	**Not Covered**	**You must pay the first $20 per visit, in addition to your coinsurance. Only one co-pay is required per provider per date of service. Limited to 1 each every 2 years.**

Benefit Description	Annual Deductible	Network Plan Pays	Non-Network Plan Pays	Additional Limitations And Explanations
Obesity-Related Office Visits	**NO**	**100%**	**Not Covered**	**You must pay the first $20 per visit to a primary care provider or the first $35 per visit to a specialist. Only one co-pay is required per provider per date of service. Limited to 4 visits per year. Expenses for related diagnostic x-rays and laboratory services will be considered as specified on this schedule.**
Home Health Care	**YES**	**80%**	**80%**	**Limited to 120 visits per year. To help reduce your out-of-pocket costs, you should notify Coventry Health Care by calling Member Services prior to receiving any home health care benefits.**
Outpatient Private-Duty Nursing Care	**YES**	**80%**	**80%**	**Limited to 70 visits per year. To help reduce your out-of-pocket costs, you should notify Coventry Health Care by calling Member Services prior to receiving any private-duty nursing care.**
Chiropractic Services	**NO**	**100%**	**Not Covered**	**You must pay the first $35 per visit. Limited to 20 visits per year.**
Outpatient Therapy Services	**NO**	**100%**	**Not Covered**	**You must pay the first $35 per visit. Benefits include physical, occupational and speech therapies. Services will be reviewed for medical necessity after the 12th visit for physical therapy or after the initial consultation for speech and occupational therapy. You should contact Coventry Health Care prior to continuing a treatment plan.**
Acupuncture	**NO**	**100%**	**100%**	**You must pay the first $35 per visit. Limited to 10 visits per year, including the initial consultation.**
Biofeedback	**NO**	**100%**	**100%**	**You must pay the first $35 per visit. Limited to 10 visits per year, including the initial consultation. Expenses for related labs or x-rays will be considered as All Other Covered Medical Expenses.**
Dental Services Due To Accidental Injury	**YES**	**80%**	**80%**	**$5,000 individual maximum per accident. Treatment must begin within 90 days of the injury. Benefits include practitioner and facility expenses, replacement of teeth and any related x-rays. An accidental injury does not include teeth cracked or broken due to biting or chewing.**

Benefit Description	Annual Deductible	Network Plan Pays	Non-Network Plan Pays	Additional Limitations And Explanations
Lab Savings Program	**NO**	**100%**	**Not Covered**	**You can use this voluntary program for covered lab tests. Show your plan ID card and ask your physician to send your lab order to Quest Diagnostics. Note: This benefit applies to eligible expenses for lab tests only. Related expenses for services provided by a physician (i.e. charges for an office visit or blood draw) are subject to applicable co-payments and coinsurance. See the Health Care Management Services section of this plan for details. Expenses for lab tests not performed by Quest will be considered as specified on this schedule.**
Diagnostic Testing/ X-Ray And Laboratory Services	**YES**	**80%**	**80%**	**Benefits include non-routine services including, but not limited to, diagnostic charges for x-rays and laboratory services, pre-admission testing, genetic testing/ screenings associated with amniocentesis and ultrasounds. The plan's payment for MRI, MRA, CT Scans and PET Scans will be reduced by $400 if you do not follow the procedures required by the health care management services program. This penalty does not apply to the out-of-pocket maximum.**
Routine Pregnancy-Related Ultrasounds	**YES**	**80%**	**Not Covered**	**Limited to 2 per pregnancy. Additional ultrasounds may be authorized if you follow the required review procedures outlined in the Health Care Management Services section of this plan.**
Urgent Care Services	**NO**	**100%**	**Not Covered**	**You must pay the first $50 per visit. Please see your regular physician or practitioner for routine care. Contact Coventry Health Care if you need assistance with locating network providers.**
Emergency Room Services	**NO**	**80%**	**80%**	**You must pay the first $150 per emergency room visit, in addition to your coinsurance. Your $150 co-pay applies to the facility only and will be waived if you are admitted. Benefits include:** **· physician and facility services; and** **· 1 follow-up visit from a non-network provider, not subject to reduction for usual and customary charges.** **Non-emergency use of the emergency room is not covered. Please see your regular physician or practitioner for non-emergency or routine care.**
Ambulance Services	**YES**	**80%**	**80%**	

Benefit Description	Annual Deductible	Network Plan Pays	Non-Network Plan Pays	Additional Limitations And Explanations
Inpatient Physician Services	**YES**	**80%**	**Not Covered**	**Benefits include inpatient physician services such as inpatient visits, surgeon and assistant surgeon services.**
Inpatient Hospital Services	**YES**	**80%**	**Not Covered**	**You must pay the first $150 per admission, in addition to your deductible and coinsurance. A non-network hospital may be covered when admission is due to a medical emergency as outlined in the NOTES section. Benefits include, but are not limited to, administration of injectable medications, including the cost of the medication; infusion therapy; room and board expenses; and miscellaneous hospital services. The plan's payment for hospital expenses will be reduced by $400 if you do not follow the procedures required by the health care management services program. This penalty does not apply to the out-of-pocket maximum.**
Outpatient Surgery	**YES**	**80%**	**Not Covered**	**You are encouraged to notify Coventry Health Care by calling Member Services prior to scheduling any outpatient surgery. Upon request, Coventry Health Care will provide a pre-determination of benefits which will give you a description of which services are covered by the plan. This pre-determination of benefits is not a guarantee of payment by the plan, but is a tool to help you plan for your own expenses.**
Treatment Of TMJ	**YES**	**80%**	**Not Covered**	**$2,000 individual lifetime maximum. Benefits include surgical and non-surgical treatment.**
Treatment Of Infertility:				**$15,000 individual lifetime maximum. You must pay the first $35 per office visit. Benefits include: surgical and non-surgical treatments, including, but not limited to, supplies and devices necessary for treatment; tests; and surgical and non-surgical impregnation procedures. For non-covered females, surrogate expenses are covered for tests and impregnation (actual or attempted). Surrogate expenses after a successful impregnation (e.g., physician office visits, delivery charges) are not covered. Fertility medications are excluded, but may be available through your prescription drug plan.**
Office Visits	**NO**	**100%**	**Not Covered**	
Other Expenses	**YES**	**80%**	**Not Covered**	
Skilled Nursing Facility	**YES**	**80%**	**80%**	**Limited to 60 days per year. To help reduce your out-of-pocket costs, you should notify Coventry Health Care by calling Member Services prior to your admission.**

