Coventry Health Care of Missouri: Silver \$15 Copay PPO Plan

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Individual, Individual and Spouse and Family

| Plan Type: PPO

Coverage Period: 01/01/2014 - 12/31/2014

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This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at http://coventryone.com/chcmissouri or by calling 855-449-2889.

Important Questions	Answers	Why This Matters:
What is the overall	In network: \$3750 person \$7500 family	You must pay all the costs up to the <u>deductible</u> amount before this plan begins to
deductible?	Out of network: \$6400 person \$12800	pay for covered services you use. Check your policy or plan document to see
	family. Does not apply to preventive	when the deductible starts over (usually, but not always, January 1st). See the
	care, office visits, convenience care,	chart starting on page 2 for how much you pay for covered services after you
	urgent care	meet the <u>deductible</u> .
Are there other <u>deductibles</u>	Pharmacy: \$1000 Individual	You must pay all of the costs for these services up to the specific <u>deductible</u>
for specific services?		amount before this plan begins to pay for these services.
Is there an out-of-pocket	In network: \$6350 person \$12700 family	The out-of-pocket limit is the most you could pay during a coverage period
<u>limit</u> on my expenses?	Out of network: \$12800 person \$25600	(usually one year) for your share of the cost of covered services. This limit helps
	family	you plan for health care expenses.
What is not included in the	Premiums, Balance-billed charges,	Even though you pay these expenses, they don't count toward the <u>out-of-pocket</u>
out-of-pocket limit?	Health care this plan doesn't cover,	<u>limit</u> .
	Prior authorization penalties.	
Is there an overall annual	No	The chart starting on page 2 describes any limits on what the plan will pay for
limit on what the plan pays?		specific covered services, such as office visits.
Does this plan use a network	Yes	If you use an in-network doctor or other health care provider , this plan will pay
of <u>providers</u> ?	Phone: 855-449-2889; Web:	some or all of the costs of covered services. Be aware, your in-network doctor or
	http://coventryone.com/chcmissouri	hospital may use an out-of-network <u>provider</u> for some services. Plans use the
		term in-network, <u>preferred</u> , or participating for <u>providers</u> in their <u>network</u> . See
		the chart starting on page 2 for how this plan pays different kinds of <u>providers</u> .
Do I need a referral to see a	No	You can see the specialist you choose without permission from this plan.
specialist?		
Are there services this plan	Yes. See your plan document for	Some of the services this plan doesn't cover are listed on page 5. See your policy
doesn't cover?	additional information about excluded	or plan document for additional information about excluded services .
	services.	

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- <u>Co-payments</u> are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- Co-insurance is your share of the costs of a covered service, calculated as a percent of the <u>allowed amount</u> for the service. For example, if the plan's <u>allowed amount</u> for an overnight hospital stay is \$1,000, your <u>co-insurance payment</u> of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the <u>allowed amount</u>. If an out-of-network provider charges more than the <u>allowed amount</u>, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the <u>allowed amount</u> is \$1,000, you may have to pay the \$500 difference. (This is called <u>balance billing</u>.)
- This plan may encourage you to use In network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

		Your cost it	you use a	
Common Medical Event	Services You May Need	In network Provider	Out of network Provider	Limitations & Exceptions
	injury or illness	\$15 co-payment (co- pay)/occurrence	50% co-insurance (co-ins)/occurrence	none
	Specialist visit	First visit: \$75 co- pay/occurrence	50% co-ins/occurrence	In-network: After 1st visit: \$75 co-pay after deductible/occurrence
If you visit a health care provider's office or clinic	Other practitioner office visit	Nurse Practitioners, Physician Assistants: \$15 co-pay/occurrence (PCP)/\$75 co- pay/occurrence (Specialist)	50% co-ins/occurrence	none
	Preventive care/ Screening/Immunization	\$0 co-pay/occurrence	50% co-ins/occurrence	none
If you have a test	Diagnostic test (x-ray, blood work)	30% co-ins/occurrence x-ray \$0 co-pay/occurrence if in prefferred indpendent lab	x-ray	Pre-authorization (Pre-auth) required. Innetwork Lab: if in PCP, included in Office visit co-pay. If in Specialist office/Outpatient facility: 30% co-ins/occurrence
	Imaging (CT/PET scans, MRIs)	\$250 co-pay + 30% co- ins/occurrence	\$250 co-pay + 50% co- ins/occurrence	Pre-auth is required.

