Coventry Health and Life Insurance Company

Individual Policy PPO Schedule of Benefits

State(s) of Issue: Kansas
PPO Plan: KI C10025 20

Covered Services	Cost to Member when Receiving Services from Participating Providers (In-Network)	Cost to Member when Receiving Services from Non-Participating Providers (Out-of- Network) [2]
Annual Plan Deductible	$1,000 Individual	$1,000 Individual
Coinsurance For All Eligible Expenses (unless otherwise noted)	Deductible Plus 20% Coinsurance	Deductible Plus 40% Coinsurance
Out-of-Pocket Maximum Only Includes coinsurance	$2,500 Individual	$5,000 Individual
Combined Lifetime Benefit Maximum	$2,000,000	
Primary Care Physician (PCP) Services[1]		
▪ Physician Office Visit	$20 Copayment	Deductible Plus 40% Coinsurance
▪ Physician Office Surgery	$20 Copayment	Deductible Plus 40% Coinsurance
▪ Allergy Injections	$0 Copayment	Deductible Plus 40% Coinsurance
▪ Allergy Testing	Deductible Plus 20% Coinsurance	Deductible Plus 40% Coinsurance
Specialty Physician Services[1]		
▪ Physician Office Visit	$35 Copayment	Deductible Plus 40% Coinsurance
▪ Physician Office Surgery	$35 Copayment	Deductible Plus 40% Coinsurance
▪ Allergy Injections	$0 Copayment	Deductible Plus 40% Coinsurance
▪ Allergy Testing	Deductible Plus 20% Coinsurance	Deductible Plus 40% Coinsurance
Preventive Care		
▪ Annual Well Woman Exam	Same as Physician Office Visit[1]	Deductible Plus 40% Coinsurance
▪ Mammograms (Routine Screening and Diagnostic)	$0 Copayment	Deductible Plus 40% Coinsurance

Covered Services	Cost to Member when Receiving Services from Participating Providers (In-Network)	Cost to Member when Receiving Services from Non-Participating Providers (Out-of- Network) [2]
▪ Bone Density	Same as Physician Office Visit[1]	Deductible Plus 40% Coinsurance
▪ Well Baby and Child Care	Same as Physician Office Visit[1]	Deductible Plus 40% Coinsurance
Preventive Care (continued) ▪ Annual Prostate Screening - High Risk or Symptomatic (Age 40+) and All Males (Age 50+)	Same as Physician Office Visit[1]	Deductible Plus 40% Coinsurance
▪ Routine Health Screening	Same as Physician Office Visit[1] *Limited up to $300 per Member per Calendar Year Benefit Maximum*	Deductible Plus 40% Coinsurance
Immunizations ▪ Pediatric (up to age 72 months) ▪ Covered Adult Immunizations	No Copayment No Copayment	No Copayment Deductible Plus 40% Coinsurance
Hospital Inpatient Services Services include semi-private hospital room & board, physician and surgeon services, lab, x-ray and other facility and ancillary charges.	Deductible Plus 20% Coinsurance	Deductible Plus 40% Coinsurance
Outpatient Surgery and Scopes Includes related Professional Charges ▪ **Performed in Hospital** ▪ **Performed in Ambulatory Surgery Center**	Deductible Plus 20% Coinsurance Deductible Plus 20% Coinsurance	Deductible Plus 40% Coinsurance Deductible Plus 40% Coinsurance
Outpatient Laboratory Services *Human Leukocyte Antigen testing limited to $75 per Calendar Year Benefit Maximum*	Deductible Plus 20% Coinsurance	Deductible Plus 40% Coinsurance
Outpatient X-rays Includes related Professional Charges	Deductible Plus 20% Coinsurance	Deductible Plus 40% Coinsurance
Outpatient Diagnostic Testing, Imaging, and Services (Not Listed Elsewhere) ▪ Performed in Hospital ▪ Performed in Other Outpatient Setting Includes related Professional Charges	Deductible Plus 20% Coinsurance Deductible Plus 20% Coinsurance	Deductible Plus 40% Coinsurance Deductible Plus 40% Coinsurance