Benefit Description	Annual Deductible	Network Plan Pays	Non-Network Plan Pays	Additional Limitations And Explanations
Hospice Facility	**YES**	**80%**	**80%**	**Limited to 30 days per lifetime. To help reduce your out-of-pocket costs, you should notify Coventry Health Care by calling Member Services prior to receiving any hospice care.**
Home Hospice	**YES**	**80%**	**80%**	**$5,000 individual lifetime maximum. To help reduce your out-of-pocket costs, you should notify Coventry Health Care by calling Member Services prior to receiving any hospice care.**
Inpatient Mental/ Nervous And Substance Abuse Treatment	**YES**	**80%**	**50%**	**You must pay the first $150 per admission, in addition to your deductible and coinsurance. Limited to 60 combined network and non-network days per year. Non-network days are limited to 30 per year. The plan's payment for hospital expenses will be reduced by $400 if you do not follow the procedures required by the health care management services program. This penalty does not apply to the out-of-pocket maximum.**
Outpatient Mental/ Nervous And Substance Abuse Treatment: **Network** **Non-Network**	 **NO** **YES**	 **100%** **---**	 **---** **50%**	**You must pay the first $35 per visit to a network provider. Limited to 30 combined network and non-network visits per year. Non-network visits are limited to 15 visits per year and $50 individual per visit maximum benefit. You are encouraged to notify Coventry Health Care prior to receiving any services. However, you must notify Coventry Health Care prior to receiving your 4th visit to verify medical necessity. Benefits will be denied if you do not follow the prior notification requirements of the plan.**
Alternate Mental/ Nervous And Substance Abuse Treatment	**YES**	**80%**	**50%**	**Subject to the inpatient mental/nervous and substance abuse treatment maximums (2 partial days = 1 inpatient day). Benefits include partial hospitalization, intensive outpatient treatment and residential treatment facilities. The plan's payment will be reduced by $400 if you do not follow the procedures required by the health care management services program. This penalty does not apply to the out-of-pocket maximum.**
Durable Medical Equipment/ Prosthetics	**YES**	**80%**	**80%**	**Examples of durable medical equipment include wheelchairs, hospital beds, walkers, oxygen equipment, insulin infusion pumps and artificial limbs. To help reduce your out-of-pocket costs, you should notify Coventry Health Care by calling Member Services prior to ordering, renting or purchasing any durable medical equipment or prosthetics. You are strongly encouraged to notify Coventry Health Care prior to renting or purchasing a TENS unit of $500 or more.**

Benefit Description	Annual Deductible	Network Plan Pays	Non-Network Plan Pays	Additional Limitations And Explanations
Wigs And Artificial Hairpieces	**YES**	**80%**	**80%**	**$300 individual lifetime maximum. Limited to replacement of hair loss due to medical treatment, e.g., radiation therapy or chemotherapy.**
All Other Covered Medical Expenses	**YES**	**80%**	**Not Covered**	**Benefits are provided for expenses listed in the Covered Medical Expenses section of this plan. See pages 21-27.**

Member Services/Health Care Management Services toll free number: 1-800-272-8931

NOTES: **The word lifetime refers to the period of time you or your eligible dependents participate in this plan or any other plan sponsored by Caremark Rx, Inc.**

Required Outpatient Review: Some outpatient services, whether performed in a physician's office or hospital/facility setting, require prior certification or your plan benefits may be reduced. For a list of these services, see Prior Notification Requirements in the Health Care Management Services section of this plan. The plan's payment will be reduced by $400 if you do not follow the procedures required by the health care management services program. This penalty does not apply to the out-of-pocket maximum.

Usual And Customary Charges: Covered non-network expenses considered at the network level of benefits are subject to reduction for usual and customary charges.

No Choice Of Provider – REAP Ancillary Providers: If you receive treatment from a network provider or facility, related charges for non-network emergency room physicians, anesthesiology, x-rays and laboratory services will be considered at the network level of benefits, not subject to reduction for usual and customary charges. (For all other ancillary providers, refer to the "No Choice Of Provider – Other Ancillary Providers" note on this schedule.) Any follow-up care from a non-network provider will be denied, except as specified under Emergency Room Services.

No Choice Of Provider – Other Ancillary Providers: If you receive treatment from a network provider or facility, expenses for services received from a non-network ancillary provider (for example, an assistant surgeon or inpatient physician) may be covered at the network level of benefits less 10% (e.g., 80% less 10% = 70%), not subject to reduction for usual and customary charges. This does not include emergency room physicians, anesthesiology, x-rays and laboratory services (see separate provision in NOTES for REAP Ancillary Providers.) To qualify, you must file an appeal within the required timeframe outlined in the "How To Appeal A Denial Of Benefits Or Clinical Non-Certification" section of this document. Any follow-up care from a non-network provider will be denied.

