Schedule of Benefits: QAR 2500 E - 100/80

This Summary of Benefits summarizes your obligation towards the cost of certain covered services. Refer to your Certificate of Coverage for a detailed description of covered services and limitations or exclusions.

To receive In-Network benefits, all covered services, except for Emergency Health Services, must be performed or referred by a participating Coventry Health Care of Missouri provider or authorized in advance by the Plan.

All services must be medically necessary as a condition of coverage and not otherwise limited or excluded.

	BENEFITS AND SERVICES	MEMBER RESPONSIBILITY	
		IN-NETWORK	OUT-OF-NETWORK
1	**Annual Deductible** Total amount a plan member is required to pay each benefit period before he or she is eligible for certain health services. If you have individual coverage, you must satisfy the individual deductible before any benefit will be paid. If you have family coverage, you must satisfy the family deductible before any benefits will be paid for any member. Both Medical and Pharmacy services accumulate toward the deductible and maximum out of pocket amounts.	**Individual** $2500 **Family** $5000	**Individual** $5000 **Family** $10000
2	**Annual Out-of-Pocket Maximum** Copayments, annual deductible, coinsurance, and prescription drug costs apply to the out-of-pocket maximum. The annual out-of-pocket maximum need only be met once per plan member per calendar year.	**Individual** $3500 **Family** $7000	**Individual** $10000 **Family** $20000
3	**Maximum Lifetime Benefit** Combined total of all benefits.	Unlimited	Unlimited
4	**Physician Office Visit – Preventive Care** Services include routine health assessment, well-child care, child health supervision services, immunizations and injections, hearing test, annual self-referred gynecological examination and pap smear, and mammogram screening.	**For Primary Care Services** $0 Co-pay per visit **For Specialty Care Services** $0 Co-pay per visit	**For Primary Care Services** 20% Co-insurance per visit after deductible **For Specialty Care Services** 20% Co-insurance per visit after deductible
5	**Physician Office Visit – Medical Services (includes Walk-In Clinic Physician Services)** Services include diagnosis, consultation and treatment, diagnostic tests and radiology services, surgery, vision examination and refraction, and allergy tests and treatment.	**For Primary Care Services** 0% Co-insurance per visit **For Specialty Care Services** 0% Co-insurance per visit	**For Primary Care Services** 20% Co-insurance per visit after deductible **For Specialty Care Services** 20% Co-insurance per visit after deductible
8	**Chiropractic Services** Coverage is provided for chiropractic services up to 26 visits.	0% Co-insurance per visit after deductible	20% Co-insurance per visit after deductible
9	**Emergency Room Services** Coverage is provided for worldwide emergency health services as defined in the COC.	0% Co-insurance per visit after deductible (Waived if patient is admitted)	0% Co-insurance per visit after deductible (Waived if patient is admitted)
10	**Emergency Ambulance Services** Coverage is provided for Emergencies as defined in the COC.	0% Co-insurance per occurrence after deductible	0% Co-insurance per occurrence after deductible

	BENEFITS AND SERVICES	MEMBER RESPONSIBILITY	
		IN-NETWORK	OUT-OF-NETWORK
11	**Urgent Care Services** Urgent care services at participating alternate facilities both in and out of the service area are covered.	0% Co-insurance per visit after deductible	0% Co-insurance per visit after deductible
12	**Maternity Care Office Visits** Covered services include pre-natal and post-natal care, examinations, tests and educational services.	0% Co-insurance first visit only after deductible	20% Co-insurance per visit after deductible
13	**Maternity Care, Inpatient Hospital** Covered services include all physician services for mother and newborn(s), delivery, newborn nursery services and semi-private room.	0% Co-insurance per admission after deductible	20% Co-insurance per visit after deductible $1,000 penalty for failure to precertify
14	**Outpatient Services and Diagnostic Procedures and Tests** Coverage includes diagnostic procedures and tests, including but not limited to lab and radiology. Certain procedures and tests are considered surgery, including but not limited to colonoscopy and endoscopy. Refer to the Outpatient Surgery section.	0% Co-insurance per visit after deductible	20% Co-insurance per visit after deductible 20% penalty for failure to precertify
15	**High Technology Diagnostic Services, Tests, and Procedures** Including, but not limited to: MRI, MRA, CT Scans, Thallium Scans, Nuclear Stress Tests, PET Scans, Echocardiograms, Ultrasounds (regardless of where service is performed). Requires prior authorization.	0% Co-insurance per visit after deductible	20% Co-insurance per visit after deductible 20% penalty for failure to precertify
16	**Outpatient Surgery** Benefits are provided for covered services rendered at an outpatient hospital or free standing surgery center.	0% Co-insurance per visit after deductible	20% Co-insurance per visit after deductible 20% penalty for failure to precertify
17	**Inpatient Hospital Services** Unlimited coverage is provided for medically necessary physician and surgeon services, semi-private rooms, operating rooms and related facilities, intensive and coronary care units, laboratory, x-rays, radiology services and procedures, medications and biologicals, anesthesia, special duty nursing as prescribed, short-term rehabilitation services, nursing care, meals and special diets.	0% Co-insurance per visit after deductible	20% Co-insurance per visit after deductible $1,000 penalty for failure to precertify
18	**Skilled Nursing Facility** Coverage is provided in lieu of an inpatient hospital admission when approved by the Plan. Coverage is provided for a semi-private room. Limited to 45 days per benefit year.	0% Co-insurance per visit after deductible	20% Co-insurance per visit after deductible $1,000 penalty for failure to precertify
19	**Home Health Care and Hospice** Coverage is provided when services are authorized in advance by the Plan.	0% Co-insurance per visit after deductible	20% Co-insurance per visit after deductible 20% penalty for failure to precertify
20	**Orthotics and Prosthetics** Coverage is provided when services authorized in advance by the Plan.	0% Co-insurance of covered expenses after deductible	20% Co-insurance of covered expenses after deductible 20% penalty for failure to precertify
21	**Prosthetics and Customized Orthotics Devices** Coverage is provided when services authorized in advance by the Plan.	0% Co-insurance per visit after deductible	20% Co-insurance of covered expenses after deductible 20% penalty for failure to precertify

	BENEFITS AND SERVICES	MEMBER RESPONSIBILITY	
		IN-NETWORK	OUT-OF-NETWORK
22	**Physical, Occupational, and Speech Therapy** Coverage is provided for medically necessary outpatient physical, occupational and speech therapy when authorized in advance by the Plan. Limited to 60 combined visits.	0% Co-insurance per visit after deductible **Physical Therapy Office Visit** 0% Co-insurance per visit	20% Co-insurance per visit after deductible 20% penalty for failure to precertify
23	**Mental Health/Substance Abuse, Inpatient** All mental health services must be prior authorized in advance by calling the Coventry Health Care of Missouri behavior health line toll free at 877-227-3520.	0% Co-insurance per admission after deductible	20% Co-insurance per admission after deductible $1,000 penalty for failure to precertify
24	**Mental Health/Substance Abuse, Outpatient** All mental health services must be prior authorized in advance by calling the Coventry Health Care of Missouri behavior health line toll free at 877-227-3520.	0% Co-insurance per visit	20% Co-insurance per visit after deductible
25	**Hearing Aids** Coverage is provided for hearing aids.	0% Co-insurance per hearing aid after deductible. Limited to a benefit maximum of $2,600	20% Co-insurance per visit after deductible