SCHEDULE OF BENEFITS

The following Schedule of Benefits is a summary that describes the Coinsurance and or Copayment amounts that apply to specific types of Covered Services under this Health Plan. Some Services require Preauthorization by WINhealth Partners. Other Services may have limits and certain Services are excluded altogether. For a more complete description, please refer to Sections of the Evidence of Coverage that discuss General Information about Healthcare Services, Obtaining Covered Services, Covered Services and Limitations and Exclusions.

Freedom 5000 Plan

Benefits and Coverage	Limits and Maximums	Notes and Descriptions
ANNUAL PLAN YEAR DEDUCTIBLE (Deductible must be met before benefit payments are made).	Individual: $5,000 Family: $10,000	Aggregate[1]
ANNUAL OUT-OF-POCKET MAXIMUM WIN pays 100% of Covered Services after the Annual Out-of-Pocket Maximum is met. **Does not include** Charges above Reasonable and Customary, prescription drug Copays or non-covered charges including charges incurred after the benefit maximum has been reached).	Individual: $5,000 Family: $10,000	
SPECIALTY PHARMACEUTICALS ANNUAL PLAN YEAR OUT-OF-POCKET MAXIMUM	$5,000 per person	Each individual must meet the maximum after which WIN pays 100% of covered charges.
PRE-EXISTING CONDITION LIMITATION (Does not apply to newborns, and newly adopted children).	No Pre-Existing Condition Limitation if prior Creditable Coverage in preceding twelve (12) months.	Pre-Existing Limitation may apply if there are gaps in coverage during the twelve (12) months prior to enrolling with WIN.
MAXIMUM ANNUAL BENEFIT	$1,000,000	Maximum benefit applies to each covered individual.
MAXIMUM LIFETIME BENEFIT	$2,000,000	Maximum benefit applies to each covered individual.
MAXIMUM LIFETIME HOSPICE BENEFIT	Six (6) months.	Hospice benefits will be paid for Covered Services for a six (6) month period.
MAXIMUM LIFETIME SKILLED NURSING HOME BENEFIT	One-hundred (100) days	Skilled Nursing Home benefits will be paid for Covered Services for one-hundred (100) days.
Benefits and Coverage	**Member Cost Sharing**	**Notes and**

[1] The individual deductible and out-of-pocket maximum amount apply only to members enrolled in single coverage. For coverage greater than single coverage, eligible expenses for all covered family members are combined toward the family deductible and out-of-pocket maximum amount.

	(Coinsurance/Copayments)	Descriptions
PHYSICIAN SERVICES Including Primary Care office visits & Specialist office visits.	• $0 Coinsurance after Deductible	Office visits are subject to the deductible.
Outpatient/Office Surgery	• $0 Coinsurance after Deductible	Coinsurance applies to all surgical procedures.
Specialty Pharmaceuticals (Injectable forms administered in Physician's office)	• $0 Coinsurance after Deductible	Preauthorization required. Coinsurance applies to injectable medications except chemotherapy, epinephrine, insulin allergens and immunizations.
Allergy Services • Testing • Serum (allergen/extracts) • Injections • Injections such as insulin, heparin, epinephrine and antibiotics	• $0 Coinsurance after Deductible	Copays for allergy injections apply when administered in an office.
Infertility Services Including, but not limited to, testing, drugs and injections.	• **NOT COVERED**	All infertility services are Excluded from Coverage.
HOSPITAL SERVICES Inpatient including:		Requires Preauthorization.
• Room and board and other Inpatient services	• $0 Coinsurance after Deductible	
• In-Hospital Physician visits, surgeons, anesthesiologist	• $0 Coinsurance after Deductible	
• Maternity care including delivery and pregnancy related conditions	• **NOT COVERED**	All Maternity services are Excluded from Coverage.

