CoventryOne.

# Schedule of Benefits
# Individual PPO

HSA 1500 Plan
(Individual)

| | In-Network | Out-of-Network |
|---|---|---|
| Deductible Individual (per contract year)*<br>*(amount an Insured must pay before Coventry will make any payment toward certain Covered Services)*<br>*Covered Persons enrolled under Family coverage must satisfy the Family Deductible before benefits begin for any Family member.* | $1,500 | $3,000 |
| Coinsurance *(the sharing of expenses for Covered Services between Coventry and the Insured)* | Covered at 100% | 30% |
| Out-of-Pocket Maximum Individual (per contract year)*<br>*(maximum amount of Deductible and Coinsurance an Insured will pay)* | $1,500 | $6,000 |
| Lifetime Maximum Individual Benefit | $5,000,000 | |
| **Preventive Care Services** | **Insured's Responsibility – In-Network NOT subject to Deductible** | |
| Annual Adult Check-up, annual well woman exam and Physical Examinations, including immunizations<br>Limitation: $300 maximum per contract year | Covered at 100% - No deductible | 30% |
| Well-child Care Visits to age 18, including immunizations and vision and hearing screenings | $30 copay – No deductible | 30% |
| Preventive Mammography *(based on established guidelines)* | Covered at 100% - No deductible | Covered at 100% - No deductible |
| **Inpatient Hospital / Physician Services** | **Insured's Responsibility – Subject to Deductible** | |
| Inpatient Hospital Facility Services *(includes pre-admission testing, room and board, diagnostic tests, x-rays, operating & recovery room, intensive & special care units, general nursing care, anesthesia, prescribed drugs, radiation therapy & chemotherapy, surgeon services, anesthesiologist services, specialist consultation, physician visits, human organ transplants)* | Covered at 100% | 30% |
| Rehabilitative Services<br>Limitation: 30 days per contract year | Covered at 100% | 30% |
| **Outpatient Medical Services** | **Insured's Responsibility – Subject to Deductible** | |
| Primary Care Physician Office Visits | Covered at 100% | 30% |
| Specialist Office Visits and Consultations | Covered at 100% | 30% |
| Non-surgical Spine and Back Treatment<br>Limitation: 20 visits per contract year | Covered at 100% | 30% |
| Outpatient Diagnostic Services | Covered at 100% | 30% |
| Outpatient Advanced Imaging Services (MRI, CT Scans, PET Scans, etc) | Covered at 100% | 30% |
| Outpatient Surgery *(includes physician and facility services)* | Covered at 100% | 30% |
| Outpatient Physical, Speech and Occupational Therapy<br>Limitation: 20 visits per contract year, combined for all therapies | Covered at 100% | 30% |
| Outpatient Cardiac and Respiratory Therapy | Covered at 100% | 30% |
| Outpatient Radiation and Chemotherapy | Covered at 100% | 30% |
| Outpatient Dialysis Treatment | Covered at 100% | 30% |
| Second Medical and Surgical Opinion | Covered at 100% | 30% |
| Emergency and Urgent Care | | |
| • in hospital emergency room | Covered at 100% | 30% |
| • in urgent care facility | Covered at 100% | 30% |
| • in physician's office | Covered at 100% | 30% |
| • Ambulance service to hospital | Covered at 100% | 30% |
| Family Planning<br>• Intrauterine Devices (IUD) *(device, insertion, removal)* | Covered at 100% | 30% |

