

WellPath Select, Inc.
2801 Slater Road, Suite 200
Morrisville, North Carolina 27560

CoventryOneSM

INDIVIDUAL SCHEDULE OF PAYMENTS

The following **Schedule of Payments**, explains Your out-of-pocket cost for the health care services and supplies Covered under the Policy. 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 5, Covered Services, of Your Policy and any applicable Riders or Amendments. **Coverage is always subject to the terms, exclusions and limitations of Your Policy and any applicable Riders or Amendments.**

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

Capitalized terms used in this Schedule of Payments 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 5, Covered Services, of Your Policy, (3) that are not excluded under the Exclusions and Limitations Section of Your Policy, and (4) when You are eligible for Coverage under this Policy on the date of service. Emergency Services do not need Prior Authorization and are Covered at the Participating Provider 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. **It also lists Your Maximum Lifetime Benefit. Once You have reached Your Maximum Lifetime Benefit, services will no longer be Covered under the Policy.**

Once You have reached the Annual Maximum for a coverage category as explained in Your Policy, You will be responsible for the full cost of any additional services received in that category for the remainder of the Policy Year.

Once You have reached the Benefit Maximum for a coverage category as explained in Your Policy, You will be responsible for the full cost of any additional services received in that category for the remainder of the time You are covered under the Policy.

Refer to the section below entitled, Categories of Payment, for the specific Coinsurance amount and dollar amounts of each Copayment and Deductible type. For example, when you see "Coinsurance" listed next to a Covered Service, the amount of Coinsurance will be listed in the Categories of Payment section. Also refer to the Categories of Payment section for Your Coinsurance Maximum at each Level of Coverage. With a few exceptions, once You have reached the Coinsurance Maximum, You are no longer required to pay Coinsurance for the remainder of the Policy Year. The following are NOT applied to Your Coinsurance Maximum: Copayments, amounts above our Eligible Charges that may be billed to You by Non-Participating Providers, and Coinsurance for Prescription Drugs and related Supplies, Ancillary Charges for Prescription Drugs and related supplies, and any Prior Authorization penalties. You are only excused from paying Coinsurance after the Coinsurance Maximum has been reached.

Even if You have reached the Coinsurance Maximum, a Non-Participating Provider may require that You pay amounts that exceed Our Eligible Charges. This amount could be substantial.

Student Dependents eligible to age:	25
Maximum Lifetime Benefit:	\$2 Million (combined Participating Provider Level and Non-Participating Provider Level).

CATEGORIES OF PAYMENT

The following lists Your specific payment responsibility for Coinsurance referenced in the table of Covered Services below. For most Covered Services, including Prescription Drugs, the Deductible amount for the Policy must be met at each Level of Coverage before services are Covered under this Policy at that Level of Coverage.

CATEGORIES OF PAYMENT	YOUR PAYMENT RESPONSIBILITY	
	at the Participating Provider Level	at the Non-Participating Provider Level*
Deductible for the Individual Policy:	Individual: \$500 Family: 3 times the Individual Deductible	Individual: \$1,000 Family: 3 times the Individual Deductible
Coinsurance:	10% of Eligible Charges	30% of Eligible Charges
Coinsurance Maximum:	Individual: \$1,500 Family: 2 times the Individual Coinsurance Maximum	Individual: \$3,000 Family: 2 times the Individual Coinsurance Maximum

