

Your Guide to Individual Health Benefit Policies

Missouri



CoventryOneSM is underwritten by Coventry Health and Life Insurance Company, and administered by Coventry Health Care of Kansas, Inc.

Reasons to Choose Coventry Health Care of Kansas

- **Premier Customer Service**

Coventry's customer service and claims paying is among the strongest in the nation. Our team of extensively trained customer service representatives is there for you when it matters. Our representatives deliver courteous service, accurate claims payment, as well as efficient claims turnaround for physicians, hospitals and members.

- **Wellness and Preventive Services**

Coventry encourages you to take advantage of the wellness and preventive services covered within all the benefit plans we offer, such as routine physicals for children and adults, well woman exams, mammography, and immunizations for children and adults. The Coventry WellBeingSM Self-Care and Wellness Program provides a broad spectrum of tools to empower you to benchmark and improve your health. Tools include educational materials, web-based health assessment and fitness programs, discount offers, electronic wellness reminders, and more.

- **Financial Strength and Stability**

Leading business publications regularly chart the financial progress of America's publicly traded companies, printing the rankings and lists throughout the year. Coventry Health Care, Inc. is a *Fortune* 500 company (2002, 2003, 2004, 2005 and 2006). Coventry Health Care, Inc., is a member of the *Forbes* Platinum 400 (2002, 2003, 2004, 2005 and 2006) and is listed among the *Barron's* 500 (2002, 2003, 2004, 2005 and 2006). In August 2005, Coventry was added to the Standard & Poor's Index – the S&P 500.

- **An Extensive Network of Physicians, Hospitals and Health Care Providers**

Coventry's high quality, cost-efficient provider network covers both Kansas and Missouri. We have thousands of physicians across both states available to care for you.

- **Technology Tools for Members**

You can manage personal benefit information online when it's convenient for you. Through *My Online Services*, a secure and password-protected website tool, you can ask questions of customer service, review claims history and claims payment, view eligibility, make account changes, order and print ID cards, request literature, change address / phone number, or obtain information about health benefits.

- **Medical Management and Case Management Services**

The Coventry medical management and case management teams work to improve the health and well being of those with chronic conditions and severe health issues through education and partnership with physicians.

About Coventry Health Care, Inc.

Coventry Health Care, Inc. (Coventry) is a publicly traded company that operates health plans, insurance companies and rental networks in regions throughout the United States. We have experienced steady growth at a time when other health plans are struggling or leaving the business. Coventry's health plans and insurance companies serve over 4 million members with business in all 50 states.

Customers benefit from this affiliation with a national parent company that invests in the latest technology, develops talent with industry-leading training, implements common programs and fosters a "best practices" mentality across the organization.

Backed by the strength of our parent company, Coventry Health Care maintains a responsive local team to serve our employers, members, providers and brokers. Our local team includes professionals with a primary responsibility for group account servicing.

Visit www.chckansas.com for more information about our company and provider networks.

Important Disclaimer

This material is presented for informational purposes only and should not be considered an offer of coverage. This guide contains only a partial, general description of a CoventryOne Policy and does not constitute a contract. **Please consult the Policy documents (Schedule of Benefits, Riders, Application Agreement) to determine governing contractual provisions, including procedures, definitions, and any exclusions and limitations.** All the terms and conditions of the Policy are subject to applicable laws, regulations and policies.

As a prospective or current member of Coventry Health and Life Insurance Company, we believe it is important for you to fully understand all aspects of the health plan prior to selecting a plan. Please read all information in this booklet carefully, consult the Policy documents and call your broker with any further questions.

This summary is a partial description of the CoventryOne Policy underwritten by Coventry Health and Life Insurance Company, and in no way details all of the benefits, limitations, or exclusions of the plan. Please refer to the Individual Policy, Schedule of Benefits and applicable Riders to determine exact terms, conditions and scope of coverage, including all exclusions and limitations and defined terms.

Choosing the *One* Plan That’s Right for You

We know that selecting the right health benefits plan can be overwhelming. Start out by considering what’s most important to you:

- Paying a set amount for office visits
- Lower monthly premiums
- Freedom to go to a specialist without referral

Use the chart below to help you narrow your plan choices.

Plan code	“I want to pay a set amount for office visits.”	“I want a lower monthly premium. As a trade-off, I’ll pay a higher deductible, coinsurance or office visit copayment.”	“I want to be able to go directly to a specialist, without having to get a referral first.”
MI C05020 20	X		X
MI C10025 20	X		X
MI C20040 25	X		X
MI C25045 25	X		X
MI C30050 30	X		X
MI C50075 99		X	X
MI C500150 99		X	X
MI F20040 99		X	X

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CoventryOne PPO plans at-a-glance

