Coventry Health Care of Missouri: PPO R836

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

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

Coverage for: Employee, Emp+Spouse, Emp+Child. 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.chcmissouri.coventryhealthcare.com or by calling 1-800-755-3901.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In network: $2500 individual $5000 family Out of network: $5000 individual $10000 family. Does not apply to preventive care, specialist/other office visits, emergency services, urgent care, prescription drugs.	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?	No	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses?	In network: Yes $6000 individual $12000 family Out of network: Yes $8000 individual Yes $16000 family	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-billed charges, Health care this plan doesn't cover, Prior authorization penalties.	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 Phone: 1-800-755-3901; Web: www.chcmissouri.com	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. See your plan document for additional information about excluded services.	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	$30 co-payment (co-pay)/occurrence	30% co-insurance (co-ins)/occurrence	----------none----------
	Specialist visit	$60 co-pay/occurrence	30% co-ins/occurrence	----------none----------
	Other practitioner office visit	Chiro: $20 co-pay/occurrence; Nurse Practitioners and Physician Assistants: $30 co-pay/occurrence (PCP) / $60 co-pay/occurrence (Specialist)	30% co-ins/occurrence	Chiro services limited to 26 visits/benefit year.
	Preventive care/ Screening/Immunization	$0 co-pay/occurrence	30% co-ins/occurrence	----------none----------
If you have a test	Diagnostic test (x-ray, blood work)	0% co-ins/occurrence x-ray $0 co-pay if in preferred independent lab. $30 co-pay/occurrence (PCP) / $60 co-pay/occurrence (Specialist) lab	30% co-ins/occurrence x-ray 30% co-ins/occurrence lab	Pre-authorization (Pre-auth) required. Failure: Additional charges equal to 20% of the Out-of-Network (OON) rate.
	Imaging (CT/PET scans, MRIs)	$0 co-pay/occurrence	30% co-ins/occurrence	Pre-auth required. Failure: Additional charges equal to 20% of the OON rate.

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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 need drugs to treat your illness or condition. More information about prescription drug coverage is available at www.chcmissouri.coventryhealthcare.com.	Generic drugs	$10 co-pay (retail)/ $20 co-pay (mail order)	Not covered	31-day supply retail, 90-day supply mail order. May require pre-auth.
	Preferred brand drugs	$35 co-pay (retail)/$70 co-pay (mail order)	Not covered	31-day supply retail, 90-day supply mail order. May require pre-auth.
	Non-preferred brand drugs	$60 co-pay (retail)/$120 co-pay (mail order)	Not covered	31-day supply retail, 90-day supply mail order. May require pre-auth.
	Specialty drugs	$35/$60 co-pay	Not covered	Preauthorization may be required for some drugs.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% co-ins/occurrence	30% co-ins/occurrence	Pre-auth required. Failure: Additional charges equal to 20% of the OON rate.
	Physician/surgeon fees	0% co-ins/occurrence	30% co-ins/occurrence	Pre-auth required. Failure: Additional charges equal to 20% of the OON rate.
If you need immediate medical attention	Emergency room services	$250 co-pay/occurrence	$250 co-pay/occurrence	Must meet emergency criteria. Co-pay waived if patient is admitted.
	Emergency medical transportation	0% co-ins/occurrence	30% co-ins/occurrence	Must meet emergency criteria.
	Urgent care	$75 co-pay/occurrence	$75 co-pay/occurrence	Must meet urgent care criteria.
If you have a hospital stay	Facility fee (e.g., hospital room)	0% co-ins/occurrence	30% co-ins/occurrence	Pre-auth required unless Emergency admission. Failure: Additional charge of $1,000 for OON services.
	Physician/surgeon fee	0% co-ins/occurrence	30% co-ins/occurrence	Pre-auth required unless Emergency admission. Failure: Additional charge of $1,000 for OON services.
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$60 co-pay/occurrence	30% co-ins/occurrence	----------none----------