***You are responsible for amounts in excess of the Out-of-Network Rate/Eligible Charges.**

COVERED SERVICE	YOUR PAYMENT RESPONSIBILITY	
	at the Participating Provider Level	at the Non-Participating Provider Level*
Prior Authorization Penalty	Not applicable	50% of Eligible Charges up to a maximum of \$500
Primary Care Physician/Provider (PCP) Office Visits (Diagnostic and Treatment Services) Please Note: <i>All other services not listed are subject to the applicable Copayment, Coinsurance and/or Deductible noted in Your Schedule of Copayments, in addition to Your regular PCP office visit Copayment, Coinsurance and/or Deductible.</i>	\$20 Copayment	Deductible/30% Coinsurance
Specialist Office Visits (Diagnostic and Treatment Services) Please Note: <i>All other services not listed are subject to the applicable Copayment, Coinsurance and/or Deductible noted in Your Schedule of Copayments, in addition to Your regular Specialist office visit Copayment, Coinsurance and/or Deductible.</i>	\$40 Copayment	Deductible/30% Coinsurance
Ambulance	Deductible/Coinsurance	Deductible/Coinsurance
Blood and Blood Products	Deductible/Coinsurance	Deductible/Coinsurance
Bone Mass Measurement	Your payment responsibility depends on the place of service. Refer to the specific Covered Service category that applies to Your treatment	Your payment responsibility depends on the place of service. Refer to the specific Covered Service category that applies to Your treatment
Breast Reconstruction (Post-Mastectomy)	Your payment responsibility depends on the place of service. Refer to the specific Covered Service category that applies to Your treatment	Your payment responsibility depends on the place of service. Refer to the specific Covered Service category that applies to Your treatment
Cardiac and Pulmonary Rehabilitation Therapy Limited to \$1,500 per Member per lifetime, in- and out-of-network combined.	Your payment responsibility depends on the place of service. Refer to the specific Covered Service category that applies to Your treatment	Your payment responsibility depends on the place of service. Refer to the specific Covered Service category that applies to Your treatment

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COVERED SERVICE	YOUR PAYMENT RESPONSIBILITY	
	at the Participating Provider Level	at the Non-Participating Provider Level*
Cervical and Ovarian Cancer Screening	Your payment responsibility depends on the place of service. Refer to the specific Covered Service category that applies to Your treatment	Your payment responsibility depends on the place of service. Refer to the specific Covered Service category that applies to Your treatment
Chemotherapy and Radiation Therapy	Deductible/Coinsurance	Deductible/Coinsurance
Cleft Lip and Cleft Palate	Your payment responsibility depends on the place of service. Refer to the specific Covered Service category that applies to Your treatment	Your payment responsibility depends on the place of service. Refer to the specific Covered Service category that applies to Your treatment
Colon Cancer Screening	Your payment responsibility depends on the place of service. Refer to the specific Covered Service category that applies to Your treatment	Your payment responsibility depends on the place of service. Refer to the specific Covered Service category that applies to Your treatment
Dental & Oral Surgical Services – Accidental Injury Limited to \$1,000 per Member per Policy Year, in- and out-of-network combined.	Deductible/Coinsurance	Deductible/Coinsurance
Diabetic Care Benefits	Your payment responsibility depends on the place of service. Refer to the specific Covered Service category that applies to Your treatment	Your payment responsibility depends on the place of service. Refer to the specific Covered Service category that applies to Your treatment
Dialysis	Deductible/Coinsurance No Copayment/No Coinsurance for dialysis in the home.	Deductible/Coinsurance Dialysis in the home is NOT COVERED out-of-network
Disposable Supplies (ostomy supplies only)	Deductible/Coinsurance	Deductible/Coinsurance
Durable Medical Equipment (DME) and Associated DME Supplies Limited to \$8,000 per Member per Policy Year, in- and out-of-network combined.	Deductible/Coinsurance Costs for upgrades to equipment beyond the cost of the basic Medically Necessary and adequate equipment are Your responsibility.	Deductible/Coinsurance Costs for upgrades to equipment beyond the cost of the basic Medically Necessary and adequate equipment are Your responsibility.
Emergency Services	\$150 Copayment if meets the definition of Emergency Medical Condition. Otherwise, the services are Not Covered .	Covered at the Participating Provider Level if meets the definition of Emergency Medical Condition. Otherwise, the services are Not Covered .

