COVENTRY HEALTH AND LIFE INSURANCE COMPANY

COVENTRY*ONE*. PPO

ADMINISTERED BY ALTIUS HEALTH PLANS INC.

INDIVIDUAL MAJOR MEDICAL

OUTLINE OF COVERAGE

(Policy Form #CHL-ID-PPO-COI-0312)

READ AND KNOW YOUR POLICY
This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance policy and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and Coventry Health and Life Insurance Company (CHL). It is, therefore, important that you **READ YOUR POLICY CAREFULLY!**

MAJOR MEDICAL EXPENSE COVERAGE
Major medical expense coverage is designed to provide, to persons insured, comprehensive coverage for major hospital, medical, and surgical expenses incurred as a result of a covered accident or sickness. Coverage is provided for daily hospital room and board, miscellaneous hospital services, surgical services, anesthesia services, in-hospital medical services and out-of-hospital care, subject to any deductibles, copayments, coinsurance provisions or other limitations and exclusions that may be set forth in the Policy.

CHL utilizes the Altius Health Plans Idaho Preferred Network as participating providers (as defined in the Policy). When you need medical services, visit our website at www.coventryone.com or call our customer service department toll free at 855-385-5180
to verify that your provider is participating. You may receive a higher level of benefits by using participating providers.

SUMMARY OF COVERED SERVICES
For specific benefit coverage levels, see your Schedule of Benefits, which is included as part of your Policy. Benefits listed below are subject to all applicable limitations, exclusions, and requirements of the Policy.

Inpatient Services:
- Facility Services: daily hospital room and board, miscellaneous hospital services, and medically necessary supplies
- Professional Services: inpatient physician visits, surgeons, anesthesiologists, radiologists and pathologists

Maternity Services:
Coverage is provided for the policy holder or the policy holder's spouse only. This benefit is subject to a separate deductible per pregnancy as outlined in your Schedule of Benefits. After the deductible is met, remaining eligible charges are covered at 100%, when care is received through participating providers. Out-of-network benefits apply to remaining eligible charges when services are received through non-participating providers. Benefit includes:

- Facility services: hospital, birthing center, observation
- Professional Services: prenatal care, delivery, anesthesia, postnatal care, and related lab and radiology services.

The benefit for prenatal care is determined by the coverage in effect at the time of delivery. If prenatal care is billed by a provider who does not perform the delivery, the benefit for such care is determined by the coverage in effect at the time of the last prenatal visit with that provider.

Complications of pregnancy are covered under regular medical benefits for all Insureds enrolled under this Policy.

Outpatient Services:
- Office Visits: preventive services including annual adult physical examinations, well child care, and limited vaccinations and immunizations; specialist visits and consultations; diagnostic services such as lab and x-ray; therapeutic services including limited therapeutic injections; eye exams

- Outpatient Facility and Ancillary Services: surgical facility services; observation; other diagnostic and therapeutic services such as lab, radiology, chemotherapy, radiation therapy, dialysis, cardiovascular services, infusion therapy, endoscopy, and pulmonary services
- Outpatient Professional Services: surgery and anesthesia; services provided in an outpatient facility as outlined above
- Emergency Room Services
- Urgent Care
- Ambulance and Emergency Transportation

Maximum Dollar Amount for Covered Charges under this Policy:
- No general maximum dollar amount applies. See the Schedule of Benefits in this policy for dollar limits that may apply to certain benefits. See the Schedule of Benefits in this policy for the annual maximum that may apply.

Other Benefits:
- Medical Supplies, including oxygen
- Medically necessary nutritional formulas
- Injectable or Implantable Medications: coinsurance amounts differ for preferred and non-preferred injectable or implantable medications.
- Prescription Drugs: includes birth control pills, insulin, and specific diabetic testing supplies and insulin syringes. Copays differ for Tier 1, Tier 2, and Tier 3 drugs. If you receive a Tier 2 or Tier 3 brand name drug when a Tier 1 generic equivalent can be substituted, you will pay the difference in cost between the generic and the brand name drug, any applicable deductible, and/or the Tier 1 copay. Regular benefits apply if a Tier 1 cannot be substituted. Unless noted otherwise, the following types of drugs, medications, pharmaceutical products, and pharmacy costs are not covered, or the benefits we provide will be limited in the manner specified: Experimental medications; medications for non-approved FDA indications; over-the-counter medications and products, except those specifically listed in the CHL formulary and those for which coverage is required by law; prescription medications that have an over-the-counter equivalent or alternative, unless otherwise specified in the CHL formulary; medications for athletic and mental performance; compounding fees; non-covered ingredients used in a compounded medication; medications for cosmetic indications; hair growth products and medications; homeopathic medications; hypodermic needles; medications for the treatment of sexual dysfunction and/or impotence; medications for the treatment of infertility; skin patches for motion sickness; medications for the treatment of nail fungus; progesterone cream and suppositories; smoking cessation products including any medications prescribed for smoking cessation; medications required exclusively for foreign travel; oral vitamins (except prescription prenatal vitamins); medications for shift work sleep disorder; medications or nutritional supplements for weight loss, or for weight gain for non-medical conditions.

