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.com or by calling 1-800-431-1211.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	In-network: None Does not apply to preventive care. Out-of-network: Not Covered	See the chart starting on page 2 for your costs for services this plan covers.
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. Individual: $3,000 Family: $6,000 Out-of-network: Not Covered	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. Web: www.chcillinois.com; Phone: 1-800-431-1211.	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	This plan will pay some or all of the costs to see a specialist for covered services.
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 4. See your policy or plan document for additional information about excluded services.

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Questions: Call 1-800-431-1211 or visit us at www.chcillinois.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.chcillnois.com or call 1-800-431-1211 to request a copy.

- **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 preferred **providers** by charging you lower **deductibles**, **co-payments** and **co-insurance** 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
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 co-pay /visit	Not Covered	None
	Specialist visit	$20 co-pay /visit	Not Covered	None
	Other practitioner office visit	Chiropractic services, Nurse Practitioners, and Physician Assistants: $20 co-pay /visit	Not Covered	None
	Preventive care/screening/immunization	$0 co-pay /visit	Not Covered	None
If you have a test	Diagnostic test (x-ray, blood work)	$0 co-pay/visit x-ray $0 if in preferred independent lab	Not Covered x-ray Not Covered lab	$20 co-pay/visit in the doctors office.
	Imaging (CT/PET scans, MRIs)	$0 co-pay/visit	Not Covered	None
If you need drugs to treat your illness or condition	Generic drugs	$10 co-pay (retail) / $25 co-pay (mail order)	Not covered.	30-day supply retail, 90-day supply mail order. May require pre-authorization (pre-auth).

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
More information about **prescription drug coverage** is available at www.chcmissouri.coventryhealthcare.com.	Preferred brand drugs	$20 co-pay (retail) / $50 co-pay (mail order)	Not covered.	30-day supply retail, 90-day supply mail order. May require pre-auth.
	Non-preferred brand drugs	$40 co-pay (retail) / $100 co-pay (mail order)	Not covered.	30-day supply retail, 90-day supply mail order. May require pre-auth.
	Specialty drugs	$20/$40 co-pay/script	Not covered.	Preauthorization may be required for some drugs.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$150 co-pay/visit	Not Covered	None
	Physician/surgeon fees	$0 co-pay/visit	Not Covered	None
If you need immediate medical attention	Emergency room services	$200 co-pay/visit	$200 co-pay/visit	Must meet emergency criteria. Co-pay is waived if patient is admitted.
	Emergency medical transportation	$0 co-pay/visit	Not Covered	Must meet emergency criteria.
	Urgent care	$20 co-pay /visit	$20 co-pay /visit	Must meet urgent care criteria.
If you have a hospital stay	Facility fee (e.g., hospital room)	$250 co-pay/admission	Not Covered	None
	Physician/surgeon fee	$0 co-pay/admission	Not Covered	None
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$20 co-pay /visit	Not Covered	None
	Mental/Behavioral health inpatient services	$250 co-pay/admission	Not Covered	None
	Substance use disorder outpatient services	$20 co-pay/visit	Not Covered	None
	Substance use disorder inpatient services	$250 co-pay/admission	Not Covered	None
If you are pregnant	Prenatal and postnatal care	$0 co-pay/visit	Not Covered	None
	Delivery and all inpatient services	$250 Co-pay/admission	Not Covered	Notification required for 48/96 hours for vaginal delivery or cesarean section. Stays beyond these time frames require prior authorization.

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 help recovering or have other special health needs	Home health care	$15 co-pay/visit	Not Covered	Pre-auth required
	Rehabilitation services	Inpatient: $250 Co-pay/admission Outpatient: $20 co-pay/visit	Inpatient: Not Covered Outpatient: Not Covered	Limit: 60 visits/benefit year for Physical Therapy and Occupational Therapy; 20 visits/benefit year for Speech Therapy. Physical Therapy Office Visits: $20 co-pay/visit
	Habilitation services	Inpatient: $250 Co-pay/admission Outpatient: $20 co-pay/visit	Inpatient: Not Covered Outpatient: Not Covered	Limit: 60 visits/benefit year for Physical Therapy and Occupational Therapy; 20 visits/benefit year for Speech Therapy. Physical Therapy Office Visits: $20 co-pay/visit
	Skilled nursing care	$0 co-pay/visit	Not Covered	Limit: 120 days/benefit year
	Durable medical equipment	20% co-ins/unit	Not Covered	Pre-auth required for medical equipment purchase over $500 and all rental equipment (oxygen and TENS units not included). Prosthetic devices: $0 co-pay/unit
	Hospice service	$0 co-pay/visit	Not Covered	Pre-auth required
If your child needs dental or eye care	Eye exam	$20 co-pay/visit	Not Covered	Coverage is provided for 1 annual eye examination per plan member.
	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 excluded services.)**

- Acupuncture
- Child/Glasses
- Infertility Treatment
- Private-Duty Nursing
- Bariatric Surgery
- Cosmetic Surgery
- Long-Term Care
- Routine Foot Care
- Child/Dental Check-up
- Dental Care (Adult
- Non-Emergency Care when Traveling Outside the U.S..
- 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
- 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:

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 Illinois Department of Insurance 320 W. Washington Street Springfield, IL 62767 Consumer Assistance Hotline: 866-445-5364 (Toll-Free) Email: DOI.InfoDesk@illinois.gov 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 Illinois Department of Insurance 320 W. Washington Street Springfield, IL 62767 Consumer Assistance Hotline: 866-445-5364 (Toll-Free) Email: DOI.InfoDesk@illinois.gov Missouri Department of Insurance P.O. Box 690 Jefferson City, MO 76102-0690 800-726-7390 (Toll Free) Email: consumeraffairs@insurance.mo.gov.

Additionally, a consumer assistance program can help you file your appeal. Contact Illinois Department of Insurance 320 W. Washington St, 4th Floor, Springfield, IL 62767 (877) 527-9431http://www.insurance.illinois.gov DOI.Director@illinois.gov Missouri Department of Insurance 301 W. High Street, Room 830 Harry S. Truman State Office Building Jefferson City, MO 65101 (800) 726-7390 www.insurance.mo.gov 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): 在西班牙的援助要求, 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.

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)

- **Amount owed to providers:** $7,540
- **Plan pays** $7,125
- **Patient pays** $415

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	$0
Co-pays	$265
Co-insurance	$0
Limits or exclusions	$150
Total	**$415**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $3,735
- **Patient pays** $1,665

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	$0
Co-pays	$1,550
Co-insurance	$0
Limits or exclusions	$115
Total	**$1,665**

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**, **co-payments**, and **co-insurance** 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 **co-payments**, **deductibles**, and **co-insurance**. 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.