Emergency Admission To A Network Hospital: If you are admitted to a network hospital due to a medical emergency, all related facility and physician expenses will be considered at the in-network level of benefits. You or your authorized representative must contact Coventry Health Care by calling the toll-free number within 48 hours (2 calendar days) of admission. When you call, Health Care Management Services will help identify appropriate network providers, if necessary.

NOTES continued:

<u>Emergency Admission To A Non-Network Hospital</u>: If you are admitted to a non-network hospital due to a medical emergency, all related facility and physician expenses will be considered at the in-network level of benefits until the plan notifies you or your health care provider that it considers your condition to be stable. Once your condition has stabilized, Health Care Management Services will help identify an appropriate network provider and arrange for a safe and timely transfer. Reasonable transportation expenses related to such transfer will be covered by the plan. However, if you choose not to transfer to a network hospital, expenses will be denied starting the day after your condition has stabilized. You or your authorized representative must contact Coventry Health Care by calling the toll-free number within 48 hours (2 calendar days) of admission.

<u>Network Specialists Not Available</u>: If you live within the network service area and you need specialty care that is not available from a network provider within 30 miles of your home address, you may receive treatment from a non-network specialty provider and have your benefits paid at the in-network level. To qualify, you must call Coventry Health Care's toll-free number prior to receiving any care. After your approval to receive care from a non-network specialist, you must call every 6 months to continue care with that provider. If you do not call, benefits will be denied.

<u>Network Providers Not Available While Traveling On Vacation</u>: If you are traveling on vacation, and no network providers are available within 30 miles of your location, you may utilize a non-network provider and have your benefits paid at the in-network level. To qualify, you must call Coventry Health Care's toll-free number prior to receiving any care. If you do not call, benefits will be denied.

<u>Transition Of Benefits</u>: If prior to your enrollment in this plan, you were receiving on-going medical care for pregnancy in the second or third trimester; cardiac rehabilitation; physical, occupational or speech therapy; radiation therapy or chemotherapy; mental/nervous or substance abuse treatment; or post-surgical care for surgery performed prior to the date your benefits became effective, expenses for related services will be considered at the in-network level of benefits for the first 90 days from your effective date of coverage for medical care, or through delivery and post-partum care for pregnancy (limited to initial hospital confinement for newborns). To qualify for these transition benefits, you must call Coventry Health Care at the toll-free number before continuing to receive services. Please refer to the Health Care Management Services section of this plan for additional information. If you are currently in a course of treatment for a condition not listed above, but think you may be eligible for transition benefits, call Coventry Health Care at 1-800-272-8931. If you do not call, benefits will be denied.

* **A surgical procedure is any operative or diagnostic procedure performed in the treatment of an injury or illness by instrument or cutting procedure through any natural body opening or incision (e.g., the removal of skin cancer, moles or lesions).**

SCHEDULE OF MEDICAL BENEFITS
Option 4

Annual Deductibles:	Annual Out-Of-Pocket Maximums:
$1,000 Individual	(Excludes Deductible)
$2,000 Family	$4,000 Individual
	$8,000 Family

Lifetime Benefit Maximum:
(Includes All Other Maximums)
$2,000,000 Individual

You must receive services only from health care providers participating in the network or benefits will not be covered by the plan. Expenses for non-network providers will only be considered as specified in the NOTES or Additional Limitations And Explanations sections of this schedule.

The following schedule summarizes coinsurance amounts paid by the plan, benefit maximums and additional explanation needed for your benefits. The plan's payment will be reduced if you do not follow the procedures outlined in the Health Care Management Services section of this plan. Please refer to the text for additional plan provisions which may affect your benefits.

Benefit Description	Annual Deductible	Network Plan Pays	Non-Network Plan Pays	Additional Limitations And Explanations
Physician Office Visits	NO	100%	Not Covered	You must pay the first $25 per visit to a primary care provider or the first $50 per visit to a specialist. Your co-pay applies to the office visit only. Only one co-pay is required per provider per date of service. For maternity visits, you are only required to pay the co-pay at the initial visit. Benefits include all non-surgical* services performed during the visit and billed by the physician/physician's office, including services and supplies for the administration of injectable medications, excluding the cost of the medication. Infusion therapy will be considered for the initial visit only. Subsequent infusion drugs and all injectable medications must be obtained through Caremark Specialty Services by calling (Caremark Connect) 1-800-237-2767 before receiving additional infusion and injectable drugs. The cost for administration of injectable medications, and services and supplies for the administration of infusion drugs, will be included with the office visit. For purposes of this plan, a primary care physician (PCP) may be a general or family practitioner, an internist, an obstetrician/gynecologist or a pediatrician.
Allergy Treatment: Testing/Treatment Injections/Serum	 NO YES	 80% 80%	 Not Covered Not Covered	You must pay the first $25 per visit to a primary care provider or the first $50 per visit to a specialist, in addition to your coinsurance. Your co-pay applies to the office visit for testing and treatment only. Only one co-pay is required per provider per date of service.