• Detoxification	• **NOT COVERED**	Substance Abuse services are Excluded
Benefits and Coverage	**Member Cost Sharing (Coinsurance/Copayments)**	**Notes and Description**
• Behavioral Health Services	• **NOT COVERED**	All Behavioral Health services are Excluded from coverage.
MEDICAL SERVICES • Outpatient Surgery **Laboratory Tests and X-Ray** **Radiation Therapy** (non-surgical) **Specialty Pharmaceuticals** • Oral or inhalation forms/self-administered • Intravenous (IV) • Chemotherapy **Diagnostic Imaging** • Computed Axial Tomography (CAT) Scans • Positron Emission Tomography (PET) Scans • Magnetic Resonance Imaging (MRI) tests	• $0 Coinsurance after Deductible • $0 Coinsurance after Deductible • $0 Coinsurance after Deductible • $0 Coinsurance after Deductible • $0 Coinsurance after Deductible • $0 Coinsurance after Deductible • $0 Coinsurance after Deductible • $0 Coinsurance after Deductible • $0 Coinsurance after Deductible	Some surgical procedures require Preauthorization. Requires Preauthorization. Coinsurance applies to specialty medications and injectables except chemotherapy, epinephrine, insulin allergens and immunizations. All Diagnostic Imaging requires Preauthorization.
SLEEP STUDIES	• $0 Coinsurance after Deductible	Requires Preauthorization.
RECONSTRUCTIVE SURGERY	• $0 Coinsurance after	Requires Preauthorization.

	Deductible	
EMERGENCY ROOM CARE (Including trauma services)	• $0 Copay after Deductible	Stand-by trauma services are not a Covered Service.

Benefits and Coverage	Member Cost Sharing (Coinsurance/Copayments)	Notes and Descriptions
URGENT CARE	• $0 Coinsurance after Deductible	Urgent Care services subject to Deductible and applicable Coinsurance.
AMBULANCE SERVICES Emergency or high risk • Ground ambulance • Air ambulance	• $0 Coinsurance after Deductible • $0 Coinsurance after Deductible	Coverage is for emergent transport only. Benefit maximum per trip applies.
PREVENTIVE SERVICES • Adult Health Maintenance Exams • Well child care including vision and hearing screening • Lab screening tests including cholesterol, PSA, etc • Mammograms • Cytologic (Pap Smear), Human Papillomavirus (HPV) screening **Immunizations and Vaccines** • Childhood immunizations • Shingles vaccine (age requirement applies) • Influenza (for high risk population only) • Hepatitis B vaccine	• $10 Copay • $10 Copay • $0 Coinsurance after Deductible • $0 Coinsurance after Deductible • $0 Coinsurance after Deductible • $0 Coinsurance after Deductible • $0 Coinsurance after Deductible • $0 Coinsurance after Deductible • $0 Coinsurance after Deductible	Deductible does not apply to preventive services. Deductible does not apply to preventive services. See schedule of preventive services to determine coverage guidelines by age and gender.

Benefits and Coverage	Member Cost Sharing (Coinsurance/Copayments)	Notes and Descriptions
DIABETES SERVICES • Office visit and Diabetes Education	• $0 Coinsurance after Deductible	Deductible is waived for the physician office visit **only**. All other services received during the office visit are subject to Deductible and applicable Coinsurance.
• Nutritional Counseling • Diabetes supplies (purchased through a Durable Medical Equipment provider). • Diabetes supplies (Purchased through a Participating Pharmacy)	• $0 Coinsurance after Deductible • $0 Coinsurance after Deductible • $0 Coinsurance after Deductible	Nutritional counseling benefits apply for initial visit and for visit following clinical changes. Preauthorization required. Preauthorization required. Benefit maximum of $5,000 per plan year.
PRESCRIPTION DRUGS • Retail (30 day supply) • Retail/Mail Order (90 day supply)	• $0 Coinsurance after Deductible • $0 Coinsurance after Deductible	
MENTAL HEALTH SERVICES	• **NOT COVERED**	All Behavioral Health Services are Excluded from Coverage.
SUBSTANCE ABUSE/DETOXIFICATION	• **NOT COVERED**	All Substance Abuse Services are Excluded from Coverage.
CARDIAC REHABILITATION	• $0 Coinsurance after	Benefit maximum of $2,500

	Deductible	per incident. Preauthorization required.

