
Coventry Health and Life Insurance Company
10421 South Jordan Gateway, Suite 400
South Jordan, Utah 84095

COVENTRYONE. PPO

ADMINISTERED BY ALTIUS HEALTH PLANS INC.

INDIVIDUAL SCHEDULE OF BENEFITS

The following **Schedule of Benefits** explains Your out-of-pocket cost for the health care services and supplies Covered under the Individual Agreement (“Agreement”). This schedule is provided to assist You with determining what You will have to pay at each level of Coverage for Covered Services when determined to be Medically Necessary. Covered Services are explained in Section 6, “Provisions Relating to Covered Benefits and Services”, of Your Policy and any applicable Riders, addenda or amendments. **Coverage is always subject to the terms, conditions, exclusions and limitations of Your Policy and any applicable Riders, addenda or amendments.**

Please keep this Schedule of Benefits with Your Policy. It is part of the Agreement.

Capitalized terms used in this Schedule of Benefits shall have the same meaning set forth in the Policy.

We cover only health services and supplies (1) that are deemed Medically Necessary, (2) that are expressly listed in Section 6, “Provisions Relating to Covered Benefits and Services”, of Your Policy, (3) that are not excluded under the Exclusions and Limitations Section of Your Policy, and (4) when You are an Insured under this Agreement on the date of service. Emergency Services do not need Prior Authorization and are Covered at the In-Network level regardless of whether the Provider is a Participating Provider or a Non-Participating Provider.

The schedule below lists Covered Services, additional Limitations, and Your payment responsibility at each level of Coverage.

Once You have reached a Limitation for a coverage category as explained in Your Policy, You will be responsible for the Allowed Amount of any additional Covered Services received in that category for the remainder of the time You are covered under the Agreement.

Refer to the Schedule of Benefits for the specific Coinsurance amount and dollar amounts of each Copayment and Deductible type. Also refer to the Schedule of Benefits for Your Out-of-Pocket Maximum at each Level of Coverage. With a few exceptions, once You have reached the Out-of-Pocket Maximum, You are no longer required to pay Coinsurance for the remainder of the Contract Year. The following are NOT applied to Your Out-of-Pocket Maximum: Copayments; amounts above our Eligible Medical Expenses that may be billed to You by Non-Participating Providers; Copayments, Deductible and Coinsurance for Prescription Drugs and related Supplies; Ancillary Charges for Prescription Drugs and related Supplies; charges for non-Covered Services; and any Prior Authorization penalties.

Even if You have reached the Out-of-Pocket Maximum, a Non-Participating Provider may require that You pay amounts that exceed Our Eligible Medical Expenses. This amount could be substantial.

CoventryOne. TORCH

SCHEDULE OF BENEFITS

Torch	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.	<u>Individual</u>	<u>Family</u>	<u>Individual</u>	<u>Family</u>
	\$2,000	\$4,000	\$4,000	\$8,000
	\$3,000	\$6,000	\$6,000	\$12,000
	\$5,000	\$10,000	\$10,000	\$20,000
	\$7,500	\$15,000	\$15,000	\$30,000
	\$10,000	\$20,000	\$20,000	\$40,000
Out-of-Pocket Maximum – (Individual / Family) Fixed dollar copays do not apply. Cumulative across benefit levels.	<u>Individual</u>	<u>Family</u>	<u>Individual</u>	<u>Family</u>
	\$3,000	\$6,000	\$8,000	\$16,000
	\$5,000	\$10,000	\$12,000	\$24,000
	\$5,000	\$10,000	\$20,000	\$40,000
	\$5,000	\$10,000	\$30,000	\$60,000
	\$5,000	\$10,000	\$40,000	\$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		50%* AD	
Office Visits – Primary Care	\$25		50%* AD	
Office Visits – Specialty Care	\$50 AD		50%* AD	
After-Hours Care / Urgent Care – Care received in a primary care physician’s office or urgent care facility.	\$50		50%* AD	
Eye Exams – Optometrist	\$25		50%* AD	
Major Diagnostic Services – Sleep studies, laboratory tests and radiology, including, but not limited to CT scans and MRIs.	30%* AD		50%* AD	
Minor Diagnostic Laboratory Tests and X-Rays	30%* AD		50%* 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.	30%* AD		50%* AD	
Outpatient Surgery – Surgical procedures performed in a hospital or short-stay surgical facility.	30%* AD		50%* 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

SCHEDULE OF BENEFITS

Torch	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	50%* 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	50%* 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	50%* AD
Ambulance / Paramedics – (including Air Ambulance) When medically necessary.	30%* AD	In-Network Benefit Applies
INPATIENT SERVICES		
YOU PAY		
Inpatient Hospital / Facility Services	30%* AD	50%* 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.	30%* AD	50%* AD
Physician, Surgeon, Assistant Surgeon, Anesthesiologist	30%* AD	50%* 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.	30%* AD	50%* 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.	30%* After Maternity Deductible	50%* After Maternity Deductible
Inpatient Hospital / Facility Services	30%* After Maternity Deductible	50%* After Maternity Deductible

- Benefits Continued on Next Page -

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Torch	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)	30%* AD	50%* AD
Injectable or Implantable Medications – Pharmacy (Preferred / Non-Preferred)	30%* APD	50%* 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	50%* AD
Serum and Treatment	30%* AD	50%* AD
Injections – Professional charges for allergen immunotherapy injections, when billed separately from charges for allergy serum.	30%* AD	50%* 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.	30%* AD	50%* AD

- Benefits Continued on Next Page –

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OTHER BENEFITS (Continued)	YOU PAY	
Implantable Contraceptives and Intra-Uterine Devices (IUDs) – Includes charges for insertion and removal.	30%*	50%* 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.	50%* AD	50%* AD
Sterilization Procedures – Services received at a physician's office.	\$50	50%* AD
Sterilization Procedures – Services received at an outpatient facility.	30%* AD	50%* 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.		

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