Coventry Health and Life Insurance Company: Silver $10 Co-pay PPO Exchange

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

Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage for:** Individual, Family **| Plan Type:** PPO

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 www.chckansas.com or by calling 855-449-2889.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-network: Individual (Ind): $3,750. Family: $7,500. Doesn't apply to: preventive care, PCP office visits, convenience care, urgent care, pre/postnatal visits, pediatric vision. Out-of-network: Ind: $6,400. Family: $12,800.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	Yes. $1,000 deductible on prescription drugs.	You must pay all of the costs for these services up to the specific **deductible** amount before this plan begins to pay for these services.
Is there an out-of-pocket limit on my expenses?	In-network: Yes. Ind: $6,350. Family: $12,700. Out-of-network: Yes. Ind: $16,500. Family: $33,000.	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Premiums, balance-billing and health care this plan does not cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes For a list of In-network providers, visit www.chckansas.com or call 855-449-2889.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

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- **Co-payments** 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 **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **co-insurance** payment 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 **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use In-network **providers** by charging you lower **deductibles, copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In-network Provider	Out-of-network Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$10 Co-payment (Co-pay)	50% Co-insurance (Co-ins)	None
	Specialist visit	First Visit: $75 Co-pay	50% Co-ins	2+ visits will be Co-pay plus deductible
	Other practitioner office visit	30% Co-ins spinal manipulation (chiropractic care)	50% Co-ins spinal manipulation (chiropractic care)	None
	Preventive care/ Screening/Immunization	$0 Co-pay	50% Co-ins	None
If you have a test	Diagnostic test (x-ray, blood work)	30% Co-ins x-ray 30% Co-ins lab	50% Co-ins x-ray 50% Co-ins lab	None
	Imaging (CT/PET scans, MRIs)	$250 Co-pay	50% Co-ins	May require prior authorization (prior auth). Failure to prior auth may result in non-covered services.
If you need drugs to treat your illness or condition. More information about prescription drug coverage is available at www.chckansas.com.	Generic drugs	Preferred Pharmacy: $15 Co-pay / 31 day supply	Non Preferred Pharmacy: $20 Co-pay / 31 day supply	Includes $5 Co-pay for select generic drugs. Prior Auth is required for some drugs. Failure to prior auth may result in non-covered services. Mail order is available for 2x the retail Copay / 90 day supply.
	Preferred brand drugs	Preferred Pharmacy: Deductible + $45 Co-pay / 31 day supply	Non Preferred Pharmacy: Deductible + $55 Co-pay / 31 day supply	Prior Auth is required for some drugs. Failure to prior auth may result in non-covered services. Mail order is available for 2.5x the retail Copay / 90 day supply.

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Common Medical Event	Services You May Need	Your cost if you use a In-network Provider	Your cost if you use a Out-of-network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition. More information about prescription drug coverage is available at www.chckansas.com.	Non-preferred brand drugs	Preferred Pharmacy: Deductible + $75 Co-pay / 31 day supply	Non Preferred Pharmacy: Deductible + $85 Co-pay / 31 day supply	Prior Auth is required for some drugs. Failure to prior auth may result in non-covered services. Mail order is available for 3x the retail Copay / 90 day supply.
	Specialty drugs	Preferred Drugs: Deductible + 30% Co-ins; Non-Preferred Drugs: Deductible + 40% / 31 day supply	Not Applicable	Prior Auth is required for some drugs. Failure to prior-auth may result in non-covered services.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$250 Co-pay plus 30% Co-ins	$250 Co-pay plus 50% Co-ins	May require prior auth. Failure to prior auth may result in non-covered services.
	Physician/surgeon fees	30% Co-ins	50% Co-ins	May require prior auth. Failure to prior auth may result in non-covered services.
If you need immediate medical attention	Emergency room services	First Visit: $500 Co-pay	First Visit: $500 Co-pay	2+ Visits: $500 Co-pay plus deductible. Must meet emergency criteria.
	Emergency medical transportation	30% Co-ins	30% Co-ins	Must meet emergency criteria.
	Urgent care	$75 Co-pay	50% Co-ins	None
If you have a hospital stay	Facility fee (e.g., hospital room)	$500 Co-pay / admission plus 30% Co-ins	$1,000 Co-pay / admission plus 50% Co-ins	Prior auth required. Failure to prior auth may result in non-covered services.
	Physician/surgeon fee	30% Co-ins	50% Co-ins	Prior auth required. Failure to prior auth may result in non-covered services.
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	First Visit: $75 Co-pay	50% Co-ins	2+ visits will be Co-pay plus deductible
	Mental/Behavioral health inpatient services	$500 Co-pay / admission plus 30% Co-ins	$1,000 Co-pay / admission plus 50% Co-ins	Prior auth required. Failure to prior auth may result in non-covered services. Call MHNet at 1-866-607-5970.
	Substance use disorder outpatient services	First Visit: $75 Co-pay	50% Co-ins	2+ visits will be Co-pay plus deductible