The following benefits are limited by dollar amount or number of days or visits as outlined in your Schedule of Benefits:
- Dental Care Benefits for accidental injury to sound natural teeth
- Infertility Diagnostic Procedures
- Inpatient/Outpatient Rehabilitation, Physiotherapy Services
- Skilled Nursing Facility Services
- Home Health Care
- TMJ Services

All services must be received while the Policy is in force.

DEDUCTIBLE AND OUT OF POCKET MAXIMUM
After your coinsurance totals the out-of-pocket maximum amounts stated in the Schedule of Benefits in any calendar year, you do not have to pay any more for certain covered services for the remainder of that calendar year. Deductible and out-of-pocket limits are cumulative. This means that when you pay toward a deductible or out-of-pocket limit on one level, it applies to the other level at the same time. The maximum limits for services received through non-participating providers represent the total maximum deductible and out-of-pocket expenses you will pay for applicable covered services in any calendar year.

Your plan deductible DOES NOT apply to the Out-of-Pocket Maximum. In addition, the following expenses DO NOT apply to the Out-of-Pocket Maximum, and you must continue to pay these expenses even after you meet your Out-of-Pocket Maximum:

- Deductibles
- Fixed copay amounts

- Coinsurance for the following benefits:
  - Durable medical equipment , corrective appliances, and prosthetic devices
  - Medical supplies
  - TMJ services
  - Accident-related dental services
  - Infertility services
- Prescription drugs
- Charges that exceed eligible medical expenses
- Non-covered services

BENEFIT ACCUMULATION
Unless noted otherwise on your Schedule of Benefits, benefits are calculated on a calendar year basis regardless of when you are enrolled. Out-of-pocket maximums and limited benefits start over on January 1, except for benefits limited per condition rather than per year.

If you are a current Insured and you re-apply for coverage on a different policy, your deductible will start over regardless of the date your new plan coverage begins. If you change deductible options on the same policy, your deductible will not start over.

PRIOR AUTHORIZATION OF SERVICES
Prior authorization is required for certain services in order to verify that the service to be provided is medically necessary and appropriate for the treatment of your medical condition, and to initiate the involvement of the CHL Utilization staff (or designee) in the management of your care. In addition, the process is helpful for both providers and Insureds because the CHL Utilization staff can verify your status as a CHL Insured and also verify that the service to be provided is a covered benefit.

For a list of services that require prior authorization, please call our Customer Service department at 855-385-5180, or visit our website at www.coventryone.com. A complete list is also included in your policy.

PRE-EXISTING CONDITIONS
A condition that would have caused an ordinarily prudent person to seek medical advice, diagnosis, care or treatment during the six (6) months immediately preceding the effective date of coverage; a condition for which medical advice, diagnosis, care or treatment was recommended or received within six (6) months immediately preceding your effective date of coverage.

If you are 19 years of age or older, coverage is excluded for the care and treatment of pre-existing conditions until 12 months after you apply. Acceptance under this policy does not imply any waiver of pre-existing condition exclusion periods. See the policy for details.

Note: If medical records or claims for you and/or your dependents document the presence of a pre-existing condition that was not fully disclosed on the health questionnaire, your coverage may be revised or terminated.

Pre-Existing Condition Exclusion Period
If you or your dependents 19 years of age or older are considered newly covered, the first 12 months after we receive your completed application is referred to as a pre-existing condition exclusion period. This means that if you have a medical condition before your policy becomes effective, coverage for that condition will be excluded until 12 months after you apply. This exclusion applies only to conditions for which medical advice, diagnosis, care or treatment was recommended or received within the six-month period ending the day before we receive your completed application. The pre-existing condition exclusion does not apply to Insureds under age 19; or to a child who is enrolled in the policy within sixty (60) days of his/her birth, adoption, or placement for adoption.