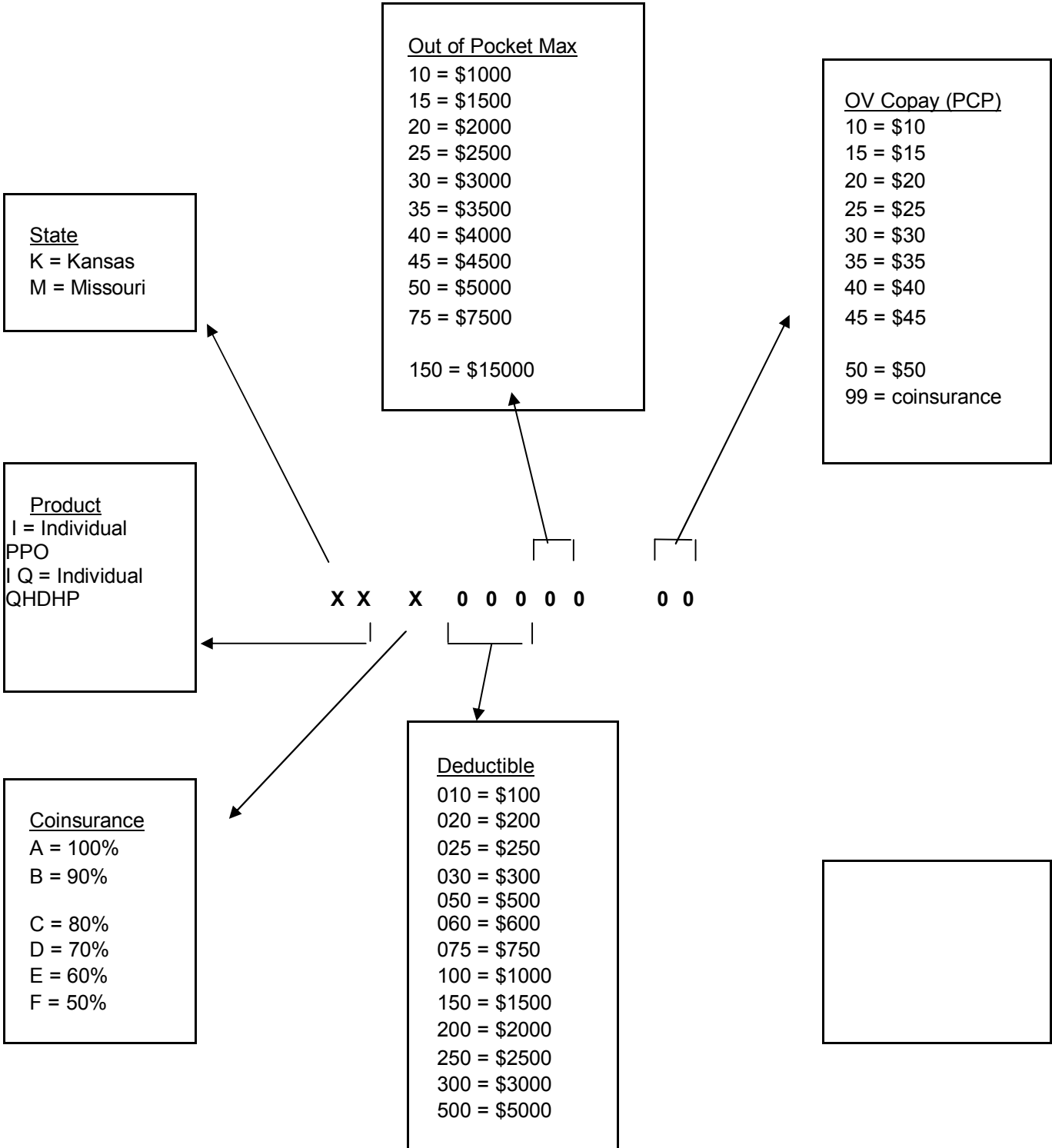
Here is an overview of what the CoventryOne plans offer. Costs illustrated here represent services received from physicians and facilities in the Coventry PPO Network.

Plan code	MI C05020 20	MI C10025 20	MI C20040 25	MI C25045 25	MI C30050 30	MI C50075 99	MI C500150 99	MI F20040 99
Annual deductible	\$500	\$1,000	\$2,000	\$2,500	\$3,000	\$5,000	\$5,000	\$2,000
Out-of-pocket max	\$2,000	\$2,500	\$4,000	\$4,500	\$5,000	\$7,500	\$15,000	\$4,000
Office visits Primary care Specialist	\$20 \$35	\$20 \$35	\$25 \$40	\$25 \$40	\$30 \$45	Deductible + 20% coinsurance	Deductible + 20% coinsurance	Deductible + 50% coinsurance
Inpatient hospital care	Deductible + 20% coinsurance	Deductible + 20% coinsurance	Deductible + 20% coinsurance	Deductible + 20% coinsurance	Deductible + 20% coinsurance	Deductible + 20% coinsurance	Deductible + 20% coinsurance	Deductible + 50% coinsurance
Emergency care	\$100 + 20% coinsurance	\$100 + 20% coinsurance	\$125 + 20% coinsurance	\$125 + 20% coinsurance	\$150 + 20% coinsurance	\$150 + 20% coinsurance	\$200 + 20% coinsurance	\$125 + 50% coinsurance
Urgent care	\$50	\$50	\$75	\$75	\$100	Deductible + 20% coinsurance	Deductible + 20% coinsurance	Deductible + 50% coinsurance
Prescription drugs	\$10/\$35/\$60	\$10/\$35/\$60	\$10/\$35/\$60	\$10/\$35/\$60	\$10/\$35/\$60	\$10/\$35/\$60	\$10/\$35/\$60	\$10/\$35/\$60

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Understanding the Plan Codes

All of the plan design summaries found in this booklet have an alphanumeric code that identifies key attributes. Use this diagram as a guide to understanding these codes.