Benefits and Coverage	Member Cost Sharing (Coinsurance/Copayments)	Notes and Descriptions
SHORT-TERM REHABILITATION • Physical Therapy • Occupational Therapy • Speech Therapy	• $0 Coinsurance after Deductible • $0 Coinsurance after Deductible • $0 Coinsurance after Deductible	Requires Preauthorization. Benefit maximum of $2,500 per incident per plan year. Speech therapy following head injury or stroke. Benefit maximum of $2,500 per incident per plan year.
TRANSPLANTS	• $0 Coinsurance after Deductible	Preauthorization required.
CHIROPRACTIC THERAPIES	• **NOT COVERED**	**NOT COVERED**
SKILLED NURSING FACILITY	• $0 Coinsurance after Deductible	Preauthorization required. One-hundred (100) day lifetime benefit maximum.
HOME HEALTHCARE SERVICES/ HOME INTRAVENOUS SERVICE • Services provided by an RN, LPN or other specified specialist. • Home intravenous services and supplies (up to sixty (60) days per plan year).	• $0 Coinsurance after Deductible • $0 Coinsurance after Deductible	Sixty (60) day benefit maximum per plan year.
HOSPICE CARE • Outpatient • Inpatient	• $0 Coinsurance after Deductible • $0 Coinsurance after Deductible	Six (6) month lifetime benefit.
DURABLE MEDICAL EQUIPMENT, PROSTHETICS, ORTHOTICS AND APPLIANCES	• $0 Coinsurance after Deductible	Preauthorization required. $5,000 benefit maximum per plan year.

Benefits and Coverage	Member Cost Sharing (Coinsurance/Copayments)	Notes and Descriptions
EYEGLASSES AND CONTACT LENSES	• **NOT COVERED**	Routine vision exams and eyewear are Excluded from Coverage.
OUTPATIENT SERVICE(S) • Dialysis/Plasmapheresis/Photophoresis	• $0 Coinsurance after Deductible.	

PLAN EXCLUSIONS AND LIMITATIONS

Refer to the Evidence of Coverage for a more complete description of Exclusions & Limitations.

EXCLUSIONS FOR FREEDOM 5000 PLAN:

- **Alcoholism and Substance Abuse services.**
- **Alternative/complementary therapies.**
- **Any service**, treatment, procedure, facility, equipment, drugs, drug usage, device or supply that are inconsistent with generally accepted principals of professional medical practice.
- **Artificial aids** including speech synthesis devices except items identified in the Evidence of Coverage.
- **Athletic trainers.**
- **Autopsies** and/or transportation costs for deceased Members.
- **Baby food** (including baby formula or breast milk) or other regular grocery products that can be puréed for oral or tube feedings.
- **Benefits and services not specified as Covered Services.**
- **Biofeedback.**
- **Breast Reduction and Breast Augmentation surgery.**
- **Care for Conditions which State or local law requires** be treated in a public or correctional facility.
- **Care for military service connected disabilities** to which the Member is legally entitled to receive treatment and for which facilities are reasonably available to the Member.
- **Care for any Condition** which an insured would have no legal obligation to pay in the absence of this or any similar Coverage or that is rendered by a provider who is a member of the insured’s immediate family.
- **Care or treatment of an Injury** incurred in connection with war or any act of war, whether declared or undeclared; any act of terrorism; sickness or treatment of a

medical Condition arising out of service in the armed forces or units auxiliary thereto; or participation in a felony with a conviction, assault, riot, or insurrection.

