COVENTRY
Health Care of Louisiana, Inc.

3838 N. Causeway Blvd., Suite 3350, Metairie, LA 70002
1-866-364-5663

Coventry Health and Life Insurance Company
POS Plan Description
SCHEDULE OF BENEFITS
St. John the Baptist

This Schedule of Benefits is part of your Certificate of Coverage but does not replace it. Many words are defined elsewhere in the Certificate of Coverage, and other limitations or exclusions may be listed in other sections of your Agreement. Reading this Schedule by itself could give you an inaccurate impression of the terms of your coverage. This Schedule must be read with the rest of your Certificate of Coverage. A complete list of covered services, exclusions, and limitations can be found in your Certificate of Coverage.

Pre-authorization may be required as a condition of coverage for certain services. For a complete listing of pre-authorization requirements, please see your Certificate of Coverage or visit www.chcla.com. Prior authorization is required for all Out-of-Network services. All services must Be Medically Necessary.

BENEFITS	MEMBER PAYS In Network	MEMBER PAYS Out of Network
MEDICAL DEDUCTIBLE[i] (per Calendar Year) In-Network and Out-of-Network deductibles are not combined.	Individual: $750	Individual: $1,500
	Family: $1,500 Deductible is equal to 2 times the Individual Deductible.	Family: $3,000 Deductible is equal to 2 times the Individual Deductible.
COINSURANCE (Member pays)	30% of Eligible Charges after applicable Deductibles are applied.	50% of Eligible Charges after applicable Deductibles are applied.
OUT-OF-POCKET MAXIMUM (per Calendar Year) Deductibles and Coinsurance apply to the Out-of-Pocket Maximum. Copayments and Prescription Drug benefits do not apply to the Out-of-Pocket Maximum. Member's total Out-of-Pocket maximum includes medical deductible and Out-of-Pocket amounts listed on schedule.	Individual: $3,000	Individual: $6,000
	Family: $6,000	Family: $12,000
LIFETIME MAXIMUM (per Member)	Unlimited	Unlimited
PRIMARY CARE PHYSICIAN (PCP) SERVICES		
Office Visits Includes laboratory services when performed and billed in physician's office. Immunizations (non-preventative). Allergy Testing, Treatment and Injections. Radiology when test is performed in office. Chiropractic Office Visits (Services must be clinically appropriate and within the chiropractor's scope of practice.)	$20 Copayment	Deductible Applies, 50% Coinsurance
SPECIALIST PHYSICIAN SERVICES		
Office Visits Includes laboratory services when performed and billed in physician's office. Radiology when test is performed in office. Allergy Testing, Treatment and Injections.	$40 Copayment	Deductible Applies, 50% Coinsurance

BENEFITS	MEMBER PAYS In Network	MEMBER PAYS Out of Network
BLOOD ADMINISTRATION		
Blood and Blood Products are not covered.	Inpatient: Deductible Applies, 30% Coinsurance	Inpatient: Deductible Applies, 50% Coinsurance
	Outpatient: Deductible Applies, 30% Coinsurance	Outpatient: Deductible Applies, 50% Coinsurance
DURABLE MEDICAL EQUIPMENT, PROSTHETICS AND ORTHOTICS*		
	Deductible Applies, 30% Coinsurance	Deductible Applies, 50% Coinsurance
EMERGENCY CARE SERVICES		
Hospital Emergency Facility	$100 Copayment, Waived if Admitted	
Ambulance	Deductible Applies, 30% Coinsurance	
Urgent Care Facility	$50 Copayment	
FAMILY PLANNING		
Insertion and Removal of Intrauterine Devices/Diaphragm	$40 Copayment	Deductible Applies, 50% Coinsurance
Tubal Ligation and Vasectomy	Inpatient: Deductible Applies, 30% Coinsurance Outpatient: Deductible Applies, 30% Coinsurance Specialist: $40 Copayment	Deductible Applies, 50% Coinsurance
Infertility Diagnostic Testing ($1,500 Benefit Maximum)	Deductible Applies, 30% Coinsurance	Deductible Applies, 50% Coinsurance
HEARING AIDS		
Covered only for children under 18 years of age Coverage shall not exceed $1,400 per ear every 36 months	Deductible Applies, 30% Coinsurance	Deductible Applies, 50% Coinsurance
HOME HEALTH CARE *		
	Deductible Applies, 30% Coinsurance	Deductible Applies, 50% Coinsurance
	PCP: $20 Copayment Specialist: $40 Copayment	Deductible Applies, 50% Coinsurance
HOSPICE CARE *		
	Deductible Applies, 30% Coinsurance	Deductible Applies, 50% Coinsurance
INPATIENT HOSPITAL CARE*		
Maternity Services Room and Board Medication & Drugs/Therapies Professional Services X-Ray/Laboratory/Blood Administration Intensive Care/Coronary Care	Deductible Applies, 30% Coinsurance	Deductible Applies, 50% Coinsurance
LOW PROTEIN FOOD PRODUCTS		
	Deductible Applies, 30% Coinsurance	Deductible Applies, 50% Coinsurance

