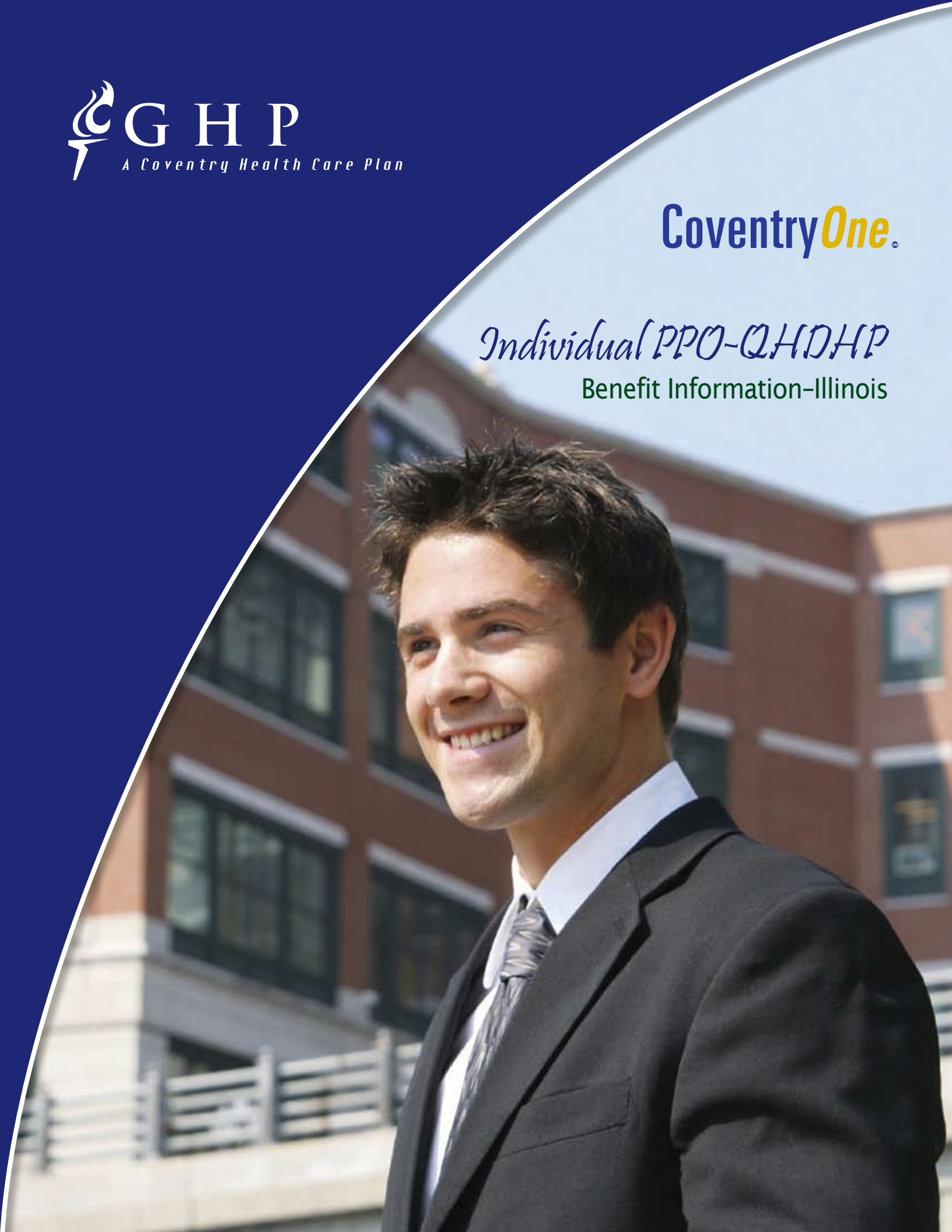




CoventryOne<sup>®</sup>

*Individual PPO-QHDHP*  
Benefit Information-Illinois





PPO-QHDHP Member Responsibility	100% / 60% Coinsurance					
	QHDHP-PPO 1500		QHDHP-PPO 2000		QHDHP-PPO 3000	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
<b>Lifetime maximum</b>	\$5,000,000	\$1,000,000	\$5,000,000	\$1,000,000	\$5,000,000	\$1,000,000
<b>Deductible</b> (per member/per contract year) family deductible is 2x the individual deductible ¥	\$1,500	\$4,500	\$2,000	\$6,000	\$3,000	\$9,000
<b>Out-of-pocket maximum</b> (per member/per contract year) family out-of-pocket maximum is 2x the individual out-of-pocket maximum ¥	\$2,000	\$10,500	\$2,500	\$12,000	\$3,500	\$15,000
	In-Network You Pay	Out-of-Network You Pay	In-Network You Pay	Out-of-Network You Pay	In-Network You Pay	Out-of-Network You Pay
<b>PCP and preventive care office visit</b> - deductible waived for preventive care	\$25 copay per visit after deductible	40% per visit after deductible	\$25 copay per visit after deductible	40% per visit after deductible	\$30 copay per visit after deductible	40% per visit after deductible
<b>Specialist and outpatient office visit</b>	\$25 copay per visit after deductible	40% per visit after deductible	\$25 copay per visit after deductible	40% per visit after deductible	\$30 copay per visit after deductible	40% per visit after deductible
<b>Emergency room services</b> - copay waived if admitted to hospital	\$200 copay per visit after deductible		\$200 copay per visit after deductible		\$250 copay per visit after deductible	
<b>Ambulance</b> (emergent - as defined in the COC)	0% per occurrence after deductible	40% per occurrence after deductible	0% per occurrence after deductible	40% per occurrence after deductible	0% per occurrence after deductible	40% per occurrence after deductible
<b>Urgent care [PA]</b> (at participating facilities)	\$50 copay per visit after deductible		\$50 copay per visit after deductible		\$75 copay per visit after deductible	
<b>Inpatient hospital</b> ∞	0% per admission after deductible	40% per admission after deductible	0% per admission after deductible	40% per admission after deductible	0% per admission after deductible	40% per admission after deductible
<b>Outpatient services/surgery and diagnostic procedures and tests</b> § - X-ray, lab, diagnostic services, MRI, CAT & PET scans, surgery, anesthesia, etc.	0% per visit after deductible	40% per visit after deductible	0% per visit after deductible	40% per visit after deductible	0% per visit after deductible	40% per visit after deductible
<b>Physical, speech and occupational therapies [PA]</b> § ◊ - limited to 60 combined visits per contract year	0% per visit after deductible	40% per visit after deductible	0% per visit after deductible	40% per visit after deductible	0% per visit after deductible	40% per visit after deductible