- **Charges above Reasonable and Customary charges**.
- **Charges that are determined to be unreasonable by WINhealth Partners.**
- **Charges for failure** to keep a scheduled visit, charges for completion of any form or charges for medical information.
- **Circumcisions** performed other than during the newborn's Hospital stay, unless Medically Necessary.
- **Clothing** or other protective devices including prescribed photo-protective clothing, windshield tinting, lighting fixtures and/or shields, and other terms or devices whether by prescription or not.
- **Co-dependency** treatment.
- **Convenience items** and personal hygiene items such as, but not limited to, air conditioners, humidifiers or physical fitness equipment.
- **Complications or side effects** arising from services, procedures, or treatments excluded by this policy.
- **Cosmetic Surgery, treatments, devices, orthotics, and medications,** including surgery and any related services intended solely to improve appearance but not restore bodily function or correct deformity resulting from disease, trauma, congenital, or developmental anomalies or for the correction of, or complications arising from, treatment or an operation to improve appearance if the original treatment or operation either was not a covered expense under this Health Plan of benefits or would not have been covered if the patient had been insured.
- **Costs for extended warranties** and premiums for other insurance coverage.
- **Counseling**.
- **Court ordered evaluation or treatment.**
- **Covered Services obtained from a Non-Participating Provider/Practitioner** except as provided in the Evidence of Coverage and as Preauthorized by WINhealth Partners.
- **Custodial or Domiciliary care** or rest cures or treatment in a facility or part of a facility that is mainly a place for rest convalescence, Custodial Care, the aged, the care or treatment of alcoholism or drug addiction, or training schooling, or occupational therapy.
- **Dental care** and dental x-rays, except as provided in the Evidence of Coverage.
- **Dental implants.**
- **Disposable medical supplies**, except when provided in a Hospital or Physician's office or by a home health professional.
- **Donor Sperm.**
- **Durable Medical Equipment/Prosthetics/Orthotics –** Additional wheelchairs, duplicate items, convenience items, upgraded or deluxe items, loss, neglect, theft, misuse, abuse, to improve appearance, or for convenience or items under the manufacturer or supplier's warranty.
- **Elastic support hose.**
- **Emergency facility** used for non-emergent services.

- **Exercise equipment** and videos, personal trainers, club memberships and weight reduction programs.
- **Experimental or investigational** drugs, medicines, treatments, or procedures devices and/or drugs shall be deemed excluded (not Covered) as Experimental, Investigational, Unproven, Unusual or Not Customary if:
    - It cannot be lawfully marketed without the approval of the Food and Drug Administration (FDA) or other governmental agency and such approval has not been granted at the time of its use or proposed use; or
    - It is the subject of a current Investigational new drug or new device application on file with the FDA; or
    - It is being provided pursuant to a Phase I or Phase II clinical trial or as the Experimental or research arm of a Phase III clinical trial; or
    - It is being provided pursuant to a written protocol that describes among its objectives, determinations of safety, toxicity, effectiveness in comparison to conventional alternatives; or
    - It is being delivered or should be delivered subject to the approval and supervision of an Institutional Review Board (IRB) as required and defined by Federal Regulations, particularly those of the FDA or the Department of Human Health Services (HHS); or
    - The predominant opinion among experts as expressed in the published authoritative literature is that usage should be substantially confined to research settings; or
    - The predominant opinion among experts as expressed in the published authoritative literature is that further research is necessary in order to define safety, toxicity, effectiveness or effectiveness compared with conventional alternatives; or
    - It is Experimental, Investigational, Unproven, Unusual or not a generally acceptable medical practice in the predominant opinion of independent experts; or
    - A majority of a representative sample of not less than Three (3) health insurance or benefit providers or administrators consider the requested treatment, procedure, device or drugs to be Experimental, Investigational, Unproven, Unusual, or Not Customary based upon criteria and standards regularly applied by the industry; or it is not Experimental or Investigational in itself pursuant to the above, and would not be Medically Necessary, but for being provided in conjunction with the provision of a treatment, procedure, device or drug which is Experimental, Investigational, Unproven, Unusual or Not Customary.
    - A nationally recognized resource including, but not limited to; Hayes Inc., DATTA or other recognized source has deemed that Healthcare Services to be Experimental, or Investigational. All such determinations shall be final, conclusive and binding.
- **Extracorporeal shock wave therapy.**
- **Eye movement therapy.**