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COVERED SERVICE	YOUR PAYMENT RESPONSIBILITY	
	at the Participating Provider Level	at the Non-Participating Provider Level*
Eyeglasses and Corrective Lenses Following Cataract Removal Surgery Limited to \$100 benefit per Member per surgery.	Your payment responsibility depends on the place of service. Refer to the specific Covered Service category that applies to Your treatment	Not Covered
Family Health Planning	Your payment responsibility depends on the place of service. Refer to the specific Covered Service category that applies to Your treatment	Your payment responsibility depends on the place of service. Refer to the specific Covered Service category that applies to Your treatment
Genetic Counseling, Testing and Screening	Your payment responsibility depends on the place of service. Refer to the specific Covered Service category that applies to Your treatment	Your payment responsibility depends on the place of service. Refer to the specific Covered Service category that applies to Your treatment
Growth Hormone	Deductible/Coinsurance	Not Covered
High Technology Diagnostic Services All high technology diagnostic services, tests, and procedures, including but not limited to: <ul style="list-style-type: none"> • MRI • MRA • CT Scans • Nuclear Medicine Studies • PET Scans • Echocardiograms • Ultrasounds • Supplies • Professional, anesthesia and ancillary services 	Deductible/Coinsurance	Deductible/Coinsurance
Home Health Care and Home Infusion Services Home Health limited to 30 days per Member per Policy Year. Home Infusion limited to 90 days per Member per Policy Year.	Deductible/Coinsurance	Not Covered
Hospice Limited to 210 days per Member per Policy Year.	Deductible/Coinsurance	Not Covered
Infertility (Diagnosis only) Limited to \$500 benefit per Member per lifetime.	Your payment responsibility depends on the place of service. Refer to the specific Covered Service category that applies to Your treatment	Your payment responsibility depends on the place of service. Refer to the specific Covered Service category that applies to Your treatment

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COVERED SERVICE	YOUR PAYMENT RESPONSIBILITY	
	at the Participating Provider Level	at the Non-Participating Provider Level*
Injectable Drugs	Deductible/Coinsurance	Deductible/Coinsurance
Inpatient Hospital Care	Deductible/Coinsurance	Deductible/Coinsurance
Inpatient Rehabilitation Facility Limited to 30 days per Member per Policy Year, in- and out-of-network combined.	Deductible/Coinsurance	Deductible/Coinsurance
Inpatient Skilled Nursing Facility Limited to 75 days per Member per Policy Year.	Deductible/Coinsurance	Not Covered
Laboratory and Reference Pathology Services	No Copayment, No Coinsurance	Deductible/30% Coinsurance
Mammography	No Copayment, No Coinsurance	Deductible/30% Coinsurance
Maternity Services	Not a Covered Service except for Complications of Pregnancy. Refer to Your Policy for details. For Complications: Your payment responsibility depends on the place of service.	
Occupational Therapy Limited to 20 visits per Member per Policy Year, in- and out-of-network combined.	Your payment responsibility depends on the place of service. Refer to the specific Covered Service category that applies to Your treatment	Your payment responsibility depends on the place of service. Refer to the specific Covered Service category that applies to Your treatment
Outpatient Hospital and Outpatient Surgery	Deductible/Coinsurance	Deductible/Coinsurance
Physical Therapy Limited to 20 visits per Member per Policy Year, in- and out-of-network combined.	Your payment responsibility depends on the place of service. Refer to the specific Covered Service category that applies to Your treatment	Your payment responsibility depends on the place of service. Refer to the specific Covered Service category that applies to Your treatment
Podiatry	Your payment responsibility depends on the place of service. Refer to the specific Covered Service category that applies to Your treatment	Not Covered
Prescription Drugs Retail Copayment for Formulary generic Prescription Drugs and plan-approved test strips Self-Administered Injectable Drug Copayment for Formulary generic Self-Administered Injectable Drugs Retail Copayment for Formulary brand name Prescription Drugs and plan-approved test strips	\$10 per Prescription Order or Refill 10% Coinsurance \$25 per Prescription Order or Refill	Not Covered, except for Emergency Out of the Service Area Not Covered, except for Emergency Out of the Service Area Not Covered, except for Emergency Out of the Service Area