If you had health insurance before you applied for coverage with CHL, you can reduce the length of this exclusion period by the number of days of your prior "creditable coverage." Most prior health coverage is creditable coverage and can be used to reduce the pre-existing condition exclusion period, unless your previous coverage was terminated more than 63 days prior to the date we received your completed application. To reduce your pre-existing condition exclusion period, you should give us a copy of any certificates of creditable coverage you have. If, after making reasonable efforts, you are unable to obtain a certificate from your previous insurance carrier or plan, we will help you. There are also other ways that you can show you have creditable coverage. Please contact us if you need help demonstrating creditable coverage.

All questions about the pre-existing condition exclusion and creditable coverage should be directed to:

Coventry Health and Life Insurance Company
10421 South Jordan Gateway #400
South Jordan, UT 84095
855-385-5180

OTHER LIMITATIONS

- Physiotherapy services (occupational, physical and speech) are limited to medically necessary services for conditions resulting from illness or injury where therapy can be provided in a short-term rehabilitation program that is likely to significantly improve the Insured's condition, as determined by CHL.
- CHL reserves the right to include only one manufacturer's product on the CHL formulary when the same or similar drug (that is, a drug with the same active ingredient), supply, or equipment is made by two or more different manufacturers. The product or products not listed on the CHL formulary will be excluded from coverage.
- CHL reserves the right to include only one dosage or form of a drug on the CHL formulary when the same drug is available in different dosages or forms (for example, dissolvable tablets, capsules, etc.), from the same or different manufacturers. The product or products in other forms or dosages that are not listed on the CHL formulary will be excluded from coverage.
- Implantable contraceptive capsules such as Norplant and Implanon are limited to one implantation and removal during the maximum implantation period of the product, as determined by the product manufacturer.
- Neuropsychological evaluation and treatment is limited to those services that diagnose or treat an underlying medical condition and is covered only when there is clinically significant brain dysfunction.
- Accident-related dental services are covered only when required as a result of an accidental injury to sound, natural teeth. Dental services must be received within two years following the accidental injury.
- A determination that a service is infertility-related may be based on medical records or other documented evidence, and is not dependent on whether CHL actually receives a claim with a diagnosis of infertility.
- Certain medications, including those that are administered by a medical professional, are covered only when they are purchased through pharmacy vendors. To obtain a current list of these medications, visit the CHL website at www.coventryone.com or call Customer Service.

GENERAL LIMITATIONS AND EXCLUSIONS

Accepted Medical Practice
Services determined to be experimental or investigational or illegal are excluded. Procedures, devices, drugs, or "biologics" for which there is insufficient evidence to determine their likely effect on patients' health outcomes, are also excluded.

Claims After One Year
Claims are denied if submitted to CHL more than one year after services were rendered unless you can show that notice was given or proof of loss was filed as soon as reasonably possible. Adjustments or corrections to claims are denied if submitted to CHL more than one year after claims were first processed unless you can show that the additional information relating to the claim was filed as soon as reasonably possible. When this policy is secondary coverage, coordination of benefits claims will be denied if submitted to CHL more than one year after the date the claim was first processed by the primary carrier, unless you show that notice was given or proof of loss was filed as soon as reasonably possible.

Excess Charges
Amounts exceeding eligible medical expenses are excluded. You are not responsible for excess charges for covered services from participating providers. However, you are responsible for excess charges for covered services from non-participating providers.

Limited Benefits
Normally covered services that exceed benefit limits specified on the Schedule of Benefits (e.g., dollars, days, visits, etc.) are excluded and not applied to out-of-pocket maximums. This includes, but is not limited to, services exceeding benefit limits for skilled nursing facilities, rehabilitation therapy, home health care, etc.

Medically Unnecessary Services and Supplies
Medically unnecessary services and supplies are excluded.

Non-Covered Services & Complications
Expenses related to non-covered services, including pre- and post-operative evaluation, diagnostic testing, and complications resulting from non-covered services, supplies, and/or medications are excluded. When a non-covered procedure is performed as part of the same operation or process as a covered service, only eligible medical expenses relating to the covered service will be eligible for benefits. Eligible medical expenses may be calculated to exclude any charges related to the non-covered service.

Out-of-Network Benefits
This policy includes coverage for services received through both Participating and Non-Participating providers. Refer to the Schedule of Benefits for details.