Covered Services	Cost to Member when Receiving Services from Participating Providers (In-Network)	Cost to Member when Receiving Services from Non-Participating Providers (Out-of- Network) [2]
Emergency Services ▪ Emergency Room Copayment and Coinsurance waived if admitted	$100 Copayment and 20% Coinsurance for Facility Charges	$100 Copayment and 20% Coinsurance for Facility Charges
▪ Related Professional Fees	20% Coinsurance for Related Professional Fees	20% Coinsurance for Related Professional Fees
Ambulance/Emergency Transportation (Ground or Air)	Deductible Plus 20% Coinsurance	Deductible Plus 20% Coinsurance
Urgent Care	$50 Copayment	$50 Copayment
Outpatient Short Term Therapy ▪ Physical Therapy ▪ Occupational Therapy ▪ Speech Therapy	Deductible Plus 20% Coinsurance *Combined Limit of 20 visits per Condition Benefit Maximum*	Deductible Plus 40% Coinsurance
Spinal Manipulation	Same as Physician Office Visit[1] *Combined Limit of 26 visits per Calendar Year Benefit Maximum*	Deductible Plus 40% Coinsurance
Rehabilitation ▪ Inpatient	Deductible Plus 20% Coinsurance *Combined Limit of 20 days per Calendar Year Benefit Maximum*	Deductible Plus 40% Coinsurance
▪ Partial Day Programs (4 hours or greater)	Deductible Plus 20% Coinsurance *Combined Limit of 20 visits per Calendar Year Benefit Maximum*	Deductible Plus 40% Coinsurance
▪ Outpatient (Pulmonary, Cardiac)	Deductible Plus 20% Coinsurance *Combined Limit of 20 visits per Calendar Year Benefit Maximum*	Deductible Plus 40% Coinsurance
Home Health Care	Deductible Plus 20% Coinsurance	Deductible Plus 40% Coinsurance
Skilled Nursing Facility	Deductible Plus 20% Coinsurance *Combined Limit of 60 days per Calendar Year Benefit Maximum*	Deductible Plus 40% Coinsurance
Hospice Care ▪ Inpatient	Deductible Plus 20% Coinsurance *Combined Limit of 15 days per Calendar Year Benefit Maximum*	Deductible Plus 40% Coinsurance
▪ Outpatient	Deductible Plus 20% Coinsurance	Deductible Plus 40% Coinsurance

Covered Services	Cost to Member when Receiving Services from Participating Providers (In-Network)	Cost to Member when Receiving Services from Non-Participating Providers (Out-of- Network) [2]
Durable Medical Equipment	Deductible Plus 20% Coinsurance *Combined Limit of $1,000 per Calendar Year Benefit Maximum*	Deductible Plus 40% Coinsurance
Prosthetics & Braces	Deductible Plus 20% Coinsurance *Combined Limit of $1,000 per Calendar Year Benefit Maximum*	Deductible Plus 40% Coinsurance
Organ Transplant	See Appropriate Benefits *Limited to $500,000 Lifetime Benefit Maximum*	Not Covered
Outpatient Dialysis	Deductible Plus 20% Coinsurance	Deductible Plus 40% Coinsurance
Nutritional Evaluation & Diabetes Management/Self-Training	Deductible Plus 20% Coinsurance	Deductible Plus 40% Coinsurance
Mental Illness, Nervous & Mental Disorders and Alcohol or Chemical Dependency Treatment	**Inpatient:** Same as Hospital Inpatient Services **Outpatient:** Same as Specialist Office Visit *See Mental Health and Chemical Dependency Rider for Details* *Limits may apply*	**Inpatient:** Same as Hospital Inpatient Services **Outpatient:** Same as Specialist Office Visit *See Mental Health and Chemical Dependency Rider for Details* *Limits may apply*
Prescription Drug	*See Prescription Drug Rider for Details*	*See Prescription Drug Rider for Details*

Please Note: Maximum Benefit Limits do not guarantee that all services will be approved to the Maximum number allowed under this plan. Payments that are on a percentage basis will be applied to the contracted allowed amount reimbursed to the provider, if applicable.

1. Primary Care Physicians (PCP) generally include those physicians who practice in the specialties of Family Practice, Internal Medicine, General Practice, or Pediatrics. If you are not sure if a physician is a PCP, please contact the Customer Service Number on the back of your ID card. If you receive this service from a Primary Care Physician (PCP), your PCP payment will apply. If you receive these services from a Specialist, your Specialist payment will apply.