Benefit Description	Annual Deductible	Network Plan Pays	Non-Network Plan Pays	Additional Limitations And Explanations
Rabies Shots Administered By A Local Health Department	**NO**	**100%**	**100%**	**You must pay the first $25 per visit. You must pay for the shot at the time of service and submit a claim to the plan for reimbursement. You will be reimbursed the cost of the shot, less your co-pay. See the "Filing A Claim For Payment Of Benefits" section of this plan for additional information.**
Routine And Wellness Benefits	**NO**	**100%**	**Not Covered**	**You must pay the first $25 per visit to a primary care provider or the first $50 per visit to a specialist. Your co-pay applies to the office visit only. Only one co-pay is required per provider per date of service. Benefits include:** **· physicals for covered individuals age 2 and over, limited to 1 per year;** **· well-child checkups, limited to 8 visits from birth to 26 months of age;** **· all related x-rays and laboratory services (e.g. cholesterol screenings, TSH and resting EKGs);** **· PAP tests, including gynecological exams, limited to 1 per year;** **· PSA tests, limited to 1 per year for covered males age 50 and over;** **· digital rectal exams, limited to 1 per year for covered males age 40 and over;** **· occult blood tests, limited to 1 per year;** **· sigmoidoscopy, for individuals age 50 and over, limited to 1 every 5 years;** **· colonoscopy in lieu of sigmoidoscopy, limited to 1 colonoscopy for individuals age 50 through 59 and 1 colonoscopy every 5 years for individuals age 60 and over; and** **· flu and pneumonia shots, vaccinations, inoculations and immunizations.** **PAP tests and well-child checkups are subject to the PCP co-pay only. The age limit for PSA tests, digital rectal exams, colonoscopies and sigmoidoscopies will be waived if you have any family history of cancer, as documented by your practitioner.**
Routine Mammograms	**NO**	**100%**	**Not Covered**	**Limited to 1 per year for covered females age 40 and over. The age limit will be waived if you have any family history of cancer, as documented by your practitioner.**
Routine Vision And Hearing Exams	**NO**	**80%**	**Not Covered**	**You must pay the first $25 per visit, in addition to your coinsurance. Only one co-pay is required per provider per date of service. Limited to 1 each every 2 years.**

Benefit Description	Annual Deductible	Network Plan Pays	Non-Network Plan Pays	Additional Limitations And Explanations
Obesity-Related Office Visits	**NO**	**100%**	**Not Covered**	**You must pay the first $25 per visit to a primary care provider or the first $50 per visit to a specialist. Only one co-pay is required per provider per date of service. Limited to 4 visits per year. Expenses for related diagnostic x-rays and laboratory services will be considered as specified on this schedule.**
Home Health Care	**YES**	**80%**	**80%**	**Limited to 120 visits per year. To help reduce your out-of-pocket costs, you should notify Coventry Health Care by calling Member Services prior to receiving any home health care benefits.**
Outpatient Private-Duty Nursing Care	**YES**	**80%**	**80%**	**Limited to 70 visits per year. To help reduce your out-of-pocket costs, you should notify Coventry Health Care by calling Member Services prior to receiving any private-duty nursing care.**
Chiropractic Services	**NO**	**100%**	**Not Covered**	**You must pay the first $50 per visit. Limited to 20 visits per year.**
Outpatient Therapy Services	**NO**	**100%**	**Not Covered**	**You must pay the first $50 per visit. Benefits include physical, occupational and speech therapies. Services will be reviewed for medical necessity after the 12th visit for physical therapy or after the initial consultation for speech and occupational therapy. You should contact Coventry Health Care prior to continuing a treatment plan.**
Acupuncture	**NO**	**100%**	**100%**	**You must pay the first $50 per visit. Limited to 10 visits per year, including the initial consultation.**
Biofeedback	**NO**	**100%**	**100%**	**You must pay the first $50 per visit. Limited to 10 visits per year, including the initial consultation. Expenses for related labs or x-rays will be considered as All Other Covered Medical Expenses.**
Dental Services Due To Accidental Injury	**YES**	**80%**	**80%**	**$5,000 individual maximum per accident. Treatment must begin within 90 days of the injury. Benefits include practitioner and facility expenses, replacement of teeth and any related x-rays. An accidental injury does not include teeth cracked or broken due to biting or chewing.**

Benefit Description	Annual Deductible	Network Plan Pays	Non-Network Plan Pays	Additional Limitations And Explanations
Lab Savings Program	**NO**	**100%**	**Not Covered**	**You can use this voluntary program for covered lab tests. Show your plan ID card and ask your physician to send your lab order to Quest Diagnostics. Note: This benefit applies to eligible expenses for lab tests only. Related expenses for services provided by a physician (i.e. charges for an office visit or blood draw) are subject to applicable co-payments and coinsurance. See the Health Care Management Services section of this plan for details. Expenses for lab tests not performed by Quest will be considered as specified on this schedule.**
Diagnostic Testing/ X-Ray And Laboratory Services	**YES**	**80%**	**80%**	**Benefits include non-routine services including, but not limited to, diagnostic charges for x-rays and laboratory services, pre-admission testing, genetic testing/screenings associated with amniocentesis and ultrasounds. The plan's payment for MRI, MRA, CT Scans and PET Scans will be reduced by $400 if you do not follow the procedures required by the health care management services program. This penalty does not apply to the out-of-pocket maximum.**
Routine Pregnancy-Related Ultrasounds	**YES**	**80%**	**Not Covered**	**Limited to 2 per pregnancy. Additional ultrasounds may be authorized if you follow the required review procedures outlined in the Health Care Management Services section of this plan.**
Urgent Care Services	**NO**	**100%**	**Not Covered**	**You must pay the first $100 per visit. Please see your regular physician or practitioner for routine care. Contact Coventry Health Care if you need assistance with locating network providers.**
Emergency Room Services	**NO**	**80%**	**80%**	**You must pay the first $200 per emergency room visit, in addition to your coinsurance. Your $200 co-pay applies to the facility only and will be waived if you are admitted. Benefits include:** **· physician and facility services; and** **· 1 follow-up visit from a non-network provider, not subject to reduction for usual and customary charges.** **Non-emergency use of the emergency room is not covered. Please see your regular physician or practitioner for non-emergency or routine care.**
Ambulance Services	**YES**	**80%**	**80%**	