No Presumption of Coverage
There is no presumption of coverage. Services not specified as covered are excluded.

Services Outside of the United States
Services provided outside of the United States of America and its territories are excluded, except as required for an emergency or urgent condition.

EXCLUDED SERVICES
Unless noted otherwise in your Schedule of Benefits, the following services are excluded:

- New procedures, services, supplies, and medications until they are reviewed for safety, efficacy, and cost effectiveness and approved by CHL.
- Experimental or investigational treatment, procedures, tests, equipment, or facilities, or any health care service which is still undergoing evaluation and review.
- Services, drugs, and supplies that are not medically necessary.
- Medication amounts in excess of maximum quantity and/or dosage levels indicated by the drug manufacturer and the FDA.
- Replacement of lost, stolen, or damaged prescription drugs.
- Food supplements, food substitutes, medical foods, and formulas when taken orally, except when related to inborn errors of amino acid or urea cycle metabolism.
- Infertility-related treatment.
- In-vitro fertilization, GIFT, ZIFT, artificial insemination, and similar services. This includes any related services such as prescription medications, embryo transport, collection, and preparation costs.
- Reversal of elective sterilization.
- Amniocentesis and ultrasonography for sex determination.
- Predictive genetic testing.
- Elective abortions are not Covered for any reason other than to preserve the life of the female upon whom the abortion is performed.
- Gastric bypasses, “mini” gastric bypasses, stomach stapling, gastric balloons, jejunal bypasses, gastric banding, gastroplasty, partial or total gastroectomy, Gastric Restrictive procedure, Biliopancreatic Diversion Duodenal Switch (BPD-DS), and directly associated professional medical and/or inpatient or outpatient facility services. Reversal of and/or complications from these surgeries are also excluded.
- Sex change operations or related health care services.
- Treatment, services, devices, and supplies related to sexual dysfunction. This exclusion does not apply to implantation of a penile prosthesis or use of an external device for impotence caused by an organic disease such as diabetes mellitus or hypertension, or caused by surgery for genitourinary cancer.
- Cosmetic surgery, except when necessary to treat an accidental injury, infection, or disease of the involved part; or to correct congenital anomalies in a covered dependent child.
- Health education services not closely related to the care and treatment of an illness or injury, except as specifically recommended by the USPSTF and provided within USPSTF guidelines.
- Services provided by an athletic trainer or a personal trainer.
- Telephone consultations, electronic mail communication, and communication services that do not require direct face-to-face contact between the patient and the provider.
- Charges for failure to keep a scheduled appointment.
- Interest or finance charges, except as specifically required by law.
- Services for cross matching and/or harvesting organs when the organ recipient is not a CHL Insured.