- **Eye refractive procedures,** including radial keratotomy, laser procedures and other techniques. **Eyeglasses (Corrective)** or sunglasses, frames, lens prescription, contact lenses or the fitting thereof.
- **Foot care (routine)**, except as provided in the Evidence of Coverage.
- **Foot orthotics** functional and/or customized except as described in the Evidence of Coverage.
- **"Get acquainted"** visits without physical assessment or diagnostic or therapeutic intervention provided.
- **Gloves,** unless part of a wound treatment kit.
- **Hair-loss** (or baldness) treatments, medications, supplies and devices including wigs, and special brushes.
- **Halfway houses**.
- **Healthcare Services that are not a Covered Service** regardless of the recommendation or order by a Participating or Non-Participating Provider.
- **Health fair services.**
- **Hearing aids** and the evaluation for the fitting of hearing aids or cochlear implants.
- **Hospice benefits are not available for the following services**: food, housing, and delivered meals, volunteer services, comfort items such as, but not limited to, aromatherapy, clothing, pillows, special chairs, pet therapy, fans, humidifiers, and special beds (excluding those covered under Durable Medical Equipment) homemaker and housekeeping services, private duty nursing, pastoral and spiritual counseling or bereavement counseling.
- **Hospital, physician, mid-wife** and other charges related to prenatal care and delivery of a newborn child.
- **Hypnotherapy**.
- **Infant formula**.
- **Infertility treatment/Artificial Conception and drugs.**
- **Intra Discal Electro Therapy (IDET) procedures.**
- **In-vitro, GIFT and ZIFT fertilization**.
- **Lithotripsy of plantar fascia for plantar fasciitis.**
- **Malocclusion treatment**, if part of routine dental care and orthodontics.
- **Maternity/Obstetrical Care** including, but not limited to, any condition which is pregnancy related, prenatal care, delivery and postnatal care, including conception in dependent Children.
- **Massage Therapy.**
- **Medical and Hospital services of a donor** when the recipient of an organ transplant is not a Member or when the transplant procedure is not a Covered Service.
- **Mental Health Services.**
- **New medications** for which the determination of criteria for Coverage has not yet been established by WINhealth Partners' Pharmacy and Therapeutics Committee.
- **Nutritional supplements**.
- **Organ transplants (Non-human),** except for porcine (pig) heart valve.

- **Orthodontic appliances, endodontics, dental prosthetics, crowns, bridges and dentures**.
- **Orthodontic appliances** and orthodontic treatment (braces), crowns, bridges and denture used for the treatment of Craniomandibular (CMJ) and Temporomandibular Joint (TMJ) disorders.
- **Orthomolecular therapy** including nutrients, vitamins and food supplements.
- **Orthopedic or corrective shoes**, arch supports, shoe appliances, foot orthotics and custom fitted braces or splints except for patients with diabetes or other significant peripheral neuropathies.
- **Over-the-counter medications**.
- **Personal or comfort items, services or treatments**.
- **Photopheresis** for all conditions other than mycosis fungoides.
- **Physical examinations**, vaccinations, drugs and immunizations for the primary intent of medical research or for purpose(s) such as, but not limited to, licensing, certification, employment, insurance, flight, travel, passports or functional capacity examinations related schooling, sports or employment.
- **Prescriptions** purchased at a Non-Participating Pharmacy**.**
- **Prescription Drug** replacements due to loss, theft or destruction.
- **Prescription Drugs** received upon Hospital discharge or provided by a Hospital pharmacy.
- **Prescription Drugs** hormone replacement therapy (including estrogen, testosterone or progesterone) or compounded medications.
- **Prescription Drugs requiring Preauthorization when Preauthorization was not obtained**.
- **Private duty nursing.**
- **Psychological testing.**
- **Reduction mammoplasty.**
- **Residential Treatment Centers.**
- **Reversals of voluntary sterilization**.
- **Services for which the Member is eligible under any governmental program** (except Medicaid) or services for which, in the absence of any health service plan or insurance plan, no charge would be made to the Member.
- **Services incurred** after the Termination Date of the Member's Coverage.
- **Smoking cessation.**
- **Covered Services requiring Preauthorization** when Preauthorization was not obtained.
- **Sex transformation surgery and drugs related to sex transformation**.
- **Sexual dysfunction treatment**, including medication, counseling and clinics.
- **Special education**, school testing or evaluations, counseling, therapy or care for learning deficiencies or behavioral or disciplinary problems. This applies whether or not associated with manifest mental illness or other disturbances.
- **Special Medical Foods.**