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Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In-network Provider	Out-of-network Provider	
If you have mental health, behavioral health, or substance abuse needs	Substance use disorder inpatient services	$500 Co-pay / admission plus 30% Co-ins	$1,000 Co-pay / admission plus 50% Co-ins	Prior auth required. Failure to prior auth may result in non-covered services. Call MHNet at 1-866-607-5970.
If you are pregnant	Prenatal and postnatal care	$250 Co-pay	50% Co-ins	One time copayment for physician charges, prenatal, postnatal, ultrasound and delivery
	Delivery and all inpatient services	$500 Co-pay / admission plus 30% Co-ins	$1,000 Co-pay / admission plus 50% Co-ins	Stays beyond 48/96 hours for vaginal delivery/cesarean section require prior auth. Failure to prior auth may result in non-covered services.
If you need help recovering or have other special health needs	Home health care	30% Co-ins	50% Co-ins	Prior auth required. Failure to prior auth may result in non-covered services.
	Rehabilitation services	Inpatient $500 Co-pay / admission plus 30% Co-ins Outpatient 30% Co-ins	Inpatient $1,000 Co-pay / admission plus 50% Co-ins Outpatient 50% Co-ins	Prior auth required. Failure to prior auth may result in non-covered services. Limited to 20 visits per therapy per calendar year.
	Habilitation services	30% Co-ins	50% Co-ins	Prior auth required. Failure to prior auth may result in non-covered services. Limited to 20 visits per therapy per calendar year.
	Skilled nursing care	30% Co-ins	50% Co-ins	Prior auth required. Failure to prior auth may result in non-covered services. Limited to 60 days per Calendar Year.
	Durable medical equipment	30% Co-ins	50% Co-ins	Prior auth required. Failure to prior auth may result in non-covered services.
	Hospice Service	30% Co-ins	50% Co-ins	Prior auth required. Failure to prior auth may result in non-covered services. Inpatient limited to 15 days per Calendar Year.
If your child needs dental or eye care	Eye exam	$0 Co-pay	40% Co-ins	One exam per calendar year.
	Glasses	$0 Co-pay	40% Co-ins	Lenses or Contact Lenses – Once each Calendar Year; Frame – Once each Calendar year
	Dental check-up	Not Covered	Not Covered	Excluded Service

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Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)		
• Acupuncture	• Bariatric Surgery	• Child/Dental Check-up
• Cosmetic Surgery	• Dental Care (Adult)	• Hearing Aids
• Infertility Treatment	• Long-Term Care	• Routine Foot Care
• Weight Loss Programs		

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)		
• Chiropractic Care	• Non-Emergency Care when Traveling Outside the U.S.	• Private-Duty Nursing
• Routine Eye Care (Adult)		

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 (Toll Free) 800-726-7390 E-mail: consumeraffairs@insurance.mo.gov.

Your Grievance and Appeals Rights:

If you have a complaint 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 (Toll Free) 800-726-7390 E-mail: consumeraffairs@insurance.mo.gov

Missouri Department of Insurance 301 W. High Street, Room 830 Harry S. Truman State Office Building Jefferson City, MO 65101 (Toll Free) 800-726-7390 or online at www.insurance.mo.gov or consumeraffairs@insurance.mo.gov

Does this Coverage Provide Minimum Essential Coverage?

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

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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 does 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)

- **Amount owed to providers:** $7,540
- **Plan pays:** $3,840
- **You pay:** $3,700

Sample care costs:

Hospital charges (mother)	$2,700
Routine Obstetric Care	$2,100
Hospital Charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

You pay:

Deductibles	$2,700
Co-pays	$800
Coinsurance	$0
Limits or exclusions	$200
Total	**$3,700**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays:** $2,440
- **You pay:** $2,960

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	$1,100
Co-pays	$1,800
Coinsurance	$0
Limits or exclusions	$60
Total	**$2,960**

Note: These numbers assume the patient is participating in our diabetes wellness program. If you have diabetes and do not participate in the wellness program, your costs may be higher. For more information about the diabetes wellness program, please contact: 855-449-2889

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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 **premiums**.
- 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 in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** 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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