BENEFITS	MEMBER PAYS In Network	MEMBER PAYS Out of Network
MATERNITY CARE		
Notification required once pregnancy confirmed. One payment per pregnancy unless a member changes Physician before delivery, then required to pay an additional Copayment, Coinsurance and/or Deductible for first office visit with new physician. Services provided by any Physicians other than Primary OB/GYN requires payment of an additional Copayment, Coinsurance and/or Deductible.	$40 Copayment	Deductible Applies, 50% Coinsurance
MENTAL HEALTH AND CHEMICAL DEPENDENCY[ii] *		
Covered on the same terms and conditions as other Illnesses and Injuries. See applicable benefit description and limitations listed in the Certificate of Coverage. Penalty for failure to precertify. Inpatient and partial hospitalization services	Inpatient: Deductible Applies, 30% Coinsurance	Inpatient: Deductible Applies, 50% Coinsurance
Outpatient Services	Outpatient: $40 Copayment	Outpatient: Deductible Applies, 50% Coinsurance
Office Visit	Specialist: $40 Copayment	Specialist: Deductible Applies, 50% Coinsurance
AUTISM*		
Applies to Children under 17 Years of Age in Employer Groups of over 50 Employees Physician's Office	PCP: $20 Copayment Specialist: $40 Copayment	PCP: Deductible Applies, 50% Coinsurance Specialist: Deductible Applies, 50% Coinsurance
Autism Service Provider, Certified as a Behavior Analyst	Specialist: $40 Copayment	Specialist: Deductible Applies, 50% Coinsurance
OUTPATIENT SERVICES AT HOSPITAL/FREE STANDING FACILITY*		
Ambulatory Surgery	Deductible Applies, 30% Coinsurance	Deductible Applies, 50% Coinsurance
Chemotherapy and Radiation Treatment	Deductible Applies, 30% Coinsurance	Deductible Applies, 50% Coinsurance
PREVENTIVE SERVICES FOR ADULTS AND CHILDREN (PCP & Specialist) Includes A and B Services recommended by the US Preventive Services Task Force		
Preventative Immunizations Physical Exam Well Child Well Woman (Limited to 2 routine visits per year) Preventative Screenings - Routine Mammograms, Pap Smears and PSA Tests	Covered in Full	Deductible Applies, 50% Coinsurance
SECOND OPINION*	Covered in Full	

BENEFITS	MEMBER PAYS In Network	MEMBER PAYS Out of Network
SHORT TERM THERAPIES		
Speech, Physical, and Occupational Therapies Limited to 60 visits of combined therapy per Calendar year. No authorization required. In-Network and Out-of-Network coverage is combined.	$20 Copayment	Deductible Applies, 50% Coinsurance
Cardiac Rehabilitation and Pulmonary Therapy* Limited to 36 visits per occurrence. Authorization is required.	$20 Copayment	Deductible Applies, 50% Coinsurance
SKILLED NURSING FACILITIES		
Facility, supplies and equipment* Limited to 30 days per Calendar Year In-Network and Out-of-Network coverage is combined.	Deductible Applies, 30% Coinsurance	Deductible Applies, 50% Coinsurance
TRANSPLANT SERVICES*		
Must be performed at a Coventry Transplant Network Facility Limited to testing 4 potential donors	Deductible Applies, 30% Coinsurance	Not Covered
X-RAY LABORATORIES AND DIAGNOSTIC TESTS		
Lab Outpatient[iii]	Covered in Full	Deductible Applies, 50% Coinsurance
CT, MRI, MRA, PET Scans*	Deductible Applies, 30% Coinsurance	Deductible Applies, 50% Coinsurance
All Other X-Rays Outpatient	Covered in Full	Deductible Applies, 50% Coinsurance

"* "denotes that service(s) require Prior Authorization

All plans are subject to a six (6) month waiting period for Pre-Existing Medical Conditions or eighteen (18) months in the case of a Late Enrollee, which shall begin on the Enrollment Date. Pre-Existing Medical Condition means the existence of symptoms which would cause an ordinarily prudent person to seek diagnosis, care, or treatment, or a condition for which medical advice or treatment was recommended by or received from a provider of health care services, within 6 months preceding the effective date of coverage of the insured. Dependent children under the age of 19 are not subject to any Pre-Existing Medical Conditions exclusions or limitations. If there is a waiting period, the Pre-Existing Medical Condition exclusion period is offset by the period of time beginning with the first (1st) day of the waiting period and ending on the first (1st) day of Coverage under this Agreement. The exclusion period for Pre-Existing Medical Conditions will be reduced by Your prior period of Creditable Coverage, provided that there is no break in Creditable Coverage of more than sixty-three (63) consecutive days. A prior period of Creditable Coverage is the number of days credited to a Member that operates to reduce or eliminate the Health Plan's Pre-Existing Medical Condition exclusion period.

This summary is a partial description of coverage and does not detail all benefits, limitations and exclusions. Please consult the Certificate of Coverage and applicable Riders to determine the exact terms, conditions and scope of coverage.

---

[i] Family Deductible: Coverage for Covered Services are payable for all Members in a family without additional Deductibles during the remainder of a Contract year upon the earliest of: (1) the date the number of Members in a family referenced in Your Schedule of Benefits have each satisfied the individual Deductible; or (2) the date family Members have cumulatively satisfied the Deductible amount set forth in Your Schedule of Benefits. However, if this amount is not met, each Member must meet one hundred percent (100%) of the individual Deductible.

[ii] For authorization of services, please contact MHNet at the number on the back of your Member ID card.

[iii] Quest Diagnostics® is the exclusive laboratory Provider for members residing in the Greater New Orleans region.