



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.chcillinois.coventryhealthcare.com or by calling 1-866-557-8751.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	In-network: \$300 Individual. \$600 Family. Out-of-Network: \$500 Individual; \$1,000 Family. Does not apply to accident benefit and second surgical opinions, routine immunizations, prescriptions, preventive exams, well baby/child care, emergency room copays.	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 1 st). 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 <u>out-of-pocket limit</u> on my expenses?	Yes. In-network: \$1,000 Individual. \$2,000 Family. Out-of-network: \$2,000 Individual. \$4,000 Family.	The <u>out-of-pocket limit</u> 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 <u>out-of-pocket limit</u>?	Premiums, balance-billed charges, health care this plan doesn't cover, deductibles, emergency room co-pays, prescriptions, pre-auth penalties and charges over the out of network rate.	<u>Even though you pay these expenses, they don't count toward the out-of-pocket limit.</u>
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 <u>network of providers</u>?	Yes. For a list of participating providers, see www.chcillinois.coventryhealthcare.com or call 1-866-557-8751.	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 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 <u>specialist</u>?	No	You can see the specialist you choose without permission from this plan.

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<p>Are there services this plan doesn't cover?</p>	<p>Yes.</p>	<p>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.</p>
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- **Copayments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** 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 **coinsurance** 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 preferred **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
<p>If you visit a health care provider's office or clinic</p>	<p>Primary care visit to treat an injury or illness</p>	<p>10% Co-insurance</p>	<p>30% Coinsurance</p>	<p>None</p>
	<p>Specialist visit</p>	<p>10% Co-insurance</p>	<p>30% Coinsurance</p>	<p>None</p>
	<p>Other practitioner office visit</p>	<p>10%/30% Co-insurance for nurse practitioners and physician assistants. 20% Coinsurance for chiropractic</p>	<p>30% Coinsurance 20% Coinsurance for chiropractic</p>	<p>Chiro Limit: 20 visits per contract year</p>
	<p>Preventive care/screening/immunization</p>	<p>0% Coinsurance</p>	<p>Not covered</p>	<p>None</p>
<p>If you have a test</p>	<p>Diagnostic test (x-ray, blood work)</p>	<p>20% Coinsurance</p>	<p>20% Coinsurance</p>	<p>Pre-auth required. Penalty: Addtl 50% reduction in benefits.</p>
	<p>Imaging (CT/PET scans, MRIs)</p>	<p>20% Coinsurance</p>	<p>20% Coinsurance</p>	<p>Pre-auth required. Penalty: Addtl 50% reduction in benefits.</p>

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Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an 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.chcillinois.coventryhealthcare.com .	Generic drugs	\$15 co-pay retail/mail	\$15 co-pay retail/mail	50% Coinsurance for a brand when generic is available. Covers up to 30-day supply retail; 90-day mail. Some drugs require-prior authorization (pre-auth).
	Preferred brand drugs	\$15 co-pay retail/mail	\$15 co-pay retail/mail	50% Coinsurance for a brand when generic is available Covers up to 30-day supply retail; 90-day mail. Some drugs require-pre-auth
	Non-preferred brand drugs	50% Coinsurance	50% Coinsurance	Covers up to 30-day supply retail; 90-day mail. Some drugs require-pre-auth
	Specialty drugs	50% Coinsurance	50% Coinsurance	Limit: 30-day supply per script. Pre-auth required.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% Coinsurance	30% Coinsurance	Pre-auth required. Penalty: Addt'l 50% reduction in benefits.
	Physician/surgeon fees	10% Coinsurance	30% Coinsurance	Pre-auth required. Penalty: Addt'l 50% reduction in benefits.
If you need immediate medical attention	Emergency room services	\$50 Co-pay per ER visit up to max of \$300 then 10% Coinsurance	\$50 Co-pay per ER visit up to max of \$300 then 30% Coinsurance	Must meet emergency criteria. Co-pay waived if admitted. Emergency Room Accident Services Benefit: 10% Coinsurance In and Out-of-network.
		Physician Services 20% Coinsurance	Physician Services 20% Coinsurance	
	Emergency medical transportation	20% Coinsurance	20% Coinsurance	Covered for air or land transport when medically necessary
	Urgent care	10% Coinsurance	30% Coinsurance	Must meet urgent care criteria.
If you have a hospital stay	Facility fee (e.g., hospital room)	10% Coinsurance	30% Coinsurance	Pre-auth required. Penalty: Addt'l 50% reduction in benefits.