Benefit Description	Annual Deductible	Network Plan Pays	Non-Network Plan Pays	Additional Limitations And Explanations
Inpatient Physician Services	**YES**	**80%**	**Not Covered**	**Benefits include inpatient physician services such as inpatient visits, surgeon and assistant surgeon services.**
Inpatient Hospital Services	**YES**	**80%**	**Not Covered**	**You must pay the first $500 per admission, in addition to your deductible and coinsurance. A non-network hospital may be covered when admission is due to a medical emergency as outlined in the NOTES section. Benefits include, but are not limited to, administration of injectable medications, including the cost of the medication; infusion therapy; room and board expenses; and miscellaneous hospital services. The plan's payment for hospital expenses will be reduced by $400 if you do not follow the procedures required by the health care management services program. This penalty does not apply to the out-of-pocket maximum.**
Outpatient Surgery	**YES**	**80%**	**Not Covered**	**You are encouraged to notify Coventry Health Care by calling Member Services prior to scheduling any outpatient surgery. Upon request, Coventry Health Care will provide a pre-determination of benefits which will give you a description of which services are covered by the plan. This pre-determination of benefits is not a guarantee of payment by the plan, but is a tool to help you plan for your own expenses.**
Treatment Of TMJ	**YES**	**80%**	**Not Covered**	**$2,000 individual lifetime maximum. Benefits include surgical and non-surgical treatment.**
Treatment Of Infertility: **Office Visits** **Other Expenses**	 **NO** **YES**	 **100%** **80%**	 **Not Covered** **Not Covered**	**$15,000 individual lifetime maximum. You must pay the first $50 per office visit. Benefits include: surgical and non-surgical treatments, including, but not limited to, supplies and devices necessary for treatment; tests; and surgical and non-surgical impregnation procedures. For non-covered females, surrogate expenses are covered for tests and impregnation (actual or attempted). Surrogate expenses after a successful impregnation (e.g., physician office visits, delivery charges) are not covered. Fertility medications are excluded, but may be available through your prescription drug plan.**
Skilled Nursing Facility	**YES**	**80%**	**80%**	**Limited to 60 days per year. To help reduce your out-of-pocket costs, you should notify Coventry Health Care by calling Member Services prior to your admission.**

Benefit Description	Annual Deductible	Network Plan Pays	Non-Network Plan Pays	Additional Limitations And Explanations
Hospice Facility	**YES**	**80%**	**80%**	**Limited to 30 days per lifetime. To help reduce your out-of-pocket costs, you should notify Coventry Health Care by calling Member Services prior to receiving any hospice care.**
Home Hospice	**YES**	**80%**	**80%**	**$5,000 individual lifetime maximum. To help reduce your out-of-pocket costs, you should notify Coventry Health Care by calling Member Services prior to receiving any hospice care.**
Inpatient Mental/ Nervous And Substance Abuse Treatment	**YES**	**80%**	**50%**	**You must pay the first $500 per admission, in addition to your deductible and coinsurance. Limited to 60 combined network and non-network days per year. Non-network days are limited to 30 per year. The plan's payment for hospital expenses will be reduced by $400 if you do not follow the procedures required by the health care management services program. This penalty does not apply to the out-of-pocket maximum.**
Outpatient Mental/ Nervous And Substance Abuse Treatment: **Network** **Non-Network**	 **NO** **YES**	 **100%** **---**	 **---** **50%**	**You must pay the first $50 per visit to a network provider. Limited to 30 combined network and non-network visits per year. Non-network visits are limited to 15 visits per year and $50 individual per visit maximum benefit. You are encouraged to notify Coventry Health Care prior to receiving any services. However, you must notify Coventry Health Care prior to receiving your 4th visit to verify medical necessity. Benefits will be denied if you do not follow the prior notification requirements of the plan.**
Alternate Mental/ Nervous And Substance Abuse Treatment	**YES**	**80%**	**50%**	**Subject to the inpatient mental/nervous and substance abuse treatment maximums (2 partial days = 1 inpatient day). Benefits include partial hospitalization, intensive outpatient treatment and residential treatment facilities. The plan's payment will be reduced by $400 if you do not follow the procedures required by the health care management services program. This penalty does not apply to the out-of-pocket maximum.**
Durable Medical Equipment/ Prosthetics	**YES**	**80%**	**80%**	**Examples of durable medical equipment include wheelchairs, hospital beds, walkers, oxygen equipment, insulin infusion pumps and artificial limbs. To help reduce your out-of-pocket costs, you should notify Coventry Health Care by calling Member Services prior to ordering, renting or purchasing any durable medical equipment or prosthetics. You are strongly encouraged to notify Coventry Health Care prior to renting or purchasing a TENS unit of $500 or more.**

Benefit Description	Annual Deductible	Network Plan Pays	Non-Network Plan Pays	Additional Limitations And Explanations
Wigs And Artificial Hairpieces	**YES**	**80%**	**80%**	**$300 individual lifetime maximum. Limited to replacement of hair loss due to medical treatment, e.g., radiation therapy or chemotherapy.**
All Other Covered Medical Expenses	**YES**	**80%**	**Not Covered**	**Benefits are provided for expenses listed in the Covered Medical Expenses section of this plan. See pages 21-27.**

Member Services/Health Care Management Services toll free number: 1-800-272-8931

NOTES: **The word lifetime refers to the period of time you or your eligible dependents participate in this plan or any other plan sponsored by Caremark Rx, Inc.**

Required Outpatient Review: Some outpatient services, whether performed in a physician's office or hospital/facility setting, require prior certification or your plan benefits may be reduced. For a list of these services, see Prior Notification Requirements in the Health Care Management Services section of this plan. The plan's payment will be reduced by $400 if you do not follow the procedures required by the health care management services program. This penalty does not apply to the out-of-pocket maximum.

