

**PLUS \$3,000**

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

Coverage for: EE, EE/Sp, EE/1Ch, EE/Children,  
Fam

| Plan Type: POS



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 <http://www.coventryone.com/> or by calling 1-855-385-5180.

| Important Questions                                       | Answers                                                                                                                    | Why This Matters:                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
|-----------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| What is the overall <b>deductible</b> ?                   | In-Network: Individual: \$3,000; Family: \$6,000;<br>Out-of-Network: Individual: \$6,000; Family: \$12,000;                | You must pay all the costs up to the <b>deductible</b> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <b>deductible</b> 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 <b>deductibles</b> .                                                                                            |
| Are there other <b>deductibles</b> for specific services? | Pharmacy deductible: \$1,000 / Individual                                                                                  | You must pay all of the costs for these services up to the specific <b>deductible</b> amount before this plan begins to pay for these services.                                                                                                                                                                                                                                                                                                                   |
| Is there an <b>out-of-pocket limit</b> on my expenses?    | In-Network: Yes. Individual: \$0 Family: \$0<br>Out-of-Network: Yes. Individual: \$12,000; Family: \$24,000                | The <b>out-of-pocket limit</b> 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 <b>out-of-pocket limit</b> ?  | Premiums, balance-billed charges, health care this plan does not cover, deductibles, copays, and durable medical equipment | Even though you pay these expenses, they don't count toward the <b>out-of-pocket limit</b> .                                                                                                                                                                                                                                                                                                                                                                      |
| 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 <i>specific</i> covered services, such as office visits.                                                                                                                                                                                                                                                                                                                          |
| Does this plan use a <b>network</b> of <b>providers</b> ? | Yes.<br><a href="http://www.coventryone.com">www.coventryone.com</a> or call 1-855-385-5180                                | If you use an in-network doctor or other health care <b>provider</b> , 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 <b>provider</b> for some services. Plans use the term in-network, <b>preferred</b> , or participating for <b>providers</b> in their <b>network</b> . See the chart starting on page 2 for how this plan pays different kinds of <b>providers</b> . |
| Do I need a referral to see a <b>specialist</b> ?         | No.                                                                                                                        | You can see the <b>specialist</b> you choose without permission from this plan.                                                                                                                                                                                                                                                                                                                                                                                   |
| Are there services this plan doesn't cover?               | Yes.                                                                                                                       | Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about <b>excluded services</b> .                                                                                                                                                                                                                                                                                                   |

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**Questions:** Call 1-855-385-5180 or visit us at <http://www.coventryone.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 <http://cciio.cms.gov/resources/files/Files2/02102012/uniform-glossary-final.pdf> or call 1-855-385-5180 to request a copy.

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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 <u>provider's</u> office or clinic | Primary care visit to treat an injury or illness | \$25 copay / visit                                                             | Deductible then 30% coinsurance                                                  | None.                               |
|                                                               | Specialist visit                                 | Deductible then \$50 copay / visit                                             | Deductible then 30% coinsurance                                                  | None.                               |
|                                                               | Other practitioner office visit                  | Chiropractic care: Not covered                                                 | Chiropractic care: Not covered                                                   | Chiropractic care: Excluded service |
|                                                               | Preventive care/<br>Screening/Immunization       | \$0 copay / visit, 0% coinsurance                                              | Deductible then 30% coinsurance                                                  | None.                               |
| If you have a test                                            | Diagnostic test (x-ray, blood work)              | Deductible then 0% coinsurance - x-ray<br>Deductible then 0% coinsurance - lab | Deductible then 30% coinsurance - x-ray<br>Deductible then 30% coinsurance - lab | None.                               |
|                                                               | Imaging (CT/PET scans, MRIs)                     | Deductible then 0% coinsurance                                                 | Deductible then 30% coinsurance                                                  | Prior auth required                 |

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Fam

| 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 <u>prescription drug coverage</u> is available at <a href="http://www.coventryone.com/">http://www.coventryone.com/</a> . | Generic drugs                                  | Retail: \$15 copay / prescription                      | Retail: 30% coinsurance                                 | Pharmacy deductible: \$1,000 / Individual, limited to a 30-day supply, prior auth required for some drugs |
|                                                                                                                                                                                                        | Preferred brand drugs                          | Retail: Pharmacy deductible then 50% coinsurance       | Retail: Pharmacy deductible then 50% coinsurance        | Pharmacy deductible: \$1,000 / Individual, limited to a 30-day supply, prior auth required for some drugs |
|                                                                                                                                                                                                        | Non-preferred brand drugs                      | Retail: Pharmacy deductible then 50% coinsurance       | Retail: Pharmacy deductible then 50% coinsurance        | Pharmacy deductible: \$1,000 / Individual, limited to a 30-day supply, prior auth required for some drugs |
|                                                                                                                                                                                                        | Specialty drugs                                | Injectable medications: Deductible then 0% coinsurance | Injectable medications: Deductible then 30% coinsurance | Prior auth required                                                                                       |
| If you have outpatient surgery                                                                                                                                                                         | Facility fee (e.g., ambulatory surgery center) | Deductible then 0% coinsurance                         | Deductible then 30% coinsurance                         | Prior auth required                                                                                       |
|                                                                                                                                                                                                        | Physician/surgeon fees                         | Deductible then 0% coinsurance                         | Deductible then 30% coinsurance                         | Prior auth required                                                                                       |
| If you need immediate medical attention                                                                                                                                                                | Emergency room services                        | Deductible then \$250 copay / visit                    | Deductible then \$250 copay / visit                     | When medically necessary                                                                                  |
|                                                                                                                                                                                                        | Emergency medical transportation               | Deductible then 0% coinsurance                         | Deductible then 0% coinsurance                          | When medically necessary                                                                                  |
|                                                                                                                                                                                                        | Urgent care                                    | \$50 copay / visit                                     | Deductible then 30% coinsurance                         | Must meet urgent care criteria                                                                            |
| If you have a hospital stay                                                                                                                                                                            | Facility fee (e.g., hospital room)             | Deductible then 0% coinsurance                         | Deductible then 30% coinsurance                         | Prior auth required                                                                                       |
|                                                                                                                                                                                                        | Physician/surgeon fee                          | Deductible then 0% coinsurance                         | Deductible then 30% coinsurance                         | Prior auth required                                                                                       |