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Summary of Benefits for Plan Code – MI C05020 20
\$500 Deductible, 80/60% Coinsurance, \$20/35 Office Visit

Benefits	Member pays	
	In-network	Out-of-network
Annual Deductible	\$500	\$500
Out of pocket maximum (coinsurance only applies toward this maximum)	\$2,000	\$4,000
Maximum lifetime benefits	\$2,000,000	
Physician services *If provided by a Primary Care provider then Primary Care copayment applies. If provided by Specialist then Specialist copayment applies.		
Office visit and related services (including surgery performed in the office) Primary Care Specialist	\$20 copayment \$35 copayment	Deductible + 40% coinsurance Deductible + 40% coinsurance
Preventive care Well visits Mammograms Immunizations (birth up to 72 months of age) Bone Density Routine Health Screening (\$300/year limit)	*Office visit copayment No copayment No copayment *Office visit copayment *Office visit copayment	Deductible + 40% coinsurance Deductible + 40% coinsurance No copayment Deductible + 40% coinsurance Deductible + 40% coinsurance
Allergy Testing Spinal Manipulations	Deductible + 20% coinsurance *Office visit copayment	Deductible + 40% coinsurance Deductible + 40% coinsurance
Inpatient hospital services (including physician, facility and surgery charges)	Deductible + 20% coinsurance	Deductible + 40% coinsurance
Outpatient surgery and scopes	Deductible + 20% coinsurance	Deductible + 40% coinsurance
Outpatient laboratory services	Deductible + 20% coinsurance	Deductible + 40% coinsurance
Outpatient diagnostic testing	Deductible + 20% coinsurance	Deductible + 40% coinsurance
Other outpatient services	Deductible + 20% coinsurance	Deductible + 40% coinsurance
Urgent care services	\$50 copayment	Same as In-network
Emergency care services Emergency room facility (copayment waived if admitted) Emergency room physician fees Ambulance (ground or air, when medically necessary)	\$100 copayment + 20% coinsurance 20% coinsurance Deductible + 20% coinsurance	Same as In-network Same as In-network Same as In-network
Short-term therapies (physical, speech, occupational – limited to 20 visits per therapy per Calendar Year Benefit Maximum)	Deductible + 20% coinsurance	Deductible + 40% coinsurance
Skilled nursing facility services (limited to 60 days per Calendar Year)	Same as Inpatient benefit	Deductible + 40% coinsurance
Home health care	Deductible + 20% coinsurance	Deductible + 40% coinsurance
Hospice (Inpatient limited to 15 days per Calendar Year)	Deductible + 20% coinsurance	Deductible + 40% coinsurance
Durable medical equipment (limited to \$3,000 per Calendar Year)	Deductible + 20% coinsurance	Deductible + 40% coinsurance
Prosthetics & Braces (limited to \$3,000 per Calendar Year)	Deductible + 20% coinsurance	Deductible + 40% coinsurance
Outpatient prescription drugs up to a 31-day supply	Three-tier plan offered. Participating Retail Pharmacy: \$10/\$35/\$60.	See Rider document.
Prescription Mail Order program up to a 93-day supply	Three-tier plan offered. \$30/\$105/\$180.	See Rider document.
Mental health, substance abuse services	See Rider document.	

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PPO

Summary of Benefits for Plan Code – MI C10025 20
\$1,000 Deductible, 80/60% Coinsurance, \$20/35 Office Visit

Benefits	Member pays	
	In-network	Out-of-network
Annual Deductible	\$1,000	\$1,000
Out of pocket maximum (coinsurance only applies toward this maximum)	\$2,500	\$5,000
Maximum lifetime benefits	\$2,000,000	
Physician services *If provided by a Primary Care provider then Primary Care copayment applies. If provided by Specialist then Specialist copayment applies.		
Office visit and related services (including surgery performed in the office) Primary Care Specialist	\$20 copayment \$35 copayment	Deductible + 40% coinsurance Deductible + 40% coinsurance
Preventive care Well visits Mammograms Immunizations (birth up to 72 months of age) Bone Density Routine Health Screening (\$300/year limit)	*Office visit copayment No copayment No copayment *Office visit copayment *Office visit copayment	Deductible + 40% coinsurance Deductible + 40% coinsurance No copayment Deductible + 40% coinsurance Deductible + 40% coinsurance
Allergy Testing Spinal Manipulations	Deductible + 20% coinsurance *Office visit copayment	Deductible + 40% coinsurance Deductible + 40% coinsurance
Inpatient hospital services (including physician, facility and surgery charges)	Deductible + 20% coinsurance	Deductible + 40% coinsurance
Outpatient surgery and scopes	Deductible + 20% coinsurance	Deductible + 40% coinsurance
Outpatient laboratory services	Deductible + 20% coinsurance	Deductible + 40% coinsurance
Outpatient diagnostic testing	Deductible + 20% coinsurance	Deductible + 40% coinsurance
Other outpatient services	Deductible + 20% coinsurance	Deductible + 40% coinsurance
Urgent care services	\$50 copayment	Same as In-network
Emergency care services Emergency room facility (copayment waived if admitted) Emergency room physician fees Ambulance (ground or air, when medically necessary)	\$100 copayment + 20% coinsurance 20% coinsurance Deductible + 20% coinsurance	Same as In-network Same as In-network Same as In-network
Short-term therapies (physical, speech, occupational – limited to 20 visits per therapy per Calendar Year Benefit Maximum)	Deductible + 20% coinsurance	Deductible + 40% coinsurance
Skilled nursing facility services (limited to 60 days per Calendar Year)	Same as Inpatient benefit	Deductible + 40% coinsurance
Home health care	Deductible + 20% coinsurance	Deductible + 40% coinsurance
Hospice (Inpatient limited to 15 days per Calendar Year)	Deductible + 20% coinsurance	Deductible + 40% coinsurance
Durable medical equipment (limited to \$3,000 per Calendar Year)	Deductible + 20% coinsurance	Deductible + 40% coinsurance
Prosthetics & Braces (limited to \$3,000 per Calendar Year)	Deductible + 20% coinsurance	Deductible + 40% coinsurance
Outpatient prescription drugs up to a 31-day supply	Three-tier plan offered. Participating Retail Pharmacy: \$10/\$35/\$60.	See Rider document.
Prescription Mail Order program up to a 93-day supply	Three-tier plan offered. \$30/\$105/\$180.	See Rider document.
Mental health, substance abuse services	See Rider document.	

