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.chcmo.com** or by calling 1-800-775-3540.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	In-network providers: **$250** person/**$500** family. Out-of-network providers: **$500** person/**$1,000** family. If Spouse is offered & declines employer coverage: **$1,000** person in -network/**$2,000** family out-of-network	Each calendar year you must pay all the costs up to the **deductible** before the Plan begins to pay for covered services. On each January 1st, the **deductible** starts over; however, any amounts applied toward the **deductible** in October, November and December will be applied toward the new calendar year **deductible**. The **deductible** does not apply to physician office visits or prescription drugs. If spouse or same-sex domestic partner is eligible for benefits through their own employer, they must enroll for that coverage as their primary coverage. If spouse or partner **does not enroll**, they are subject to an increased deductible for in-network and out-of-network providers.
Are there other deductibles for specific services?	No.	
Is there an out–of–pocket limit on my expenses?	Yes, for in-network providers, **$1,000** person/**$2,000** family. For out-of-network providers **$2,000** person/**$4,000** 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?	Prior Authorization penalties, Charges excluded as ineligible, Amounts in excess of Usual and Reasonable, Pharmacy Co-pays	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 Annual Limit	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 **call** 1-800-775-3540 or go to **www.chcmo.com.**	Generally, the Plan will pay a higher percentage of the costs if you use an in-network doctor or other health care **provider**. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services which may increase your costs. See the chart starting on page 2 for in-network and out-of-network costs.
Do I need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the **specialist** you choose without permission from this plan. Be aware, you will generally pay less with an in-network specialist.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See the Summary Plan Description for additional information about **excluded services**.

Questions: Call 1-800-775-3540 or visit us at www.chcmo.com.
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.cciio.cms.gov or call 1-800-775-3540 to request a copy.

OMB Control Numbers 1545-2229, 1210-0147, and 0938-1146

Released on April 23, 2013 (corrected)

- **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 **in-network 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
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	10% coinsurance	40% coinsurance	————————none————————
	Specialist visit	10% coinsurance	40% coinsurance	————————none————————
	Other practitioner office visit - Chiropractic	20% coinsurance	40% coinsurance	Maximum 30 visits per calendar year. The following Out-of-Network Providers will be exluded from any coverage: Mark Eavenson DC, Corey Voss PT, Voss PT, Ashley Eavenson, DC & MRI Partners of Chesterfield
	Preventive care/screening/immunization	0% coinsurance	40% coinsurance	No deductible for the first $500.
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance	40% coinsurance	————————none————————
	Imaging (CT/PET scans, MRIs)	10% coinsurance	40% coinsurance	————————none————————

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.citizensrx.com Or 888-445-5592	Generic drugs	$10 co-payment	$10 co-payment	Mail order service is required for all maintenance medications. You may obtain up to a 90-day supply of a maintenance medication.
	Preferred brand drugs	35% or $200, whichever is lower	35% or $200, whichever is lower	Mail order service is required for all maintenance medications. You may obtain up to a 90-day supply of a maintenance medication.
	Non-preferred brand drugs	50% or $300, whichever is lower	50% or $300, whichever is lower	Mail order service is required for all maintenance medications. You may obtain up to a 90-day supply of a maintenance medication.
	Specialty drugs	$10/generic; 35% or $200/preferred brand, whichever is lower; 50% or $300/Non-preferred brand, whichever is lower	$10/generic; 35% or $200/preferred brand, whichever is lower 50% or $300/Non-preferred brand, whichever is lower	Prescriptions are required to be filled through a designated Citizens RX mail order specialty pharmacy.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	40% coinsurance	————————none————————
	Physician/surgeon fees	10% coinsurance	40% coinsurance	————————none————————
If you need immediate medical attention	Emergency room services	10% coinsurance	40% coinsurance $1,000 penalty for failure to notify.	$250 co-payment per visit before coinsurance. Waived if admitted.
	Emergency medical transportation	10% coinsurance	40% coinsurance	————————none————————
	Urgent care	10% coinsurance	40% coinsurance	$75 co-payment per visit before coinsurance for out-of-network providers.
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	40% coinsurance $1,000 penalty for failure to precertify.	————————none————————

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
	Physician/surgeon fee	10% coinsurance	40% coinsurance	————————none————————
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	10% coinsurance	40% coinsurance	Certain outpatient mental health services must be authorized in advanced by calling 877-227-3520.
	Mental/Behavioral health inpatient services	10% coinsurance	40% coinsurance $1,000 penalty for failure to pre-certify	All inpatient mental health services must be authorized in advanced by calling 877-227-3520.
	Substance use disorder outpatient services	10% coinsurance	40% coinsurance	Certain outpatient mental health services must be authorized in advanced by calling 877-227-3520.
	Substance use disorder inpatient services	10% coinsurance	40% coinsurance $1,000 penalty for failure to precertify	All inpatient mental health services must be authorized in advanced by calling 877-227-3520.
If you are pregnant	Prenatal and postnatal care	10% coinsurance	40% coinsurance	————————none————————
	Delivery and all inpatient services	10% coinsurance	40% coinsurance $1,000 penalty for failure to precertify	————————none————————

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	10% coinsurance	40% coinsurance	Home health care must be authorized in advanced and is limited to 100 visits per calendar year.
	Rehabilitation services	10% coinsurance	40% coinsurance	Rehabilitation and Habilitation Services must be authorized in advanced.
	Habilitation services	10% coinsurance	40% coinsurance	Maximum 20 visits per calendar year
	Skilled nursing care	10% coinsurance	40% coinsurance $1,000 penalty for failure to precertify	limited to 60 days/calendar year
	Durable medical equipment	10% coinsurance	40% coinsurance	Durable medical equipment must be authorized in advance.
	Hospice service	10% coinsurance	40% coinsurance	Hospice service must be authorized in advanced and is limited to 185 days per lifetime.
If your child needs dental or eye care	Eye exam	Charges in excess of $40	Charges in excess of $40	Limited to one exam in a 12 month period.
	Glasses	Charges in excess of fixed dollar amounts.	Charges in excess of fixed dollar amounts.	Limited to one pair of glasses in a 12 month period.
	Dental check-up	20% coinsurance	20% coinsurance	Separate $50 deductible for dental with a maximum benefit amount of $2,000.

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
- Cosmetic surgery
- Long-term care (custodial care)
- Non-emergency care when traveling outside the U.S.
- Routine foot care
- Weight loss programs

- Hearing Aids
- Private-duty nursing

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.)

- Bariatric Services
- Smoking Cessation

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 1-800-775-3540. 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: Coventry Health Care at 1-800-775-3540. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Additionally, a consumer assistance program can help you file your appeal. Contat the Illinois Department of Insurance at 100 Randolph St., 9th Floor, Chicago, IL 60601, 1-877-527-9431, http://www.insurance.illinois.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.**

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** $6,536
- **Patient pays** $1,004

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	$250
Copays	$50
Coinsurance	$704
Limits or exclusions	$0
Total	**$1,004**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $4,781
- **Patient pays** $619

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	$250
Copays	$160
Coinsurance	$209
Limits or exclusions	$0
Total	**$619**

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.