- Transplants other than those herein provided.
- Routine foot care. This exclusion does not apply to Insureds with severe diabetes.
- Treatment of weak, strained or imbalanced feet.
- Foot orthotics, wedges or shoe inserts. This exclusion does not apply to foot orthotics or shoe inserts for Insureds with severe diabetes.
- Corrective appliances, prostheses, artificial aids and durable medical equipment, including supplies and accessories, are excluded when determined to be primarily for convenience, comfort, non-therapeutic purposes, or in the absence of illness or injury.
- Routine periodic servicing, such as cleaning and regulating, of durable medical equipment, corrective appliances, and prostheses is not covered. Replacement is not covered unless the existing device has become inoperable through normal wear and tear and cannot be repaired, or replacement is prescribed by a physician because of a change in the Insured's physical condition.
- All shipping, handling, or postage charges, except as incidentally provided without a separate charge.
- Any devices used to aid hearing, including, but not limited to, hearing aids and cochlear implants, including the fitting of such devices and related hearing examinations.
- Visual training and vision therapy.
- Eyeglasses, contact lenses, and examinations for contact lenses. This exclusion does not apply to: (1) the first pair of contact lenses or eyeglasses following the initial diagnosis of aphakia or the surgical removal or surgical replacement of an organic lens; or (2) hydrophilic contact lenses used as a corneal bandage to treat conditions involving the cornea. In the event that eyeglasses are covered, the following are excluded: additional charges for deluxe frames or lens enhancements, including but not limited to blended lenses, oversize lenses, progressive lenses, tinted lenses, lens coatings, or other lens options not related to the correction of refractive errors.
- Eye surgeries performed primarily to correct refractive errors. Examples include, but are not limited to: PRK (photorefractive keratectomy), LASIK (laser-assisted in-situ keratomileusis), RL (refractive lensectomy), ICRS (intracorneal ring segments), Intacs, phakic intraocular lenses (unless related to post-cataract surgery), and astigmatism correction (Limbal Relaxing Procedure). This exclusion does not apply to cornea transplants.
- Non-emergency follow-up care provided in an emergency room.
- Charges for transportation, including ambulance, unless determined medically necessary.
- Travel expenses, including hotel, motel and other non-medical room and board.
- Private hospital rooms, unless medically necessary.
- Hospital take-home drugs and personal, comfort, or convenience items.
- Private duty nursing.
- Custodial care, domiciliary care, rest cures, and independent living training.
- Home health services requested for the convenience of the patient or family that do not require the training and technical skills of a nurse.
- Hospice services that are not reasonable and necessary for palliation or management of a terminal illness.
- Vocational testing and treatment.
- Physiotherapy services (occupational, physical and speech) for work hardening or for recreational purposes, including, but not limited to sports or vocal performance.
- Services for the treatment of isolated sensory processing dysfunction or sensory integration disorder. This exclusion does not apply to the initial assessment for diagnosis of the condition or to the medical management of an underlying medical illness which may be contributing to the condition.
- Chiropractic manipulative treatment, and any service provided by a chiropractor
- Mental health services and substance abuse services.
- Psychotherapy, counseling or other services in connection with marital or family problems; social, occupational, religious, or other social maladjustments; conduct disorders; chronic adjustment disorders; psychosexual disorders; chronic organic brain syndromes; personality disorders; developmental disorders; learning disabilities; or mental retardation. This exclusion does not apply to services provided by a medical (non-psychiatric) provider for management of an underlying medical illness which may be contributing to the disability.
- Substance abuse maintenance therapy, such as methadone clinics and similar clinics and services.
- Recreational therapy, wilderness therapy, or residential treatment programs.
- Evaluation, testing, and treatment provided by public or private schools.
- Charges in connection with a work-related injury or sickness for which coverage is provided under any workers' compensation, employer's liability, or occupational disease law.
- Services, supplies, or treatment for which coverage is provided under any motor vehicle no-fault plan. When the Insured is required by law to have no-fault insurance, this exclusion applies to charges up to the minimum coverage required by law whether or not such coverage is in effect.

- Expenses for which the Insured has no legal responsibility to pay or for which the Insured would not ordinarily be charged in the absence of coverage under this policy.
- Care for military service connected disability to which the Insured is legally entitled, and for which facilities are reasonably available to the Insured.
- Care or treatment of an illness or injury caused by war or any act of war (whether declared or undeclared); participation in a felony, riot or insurrection; service in the armed forces or units auxiliary to it.
- Care for conditions which state or local law requires to be treated in a public facility.
- Services and treatments provided in connection with, or to comply with, involuntary admissions, police detentions, and similar arrangements.
- Examinations and services obtained for administrative purposes, such as treatment, care, reports or appearances obtained for, or pursuant to, legal proceedings, court orders, employment, continuing or obtaining insurance coverage, governmental licensure, travel, or military services.
- Oral surgery, including but not limited to orthognathic surgery, unless determined medically necessary for treatment of obstructive sleep apnea or direct treatment of an invasive tumor or acute traumatic injury.
- Services related primarily to the treatment of Temporomandibular Joint Syndrome (TMJ). This exclusion does not apply to diagnosis and evaluation of TMJ dysfunction.
- Dental or orthodontic splints or dental prostheses, unless determined medically necessary for treatment of obstructive sleep apnea or necessitated by accidental injury.
- Services related to the care, treatment, filling, removal, or replacement of teeth or structures directly supporting the teeth, unless herein provided or necessitated by accidental injury.
- Acupuncture or acupressure.
- Holistic and homeopathic treatments.
- Alternative medicine programs such as hypnosis, massage therapy and biofeedback.
- Injury or illness sustained when committing a felony.
- Intentionally self-inflicted injuries or illnesses.
- Services for which a provider waives the Insured's copay, coinsurance, and/or deductible.
- Pre-existing conditions during the pre-existing condition exclusion period, when applicable.
- Services provided by a member of the patient's immediate family or household.
- Benefits and services not specified as covered in this outline of coverage or in the policy.

RENEWAL

Subject to all the terms and conditions of the policy, your policy is effective as of the date determined by CHL, as stated in our written notice to you. Unless either formally terminated or otherwise renegotiated, your policy will be renewed automatically each year. Your annual renewal date will be the first day of the month in which your original policy was issued. We may only terminate your coverage for the reasons stated in the policy.