Usual And Customary Charges: Covered non-network expenses considered at the network level of benefits are subject to reduction for usual and customary charges.

No Choice Of Provider – REAP Ancillary Providers: If you receive treatment from a network provider or facility, related charges for non-network emergency room physicians, anesthesiology, x-rays and laboratory services will be considered at the network level of benefits, not subject to reduction for usual and customary charges. (For all other ancillary providers, refer to the "No Choice Of Provider – Other Ancillary Providers" note on this schedule.) Any follow-up care from a non-network provider will be denied, except as specified under Emergency Room Services.

No Choice Of Provider – Other Ancillary Providers: If you receive treatment from a network provider or facility, expenses for services received from a non-network ancillary provider (for example, an assistant surgeon or inpatient physician) may be covered at the network level of benefits less 10% (e.g., 80% less 10% = 70%), not subject to reduction for usual and customary charges. This does not include emergency room physicians, anesthesiology, x-rays and laboratory services (see separate provision in NOTES for REAP Ancillary Providers.) To qualify, you must file an appeal within the required timeframe outlined in the "How To Appeal A Denial Of Benefits Or Clinical Non-Certification" section of this document. Any follow-up care from a non-network provider will be denied.

Emergency Admission To A Network Hospital: If you are admitted to a network hospital due to a medical emergency, all related facility and physician expenses will be considered at the in-network level of benefits. You or your authorized representative must contact Coventry Health Care by calling the toll-free number within 48 hours (2 calendar days) of admission. When you call, Health Care Management Services will help identify appropriate network providers, if necessary.

NOTES continued:

Emergency Admission To A Non-Network Hospital: If you are admitted to a non-network hospital due to a medical emergency, all related facility and physician expenses will be considered at the in-network level of benefits until the plan notifies you or your health care provider that it considers your condition to be stable. Once your condition has stabilized, Health Care Management Services will help identify an appropriate network provider and arrange for a safe and timely transfer. Reasonable transportation expenses related to such transfer will be covered by the plan. However, if you choose not to transfer to a network hospital, expenses will be denied starting the day after your condition has stabilized. You or your authorized representative must contact Coventry Health Care by calling the toll-free number within 48 hours (2 calendar days) of admission.

Network Specialists Not Available: If you live within the network service area and you need specialty care that is not available from a network provider within 30 miles of your home address, you may receive treatment from a non-network specialty provider and have your benefits paid at the in-network level. To qualify, you must call Coventry Health Care's toll-free number prior to receiving any care. After your approval to receive care from a non-network specialist, you must call every 6 months to continue care with that provider. If you do not call, benefits will be denied.

Network Providers Not Available While Traveling On Vacation: If you are traveling on vacation, and no network providers are available within 30 miles of your location, you may utilize a non-network provider and have your benefits paid at the in-network level. To qualify, you must call Coventry Health Care's toll-free number prior to receiving any care. If you do not call, benefits will be denied.

Transition Of Benefits: If prior to your enrollment in this plan, you were receiving on-going medical care for pregnancy in the second or third trimester; cardiac rehabilitation; physical, occupational or speech therapy; radiation therapy or chemotherapy; mental/nervous or substance abuse treatment; or post-surgical care for surgery performed prior to the date your benefits became effective, expenses for related services will be considered at the in-network level of benefits for the first 90 days from your effective date of coverage for medical care, or through delivery and post-partum care for pregnancy (limited to initial hospital confinement for newborns). To qualify for these transition benefits, you must call Coventry Health Care at the toll-free number before continuing to receive services. Please refer to the Health Care Management Services section of this plan for additional information. If you are currently in a course of treatment for a condition not listed above, but think you may be eligible for transition benefits, call Coventry Health Care at 1-800-272-8931. If you do not call, benefits will be denied.

* **A surgical procedure is any operative or diagnostic procedure performed in the treatment of an injury or illness by instrument or cutting procedure through any natural body opening or incision (e.g., the removal of skin cancer, moles or lesions).**

SCHEDULE OF TRANSPLANT BENEFITS

EPP Plans

Lifetime Transplant Benefit Maximum: (Applies To Medical Plan Maximum) $2,000,000 Individual

The following schedule summarizes coinsurance amounts paid by the plan, benefit maximums and additional explanations needed for your transplant benefits. Refer to the Schedule of Medical Benefits for the lifetime maximum. See the plan document text for additional information that may affect your benefits.

Benefit Description	Coventry Transplant Network	Non-Coventry Transplant Network*	Additional Explanations And Limitations
Human Organ And Tissue Transplants	**100%, No Deductible**	**Not Covered**	**Transplants performed outside the Coventry Transplant Network will not be covered, including any donor expenses or travel, lodging and meals related to the transplant.**
Human Organ And Tissue Donor Costs	**100%, No Deductible**	**Not Covered**	**Benefits include procurement, acquisition, harvesting, and storage. Benefits also include the cost of any care, including complications, arising from an organ donation by a non-covered individual when the recipient is a covered individual, if not covered by any other source. The living donor's coverage will end if the recipient leaves the plan, even if the maximum benefit has not been reached.**
Travel/Lodging And Meals Allowance	**100%, No Deductible Up To $10,000 Per Transplant**	**Not Covered**	**Travel, lodging and meals allowance is combined for the transplant recipient, living donor (if applicable) and his or her individual travel companion (both parents, if patient under age 19).**

Coventry Transplant Network toll-free number: 1-800-272-8931

*** Benefits when not using a Coventry Transplant Network facility.**

SCHEDULE OF BARIATRIC SURGERY BENEFITS
Option 1

Lifetime Bariatric Surgery Benefit Maximum: (Applies To Medical Plan Maximum) $30,000 Individual

The following schedule summarizes coinsurance amounts paid by the plan, benefit maximums and additional explanations needed for your bariatric surgery benefits. Refer to the Schedule of Medical Benefits for the annual deductible, out-of-pocket maximum and lifetime maximum. See the plan document text for additional information that may affect your benefits.