- **Storage or banking** of sperm, ova (human eggs), embryos, zygotes or other human tissue.
- **Surgical or chemical treatment of skin tags, or common warts, except genital or plantar warts.**
- "**Telephone visits"** by Physician or "environmental intervention" or "consultation" by telephone for which a charge is made to the patient.
- **Travel and lodging** expenses, except as provided in the Evidence of Coverage.
- **Treatment for autistic disease, hyperkinetic syndromes, learning disabilities, behavioral problems or mental retardation.**
- **Treatment for ADD/ADHD,** including initial medical diagnosis, or for inpatient Confinement for environmental changes.
- **Treatment for Injuries or Illness caused by a Member's intoxication over the legal limit, non-prescribed use of controlled substances, intention to Injure his or her self or another, or culpable negligence while sane or insane.**
- **Vision Care (routine) and Eye Refractions** for determining prescriptions for corrective lenses.
- **Visual training**.
- **Vocational Rehabilitation services and Long-Term Rehabilitation services**.
- **Weight reduction or control treatments and medications** including gastric bypass surgery or gastric banding.
- **Work-related accidents** or Injuries or occupational Illness or disease if the Member is required to be covered under Workers' Compensation insurance, whether or not such coverage actually exists.

Individual Plan Amendments

This amendment is a part of the Member Certificate and Master Group Contract. It changes certain items in the Member Certificate and Master Group Contract; the rest of the Member Certificate and Master Group Contract remains the same. This amendment is subject to all of the provisions that control the policy, unless specifically stated otherwise. The effective date of this amendment shall be July 1, 2009.

Regardless of anything in the Member Certificate and Master Group contract stated to the contrary, the following is hereby changed.

SECTION 3

DEFINITIONS

27. **FAMILY PLANNING**-A program to regulate the number and spacing of children in a family through the practice of contraception or other methods of birth control. WINhealth Partners provides coverage of physician charges for contraception management, medication for birth control, and procedures, such as an IUD insertion or vasectomy. Applicable Deductibles and Copays apply for all services received.

SECTION 6

COVERED SERVICES

19. PRENATAL CARE

Covered

- Prenatal Care billed at time of delivery.
- Covered with no copay and with a $1000.00 maximum benefit per delivery.

Limits

- Prenatal Care must be authorized for coverage.
- Member must be eligible for coverage at time of delivery.

21. PREVENTIVE SERVICES

Covered

Six Years But Less Than Twelve Years

- well-child exams (1 exam every 2 years)
- 1 routine eye exam every 2 years, max benefit per exam of $60.00
- 1 tuberculosis skin test
- 1 dipstick urine per well-child exam
- 1 hematocrit/hemoglobin per well-child exam
- 1 immunization for measles, mumps, rubella, if not done previously between ages 4-6

Twelve Years and Older

- Annual Screening for the following sexually transmitted diseases:
    - HIV
    - HPV
    - Gonorrhea
    - Syphilis

Twelve Years But Less than Eighteen Years

- health maintenance visits (1 exam every 2 years)
- 1 routine eye exam every 2 years, max benefit per exam of $60.00
- diphtheria/tetanus booster, if 10 years from previous booster
- tuberculosis skin test
- dipstick urine
- hepatitis B vaccine series
- Pelvic and Pap test for sexually active females annually