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COVERED SERVICE	YOUR PAYMENT RESPONSIBILITY	
	at the Participating Provider Level	at the Non-Participating Provider Level*
<p>Self-Administered Injectable Drug Copayment for Formulary <u>brand name Self-Administered Injectable Drugs</u></p> <p>Retail Copayment for <u>Non-Formulary Prescription Drugs</u> and test strips</p> <p>Self-Administered Injectable Drug Copayment for <u>Non-Formulary Self-Administered Injectable Drugs</u></p> <p>Maintenance Drug Copayment</p>	<p>10% Coinsurance</p> <p>\$50 per Prescription Order or Refill</p> <p>10% Coinsurance</p> <p>3 times the Retail Copayment per Prescription Order or Refill</p>	<p>Not Covered, except for Emergency Out of the Service Area</p> <p>Not Covered, except for Emergency Out of the Service Area</p> <p>Not Covered, except for Emergency Out of the Service Area</p> <p>Not Covered</p>
Prostate-Specific Antigen (PSA) Tests	Your payment responsibility depends on the place of service. Refer to the specific Covered Service category that applies to Your treatment	Your payment responsibility depends on the place of service. Refer to the specific Covered Service category that applies to Your treatment
Prosthetic, Orthotic and Corrective Devices (External) Limited to \$8,000 per Member per Policy Year, in- and out-of-network combined.	Deductible/Coinsurance	Deductible/Coinsurance
Pulmonary and Cardiac Rehabilitation Therapy Limited to \$1,500 per Member per lifetime, in- and out-of-network combined.	Your payment responsibility depends on the place of service. Refer to the specific Covered Service category that applies to Your treatment	Your payment responsibility depends on the place of service. Refer to the specific Covered Service category that applies to Your treatment
Radiology Services, such as X-rays	Deductible/Coinsurance	Deductible/Coinsurance
Speech Therapy Limited to 20 visits per Member per Policy Year, in- and out-of-network combined.	Your payment responsibility depends on the place of service. Refer to the specific Covered Service category that applies to Your treatment	Your payment responsibility depends on the place of service. Refer to the specific Covered Service category that applies to Your treatment
Temporomandibular Joint (TMJ) Non-surgical treatment limited to \$3,500 per Member per lifetime.	Your payment responsibility depends on the place of service. Refer to the specific Covered Service category that applies to Your treatment	Not Covered
Transplant Services Donor screening tests are limited to a lifetime benefit of \$10,000 per Member	Deductible/Coinsurance	Not Covered

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COVERED SERVICE	YOUR PAYMENT RESPONSIBILITY	
	at the Participating Provider Level	at the Non-Participating Provider Level*
Urgent Care Center Services	\$40 Copayment if meets the definition of Urgent Care. Otherwise, the services are Not Covered .	Covered at the Participating Provider Level if meets the definition of Urgent Care. Otherwise, the services are Not Covered .
Chiropractic Care Services Limited to 20 visits per Member per Policy Year.	\$20 Copayment	Not Covered
Vision Care Services Eye examination only. Coverage is available only when services are provided by Our designated vision provider. Please refer to the Vision Directory for list of Participating vision Providers.	\$20 Copayment	Not Covered
Weight Reduction Services Please see Your Policy for a description of Covered Services.	Your payment responsibility depends on the place of service. Refer to the specific Covered Service category that applies to Your treatment	Your payment responsibility depends on the place of service. Refer to the specific Covered Service category that applies to Your treatment
Wigs for Hair Loss Resulting From Cancer Treatment This is a combined in- and out-of-network benefit limit.	We will pay up to \$500 maximum per Member per lifetime.	We will pay up to \$500 maximum per Member per lifetime.

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