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PPO

Summary of Benefits for Plan Code – MI C20040 25
\$2,000 Deductible, 80/60% Coinsurance, \$25/40 Office Visit

Benefits	Member pays	
	In-network	Out-of-network
Annual Deductible	\$2,000	\$2,000
Out of pocket maximum (coinsurance only applies toward this maximum)	\$4,000	\$8,000
Maximum lifetime benefits	\$2,000,000	
Physician services *If provided by a Primary Care provider then Primary Care copayment applies. If provided by Specialist then Specialist copayment applies.		
Office visit and related services (including surgery performed in the office) Primary Care Specialist	\$25 copayment \$40 copayment	Deductible + 40% coinsurance Deductible + 40% coinsurance
Preventive care Well visits Mammograms Immunizations (birth up to 72 months of age) Bone Density Routine Health Screening (\$300/year limit)	*Office visit copayment No copayment No copayment *Office visit copayment *Office visit copayment	Deductible + 40% coinsurance Deductible + 40% coinsurance No copayment Deductible + 40% coinsurance Deductible + 40% coinsurance
Allergy Testing Spinal Manipulations	Deductible + 20% coinsurance *Office visit copayment	Deductible + 40% coinsurance Deductible + 40% coinsurance
Inpatient hospital services (including physician, facility and surgery charges)	Deductible + 20% coinsurance	Deductible + 40% coinsurance
Outpatient surgery and scopes	Deductible + 20% coinsurance	Deductible + 40% coinsurance
Outpatient laboratory services	Deductible + 20% coinsurance	Deductible + 40% coinsurance
Outpatient diagnostic testing	Deductible + 20% coinsurance	Deductible + 40% coinsurance
Other outpatient services	Deductible + 20% coinsurance	Deductible + 40% coinsurance
Urgent care services	\$75 copayment	Same as In-network
Emergency care services Emergency room facility (copayment waived if admitted) Emergency room physician fees Ambulance (ground or air, when medically necessary)	\$125 copayment + 20% coinsurance 20% coinsurance Deductible + 20% coinsurance	Same as In-network Same as In-network Same as In-network
Short-term therapies (physical, speech, occupational – limited to 20 visits per therapy per Calendar Year Benefit Maximum)	Deductible + 20% coinsurance	Deductible + 40% coinsurance
Skilled nursing facility services (limited to 60 days per Calendar Year)	Same as Inpatient benefit	Deductible + 40% coinsurance
Home health care	Deductible + 20% coinsurance	Deductible + 40% coinsurance
Hospice (Inpatient limited to 15 days per Calendar Year)	Deductible + 20% coinsurance	Deductible + 40% coinsurance
Durable medical equipment (limited to \$3,000 per Calendar Year)	Deductible + 20% coinsurance	Deductible + 40% coinsurance
Prosthetics & Braces (limited to \$3,000 per Calendar Year)	Deductible + 20% coinsurance	Deductible + 40% coinsurance
Outpatient prescription drugs up to a 31-day supply	Three-tier plan offered. Participating Retail Pharmacy: \$10/\$35/\$60.	See Rider document.
Prescription Mail Order program up to a 93-day supply	Three-tier plan offered. \$30/\$105/\$180.	See Rider document.
Mental health, substance abuse services	See Rider document.	

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PPO

Summary of Benefits for Plan Code – MI C25045 25
\$2,500 Deductible, 80/60% Coinsurance, \$25/40 Office Visit

