GHP
A Coventry Health Care Plan

Group Health Plan Individual Solutions

PPO Products for Illinois

CoventryOne

		In-Network Benefits						Out-of-Network Benefits					
Plan Type	Plan Name	Primary Care Provider Office Visit	Specialist Office Visit	Urgent Care [PA]/ Emergency Department	Deductible *	Inpatient/ Outpatient Surgery §	Out-of-Pocket Maximum †	Primary Care Physician Office Visit	Specialist Office Visit	Urgent Care [PA]/ Emergency Department	Deductible *	Inpatient/ Outpatient Surgery §	Out-of-Pocket Maximum †
100% / 60% Coinsurance	PPO 500	$25	$25	$50/$200	$500	100% after deductible	NA	40% after deductible	40% after deductible	$50/$200	$1,500	40% after deductible	$7,500
	PPO 1000	$25	$25	$50/$200	$1,000	100% after deductible	NA	40% after deductible	40% after deductible	$50/$200	$3,000	40% after deductible	$9,000
	PPO 1500	$25	$25	$50/$200	$1,500	100% after deductible	NA	40% after deductible	40% after deductible	$50/$200	$4,500	40% after deductible	$10,500
	PPO 2000	$25	$25	$50/$200	$2,000	100% after deductible	NA	40% after deductible	40% after deductible	$50/$200	$6,000	40% after deductible	$12,000
	PPO 3000	$30	$30	$75/$250	$3,000	100% after deductible	NA	40% after deductible	40% after deductible	$75/$250	$9,000	40% after deductible	$15,000
	PPO 5000	$30	$30	$75/$250	$5,000	100% after deductible	NA	40% after deductible	40% after deductible	$75/$250	$15,000	40% after deductible	$21,000
	SJ 1500	$25	$50 after deductible	$100/$250 after deductible	$1,500	100% after deductible	NA	40% after deductible	40% after deductible	$100/$250 after deductible	$3,000	40% after deductible	$6,000
	SJ 2500	$25	$50 after deductible	$100/$250 after deductible	$2,500	100% after deductible	NA	40% after deductible	40% after deductible	$100/$250 after deductible	$4,000	40% after deductible	$8,000
80% / 50% Coinsurance	PPO 500	$25	$25	$50/$200	$500	80% after deductible	$3,500	50% after deductible	50% after deductible	$50/$200	$1,500	50% after deductible	$9,000
	PPO 1000	$25	$25	$50/$200	$1,000	80% after deductible	$4,000	50% after deductible	50% after deductible	$50/$200	$3,000	50% after deductible	$10,500
	PPO 1500	$25	$25	$50/$200	$1,500	80% after deductible	$4,500	50% after deductible	50% after deductible	$50/$200	$4,500	50% after deductible	$12,000
	PPO 2000	$25	$25	$50/$200	$2,000	80% after deductible	$5,000	50% after deductible	50% after deductible	$50/$200	$6,000	50% after deductible	$13,500
	PPO 3000	$30	$30	$75/$250	$3,000	80% after deductible	$6,000	50% after deductible	50% after deductible	$75/$250	$9,000	50% after deductible	$16,500
	PPO 5000	$30	$30	$75/$250	$5,000	80% after deductible	$8,000	50% after deductible	50% after deductible	$75/$250	$15,000	50% after deductible	$22,500
100% / 60% PPO-QHDHP	QHDHP-PPO 1500	$25 copay after deductible	$25 copay after deductible	$50/$200 after deductible	$1,500	100% after deductible	$2,000	40% after deductible	40% after deductible	$50/$200 after deductible	$4,500	40% after deductible	$10,500
	QHDHP-PPO 2000	$25 copay after deductible	$25 copay after deductible	$50/$200 after deductible	$2,000	100% after deductible	$2,500	40% after deductible	40% after deductible	$50/$200 after deductible	$6,000	40% after deductible	$12,000
	QHDHP-PPO 3000	$30 copay after deductible	$30 copay after deductible	$75/$250 after deductible	$3,000	100% after deductible	$3,500	40% after deductible	40% after deductible	$75/$250 after deductible	$9,000	40% after deductible	$15,000
	QHDHP-PPO 5000	$30 copay after deductible	$30 copay after deductible	$75/$250 after deductible	$5,000	100% after deductible	$5,500	40% after deductible	40% after deductible	$75/$250 after deductible	$15,000	40% after deductible	$21,000

Pharmacy—All Plans

		PPO	QHDHP	SJ
Pharmacy	**Tier One**	$15	$15	$15
	Tier Two	$40	$40	$45
	Tier Three	$65	$65	$75
	Mail Order *90-Day Supply*	2x	2x	2x
	Deductible *Tier 2 & Tier 3*	N/A	after deductible	SJ Plan deductible applies

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

§ 20% out-of-network penalty for failure to precertify.

** Family deductible is 2x the individual deductible.*

† Family out-of-pocket maximum is 2x the individual out-of-pocket maximum.

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 to determine the exact terms, conditions and scope of coverage.

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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 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
- Orthotics such as 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.
- Sex transformation services or treatment for sexual dysfunction
- Travel expenses
- Vision services such as glasses and contacts, LASIK and other refractive eye surgery, eye exercises
- Work hardening programs
- Workers Compensation services

Cancellations

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

Group Health Plan Service Area

PPO Products for Illinois