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	Physician/surgeon fee	20% Coinsurance	30% Coinsurance	Pre-auth required. Penalty: Add'l 50% reduction in benefits.
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	10% Coinsurance	30% Coinsurance	None
	Mental/Behavioral health inpatient services	10% Coinsurance	30% Coinsurance	Pre-auth required. Penalty: Add'l 50% reduction in benefits.
	Substance use disorder outpatient services	10% Coinsurance	30% Coinsurance	None
	Substance use disorder inpatient services	10% Coinsurance	30% Coinsurance	Pre-auth required. Penalty: Add'l 50% reduction in benefits.
If you are pregnant	Prenatal and postnatal care	10% Coinsurance	30% Coinsurance	None
	Delivery and all inpatient services	10% Coinsurance	30% Coinsurance	Pre-auth required for stays beyond 48/96 hours. Penalty: Add'l 50% reduction in benefits.
If you need help recovering or have other special health needs	Home health care	10% Coinsurance	30% Coinsurance	Limit: 100 visits per contract year
	Rehabilitation services	Outpatient and Inpatient: 10% Coinsurance	Outpatient and Inpatient: 30% Coinsurance	Pre-auth required. Penalty: Add'l 50% reduction in benefits. Benefit maximum of 60 days per illness or injury. No coverage for pervasive developmental delay or Physical therapy related to diagnosis of multiple sclerosis.
	Habilitation services	10% Coinsurance	30% Coinsurance	Pre-auth required. Penalty: Add'l 50% reduction in benefits.
	Skilled nursing care	10% Coinsurance	30% Coinsurance	Pre-auth required. Penalty: Add'l 50% reduction in benefits.

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Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
	Durable medical equipment	20% Coinsurance	20% Coinsurance	Pre-auth required for equipment purchase over \$250 and all rental equipment (oxygen and TENS units not included). Penalty: Add'l 50% reduction in benefits.
	Hospice service	10% Coinsurance	30% Coinsurance	None
If your child needs dental or eye care	Eye exam	\$0 co-pay	Not covered	Limited to routine screening in your primary care physician's office.
	Glasses	Not covered	Not covered	Excluded service
	Dental check-up	Not covered	Not covered	Excluded service

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 <u>excluded services</u> .)		
<ul style="list-style-type: none"> Acupuncture Long-Term/Custodial Care Routine Eye Exam (Adult) Infertility Diagnosis and Treatment 	<ul style="list-style-type: none"> Cosmetic Surgery Private-Duty Nursing Routine Foot Care Hearing Aids 	<ul style="list-style-type: none"> Routine Dental Services (Adult) Weight Loss Programs Non-Emergency Care when Travelling Outside the U.S.

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.)		
<ul style="list-style-type: none"> Routine Hearing Tests (in your PCP office) 	<ul style="list-style-type: none"> Chiropractic Care 	<ul style="list-style-type: none"> Bariatric Surgery

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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 1-866-557-8751. 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: 1-866-557-8751. 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 Illinois Department of Insurance, 320 W. Washington Street, Springfield, IL 62767, Consumer Assistance Hotline: 866-445-5364 (Toll-Free) Email: DOI.InfoDesk@illinois.gov. Additionally, a consumer assistance program can help you file your appeal. Contact the Illinois Department of Insurance, 320 W. Washington Street, 4th Floor, Springfield, IL 62767, (877) 527-9431, <http://www.insurance.illinois.gov> or DOI.Director@illinois.gov.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-866-557-8751.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-557-8751.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-866-557-8751.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-866-557-8751.

-----*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 financial protection a sample patient might get if they are covered under 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)

- n Amount owed to providers: \$7,540
- n Plan pays \$6,430
- n Patient pays \$1,110

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

Patient pays:

Deductibles	\$300
Copays	\$20
Coinsurance	\$640
Limits or exclusions	\$150
Total	\$1,110

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

- n Amount owed to providers: \$5,400
- n Plan pays \$3,455
- n Patient pays \$1,945

Sample care costs:

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
Total	\$5,400

Patient pays:

Deductibles	\$300
Copays	\$673
Coinsurance	\$857
Limits or exclusions	\$115
Total	\$1,945

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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?

Ü 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?

Ü 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?

Ü 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?

Ü 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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