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# Schedule of Benefits
# Individual PPO

| Mental Health, Alcohol & Substance Abuse Services | Insured's Responsibility – Subject to Deductible | |
|---|---|---|
| Mental Health Care | Not covered | Not covered |
| Alcohol and Substance Abuse Care | Not covered | Not covered |
| **Other Covered Services** | **Insured's Responsibility – Subject to Deductible** | |
| Home Health Care<br>Limitation: 60 visits per contract year | Covered at 100% | 30% |
| Hospice Care<br>Limitation: 210 days maximum lifetime benefit | Covered at 100% | 30% |
| Skilled Nursing Facility Care<br>Limitation: 60 days per contract year | Covered at 100% | 30% |
| Insulin<br>Diabetic supplies *(includes glucose monitors, test strips, lancets, etc.)* | Covered at 100%<br>Covered at 100% | 30% |
| Durable Medical Equipment | Covered at 100% | 30% |
| External orthotics, prosthetics and breast prosthetics | Covered at 100% | 30% |
| Circumcision | Covered at 100% | 30% |
| **Services Provided by Rider or Endorsement** | **Insured's Responsibility – Subject to Deductible** | |
| Prescription drugs: 30-day supply at participating pharmacy *(includes contraceptives)***<br>Mail Order (MO): 90-day supply | Covered at 100%<br>Covered at 100% | 30%<br>Not covered |

*All QHDHP Covered Services are subject to the Deductible, except Preventive Care Services referenced above. Only Covered Services are eligible to satisfy the Deductible and contribute toward the Out-of-Pocket Maximum.

** If a brand name medication is requested when a generic is available, you must pay 100% of the difference in price between the generic and brand name medication.

This QHDHP Plan is Health Savings Account (HSA)-Qualified and satisfies the Deductible and Out-of-Pocket Maximum requirements established by the IRS. However, not all Insureds enrolled in an HSA-Qualified Health Plan are eligible to have an HSA; the IRS has specific eligibility requirements Insureds must meet. Please refer to your employer or HSA Administrator for complete details on HSA eligibility.

Certain Covered Services require Prior Authorization. If you do not obtain authorization for services which require a Prior Authorization, the benefit otherwise payable by Coventry is reduced by 20%. This additional out-of-pocket amount will not be used to satisfy Deductible, Coinsurance or Out-of-Pocket Maximum requirements. Please refer to the CoventryOne Major Medical PPO Policy for further details on Prior Authorization requirements.

All Out-of-Network services are subject to the Out-of-Network Deductible and applicable Coinsurance. In addition to the applicable Deductible and Coinsurance, Covered Persons who receive services from Non-Participating Providers shall be responsible for the difference between the Non-Participating Provider's bill and the Out-of-Network Rate.

This schedule is provided for information only; it does not contain complete details of the plan, which are available only in the CoventryOne Major Medical PPO Policy, and it does not constitute an Agreement.

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# Schedule of Benefits
# Individual PPO

HSA 3000 Plan
(Family)