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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 outpatient services   |                                                                                           |                                                                                         | -----none-----                                                                      |
|                                                                        | Mental/Behavioral health inpatient services    |                                                                                           |                                                                                         | -----none-----                                                                      |
|                                                                        | Substance use disorder outpatient services     |                                                                                           |                                                                                         | -----none-----                                                                      |
|                                                                        | Substance use disorder inpatient services      |                                                                                           |                                                                                         | -----none-----                                                                      |
| If you are pregnant                                                    | Prenatal and postnatal care                    | Maternity deductible then 0% coinsurance                                                  | Maternity deductible then 30% coinsurance                                               | None.                                                                               |
|                                                                        | Delivery and all inpatient services            | Maternity deductible then 0% coinsurance                                                  | Maternity deductible then 30% coinsurance                                               | None.                                                                               |
| If you need help recovering or have other special health needs         | Home health care                               | Deductible then 50% coinsurance                                                           | Deductible then 50% coinsurance                                                         | Limited to 30 visits per year, prior auth required                                  |
|                                                                        | Rehabilitation services                        | Inpatient Deductible then 0% coinsurance<br>Outpatient Deductible then \$50 copay / visit | Inpatient Deductible then 30% coinsurance<br>Outpatient Deductible then 30% coinsurance | Limited to 30 inpatient days and 10 outpatient visits per year, prior auth required |
|                                                                        | Habilitation services                          | Not covered                                                                               | Not covered                                                                             | Excluded service                                                                    |
|                                                                        | Skilled nursing care (facility)                | Deductible then 0% coinsurance                                                            | Deductible then 50% coinsurance                                                         | Limited to 30 days per year, prior auth required                                    |
|                                                                        | Durable medical equipment (including supplies) | Deductible then 50% coinsurance                                                           | Deductible then 50% coinsurance                                                         | Prior auth required                                                                 |
|                                                                        | Hospice Services                               | Deductible then 0% coinsurance                                                            | Deductible then 30% coinsurance                                                         | Prior auth required                                                                 |
| If your child needs dental or eye care                                 | Eye exam                                       | \$25 copay / visit                                                                        | Deductible then 30% coinsurance                                                         | 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 | 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 for others.)**

- |                                                                                                                                                                                          |                                                                                                                                                                                            |                                                                                                                                                                                                                             |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"> <li>• Acupuncture</li> <li>• Child/Glasses</li> <li>• Dental Care (Adult)</li> <li>• Infertility Treatment</li> <li>• Private-Duty Nursing</li> </ul> | <ul style="list-style-type: none"> <li>• Bariatric Surgery</li> <li>• Chiropractic Care</li> <li>• Habilitation services</li> <li>• Long-Term Care</li> <li>• Routine Foot Care</li> </ul> | <ul style="list-style-type: none"> <li>• Child/Dental Check-up</li> <li>• Cosmetic Surgery</li> <li>• Hearing Aids</li> <li>• Non-Emergency Care when Traveling Outside the U.S.</li> <li>• Weight Loss Programs</li> </ul> |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

**Other Covered Services (This isn't a complete list. Check your policy for other covered services and your costs for these services.)**

- Routine Eye Care (Adult)

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**Your Rights to Continue Coverage:**

Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay your premium. There are exceptions, however, such as if:

- You commit fraud
- The insurer stops offering services in the State
- You move outside the coverage area

For more information on your rights to continue coverage, contact the insurer at 1-855-385-5180. You may also contact your state insurance department at Idaho Department of Insurance 700 West State Street P.O. Box 83720 Boise, ID 83720-0043 208-334-4250.

**Your Grievance and Appeals Rights:**

Idaho Department of Insurance 700 West State Street P.O. Box 83720 Boise, ID 83720-0043 208-334-4250

**Language Access Services:**

Spanish (Espanol): Para obtener asistencia en Espanol, llame al 1-855-385-5180.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-855-385-5180.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-855-385-5180.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-855-385-5180.

—————*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:** \$4,391

■ **You pay:** \$3,149

#### 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           |
| <b>Total</b>               | <b>\$7,540</b> |

#### You pay:

|                      |                |
|----------------------|----------------|
| Deductibles          | \$3,000        |
| Co-pays              | \$119          |
| Coinsurance          | \$0            |
| Limits or exclusions | \$30           |
| <b>Total</b>         | <b>\$3,149</b> |

### Managing type 2 diabetes

(routine maintenance of a well-controlled condition)

■ **Amount owed to providers:** \$5,400

■ **Plan pays:** \$2,520

■ **You pay:** \$2,880

#### 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          |
| <b>Total</b>                   | <b>\$5,400</b> |

#### You pay:

|                      |                |
|----------------------|----------------|
| Deductibles          | \$137          |
| Co-pays              | \$2,646        |
| Coinsurance          | \$0            |
| Limits or exclusions | \$97           |
| <b>Total</b>         | <b>\$2,880</b> |

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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.