2. In order to receive the maximum benefits for services requiring prior authorization, you must participate in Our Utilization Management Program as outline in your Evidence of Coverage. ***Failure to do so may result in a 20% reduction in benefits for that particular service.***

**Formula & Low Protein Modified Foods for PKU & Amino Acid Disease are limited to $5,000 per Calendar Year Benefit Maximum.*

COVENTRY
Health and Life Insurance Company

PRESCRIPTION DRUG RIDER

This Prescription Drug Rider ("Rider") is made a part of Coventry Health and Life Insurance Company's Individual Policy ("Policy"). The benefits provided by this Rider become effective on the date Coverage under the Policy is effective.

DEFINITIONS

Any capitalized terms used in this Rider and not otherwise defined herein shall have the meaning set forth in the Policy. The following definitions apply to this Rider:

Ancillary Charge. A charge in addition to the Copayment You are required to pay for a Prescription Drug which, through Your request or that of the Prescribing Provider, has been dispensed by the brand name, even though the Prescription Drug is subject to the MAC and covered at the generic product level. The Ancillary Charge, if any, shall be the difference between the Plan's contracted price for the Non-Formulary or Formulary brand name drug and for the Generic Drug. You are responsible at the time of service for payment of the Ancillary Charge directly to the Participating Pharmacy.

Copayment. The amount You will be charged by the Pharmacy to dispense or refill any Prescription. You are responsible at the time of service for payment of the Copayment directly to the Pharmacy.

Covered Drugs. Prescription Drugs prescribed and approved by the Prescribing Provider and the Plan subject to the specifications listed in this Rider.

Formulary. A list of specific generic and brand name Prescription Drugs Authorized by the Plan, and subject to periodic review and modification. Since there may be more than one brand name of a Prescription Drug, not all brands of the same Prescription Drug (e.g., different manufacturers) may be included in the Formulary. The Formulary is available for review in the searchable Formulary on Our website, www.chckansas.com, in the Participating Provider's office, or by contacting the Customer Service Department.

Formulary Prescription Drug. A Prescription Drug that appears on the Plan's Formulary.

Generic Prescription Drug. A Prescription Drug as being prescribed by its generic and chemical name heading according to the principal ingredient(s) and approved by the Food and Drug Administration.

Mail Order List. A list of the Plan's designated Formulary Maintenance Medications.

Mail Order Pharmacy. When applicable, the Pharmacy contracted by the Plan to provide Maintenance Medications through the mail.

Maintenance Medication(s). Prescription Drugs, designated by the Plan and included on the Mail Order List, which are not written for episodic treatments of medical conditions.

Maximum Allowable Cost (MAC). The price assigned to Prescription Drugs that will be covered at the generic product level, subject to periodic review and modification by the Plan.

Non-Formulary Prescription Drug. A Prescription Drug that is not on the Plan's list of Formulary Prescription Drugs.

Non-Participating Pharmacy. Any pharmacy that is not a Participating Pharmacy as defined herein.

Participating Pharmacy. A pharmacy licensed in the State in which it is located that has entered into a written contract with the Plan to provide services to the Plan's Insureds, or on whose behalf a written contract has been made with the Plan which is in effect at the time services are provided.

Prescribing Provider. Any person holding the degree of Doctor of Medicine, Doctor of Osteopathy, Doctor of Dental Medicine, or Doctor of Dental Surgery or any other provider who is duly licensed in the United States to prescribe medications in the ordinary course of his or her professional practice.

Prescription Drug(s). Any medication or drug which:

- is provided for outpatient administration;
- has been approved by the Food and Drug Administration; and
- under federal or state law, is dispensed pursuant to a prescription order (legend drug).

This definition of Prescription Drug includes some over-the-counter medications or disposable medical supplies (e.g., insulin and diabetic supplies) and a compound substance when it meets the Plan's criteria and the product is not available commercially.

Prescription Order or Refill. The authorization for a legend Prescription Drug issued by a Prescribing Provider who is duly licensed to make such an authorization in the ordinary course of his or her professional practice.

Pre-Certification. A process where the Plan or its designee determines, prior to dispensing, that a Prescription Order or Refill, otherwise Covered under this Rider, has been reviewed and, based upon information provided by the Prescribing Provider, the Prescription Order or Refill satisfies the requirements for Coverage.

Self-Administered Injectable Drug(s). Self-Administered Injectable Prescription Drugs, as defined by the Plan, are commonly and customarily administered by the Insured, and are available through a Specialty Pharmacy. Examples of Self-Administered Injectable Prescription Drugs include, but are not limited to, the following: multiple sclerosis agents, growth hormones, colony stimulating factors given more than once monthly, chronic medications for hepatitis C, certain rheumatoid arthritis medications, certain injectable HIV drugs, certain osteoporosis agents, and heparin products.