| | In-Network | Out-of-Network |
|---|---|---|
| Deductible Family (per contract year)*<br>*(amount an Insured must pay before Coventry will make any payment toward certain Covered Services)*<br>*Covered Persons enrolled under Family coverage must satisfy the Family Deductible before benefits begin for any Family member.* | $3,000 | $6,000 |
| Coinsurance *(the sharing of expenses for Covered Services between Coventry and the Insured)* | Covered at 100% | 30% |
| Out-of-Pocket Maximum Family (per contract year)*<br>*(maximum amount of Deductible and Coinsurance an Insured will pay)* | $3,000 | $12,000 |
| Lifetime Maximum Individual Benefit | $5,000,000 | |
| **Preventive Care Services** | **Insured's Responsibility – In-Network NOT subject to Deductible** | |
| Annual Adult Check-up, annual well woman exam and Physical Examinations, including immunizations<br>Limitation: $300 maximum per contract year | Covered at 100% - No deductible | 30% |
| Well-child Care Visits to age 18, including immunizations and vision and hearing screenings | $30 copay – No deductible | 30% |
| Preventive Mammography *(based on established guidelines)* | Covered at 100% - No deductible | Covered at 100% - No deductible |
| **Inpatient Hospital / Physician Services** | **Insured's Responsibility – Subject to Deductible** | |
| Inpatient Hospital Facility Services *(includes pre-admission testing, room and board, diagnostic tests, x-rays, operating & recovery room, intensive & special care units, general nursing care, anesthesia, prescribed drugs, radiation therapy & chemotherapy, surgeon services, anesthesiologist services, specialist consultation, physician visits, human organ transplants)* | Covered at 100% | 30% |
| Rehabilitative Services<br>Limitation: 30 days per contract year | Covered at 100% | 30% |
| **Outpatient Medical Services** | **Insured's Responsibility – Subject to Deductible** | |
| Primary Care Physician Office Visits | Covered at 100% | 30% |
| Specialist Office Visits and Consultations | Covered at 100% | 30% |
| Non-surgical Spine and Back Treatment<br>Limitation: 20 visits per contract year | Covered at 100% | 30% |
| Outpatient Diagnostic Services | Covered at 100% | 30% |
| Outpatient Advanced Imaging Services (MRI, CT Scans, PET Scans, etc) | Covered at 100% | 30% |
| Outpatient Surgery *(includes physician and facility services)* | Covered at 100% | 30% |
| Outpatient Physical, Speech and Occupational Therapy<br>Limitation: 20 visits per contract year, combined for all therapies | Covered at 100% | 30% |
| Outpatient Cardiac and Respiratory Therapy | Covered at 100% | 30% |
| Outpatient Radiation and Chemotherapy | Covered at 100% | 30% |
| Outpatient Dialysis Treatment | Covered at 100% | 30% |
| Second Medical and Surgical Opinion | Covered at 100% | 30% |
| Emergency and Urgent Care | | |
| • in hospital emergency room | Covered at 100% | 30% |
| • in urgent care facility | Covered at 100% | 30% |
| • in physician's office | Covered at 100% | 30% |
| • Ambulance service to hospital | Covered at 100% | 30% |
| Family Planning | | |
| • Intrauterine Devices (IUD) *(device, insertion, removal)* | Covered at 100% | 30% |

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# Schedule of Benefits
# Individual PPO

| Mental Health, Alcohol & Substance Abuse Services | Insured's Responsibility – Subject to Deductible | |
|---|---|---|
| Mental Health Care | Not covered | Not covered |
| Alcohol and Substance Abuse Care | Not covered | Not covered |
| **Other Covered Services** | **Insured's Responsibility – Subject to Deductible** | |
| Home Health Care<br>Limitation: 60 visits per contract year | Covered at 100% | 30% |
| Hospice Care<br>Limitation: 210 days maximum lifetime benefit | Covered at 100% | 30% |
| Skilled Nursing Facility Care<br>Limitation: 60 days per contract year | Covered at 100% | 30% |
| Insulin<br>Diabetic supplies *(includes glucose monitors, test strips, lancets, etc.)* | Covered at 100%<br>Covered at 100% | 30% |
| Durable Medical Equipment | Covered at 100% | 30% |
| External orthotics, prosthetics and breast prosthetics | Covered at 100% | 30% |
| Circumcision | Covered at 100% | 30% |
| **Services Provided by Rider or Endorsement** | **Insured's Responsibility – Subject to Deductible** | |
| Prescription drugs: 30-day supply at participating pharmacy *(includes contraceptives)***<br>Mail Order (MO): 90-day supply | Covered at 100%<br>Covered at 100% | 30%<br>Not covered |

*All QHDHP Covered Services are subject to the Deductible, except Preventive Care Services referenced above. Only Covered Services are eligible to satisfy the Deductible and contribute toward the Out-of-Pocket Maximum.

** If a brand name medication is requested when a generic is available, you must pay 100% of the difference in price between the generic and brand name medication.

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All Out-of-Network services are subject to the Out-of-Network Deductible and applicable Coinsurance. In addition to the applicable Deductible and Coinsurance, Covered Persons who receive services from Non-Participating Providers shall be responsible for the difference between the Non-Participating Provider's bill and the Out-of-Network Rate.

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