PREMIUMS

Subject to the provisions of your policy, the premium will remain the same until your first renewal date. If federal or state law or regulations mandate that we modify benefits under this policy, we may modify the premium accordingly. We may unilaterally modify the premium after the initial term upon 45 days advance written notice to you.

Premium adjustments due to age changes will be effective on your renewal date. The age bands are as follows: 18-19 years, 20-24 years, 25-29 years, 30-34 years, 35-39 years, 40-44 years, 45-49 years, 50-54 years, 55-59 years, 60-64 years, and age 65+. Premiums are due and payable on the first day of each month.

CoventryOne. TORCH PLUS
SCHEDULE OF BENEFITS

Torch Plus	In-Network		Out-of-Network	
DEDUCTIBLE, OUT-OF-POCKET & LIMITS				
Calendar Year Deductible – Does not apply to Out-of-Pocket Maximum. Cumulative across benefit levels.	Individual $3,000 $5,000 $7,500 $10,000	Family $6,000 $10,000 $15,000 $20,000	Individual $6,000 $10,000 $15,000 $20,000	Family $12,000 $20,000 $30,000 $40,000
Out-of-Pocket Maximum – (Individual / Family) Fixed dollar copays do not apply. Cumulative across benefit levels.	Individual $0 $0 $0 $0	Family $0 $0 $0 $0	Individual $12,000 $20,000 $30,000 $40,000	Family $24,000 $40,000 $60,000 $80,000
Annual Maximum – Cumulative across benefit levels.	Unlimited		Unlimited	
Lifetime Maximum	Unlimited		Unlimited	
Prior Authorization Penalty	Not Applicable		50% of Eligible Medical Expenses	
Pre-Existing Condition Limitation – Not applicable to Insureds under age 19.	12 Months		12 Months	
OUTPATIENT SERVICES	**YOU PAY**			
Preventive Care Services – When provided in conjunction with a preventive diagnosis, including annual adult physical examinations, well child care, family planning, routine immunizations, and colonoscopies. Some services you receive during a preventive office visit may not qualify as Preventive Care Services and will be subject to applicable deductibles, copays, and/or coinsurance.	You Pay Nothing		30%* AD	
Office Visits – Primary Care	$25		30%* AD	
Office Visits – Specialty Care	$50 AD		30%* AD	
After-Hours Care / Urgent Care – Care received in a primary care physician's office or urgent care facility.	$50		30%* AD	
Eye Exams – Optometrist	$25		30%* AD	
Major Diagnostic Services – Sleep studies, laboratory tests and radiology, including, but not limited to CT scans and MRIs.	0% AD		30%* AD	
Minor Diagnostic Laboratory Tests and X-Rays	0% AD		30%* AD	
Outpatient Hospital / Facility Services – Including, but not limited to, observation, chemotherapy, radiation therapy, dialysis, cardiovascular services, infusion therapy, and pulmonary services. Includes physician charges. Cardiac rehabilitation and pulmonary rehabilitation limited to a combined benefit of 18 outpatient facility visits per Insured, per calendar year.	0% AD		30%* AD	
Outpatient Surgery – Surgical procedures performed in a hospital or short-stay surgical facility.	0% AD		30%* AD	

- Benefits Continued on Next Page –

Copays apply to each visit. Deductibles do not apply to the out-of-pocket maximum. CHL pays non-participating providers based on Eligible Medical Expenses. You are responsible for the difference between billed charges and your Eligible Medical Expenses in addition to your share of coinsurance. This difference does not apply to the out-of-pocket maximum. CHL Customer Service 1-855-385-5180 www.coventryone.com.