Benefits	Member pays	
	In-network	Out-of-network
Annual Deductible	\$2,500	\$2,500
Out of pocket maximum (coinsurance only applies toward this maximum)	\$4,500	\$9,000
Maximum lifetime benefits	\$2,000,000	
Physician services *If provided by a Primary Care provider then Primary Care copayment applies. If provided by Specialist then Specialist copayment applies.		
Office visit and related services (including surgery performed in the office) Primary Care Specialist	\$25 copayment \$40 copayment	Deductible + 40% coinsurance Deductible + 40% coinsurance
Preventive care Well visits Mammograms Immunizations (birth up to 72 months of age) Bone Density Routine Health Screening (\$300/year limit)	*Office visit copayment No copayment No copayment *Office visit copayment *Office visit copayment	Deductible + 40% coinsurance Deductible + 40% coinsurance No copayment Deductible + 40% coinsurance Deductible + 40% coinsurance
Allergy Testing Spinal Manipulations	Deductible + 20% coinsurance *Office visit copayment	Deductible + 40% coinsurance Deductible + 40% coinsurance
Inpatient hospital services (including physician, facility and surgery charges)	Deductible + 20% coinsurance	Deductible + 40% coinsurance
Outpatient surgery and scopes	Deductible + 20% coinsurance	Deductible + 40% coinsurance
Outpatient laboratory services	Deductible + 20% coinsurance	Deductible + 40% coinsurance
Outpatient diagnostic testing	Deductible + 20% coinsurance	Deductible + 40% coinsurance
Other outpatient services	Deductible + 20% coinsurance	Deductible + 40% coinsurance
Urgent care services	\$75 copayment	Same as In-network
Emergency care services Emergency room facility (copayment waived if admitted) Emergency room physician fees Ambulance (ground or air, when medically necessary)	\$125 copayment + 20% coinsurance 20% coinsurance Deductible + 20% coinsurance	Same as In-network Same as In-network Same as In-network
Short-term therapies (physical, speech, occupational – limited to 20 visits per therapy per Calendar Year Benefit Maximum)	Deductible + 20% coinsurance	Deductible + 40% coinsurance
Skilled nursing facility services (limited to 60 days per Calendar Year)	Same as Inpatient benefit	Deductible + 40% coinsurance
Home health care	Deductible + 20% coinsurance	Deductible + 40% coinsurance
Hospice (Inpatient limited to 15 days per Calendar Year)	Deductible + 20% coinsurance	Deductible + 40% coinsurance
Durable medical equipment (limited to \$3,000 per Calendar Year)	Deductible + 20% coinsurance	Deductible + 40% coinsurance
Prosthetics & Braces (limited to \$3,000 per Calendar Year)	Deductible + 20% coinsurance	Deductible + 40% coinsurance
Outpatient prescription drugs up to a 31-day supply	Three-tier plan offered. Participating Retail Pharmacy: \$10/\$35/\$60.	See Rider document.
Prescription Mail Order program up to a 93-day supply	Three-tier plan offered. \$30/\$105/\$180.	See Rider document.
Mental health, substance abuse services	See Rider document.	

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PPO

Summary of Benefits for Plan Code – MI C30050 30
\$3,000 Deductible, 80/60% Coinsurance, \$30/45 Office Visit

Benefits	Member pays	
	In-network	Out-of-network
Annual Deductible	\$3,000	\$3,000
Out of pocket maximum (coinsurance only applies toward this maximum)	\$5,000	\$10,000
Maximum lifetime benefits	\$2,000,000	
Physician services *If provided by a Primary Care provider then Primary Care copayment applies. If provided by Specialist then Specialist copayment applies.		
Office visit and related services (including surgery performed in the office) Primary Care Specialist	\$30 copayment \$45 copayment	Deductible + 40% coinsurance Deductible + 40% coinsurance
Preventive care Well visits Mammograms Immunizations (birth up to 72 months of age) Bone Density Routine Health Screening (\$300/year limit)	*Office visit copayment No copayment No copayment *Office visit copayment *Office visit copayment	Deductible + 40% coinsurance Deductible + 40% coinsurance No copayment Deductible + 40% coinsurance Deductible + 40% coinsurance
Allergy Testing Spinal Manipulations	Deductible + 20% coinsurance *Office visit copayment	Deductible + 40% coinsurance Deductible + 40% coinsurance
Inpatient hospital services (including physician, facility and surgery charges)	Deductible + 20% coinsurance	Deductible + 40% coinsurance
Outpatient surgery and scopes	Deductible + 20% coinsurance	Deductible + 40% coinsurance
Outpatient laboratory services	Deductible + 20% coinsurance	Deductible + 40% coinsurance
Outpatient diagnostic testing	Deductible + 20% coinsurance	Deductible + 40% coinsurance
Other outpatient services	Deductible + 20% coinsurance	Deductible + 40% coinsurance
Urgent care services	\$100 copayment	Same as In-network
Emergency care services Emergency room facility (copayment waived if admitted) Emergency room physician fees Ambulance (ground or air, when medically necessary)	\$150 copayment + 20% coinsurance 20% coinsurance Deductible + 20% coinsurance	Same as In-network Same as In-network Same as In-network
Short-term therapies (physical, speech, occupational – limited to 20 visits per therapy per Calendar Year Benefit Maximum)	Deductible + 20% coinsurance	Deductible + 40% coinsurance
Skilled nursing facility services (limited to 60 days per Calendar Year)	Same as Inpatient benefit	Deductible + 40% coinsurance
Home health care	Deductible + 20% coinsurance	Deductible + 40% coinsurance
Hospice (Inpatient limited to 15 days per Calendar Year)	Deductible + 20% coinsurance	Deductible + 40% coinsurance
Durable medical equipment (limited to \$3,000 per Calendar Year)	Deductible + 20% coinsurance	Deductible + 40% coinsurance
Prosthetics & Braces (limited to \$3,000 per Calendar Year)	Deductible + 20% coinsurance	Deductible + 40% coinsurance
Outpatient prescription drugs up to a 31-day supply	Three-tier plan offered. Participating Retail Pharmacy: \$10/\$35/\$60.	See Rider document.
Prescription Mail Order program up to a 93-day supply	Three-tier plan offered. \$30/\$105/\$180.	See Rider document.
Mental health, substance abuse services	See Rider document.	