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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	Mental/Behavioral health inpatient services	0% co-ins/occurrence	30% co-ins/occurrence	Pre-auth required unless Emergency admission. Failure: Additional charge of $1,000 for OON services.
	Substance use disorder outpatient services	$60 co-pay/occurrence	30% co-ins/occurrence	----------none----------
	Substance use disorder inpatient services	0% co-ins/occurrence	30% co-ins/occurrence	Pre-auth required unless Emergency admission. Failure: Additional charge of $1,000 for OON services.
If you are pregnant	Prenatal and postnatal care	$30 co-pay first visit only	30% co-ins first visit only	None
	Delivery and all inpatient services	0% co-ins/occurrence	30% co-ins/occurrence	Pre-auth required unless Emergency admission. Failure: Additional charge of $1,000 for OON services.
If you need help recovering or have other special health needs	Home health care	0% co-ins/occurrence	30% co-ins/occurrence	Pre-auth required. Failure: Additional charges equal to 20% of the OON rate.
	Rehabilitation services	Inpatient 0% co-ins/occurrence Outpatient 30% co-ins/occurrence	Inpatient 30% co-ins/occurrence Outpatient 30% co-ins/occurrence	Physical Therapy Office Visits: $30 co-pay/occurrence. Pre-auth required unless Emergency admission. Failure: Additional charges equal to 20% of the OON rate (outpatient) or $1,000 (inpatient).
	Habilitation services	0% co-ins/occurrence	30% co-ins/occurrence	Pre-auth required. Failure: Additional charges equal to 20% of the OON rate (outpatient services) or $1,000 (inpatient services).
	Skilled nursing care	0% co-ins/occurrence	30% co-ins/occurrence	Pre-auth required. Failure: Additional charge of $1,000 for OON services. Limited to 45 days per calendar year.
	Durable medical equipment	0% co-ins/occurrence	30% co-ins/occurrence	Pre-auth purchase over $500 and rental equipment (oxygen and TENS units not included). Additional charges equal to 20% of the OON rate.
	Hospice Service	0% co-ins/occurrence	30% co-ins/occurrence	None

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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 your child needs dental or eye care	Eye exam	$60 co-pay/occurrence	30% co-ins/occurrence	Limited to 1 annual eye exam per plan member.
	Glasses	Not Covered	Not Covered	Not Covered
	Dental check-up	Not Covered	Not Covered	No coverage for dental check-ups for children.

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
• Child/Glasses	• Cosmetic Surgery	• Dental Care (Adult)
• Infertility Treatment	• Long-Term Care	• Private-Duty Nursing
• 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	• Hearing Aids	• Non-Emergency Care when Traveling Outside the U.S.
• Routine Eye Care (Adult)		

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-800-755-3901. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa , or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.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:

For group health coverage subject to ERISA, you may contact 1-800-755-3901. You may also contact, the Department of Labor's Employee Benefits Security

Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform , or your state department of insurance at Missouri Department of Insurance P.O. Box 690 Jefferson City, MO 76102-0690 800-726-7390 (Toll Free) E-mail: consumeraffairs@insurance.mo.gov.

For non-federal governmental group health plans and church plans that are group health plans, you may contact 1-800-755-3901 or your state department of insurance at Missouri Department of Insurance P.O. Box 690 Jefferson City, MO 76102-0690 800-726-7390 (Toll Free) E-mail: 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.**

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 it provides.**

Language Access Services:

Spanish (Espanol): Para obtener asistencia en Espanol, llame al 1-800-755-3901.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-755-3901.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-755-3901.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-755-3901.

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:** $4,810
- **You pay:** $2,730

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	$2,500
Co-pays	$30
Coinsurance	$0
Limits or exclusions	$200
Total	**$2,730**

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

- **Amount owed to providers:** $5,400
- **Plan pays:** $3,400
- **You pay:** $2,000

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	$500
Co-pays	$1,300
Coinsurance	$0
Limits or exclusions	$200
Total	**$2,000**

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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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