Self-Administered Injectable Drug Copayment. The amount that will be charged to You by the Specialty Pharmacy to dispense or refill any Prescription Order or Refill for a Self-Administered Injectable Drug. You shall be required to pay one (1) Self-Administered Injectable Drug

Copayment per each Prescription Order or Refill. You are responsible for payment of the Self-Administered Injectable Drug Copayment directly to the Specialty Pharmacy at the time of service.

Note: For definition purposes, other injectable drugs, that are acquired through the retail Pharmacy, are not considered Self-Administered Injectable Prescription Drugs, such as: insulin, glucagon, bee sting kits, Imitrex and injectable contraceptives.

Specialty Pharmacy. A pharmacy that is able to provide certain Prescription Orders or Refills, such as Self-Administered Injectable Drugs. For assistance in locating a Speciality Pharmacy, you may contact Customer Service at the number located on the back of your ID card.

PRESCRIPTION DRUG BENEFITS

Subject to the Limitations, Exclusions, Copayments and Ancillary Charges described below, outpatient Prescription Drugs will be covered when:

- the Insured is eligible to receive Covered Services;
- written by a Prescribing Provider; and
- filled at a pharmacy, including a Mail Order Pharmacy or Specialty Pharmacy.

Generically equivalent pharmaceuticals will be dispensed whenever there is an FDA approved generic drug. If you choose to receive a brand name Prescription Drug when a Generic Drug is available, You will be responsible for the Ancillary Charge and the appropriate Copayment. The Ancillary Charge will be due regardless of whether or not the Prescribing Provider indicates that the pharmacy is to "Dispense as Written." Your total responsibility shall not exceed the average wholesale price (“AWP”) of the Prescription Drug.

ELIGIBLE CHARGES

Non Participating Pharmacy. A Prescription Order or Refill may be obtained through a Non-Participating Pharmacy, however, You may be required to pay for the cost of the Prescription Drug(s) and file a claim for reimbursement. Payment for Prescription Drugs will be at a rate consistent with that of a Participating Pharmacy less Your Copayment amount.

Pre-Certification and Specific Quantity Limits. Regardless of where a Prescription Order or Refill is filled, Covered Drugs under this Rider may be subject to Pre-Certification and quantity limits, as described below. Some drugs require Pre-Certification in order for them to be Covered Services. These include, but are not limited to, medications that may require special medical tests before use, or that are not recommended as a first-line treatment, or that have a potential misuse or abuse. Drugs requiring Pre-Certification are identified within the Formulary with “PA” next to the name of the drug.

Pre-Certification and Non-Participating Prescribing Providers. When You use a Non-Participating Prescribing Provider, it is Your responsibility to contact the Plan before a Prescription Order or Refill is filled to obtain any required Pre-Certification. If the Plan is not contacted for Pre-Certification, You may be required to pay one hundred percent (100%) of the cost for a Prescription Drug.

Specific Quantity Limits. You can get information on specific quantity limits from the searchable Formulary on the website or by contacting the Customer Service Department. Before a

Prescription Order or Refill for a drug that exceeds the specific quantity limit can be filled, the Prescribing Provider must call the Plan.

Retail Pharmacy. Prescription Drugs prescribed by a Prescribing Provider and obtained through a Pharmacy are Covered when You are eligible for Coverage under this Rider and You present Your identification card to a Pharmacy. The quantity of a Prescription Drug dispensed by a Pharmacy to fill a Prescription Order or Refill should not exceed that required for the lesser of:

- The quantity prescribed in the Prescription Order or Prescription Refill;
- A thirty-one (31) day supply;
- The amount determined to be Medically Necessary; or
- Depending on the form and packaging of the product, the following: The number of commercially prepackaged items (including but not limited to inhalers, topicals, and vials) needed for thirty-one (31) days of treatment with one copayment applied to each pre-packaged item or container.

Mail Order Pharmacy. Prescription Drugs determined by the Plan to be Maintenance Medications on the Mail Order List and prescribed by a Prescribing Provider can be filled by the Mail Order Pharmacy. The quantity of a Prescription Drug will be dispensed pursuant to a ninety-three (93) day/cycle supply of approved Maintenance Medications.

Specialty Pharmacy. Self-Administered Injectable Drugs are Covered under this Rider in the amounts described below when they are:

- Ordered by a Prescribing Provider for use by a Insured;
- Not limited or excluded elsewhere in this Rider;
- Obtained from a Specialty Pharmacy;
- Listed on the Formulary; and
- Pre-Certified.