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Summary of Benefits for Plan Code – MI C50075 99
\$5,000 Deductible, 80/60% Coinsurance

Benefits	Member pays	
	In-network	Out-of-network
Annual Deductible	\$5,000	\$5,000
Out of pocket maximum (coinsurance only applies toward this maximum)	\$7,500	\$15,000
Maximum lifetime benefits	\$2,000,000	
Physician services		
Office visit and related services (including surgery performed in the office) Primary Care Specialist	Deductible + 20% coinsurance Deductible + 20% coinsurance	Deductible + 40% coinsurance Deductible + 40% coinsurance
Preventive care Well visits Mammograms Immunizations (birth up to 72 months of age) Bone Density Routine Health Screening (\$300/year limit)	Deductible + 20% coinsurance No copayment No copayment Deductible + 20% coinsurance Deductible + 20% coinsurance	Deductible + 40% coinsurance Deductible + 40% coinsurance No copayment Deductible + 40% coinsurance Deductible + 40% coinsurance
Allergy Testing Spinal Manipulations	Deductible + 20% coinsurance Deductible + 20% coinsurance	Deductible + 40% coinsurance Deductible + 40% coinsurance
Inpatient hospital services (including physician, facility and surgery charges)	Deductible + 20% coinsurance	Deductible + 40% coinsurance
Outpatient surgery and scopes	Deductible + 20% coinsurance	Deductible + 40% coinsurance
Outpatient laboratory services	Deductible + 20% coinsurance	Deductible + 40% coinsurance
Outpatient diagnostic testing	Deductible + 20% coinsurance	Deductible + 40% coinsurance
Other outpatient services	Deductible + 20% coinsurance	Deductible + 40% coinsurance
Urgent care services	Deductible + 20% coinsurance	Same as In-network
Emergency care services Emergency room facility (copayment waived if admitted) Emergency room physician fees Ambulance (ground or air, when medically necessary)	\$150 copayment + 20% coinsurance 20% coinsurance Deductible + 20% coinsurance	Same as In-network Same as In-network Same as In-network
Short-term therapies (physical, speech, occupational – limited to 20 visits per therapy per Calendar Year Benefit Maximum)	Deductible + 20% coinsurance	Deductible + 40% coinsurance
Skilled nursing facility services (limited to 60 days per Calendar Year)	Same as Inpatient benefit	Deductible + 40% coinsurance
Home health care	Deductible + 20% coinsurance	Deductible + 40% coinsurance
Hospice (Inpatient limited to 15 days per Calendar Year)	Deductible + 20% coinsurance	Deductible + 40% coinsurance
Durable medical equipment (limited to \$3,000 per Calendar Year)	Deductible + 20% coinsurance	Deductible + 40% coinsurance
Prosthetics & Braces (limited to \$3,000 per Calendar Year)	Deductible + 20% coinsurance	Deductible + 40% coinsurance
Outpatient prescription drugs up to a 31-day supply	Three-tier plan offered. Participating Retail Pharmacy: \$10/\$35/\$60.	See Rider document.
Prescription Mail Order program up to a 93-day supply	Three-tier plan offered. \$30/\$105/\$180.	See Rider document.
Mental health, substance abuse services	See Rider document.	

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PPO

Summary of Benefits for Plan Code – MI C500150 99
\$5,000 Deductible, 80/60% Coinsurance

Benefits	Member pays	
	In-network	Out-of-network
Annual Deductible	\$5,000	\$5,000
Out of pocket maximum (coinsurance only applies toward this maximum)	\$15,000	\$30,000
Maximum lifetime benefits	\$2,000,000	
Physician services		
Office visit and related services (including surgery performed in the office)		
Primary Care	Deductible + 20% coinsurance	Deductible + 40% coinsurance
Specialist	Deductible + 20% coinsurance	Deductible + 40% coinsurance
Preventive care		
Well visits	Deductible + 20% coinsurance	Deductible + 40% coinsurance
Mammograms	No copayment	Deductible + 40% coinsurance
Immunizations (birth up to 72 months of age)	No copayment	No copayment
Bone Density	Deductible + 20% coinsurance	Deductible + 40% coinsurance
Routine Health Screening (\$300/year limit)	Deductible + 20% coinsurance	Deductible + 40% coinsurance
Allergy Testing	Deductible + 20% coinsurance	Deductible + 40% coinsurance
Spinal Manipulations	Deductible + 20% coinsurance	Deductible + 40% coinsurance
Inpatient hospital services (including physician, facility and surgery charges)	Deductible + 20% coinsurance	Deductible + 40% coinsurance
Outpatient surgery and scopes	Deductible + 20% coinsurance	Deductible + 40% coinsurance
Outpatient laboratory services	Deductible + 20% coinsurance	Deductible + 40% coinsurance
Outpatient diagnostic testing	Deductible + 20% coinsurance	Deductible + 40% coinsurance
Other outpatient services	Deductible + 20% coinsurance	Deductible + 40% coinsurance
Urgent care services	Deductible + 20% coinsurance	Same as In-network
Emergency care services		
Emergency room facility (copayment waived if admitted)	\$200 copayment + 20% coinsurance	Same as In-network
Emergency room physician fees	20% coinsurance	Same as In-network
Ambulance (ground or air, when medically necessary)	Deductible + 20% coinsurance	Same as In-network
Short-term therapies (physical, speech, occupational – limited to 20 visits per therapy per Calendar Year Benefit Maximum)	Deductible + 20% coinsurance	Deductible + 40% coinsurance
Skilled nursing facility services (limited to 60 days per Calendar Year)	Same as Inpatient benefit	Deductible + 40% coinsurance
Home health care	Deductible + 20% coinsurance	Deductible + 40% coinsurance
Hospice (Inpatient limited to 15 days per Calendar Year)	Deductible + 20% coinsurance	Deductible + 40% coinsurance
Durable medical equipment (limited to \$3,000 per Calendar Year)	Deductible + 20% coinsurance	Deductible + 40% coinsurance
Prosthetics & Braces (limited to \$3,000 per Calendar Year)	Deductible + 20% coinsurance	Deductible + 40% coinsurance
Outpatient prescription drugs up to a 31-day supply	Three-tier plan offered. Participating Retail Pharmacy: \$10/\$35/\$60.	See Rider document.
Prescription Mail Order program up to a 93-day supply	Three-tier plan offered. \$30/\$105/\$180.	See Rider document.
Mental health, substance abuse services	See Rider document.	