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		Your cost i	f you use a		
Common Medical Event	Services You May Need	In network Provider	Out of network Provider	Limitations & Exceptions	
	Generic drugs	\$15 co-pay/fill / \$30 co-pay/mail-order	Not Covered	31-day supply retail, 90-day supply mail order. May require pre-auth.	
If you need drugs to treat your illness or condition. More information about prescription drug coverage is available at	Preferred brand drugs	\$45 co-pay/fill / \$112.50 co-pay/mail- order	Not Covered	31-day supply retail, 90-day supply mail order. May require pre-auth.	
http://coventryone.com/ch cmissouri.	Non-preferred brand drugs	\$75 co-pay/fill / \$225 co-pay/mail-order	Not Covered	31-day supply retail, 90-day supply mail order. May require pre-auth.	
	Specialty drugs	30%/fill (fourth tier) / 40%/fill (fifth tier)	Not Covered	Preauthorization may be required for some drugs.	
If you have outpatient	Facility fee (e.g., ambulatory surgery center)	30% co-ins/occurrence	50% co-ins/occurrence	Pre-auth required.	
surgery	Physician/surgeon fees	30% co-ins/occurrence	50% co-ins/occurrence	Pre-auth is required.	
If you need immediate	Emergency room services	First visit: \$500 co- pay/occurrence	First visit: \$500 co- pay/occurrence	Co-pay waived if patient is admitted. In Network: After 1st visit: \$500 co-pay + deductible/occurrence	
medical attention	Emergency medical transportation	30% co-ins/occurrence	50% co-ins/occurrence	none	
	Urgent care	\$75 co-pay/occurrence	50% co-ins/occurrence	none	
If you have a hospital stay	Facility fee (e.g., hospital room)	\$500 + 30% co- ins/occurrence	\$1000 co-pay + 50% co-ins/occurrence	Pre-auth required.	
	Physician/surgeon fee	30% co-ins/occurrence	50% co-ins/occurrence	Pre-auth is required.	
If you have mental health, behavioral health, or	Mental/Behavioral health outpatient services	30% co-ins/occurrence	50% co-ins/occurrence	Office Visit In-network: \$75 co- pay/occurrence Out of Network: 50% co- ins/occurrence	
substance abuse needs	Mental/Behavioral health inpatient services	\$500 co-pay + 30% co- ins/occurrence	\$1000 co-pay + 50% co-ins/occurrence	Pre-auth is required.	

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		Your cost if you use a			
Common Medical Event	Services You May Need	In network Provider	Out of network Provider	Limitations & Exceptions	
If you have mental health, behavioral health, or	Substance use disorder outpatient services	30% co-ins/occurrence	50% co-ins/occurrence	Office Visit In-network: \$75 co- pay/occurrence Out of Network: 50% co- ins/occurrence	
substance abuse needs	Substance use disorder inpatient services	\$500 co-pay + 30% co- ins/occurrence	\$1000 co-pay + 50% co-ins/occurrence	Pre-auth is required.	
If you are pregnant	Prenatal and postnatal care	\$250 co-pay one time only	50% co-ins/occurrence	none	
	Delivery and all inpatient services	\$500 co-pay + 30% co- ins/occurrence	\$1000 co-pay + 50% co-ins/occurrence	none	
	Home health care	30% co-ins/occurrence	50% co-ins/occurrence	Limited to 90 visits per benefit period	
	Rehabilitation services	Inpatient \$500 co-pay + 30% co-ins/occurrence Outpatient 30% co-ins/occurrence	Inpatient \$1000 co-pay + 50% co- ins/occurrence Outpatient 50% co- ins/occurrence	none	
If you need help recovering or have other special health needs	Habilitation services	30% co-ins/occurrence	50% co-ins/occurrence	Limited to: 20 visits each (physical, occupational therapy, pulmonary each); 36 visits/cardiac therapy	
	Skilled nursing care (facility)	30% co-ins/occurrence	50% co-ins/occurrence	Pre-auth is required. Limited to 90 visits per benefit period	
	Durable medical equipment (including supplies)	30% co-ins/occurrence	50% co-ins/occurrence	Pre-auth is required.	
	Hospice Services	30% co-ins/occurrence	50% co-ins/occurrence	none	
	Eye exam	\$0 co-pay/occurrence	40% co-ins/occurrence	Limited to 1 annual eye exam per plan member.	
If your child needs dental or eye care	Glasses	\$0 co-pay/occurrence	40% co-ins/occurrence	Coverage for 1 pair of standard eyeglass lenses or contact lenses per yr.; 1 frame every yr.	
	Dental check-up	Not Covered	Not Covered	No coverage for dental check-ups for children.	