Self-Administered Injectable Drugs. Self-Administered Injectable Drugs are NOT available through the Mail Order Pharmacy program or at Participating retail Pharmacies. You shall pay the following to the Pharmacy, as applicable:

- Ancillary Charges; and
- One (1) Self-Administered Injectable Drug Copayment per Prescription Order or Refill.

COPAYMENTS

The Copayment for Prescription Drugs at a Participating Pharmacy is:

- $10 for Formulary generic Prescription Drugs; or
- $35 for Formulary brand name Prescription Drugs; or
- $60 for non-Formulary Prescription Drugs.

The Copayment for Prescription Drugs at a Non-Participating Pharmacy is:

- $20 for Formulary generic Prescription Drugs; or
- $70 for Formulary brand name Prescription Drugs; or
- $120 for non-Formulary Prescription Drugs.

The Copayment for Self-Administered Injectable Drugs at a Specialty Pharmacy is:

- $10 for Formulary generic Prescription Drugs; or

- $35 for Formulary brand name Prescription Drugs; or
- $60 for non-Formulary Prescription Drugs.

The Copayment for Self-Administered Injectable Drugs at a Non-Participating Pharmacy is:
- $20 for Formulary generic Prescription Drugs; or
- $70 for Formulary brand name Prescription Drugs; or
- $120 for non-Formulary Prescription Drugs.

The following also apply:
- One (1) Copayment is due each time a prescription is filled or refilled up to a thirty-one (31) day supply.
- Insulin and diabetic supplies (insulin syringes, with or without needles, needles, blood and urine glucose test strips, lancets and devices, ketone test strips and tabs), up to a ninety-three (93) day supply, may be dispensed at three times the applicable Copayment.
- Maintenance Drugs may be dispensed with three (3) Copayment(s) for a ninety-three (93) day supply.
- Only one drug and "Rx Unit" will be dispensed per prescription. The Rx Unit quantity is determined by FDA labeling, the dosage required or the Plan Formulary guidelines. Please note: One copayment is required for each Rx Unit, container, or prepackaged item.
- Oral contraceptives, up to a maximum of three (3) cycles may be dispensed at three times the applicable Copayment.
- Select over-the-counter medications as determined by the Plan in an equivalent prescription dosage strength will be covered under this Rider for a Generic Copayment. Coverage of the selected over-the-counter medications requires a physician prescription.
- Copayments and Ancillary Charges do not apply to the Out-of-Pocket Maximum listed on the Schedule of Benefits.

LIMITATIONS

1. Authorized refills will not be provided after the lesser of:
   i. twelve (12) months from the original date on the prescription order; or
   ii. the period of time limited by state or federal law.

2. Contraceptive diaphragms prescribed by a Prescribing Provider are limited to two (2) per year.

3. Coverage of injectable drugs is limited to Self-Administered Injectable Drugs as determined by the Plan and insulin, glucagon, bee sting kits, Imitrex and injectable contraceptives that are commonly and customarily administered by the Insured.

4. Selected products with narrow therapeutic index, potential for misuse and/or abuse, high cost, or a narrow or limited range of Food and Drug Administration approved indications may require Pre-Certification by the Plan and may not be available through the mail order pharmacy program.

5. The Pharmacy shall not dispense a Prescription Drug order which, in the Pharmacist's professional judgment, should not be filled.

6. To promote appropriate utilization, or following manufacturer's recommendations, certain plan approved medications may have a quantity limit on the amount of medication dispensed.

7. The Plan reserves the right to include only one (1) Prescription Drug on its Formulary when the same Prescription Drug is made or sold under two or more different names. The Prescription Drug that is listed on the Formulary will be covered at the Formulary Copayment or Mail Order Copayment level. The Prescription Drug(s) that is/are not listed on the Formulary will not be covered.

8. Coverage of therapeutic devices or supplies requiring a Prescription Order and prescribed by a Prescribing Provider is limited to Plan approved devices, supplies, or spacers for metered dose inhalers.

9. Coverage through the Mail Order Pharmacy is not available on drugs that cannot be shipped by mail due to state or federal laws or regulations, or when the Plan considers shipment through the mail to be unsafe. Examples of these types of drugs include, but are not limited to, narcotics, amphetamines, DEA controlled substances or anticoagulants.