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PPO

Summary of Benefits for Plan Code – MI F20040 99
\$2,000 Deductible, 50/30% Coinsurance

Benefits	Member pays	
	In-network	Out-of-network
Annual Deductible	\$2,000	\$2,000
Out of pocket maximum (coinsurance only applies toward this maximum)	\$4,000	\$8,000
Maximum lifetime benefits	\$2,000,000	
Physician services		
Office visit and related services (including surgery performed in the office)		
Primary Care	Deductible + 50% coinsurance	Deductible + 70% coinsurance
Specialist	Deductible + 50% coinsurance	Deductible + 70% coinsurance
Preventive care		
Well visits	Deductible + 50% coinsurance	Deductible + 70% coinsurance
Mammograms	No copayment	Deductible + 70% coinsurance
Immunizations (birth up to 72 months of age)	No copayment	No copayment
Bone Density	Deductible + 50% coinsurance	Deductible + 70% coinsurance
Routine Health Screening (\$300/year limit)	Deductible + 50% coinsurance	Deductible + 70% coinsurance
Allergy Testing	Deductible + 50% coinsurance	Deductible + 70% coinsurance
Spinal Manipulations	Deductible + 50% coinsurance	Deductible + 70% coinsurance
Inpatient hospital services (including physician, facility and surgery charges)	Deductible + 50% coinsurance	Deductible + 70% coinsurance
Outpatient surgery and scopes	Deductible + 50% coinsurance	Deductible + 70% coinsurance
Outpatient laboratory services	Deductible + 50% coinsurance	Deductible + 70% coinsurance
Outpatient diagnostic testing	Deductible + 50% coinsurance	Deductible + 70% coinsurance
Other outpatient services	Deductible + 50% coinsurance	Deductible + 70% coinsurance
Urgent care services	Deductible + 50% coinsurance	Same as In-network
Emergency care services		
Emergency room facility (copayment waived if admitted)	\$125 copayment + 50% coinsurance	Same as In-network
Emergency room physician fees	50% coinsurance	Same as In-network
Ambulance (ground or air, when medically necessary)	Deductible + 50% coinsurance	Same as In-network
Short-term therapies (physical, speech, occupational – limited to 20 visits per therapy per Calendar Year Benefit Maximum)	Deductible + 50% coinsurance	Deductible + 70% coinsurance
Skilled nursing facility services (limited to 60 days per Calendar Year)	Same as Inpatient benefit	Deductible + 70% coinsurance
Home health care	Deductible + 50% coinsurance	Deductible + 70% coinsurance
Hospice (Inpatient limited to 15 days per Calendar Year)	Deductible + 50% coinsurance	Deductible + 70% coinsurance
Durable medical equipment (limited to \$3,000 per Calendar Year)	Deductible + 50% coinsurance	Deductible + 70% coinsurance
Prosthetics & Braces (limited to \$3,000 per Calendar Year)	Deductible + 50% coinsurance	Deductible + 70% coinsurance
Outpatient prescription drugs up to a 31-day supply	Three-tier plan offered. Participating Retail Pharmacy: \$10/\$35/\$60.	See Rider document.
Prescription Mail Order program up to a 93-day supply	Three-tier plan offered. \$30/\$105/\$180.	See Rider document.
Mental health, substance abuse services	See Rider document.	

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Qualified High Deductible Health Plans

Benefit Summaries
for
MISSOURI
Individuals



CoventryOneSM is underwritten by Coventry Health and Life Insurance Company, and administered by Coventry Health Care of Kansas, Inc.