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Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy for others.) Child/Dental Check-up Acupuncture Bariatric Surgery **Cosmetic Surgery** Dental Care (Adult) Infertility Treatment Long-Term Care Routine Eye Care (Adult) **Routine Foot Care** Weight Loss Programs

Outside the U.S.

Other Covered Services (This isn't	a complete list. Ch	eck your policy for other c	overed services and your	costs for these services.)
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Chiropractic Care **Hearing Aids** Non-Emergency Care when Traveling

Private-Duty Nursing

Your Rights to Continue Coverage:

Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay your premium. There are exceptions, however, such as if:

- You commit fraud
- The insurer stops offering services in the State
- You move outside the coverage area

For more information on your rights to continue coverage, contact the insurer at 855-449-2889. You may also contact your state insurance department at Missouri Department of Insurance P.O. Box 690 Jefferson City, MO 76102-0690 Consumer Assistance Hotline: 800-726-7390 (Toll Free) Email: consumeraffairs@insurance.mo.gov.

Your Grievance and Appeals Rights:

If you have a compliant or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact:

Missouri Department of Insurance P.O. Box 690 Jefferson City, MO 76102-0690 Consumer Assistance Hotline: 800-726-7390 (Toll Free) Email: consumeraffairs@insurance.mo.gov

Additionally, a consumer assistance program can help you file your appeal. Contact Missouri Department of Insurance 301 W. High St, Room 830 Harry S. Truman State Office Building Jefferson City, MO 65101 800-726-7390 (Toll Free) www.insurance.mo.gov consumeraffairs@insurance.mo.gov

Does this Coverage Provide Minimum Essential Coverage?

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Questions: Call 855-449-2889 or visit us at http://coventryone.com/chcmissouri. If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at http://www.cms.gov/CCIIO/resources/files/downloads/uniform-glossary-final.pdf or call 855-449-2889 to

request a copy.

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy <u>provide</u> minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This** health coverage meet the minimum value standard for the benefits is provides.

Language Access Services:

Spanish (Espanol): Para obtener asistencia en Espanol, llame al 855-449-2889.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 855-449-2889.

Chinese (中文): 如果需要中文的帮助,请拨打这个号码 855-449-2889.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 855-449-2889.

——————To see examples of how this plan might cover costs for a sample medical situation, see the next page.—————

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About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much insurance protection you might get from different plans.



This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby

(normal delivery)

\$7,540 Amount owed to providers:

Plan pays: \$3,440

You pay: \$4,100

Sample care costs:

Total	\$4,100
Limits or exclusions	\$200
Coinsurance	\$0
Co-pays	\$300
Deductibles	\$3,600
You pay:	
Total	\$7,540
Vaccines, other preventive	\$40
Radiology	\$200
Prescriptions	\$200
Laboratory tests	\$500
Anesthesia	\$900
Hospital Charges (baby)	\$900
Routine Obstetric Care	\$2,100
Hospital charges (mother)	\$2,700

Managing type 2 diabetes

(routine maintenance of a well-controlled condition)

Amount owed to providers: \$5,400

Plan pays: \$2,500

You pay: \$2,900

Sample care costs:

Prescriptions	\$2,900
Medical equipment and supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccine, other preventive	\$100
Total	\$5,400
You pay:	
Deductibles	\$1,500
Deductibles Co-pays	\$1,500 \$1,200
	. ,
Co-pays	\$1,200

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Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include <u>premiums</u>.
- Sample care costs are based on national averages supplied by the U.S.
 Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from innetwork <u>providers</u>. If the patient had received care from out-of-network <u>providers</u>, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how <u>deductibles</u>, <u>copayments</u>, and <u>coinsurance</u> can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

No. Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

No. Coverage Examples are not cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

Yes. When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

Yes. An important cost is the premium you pay. Generally, the lower your premium, the more you'll pay in out-of-pocket costs, such as copayments, deductibles, and coinsurance. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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