Benefit Description	Bariatric Surgery Network	Non-Bariatric Surgery Network	Additional Limitations And Explanations
Surgical Treatment Of Morbid Obesity	95%, After Annual Deductible	Not Covered	Benefits include all physician and facility charges related to the surgery, preadmission testing, any required pre-surgical evaluations such as exercise, psychological or nutritional evaluations and complications* resulting from the surgery for up to 1 year following the date of service. If your Bariatric Surgery Network provider refers you to a non-participating provider for testing or evaluations, these expenses will be considered as shown, subject to reduction for usual and customary charges. You must follow the prior notification requirements of the plan and use a surgeon in the Bariatric Surgery Network or benefits will be denied.

Coventry Health Care/Health Care Management Services: 1-800-272-8931

NOTES: The annual deductible and lifetime maximums are outlined on the Schedule of Medical Benefits.

Bariatric Surgery Network Providers: You must use a surgeon in the Bariatric Surgery Network or benefits will be denied. You must contact Coventry Health Care before selecting a surgeon for assistance with locating a bariatric provider and for information about your benefits. A list of surgeons is also available via the website at www.mycoventryhealth.com.

Eligibility Requirements: You must satisfy certain eligibility and medical requirements to qualify for this benefit. Please refer to the Health Care Management Services section of this plan for additional plan provisions which may affect your benefits.

Disclosure Statement Required: In order to receive this benefit, Caremark requires that a signed disclosure agreement must be on file. You may obtain a copy of the disclosure agreement via the website or by calling Coventry Health Care at the toll-free number. You must sign and return the disclosure agreement before benefits will be considered.

*** You are required to use Bariatric Surgery Network providers for all complications resulting from surgery. However, expenses from any provider (network or non-network), not participating in the Bariatric Surgery Network, will be covered if you have an emergency, life-threatening complication resulting from surgery. Expenses will be considered as shown on the Schedule of Medical Benefits, subject to the $30,000 lifetime maximum benefit level shown on this schedule. If you have complications resulting from the surgery after 1 year from the date of surgery, expenses will be considered as shown on the Schedule of Medical Benefits, and will not be subject to the $30,000 lifetime maximum benefit level.**

SCHEDULE OF BARIATRIC SURGERY BENEFITS
Option 2

Lifetime Bariatric Surgery Benefit Maximum:
(Applies To Medical Plan Maximum)
$30,000 Individual

The following schedule summarizes coinsurance amounts paid by the plan, benefit maximums and additional explanations needed for your bariatric surgery benefits. Refer to the Schedule of Medical Benefits for the annual deductible, out-of-pocket maximum and lifetime maximum. See the plan document text for additional information that may affect your benefits.

Benefit Description	Bariatric Surgery Network	Non-Bariatric Surgery Network	Additional Limitations And Explanations
Surgical Treatment Of Morbid Obesity	90%, After Annual Deductible And $150 Co-Pay Per Admission	Not Covered	Your $150 co-pay applies to the facility charges only. Benefits include all physician and facility charges related to the surgery, preadmission testing, any required pre-surgical evaluations such as exercise, psychological or nutritional evaluations and complications* resulting from the surgery for up to 1 year following the date of service. If your Bariatric Surgery Network provider refers you to a non-participating provider for testing or evaluations, these expenses will be considered as shown, subject to reduction for usual and customary charges. You must follow the prior notification requirements of the plan and use a surgeon in the Bariatric Surgery Network or benefits will be denied.

Coventry Health Care/Health Care Management Services: 1-800-272-8931

NOTES: The annual deductible and lifetime maximums are outlined on the Schedule of Medical Benefits.

Bariatric Surgery Network Providers: You must use a surgeon in the Bariatric Surgery Network or benefits will be denied. You must contact Coventry Health Care before selecting a surgeon for assistance with locating a bariatric provider and for information about your benefits. A list of surgeons is also available via the website at www.mycoventryhealth.com.

Eligibility Requirements: You must satisfy certain eligibility and medical requirements to qualify for this benefit. Please refer to the Health Care Management Services section of this plan for additional plan provisions which may affect your benefits.

Disclosure Statement Required: In order to receive this benefit, Caremark requires that a signed disclosure agreement must be on file. You may obtain a copy of the disclosure agreement via the website or by calling Coventry Health Care at the toll-free number. You must sign and return the disclosure agreement before benefits will be considered.