<b>Chiropractic services [PA]</b> - limited to 26 visits per contract year - treatment plan required	\$25 copay per visit after deductible	40% per visit after deductible	\$25 copay per visit after deductible	40% per visit after deductible	\$30 copay per visit after deductible	40% per visit after deductible
<b>DME, orthotics and prosthetics [PA]</b> § ◊ - limited to \$4,000 per contract year - covers initial placement only	0% per occurrence after deductible	40% of covered expenses after deductible	0% per occurrence after deductible	40% of covered expenses after deductible	0% per occurrence after deductible	40% of covered expenses after deductible
<b>Home health care [PA]</b> § ◊ - limited to 40 visits per contract year	0% per visit after deductible	40% per visit after deductible	0% per visit after deductible	40% per visit after deductible	0% per visit after deductible	40% per visit after deductible
<b>Hospice [PA]</b> §	0% per visit after deductible	40% per visit after deductible	0% per visit after deductible	40% per visit after deductible	0% per visit after deductible	40% per visit after deductible
<b>Skilled nursing facility [PA]</b> ∞ ◊ - limited to 30 days per contract year	0% per admission after deductible	40% per admission after deductible	0% per admission after deductible	40% per admission after deductible	0% per admission after deductible	40% per admission after deductible
<b>Mental health and substance abuse [PA]</b>						
<b>Outpatient</b> § (prior authorization required through GHP Behavior Health Line at 1-877-227-3520)	\$25 copay per visit after deductible	40% of covered expenses after deductible	\$25 copay per visit after deductible	40% of covered expenses after deductible	\$30 copay per visit after deductible	40% of covered expenses after deductible
<b>Inpatient</b> ∞ (prior authorization required through GHP Behavior Health Line at 1-877-227-3520)	0% per admission after deductible	40% of covered expenses after deductible	0% per admission after deductible	40% of covered expenses after deductible	0% per admission after deductible	40% of covered expenses after deductible
<b>Prescription drugs</b>	after deductible		after deductible		after deductible	
<b>Retail pharmacy</b> - Tier 1 - preferred generic - Tier 2 - preferred formulary brand - Tier 3 - non-preferred drugs	Tier 1: \$15 Tier 2: \$40 Tier 3: \$65	in-network benefit only	Tier 1: \$15 Tier 2: \$40 Tier 3: \$65	in-network benefit only	Tier 1: \$15 Tier 2: \$40 Tier 3: \$65	in-network benefit only
<b>Mail order</b> - 90-day supply	Tier 1: \$30 Tier 2: \$80 Tier 3: \$130	in-network benefit only	Tier 1: \$30 Tier 2: \$80 Tier 3: \$130	in-network benefit only	Tier 1: \$30 Tier 2: \$80 Tier 3: \$130	in-network benefit only

[PA] Service are covered only when prior authorized by Group Health Plan.