*** Applies to out-of-pocket maximum (OOPM) , AD = after deductible, APD = after pharmacy deductible**

CoventryOne. TORCH PLUS

SCHEDULE OF BENEFITS

Torch Plus	In-Network	Out-of-Network
OUTPATIENT SERVICES (Continued)	**YOU PAY**	
Physiotherapy Services at a Provider's Office – Physical, occupational and speech therapy provided on an outpatient basis. Limited to a combined benefit of 10 provider's office and/or outpatient facility visits of each type per Insured, per calendar year.	$50 AD	30%* AD
Physiotherapy Services at an Outpatient Facility – Physical, occupational and speech therapy provided on an outpatient basis. Limited to a combined benefit of 10 provider's office and/or outpatient facility visits of each type per Insured, per calendar year.	$50 AD	30%* AD
EMERGENCY CARE	**YOU PAY**	
Emergency Room Care – When medically necessary. Includes all services provided in an Emergency Room setting. Inpatient benefit applies when admitted. Outpatient Hospital benefit applies when transferred to an operating room.	$250 AD	$250 AD
Urgent Care – When medically necessary.	$50	30%* AD
Ambulance / Paramedics – (including Air Ambulance) When medically necessary.	0% AD	In-Network Benefit Applies
INPATIENT SERVICES	**YOU PAY**	
Inpatient Hospital / Facility Services	0% AD	30%* AD
Inpatient Physiotherapy Services – Physical, occupational and speech therapy provided on an inpatient basis. Limited to 30 days per Insured, per calendar year for all therapy types combined.	0% AD	30%* AD
Physician, Surgeon, Assistant Surgeon, Anesthesiologist	0% AD	30%* AD
Organ Transplant Services – Organ and tissue transplant services, including, but not limited to, cornea, kidney, heart, lung, heart-lung, liver, pancreas, and bone marrow transplants and related services. Office visits and other services related to organ transplant may have an additional copay.	0% AD	30%* AD Limited to Lifetime Maximum $10,000 per Insured
MATERNITY SERVICES	**YOU PAY**	
Deductible	Maternity benefits have a **SEPARATE $7,500 DEDUCTIBLE** that must be met each occurrence before benefits are paid.	
Prenatal and Postnatal Care – Professional Services – Routine prenatal office visits, delivery (including surgeon and assistant surgeon), and postnatal care. Obstetrical services for cesarean delivery are included; regular benefits apply for all other involuntary complications of pregnancy. The benefit for prenatal care is determined by the coverage in effect at the time of delivery. If prenatal care is billed by a provider who does not perform the delivery, the benefit for such care is determined by the coverage in effect at the time of the last prenatal visit with that provider.	100% Coverage After Maternity Deductible	30%* After Maternity Deductible
Inpatient Hospital / Facility Services	100% Coverage After Maternity Deductible	30%* After Maternity Deductible

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Copays apply to each visit. Deductibles do not apply to the out-of-pocket maximum. CHL pays non-participating providers based on Eligible Medical Expenses. You are responsible for the difference between billed charges and your Eligible Medical Expenses in addition to your share of coinsurance. This difference does not apply to the out-of-pocket maximum. CHL Customer Service 1-855-385-5180 www.coventryone.com.

*** Applies to out-of-pocket maximum (OOPM) , AD = after deductible, APD = after pharmacy deductible**

CoventryOne. TORCH PLUS
SCHEDULE OF BENEFITS

Torch Plus	In-Network	Out-of-Network
INJECTABLE OR IMPLANTABLE MEDICATIONS	**YOU PAY**	
Injectable or Implantable Medications – Non-Facility – Injectable or implantable medications received in a physician's office or through a home health provider. (Preferred / Non-Preferred)	0% AD	30%* AD
Injectable or Implantable Medications – Pharmacy (Preferred / Non-Preferred)	0% APD	30%* APD
PRESCRIPTION DRUGS	**YOU PAY**	
If you receive a Tier 2 or Tier 3 brand name drug when a Tier 1 generic equivalent can be substituted, you will pay the difference in cost between the generic and the brand name drug, any applicable deductible, and/or the Tier 1 copay. Regular benefits apply if a Tier 1 generic cannot be substituted.		
Deductible – You must satisfy a Pharmacy deductible before these benefits are paid. This deductible is separate from your regular medical deductible. (Per Individual, Per Calendar Year)	$1,000	
Prescription Drugs – Up to a 30-day supply. This benefit also includes the following injectable medications when provided by a pharmacy: insulin, Imitrex, Symlin, Byetta, glucagon, Lovenox, and epinephrine kits (such as Epi-Pen).	Tier 1: $15 Tier 2: 50% APD Tier 3: 50% APD	Tier 1: $30 Tier 2: 50% APD Tier 3: 50% APD
ALLERGY CONDITIONS	**YOU PAY**	
Testing	$50 AD	30%* AD
Serum and Treatment	0% AD	30%* AD
Injections – Professional charges for allergen immunotherapy injections, when billed separately from charges for allergy serum.	0% AD	30%* AD
OTHER BENEFITS	**YOU PAY**	
Accident Related Dental Services – Dental services required as the result of an accidental injury. Services include, but are not limited to, crowns, caps, bridges, and root canals. Limited to a combined lifetime maximum of $1,000 per Insured.	50% AD	50% AD
Durable Medical Equipment (DME) – Including corrective appliances and prosthetic devices.	50% AD	50% AD
Home Health Care – Limited to a combined benefit of 30 visits per Insured, per calendar year.	50%* AD	50%* AD
Hospice Care – Care for a terminally ill Insured through a licensed hospice agency.	0% AD	30%* AD