EXCLUSIONS

The following are **Excluded** from Coverage under this Rider:

1. Prescription Drugs related to the treatment of a Non-Covered Service (i.e. dental services).

2. Prescription Drugs that are not Medically Necessary. The Plan reserves the right to require medical Pre-Certification for selected drugs before providing Coverage.

3. Prescription Drugs that are Experimental or Investigational, including those labeled "Caution-limited by Federal Law to Investigational Use," FDA approved drugs used for investigational indications or at investigational doses and drugs found by the FDA to be ineffective or given as a part of a study.

4. Products not approved by the FDA, Prescription Drugs with no FDA approved indications, and DESI Drugs. This exclusion shall not apply to a drug, medicine or medication that is recognized for the treatment of cancer in one of the standard reference compendia or in substantially accepted peer-review medical literature.

5. Any Prescription Drug which is to be administered, in whole or in part, while You are in a hospital, medical office or other health care facility.

6. Compounded prescriptions are excluded unless all of the following apply:
   a. there is no suitable commercially-available alternative available;
   b. the main active ingredient is a Covered Prescription Drug;
   c. the purpose is solely to prepare a dose form that is Medically Necessary and is documented by the Prescribing Provider; and
   d. the claim is submitted electronically by the Pharmacy.

7. Vitamins and minerals (both over-the-counter and legend), except legend prenatal vitamins, and liquid or chewable legend pediatric vitamins as specified on the Formulary.

8. Injectable medications, except those designated by the Plan.

9. Drugs that do not require a prescription by federal or state law, that is, over-the-counter drugs or over-the-counter products, unless specifically designated for Coverage by the Plan or the Formulary list and obtained from the Pharmacy with a Prescription Order or Refill. Also excluded are Prescription Medications that have an over-the-counter equivalent or alternatives, unless otherwise specified on the Formulary.

10. Devices or supplies of any type, even though requiring a Prescription Order, such as but not limited to, therapeutic devices, support garments, corrective appliances, non-disposable hypodermic needles, syringes or other devices, regardless of their intended use, unless otherwise specified as a Covered benefit in this Rider.

11. Implantable time released medications, (e.g., Norplant, Eligard and Zoladex) and prescription or nonprescription contraceptive devices (e.g., condoms and spermicidal agents).

12. Extemporaneous dosage forms of natural estrogen or progesterone; or any natural hormone replacement product, including but not limited to oral capsules, suppositories, creams and troches.

13. Prescription Drugs used for the treatment of impotence.

14. Anti-smoking medication or smoking cessation devices.

15. Prescription Drugs used to treat chemical dependency and/or substance abuse.

16. Drugs used primarily for hair restoration.

17. Pharmacological therapy for weight reduction, dietary supplements, appetite suppressants, and other drugs used to treat obesity, morbid obesity or assist in weight reduction.

18. Drugs, oral or injectable, used for the primary purpose of, or in connection with, treating infertility, fertilization, and/or artificial insemination.

19. Medications used for cosmetic purposes or to enhance athletic performance (i.e. anabolic steroids and minoxidil lotion, retin A (tretinoin) for aging skin). Also excluded are drugs, oral or injectable, used to slow or reverse normal aging processes (i.e. growth hormone, testosterone, etc.).

20. Prescription Drugs dispensed in unit doses, when bulk packaging is available, or repackaged Prescription Drugs.

21. Replacement for lost, destroyed or stolen prescriptions.

22. Duplicate drug therapy (i.e. two antihistamine drugs).

23. Oral dental preparations and fluoride rinses, except pediatric fluoride tablets or drops as specified on the Formulary.

24. Prescriptions that You are entitled to receive without charge under any Workers' Compensation law, occupational statute, or any law, or regulation of similar purpose.

CONDITIONS

1. The Plan and its designees shall have the right to release any and all records concerning health care services that are necessary to implement and administer the terms of this Rider or for appropriate medical/pharmaceutical review or quality assessment.

2. The Plan shall not be liable for any claim, injury, demand or judgment based on tort or other grounds (including warranty of drugs) arising out of or in connection with the sale, compounding, dispensing, manufacturing, or use of any Prescription Drug whether or not Covered under this Rider.

GENERAL PROVISIONS

1. Your Coverage under this Rider will end when Coverage under the Policy ends.

2. Nothing herein shall be held to vary, alter, waive, or extend any of the definitions, terms, conditions, provisions, agreements or limitations of the Policy, other than as stated above.

3. The Plan utilizes Prescription Drug rebates as a mechanism to reduce Prescription Drug costs.