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

All coinsurance amounts are for covered expenses only.

Products underwritten by Coventry Health and Life Insurance Company.

This summary is a partial description of coverage and does not detail all benefits, limitations and exclusions. Please consult the Certificate of Coverage (COC) to determine the exact terms, conditions and scope of coverage.

§ 20% out-of-network penalty

∞ \$1,000 out-of-network penalty

◊ Combined limit for in- and out-of-network  
¥ One or all family members' deductible/out-of-pocket maximum

Affordable options for your wallet.



QHDHP-PPO 5000	
In-Network	Out-of-Network
\$5,000,000	\$1,000,000
\$5,000	\$15,000
\$5,500	\$21,000
In-Network You Pay	Out-of-Network You Pay
\$30 copay per visit after deductible	40% per visit after deductible
\$30 copay per visit after deductible	40% per visit after deductible
\$250 copay per visit after deductible	
0% per occurrence after deductible	40% per occurrence after deductible
\$75 copay per visit after deductible	
0% per admission after deductible	40% per admission after deductible
0% per visit after deductible	40% per visit after deductible
0% per visit after deductible	40% per visit after deductible
\$30 copay per visit after deductible	40% per visit after deductible
0% per occurrence after deductible	40% of covered expenses after deductible
0% per visit after deductible	40% per visit after deductible
0% per visit after deductible	40% per visit after deductible
0% per admission after deductible	40% per admission after deductible
\$30 copay per visit after deductible	40% of covered expenses after deductible
0% per admission after deductible	40% of covered expenses after deductible
Tier 1: \$15 Tier 2: \$40 Tier 3: \$65	in-network benefit only
Tier 1: \$30 Tier 2: \$80 Tier 3: \$130	in-network benefit only

This brochure contains information on GHP's individual PPO-QHDHP plan. Please review this information carefully as it details the rates, benefits and the service area for the PPO-QHDHP plan. If you have any questions, please contact a GHP Individual Sales Representative at (866) 557-8749.

Note: Final rates are based on medical underwriting.

*Applying for coverage is simple...*

- Pick your plan** – CoventryOne has numerous plans offering different deductible, copay and coinsurance options. Select which plan best suits your needs.
- Complete the enrollment form**
- Fax or e-mail** – The completed form along with a copy of a voided check, may be faxed to (866) 255-2763, or mailed to:
 

**Group Health Plan**  
Attn: Individual Sales  
550 Maryville Centre Dr., Suite 300  
St. Louis, MO 63141-5818

---

If you need assistance with any portion of this process, please don't hesitate to call an Individual Sales Representative at (866) 557-8749.

### Exclusions

- Allergy supplies such as air filters, air conditioners, air purifiers
- Alternative therapies such as acupuncture, hypnotherapy, massage therapy
- Athletic club membership and exercise equipment
- Autopsy
- Care rendered by a relative
- Christian Science Practitioners
- Complications of a non-covered service
- Cosmetic services and surgery
- Custodial care
- Dental services such as those related to cavities, removal of teeth, teeth implants, orthodontia
- Durable medical equipment repair and replacement such as wheelchair lifts, augmentative communication devices
- Elective abortions
- Experimental and investigational services
- Food and food supplements
- Foot care services such as those relating to corns, calluses, flat feet, etc.
- Household equipment and fixtures
- Implantable hearing devices such as cochlear implants
- Infertility services
- Maternity services
- Military health services
- Non-prescription drugs
- Obesity services such as gastric bypasses, appetite suppressants, removal of excess skin
- Orthotic shoe inserts, orthopedic shoes, cranial helmets
- Over the counter supplies such as Band-Aids, Ace wraps, cold packs
- Personal comfort items
- Private duty nursing
- Rehabilitative maintenance therapy and services
- Services relating to developmental delay conditions such as learning disabilities, ADHD
- Services such as exams and immunizations relating to career, sports, education, travel, employment, etc.
- Travel expenses
- Vision services such as glasses and contacts, LASIK and other refractive eye surgery, eye exercises
- Workers Compensation services

### Cancellations

If you wish to cancel your GHP individual policy, you must notify us in writing 31 days in advance. The policy will terminate at the end of the month requested.

...y for failure to precertify.  
...nalty for failure to precertify.  
...d out-of-network.  
... must collectively satisfy  
... maximum.