- Benefits Continued on Next Page –

Copays apply to each visit. Deductibles do not apply to the out-of-pocket maximum. CHL pays non-participating providers based on Eligible Medical Expenses. You are responsible for the difference between billed charges and your Eligible Medical Expenses in addition to your share of coinsurance. This difference does not apply to the out-of-pocket maximum. CHL Customer Service 1-855-385-5180 www.coventryone.com.

*** Applies to out-of-pocket maximum (OOPM) , AD = after deductible, APD = after pharmacy deductible**

CoventryOne. TORCH PLUS
SCHEDULE OF BENEFITS

Torch Plus	In-Network	Out-of-Network
OTHER BENEFITS (Continued)	**YOU PAY**	
Implantable Contraceptives and Intra-Uterine Devices (IUDs) – Includes charges for insertion and removal.	0% AD	30%* AD
Infertility Services – Evaluation, testing, and diagnostic services. Includes services that are provided for the purpose of ruling out infertility. Limited to $750 per Insured, per calendar year, up to a lifetime maximum of $5,000.	50% AD	50% AD
Medical Supplies – Disposable medical supplies and accessories as determined medically necessary.	50% AD	50% AD
Skilled Nursing Facility – Limited to a combined benefit of 30 days per Insured, per calendar year.	0% AD	50%* AD
Sterilization Procedures – Services received at a physician's office.	$50	30%* AD
Sterilization Procedures – Services received at an outpatient facility.	0% AD	30%* AD
Temporomandibular Joint Dysfunction (TMJ) – Evaluation, testing and diagnostic services. Limited to a combined lifetime maximum of $1,000.	50% AD	50% AD

GENERAL INFORMATION

Calendar Year Deductible – You must satisfy an individual or family deductible each calendar year before certain benefits will be provided under this benefit plan. Deductibles do not count towards the out-of-pocket maximum.

Out-of-Pocket Maximum – Fixed dollar copays and deductibles do not apply. When you or your family fulfill out-of-pocket maximums during a calendar year, then no further out-of-pocket expenses will be required for the remainder of that calendar year. This provision does not apply to any payments for benefits with fixed copays, prescription drugs, dental services (even when necessitated by accidental injury), durable medical equipment, corrective appliances, prosthetic devices, medical supplies, infertility services, TMJ services, charges that exceed eligible medical expenses, or non-covered services. You are required to keep receipts for out-of-pocket expenses and furnish such proof to the CHL Claims Department when you reach an out-of-pocket maximum.

Pre-Existing Condition Limitation – Coverage is excluded for the care and treatment of pre-existing conditions, as defined in the policy, unless you have been continuously covered under a benefit plan with a health insurance carrier prior to the date CHL receives your completed application. Previous coverage may be used in satisfying all or part of the pre-existing condition exclusion period requirement, except under the following circumstance: The previous health care coverage was terminated more than 63 days prior to the date you applied for coverage with CHL.

Prior Authorization – Prior authorization is required for certain services (excluding emergency care) in order to verify that the services to be provided are covered by your benefit plan and are medically necessary and appropriate. If you receive services from a non-participating provider, you are responsible to inform your provider about our prior authorization requirements and to verify that prior authorization has been obtained when necessary. If prior authorization is not obtained, your eligible medical expenses for otherwise covered services will be reduced by 50%. You will be responsible for the difference between billed charges and the reduced eligible medical expenses in addition to your coinsurance, copayment, and/or deductible.

Copays apply to each visit. Deductibles do not apply to the out-of-pocket maximum. CHL pays non-participating providers based on Eligible Medical Expenses. You are responsible for the difference between billed charges and your Eligible Medical Expenses in addition to your share of coinsurance. This difference does not apply to the out-of-pocket maximum. CHL Customer Service 1-855-385-5180 www.coventryone.com.

*** Applies to out-of-pocket maximum (OOPM) , AD = after deductible, APD = after pharmacy deductible**