*** You are required to use Bariatric Surgery Network providers for all complications resulting from surgery. However, expenses from any provider (network or non-network), not participating in the Bariatric Surgery Network, will be covered if you have an emergency, life-threatening complication resulting from surgery. Expenses will be considered as shown on the Schedule of Medical Benefits, subject to the $30,000 lifetime maximum benefit level shown on this schedule. If you have complications resulting from the surgery after 1 year from the date of surgery, expenses will be considered as shown on the Schedule of Medical Benefits, and will not be subject to the $30,000 lifetime maximum benefit level.**

SCHEDULE OF BARIATRIC SURGERY BENEFITS
Option 3

Lifetime Bariatric Surgery Benefit Maximum: (Applies To Medical Plan Maximum) $30,000 Individual

The following schedule summarizes coinsurance amounts paid by the plan, benefit maximums and additional explanations needed for your bariatric surgery benefits. Refer to the Schedule of Medical Benefits for the annual deductible, out-of-pocket maximum and lifetime maximum. See the plan document text for additional information that may affect your benefits.

Benefit Description	Bariatric Surgery Network	Non-Bariatric Surgery Network	Additional Limitations And Explanations
Surgical Treatment Of Morbid Obesity	80%, After Annual Deductible And $150 Co-Pay Per Admission	Not Covered	Your $150 co-pay applies to the facility charges only. Benefits include all physician and facility charges related to the surgery, preadmission testing, any required pre-surgical evaluations such as exercise, psychological or nutritional evaluations and complications* resulting from the surgery for up to 1 year following the date of service. If your Bariatric Surgery Network provider refers you to a non-participating provider for testing or evaluations, these expenses will be considered as shown, subject to reduction for usual and customary charges. You must follow the prior notification requirements of the plan and use a surgeon in the Bariatric Surgery Network or benefits will be denied.

Coventry Health Care/Health Care Management Services: 1-800-272-8931

NOTES: **The annual deductible and lifetime maximums are outlined on the Schedule of Medical Benefits.**

<u>Bariatric Surgery Network Providers</u>: You must use a surgeon in the Bariatric Surgery Network or benefits will be denied. You must contact Coventry Health Care before selecting a surgeon for assistance with locating a bariatric provider and for information about your benefits. A list of surgeons is also available via the website at <u>www.mycoventryhealth.com</u>.

<u>Eligibility Requirements</u>: You must satisfy certain eligibility and medical requirements to qualify for this benefit. Please refer to the Health Care Management Services section of this plan for additional plan provisions which may affect your benefits.

<u>Disclosure Statement Required</u>: In order to receive this benefit, Caremark requires that a signed disclosure agreement must be on file. You may obtain a copy of the disclosure agreement via the website or by calling Coventry Health Care at the toll-free number. You must sign and return the disclosure agreement before benefits will be considered.

*** You are required to use Bariatric Surgery Network providers for all complications resulting from surgery. However, expenses from any provider (network or non-network), not participating in the Bariatric Surgery Network, will be covered if you have an emergency, life-threatening complication resulting from surgery. Expenses will be considered as shown on the Schedule of Medical Benefits, subject to the $30,000 lifetime maximum benefit level shown on this schedule. If you have complications resulting from the surgery after 1 year from the date of surgery, expenses will be considered as shown on the Schedule of Medical Benefits, and will not be subject to the $30,000 lifetime maximum benefit level.**

SCHEDULE OF BARIATRIC SURGERY BENEFITS
Option 4

Lifetime Bariatric Surgery Benefit Maximum: (Applies To Medical Plan Maximum) $30,000 Individual

The following schedule summarizes coinsurance amounts paid by the plan, benefit maximums and additional explanations needed for your bariatric surgery benefits. Refer to the Schedule of Medical Benefits for the annual deductible, out-of-pocket maximum and lifetime maximum. See the plan document text for additional information that may affect your benefits.

Benefit Description	Bariatric Surgery Network	Non-Bariatric Surgery Network	Additional Limitations And Explanations
Surgical Treatment Of Morbid Obesity	80%, After Annual Deductible And $500 Co-Pay Per Admission	Not Covered	Your $500 co-pay applies to the facility charges only. Benefits include all physician and facility charges related to the surgery, preadmission testing, any required pre-surgical evaluations such as exercise, psychological or nutritional evaluations and complications* resulting from the surgery for up to 1 year following the date of service. If your Bariatric Surgery Network provider refers you to a non-participating provider for testing or evaluations, these expenses will be considered as shown, subject to reduction for usual and customary charges. You must follow the prior notification requirements of the plan and use a surgeon in the Bariatric Surgery Network or benefits will be denied.

Coventry Health Care/Health Care Management Services: 1-800-272-8931

NOTES: **The annual deductible and lifetime maximums are outlined on the Schedule of Medical Benefits.**

Bariatric Surgery Network Providers: You must use a surgeon in the Bariatric Surgery Network or benefits will be denied. You must contact Coventry Health Care before selecting a surgeon for assistance with locating a bariatric provider and for information about your benefits. A list of surgeons is also available via the website at www.mycoventryhealth.com.

Eligibility Requirements: You must satisfy certain eligibility and medical requirements to qualify for this benefit. Please refer to the Health Care Management Services section of this plan for additional plan provisions which may affect your benefits.

Disclosure Statement Required: In order to receive this benefit, Caremark requires that a signed disclosure agreement must be on file. You may obtain a copy of the disclosure agreement via the website or by calling Coventry Health Care at the toll-free number. You must sign and return the disclosure agreement before benefits will be considered.

*** You are required to use Bariatric Surgery Network providers for all complications resulting from surgery. However, expenses from any provider (network or non-network), not participating in the Bariatric Surgery Network, will be covered if you have an emergency, life-threatening complication resulting from surgery. Expenses will be considered as shown on the Schedule of Medical Benefits, subject to the $30,000 lifetime maximum benefit level shown on this schedule. If you have complications resulting from the surgery after 1 year from the date of surgery, expenses will be considered as shown on the Schedule of Medical Benefits, and will not be subject to the $30,000 lifetime maximum benefit level.**