SCHEDULE OF MEDICAL BENEFITS
Out-Of-Area Option 2

Annual Deductibles:	Annual Out-Of-Pocket Maximums: (Excludes Deductible)
$300 Individual $600 Family	$1,250 Individual $2,500 Family
Lifetime Benefit Maximum: (Includes All Other Maximums) $2,000,000 Individual	

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%	100%	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 must pay the co-pay at the initial visit only. 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 Testing And 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	90%	90%	
Injections/Serum	YES	90%	90%	

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.**
Wellness Benefits	**NO**	**100%**	**100%**	**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, for individuals age 50 and over, limited to 1 every 10 years; 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%**	**100%**	**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%**	**90%**	**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%**	**100%**	**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 All Other Covered Medical Expenses.**
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%**	**100%**	**You must pay the first $35 per visit. Limited to 20 visits per year.**
Outpatient Therapy Services	**NO**	**100%**	**100%**	**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.**
Biofeedback	**NO**	**100%**	**100%**	**You must pay the first $35 per visit. Limited to 10 visits per year. Expenses for related labs or x-rays will be considered as All Other Covered Medical Expenses. Services will be reviewed for medical necessity after the initial consultation.**
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 All Other Covered Medical Expenses.**
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%**	**90%**	**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%**	**100%**	**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 visit, in addition to your coinsurance. Your $100 co-pay applies to the facility charges only and will be waived if you are admitted to the hospital. 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%**	**90%**	**Benefits include inpatient physician services such as inpatient visits, surgeon and assistant surgeon services.**
Inpatient Hospital Services	**YES**	**90%**	**90%**	**You must pay the first $150 per admission, in addition to your deductible and coinsurance. 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 coinsurance 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%**	**90%**	**You are encouraged to notify Coventry Health Care by calling Member Services prior to scheduling any outpatient surgery. 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%**	**90%**	**$2,000 individual lifetime maximum. Benefits include surgical and non-surgical treatment.**
Treatment Of Infertility: **Office Visits** **Other Expenses**	 **NO** **YES**	 **100%** **90%**	 **100%** **90%**	**$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%**	**90%**	**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. 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%** **---**	 **---** **90%**	**You must pay the first $35 per visit to a network provider. Limited to 30 combined network and non-network visits per year. 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**	**90%**	**90%**	**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 coinsurance 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 with rental or purchase price 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., chemotherapy or radiation therapy.**
All Other Covered Medical Expenses	**YES**	**90%**	**90%**	**Benefits are provided for expenses listed in the Covered Medical Expenses section of this plan.** **See pages XX-XX.**

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>Non-Network Provider Claims</u>: In some instances, your provider may not file claims for you (e.g., if you use a non-network provider) and you will be required to file a claim for those expenses. When this occurs, you will be required to pay the entire cost for expenses at the place of service and submit a claim to the plan for reimbursement. See the "Filing A Claim For Payment Of Benefits" section of this plan for additional information on this process. You will be reimbursed according to what the plan would have paid, less your applicable deductible and co-payment/coinsurance.

<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 expenses are subject to reduction for usual and customary charges, except as specified on this schedule.

<u>No Choice Of Provider</u>: <u>If you receive treatment from a network provider or facility, related charges for non-network ancillary providers will be considered at the network level of benefits, not subject to reduction for usual and customary charges.</u>

*** 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
Out-Of-Area 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

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%	100%	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 must pay the co-pay at the initial visit only. 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 Testing And 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%	80%	
Injections/Serum	YES	80%	80%	

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.**
<u>Wellness Benefits</u>	**NO**	**100%**	**100%**	**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, for individuals age 50 and over, limited to 1 every 10 years; and** • **flu and pneumonia shots, vaccinations, inoculations and immunizations.** **PAP tests and well-child checkups are subject to the PCP co-pay only. <u>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.</u>**
Routine Mammograms	**NO**	**100%**	**100%**	**Limited to 1 per year for covered females age 40 and over. <u>The age limit will be waived if you have any family history of cancer, as documented by your practitioner.</u>**
Routine Vision And Hearing Exams	**NO**	**80%**	**80%**	**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%**	**100%**	**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 All Other Covered Medical Expenses.**
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%**	**100%**	**You must pay the first $35 per visit. Limited to 20 visits per year.**
Outpatient Therapy Services	**NO**	**100%**	**100%**	**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.**
Biofeedback	**NO**	**100%**	**100%**	**You must pay the first $35 per visit. Limited to 10 visits per year. Expenses for related labs or x-rays will be considered as All Other Covered Medical Expenses. Services will be reviewed for medical necessity after the initial consultation.**
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 All Other Covered Medical Expenses.**
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%**	**80%**	**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%**	**100%**	**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 visit, in addition to your coinsurance. Your $150 co-pay applies to the facility charges only and will be waived if you are admitted to the hospital. 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.**

Benefit Description	Annual Deductible	Network Plan Pays	Non-Network Plan Pays	Additional Limitations And Explanations
Ambulance Services	**YES**	**80%**	**80%**	
Inpatient Physician Services	**YES**	**80%**	**80%**	**Benefits include inpatient physician services such as inpatient visits, surgeon and assistant surgeon services.**
Inpatient Hospital Services	**YES**	**80%**	**80%**	**You must pay the first $150 per admission, in addition to your deductible and coinsurance. 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 coinsurance 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%**	**80%**	**You are encouraged to notify Coventry Health Care by calling Member Services prior to scheduling any outpatient surgery. 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%**	**80%**	**$2,000 individual lifetime maximum. Benefits include surgical and non-surgical treatment.**
Treatment Of Infertility: **Office Visits** **Other Expenses**	 **NO** **YES**	 **100%** **80%**	 **100%** **80%**	**$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**	**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%**	**80%**	**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. 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%** **---**	 **---** **80%**	**You must pay the first $35 per visit to a network provider. Limited to 30 combined network and non-network visits per year. 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%**	**80%**	**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 coinsurance 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 with rental or purchase price 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%**	**80%**	**Benefits are provided for expenses listed in the Covered Medical Expenses section of this plan. See pages XX-XX.**

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.

Non-Network Provider Claims: In some instances, your provider may not file claims for you (e.g., if you use a non-network provider) and you will be required to file a claim for those expenses. When this occurs, you will be required to pay the entire cost for expenses at the place of service and submit a claim to the plan for reimbursement. See the "Filing A Claim For Payment Of Benefits" section of this plan for additional information on this process. You will be reimbursed according to what the plan would have paid, less your applicable deductible and co-payment/coinsurance.

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 expenses are subject to reduction for usual and customary charges, except as specified on this schedule.

No Choice Of Provider: If you receive treatment from a network provider or facility, related charges for non-network ancillary providers will be considered at the network level of benefits, not subject to reduction for usual and customary charges.

*** 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

Out-Of-Area 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
Out-Of-Area 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
Out-Of-Area 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.

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.