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PPO

Summary of Benefits for Plan Code – MIQA25025 30 (Qualified HDHP) Deductible + 0% coinsurance, \$2,500 deductible, 0/20% coinsurance

Benefits	Member pays	
	In-network	Out-of-network
Annual Deductible	\$2,500	\$2,500
Out of pocket maximum	\$2,500	\$5,000
Maximum lifetime benefits	\$2,000,000	
Physician services		
Office visit and related services (including surgery performed in the office)	Deductible + 0% coinsurance	Deductible + 20% coinsurance
Preventive care		
Well visits	\$30 Copayment	Deductible + 20% coinsurance
Mammograms	No copayment	Deductible + 20% coinsurance
Immunizations (birth up to 72 months of age)	No copayment	No copayment
Bone Density	\$30 Copayment	Deductible + 20% coinsurance
Routine Health Screening (\$300/year limit)	\$30 Copayment	Deductible + 20% coinsurance
Inpatient hospital services (including physician, facility and surgery charges)	Deductible + 0% coinsurance	Deductible + 20% coinsurance
Outpatient surgery and scopes	Deductible + 0% coinsurance	Deductible + 20% coinsurance
Outpatient laboratory services	Deductible + 0% coinsurance	Deductible + 20% coinsurance
Outpatient diagnostic testing	Deductible + 0% coinsurance	Deductible + 20% coinsurance
Other outpatient services	Deductible + 0% coinsurance	Deductible + 20% coinsurance
Urgent care services	Deductible + 0% coinsurance	Deductible + 0% coinsurance
Emergency care services		
Emergency room facility	Deductible + 0% coinsurance	Deductible + 0% coinsurance
Emergency room physician fees	Deductible + 0% coinsurance	Deductible + 0% coinsurance
Ambulance (ground or air, when medically necessary)	Deductible + 0% coinsurance	Deductible + 0% coinsurance
Short-term therapies (physical, speech, occupational – limited to 20 visits per therapy per Calendar Year Benefit Maximum)	Deductible + 0% coinsurance	Deductible + 20% coinsurance
Skilled nursing facility services (limited to 60 days per Calendar Year)	Deductible + 0% coinsurance	Deductible + 20% coinsurance
Home health care	Deductible + 0% coinsurance	Deductible + 20% coinsurance
Hospice	Deductible + 0% coinsurance	Deductible + 20% coinsurance
Durable medical equipment (limited to \$3,000 per Calendar Year)	Deductible + 0% coinsurance	Deductible + 20% coinsurance
Prosthetics & Braces (limited to \$3,000 per Calendar Year)	Deductible + 0% coinsurance	Deductible + 20% coinsurance
Outpatient prescription drugs up to a 31-day supply	Participating Retail Pharmacy: Deductible + 0% coinsurance	See Rider document for details.
Prescription Mail Order program up to a 93-day supply	Deductible + 0% coinsurance	See Rider document for details.
Mental health, substance abuse services	See Rider document for details.	

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PPO

Summary of Benefits for Plan Code – MIQA50050 20 (Qualified HDHP) Deductible + 0% coinsurance, \$5,000 deductible, 0/20% coinsurance

Benefits	Member pays	
	In-network	Out-of-network
Annual Deductible	\$5,000	\$5,000
Out of pocket maximum	\$5,000	\$10,000
Maximum lifetime benefits	\$2,000,000	
Physician services		
Office visit and related services (including surgery performed in the office)	Deductible + 0% coinsurance	Deductible + 20% coinsurance
Preventive care		
Well visits	\$20 Copayment	Deductible + 20% coinsurance
Mammograms	No copayment	Deductible + 20% coinsurance
Immunizations (birth up to 72 months of age)	No copayment	No copayment
Bone Density	\$20 Copayment	Deductible + 20% coinsurance
Routine Health Screening (\$300/year limit)	\$20 Copayment	Deductible + 20% coinsurance
Inpatient hospital services (including physician, facility and surgery charges)	Deductible + 0% coinsurance	Deductible + 20% coinsurance
Outpatient surgery and scopes	Deductible + 0% coinsurance	Deductible + 20% coinsurance
Outpatient laboratory services	Deductible + 0% coinsurance	Deductible + 20% coinsurance
Outpatient diagnostic testing	Deductible + 0% coinsurance	Deductible + 20% coinsurance
Other outpatient services	Deductible + 0% coinsurance	Deductible + 20% coinsurance
Urgent care services	Deductible + 0% coinsurance	
Emergency care services		
Emergency room facility	Deductible + 0% coinsurance	Deductible + 0% coinsurance
Emergency room physician fees	Deductible + 0% coinsurance	Deductible + 0% coinsurance
Ambulance (ground or air, when medically necessary)	Deductible + 0% coinsurance	Deductible + 0% coinsurance
Short-term therapies (physical, speech, occupational – limited to 20 visits per therapy per Calendar Year Benefit Maximum)	Deductible + 0% coinsurance	Deductible + 20% coinsurance
Skilled nursing facility services (limited to 60 days per Calendar Year)	Deductible + 0% coinsurance	Deductible + 20% coinsurance
Home health care	Deductible + 0% coinsurance	Deductible + 20% coinsurance
Hospice	Deductible + 0% coinsurance	Deductible + 20% coinsurance
Durable medical equipment (limited to \$3,000 per Calendar Year)	Deductible + 0% coinsurance	Deductible + 20% coinsurance
Prosthetics & Braces (limited to \$3,000 per Calendar Year)	Deductible + 0% coinsurance	Deductible + 20% coinsurance
Outpatient prescription drugs up to a 31-day supply	Participating Retail Pharmacy: Deductible + 0% coinsurance	See Rider document for details.
Prescription Mail Order program up to a 93-day supply	Deductible + 0% coinsurance	See Rider document for details.
Mental health, substance abuse services	See Rider document for details.	

(24290)

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Mental Health and Substance Abuse Services

Note: Mental Health and Substance Abuse benefits are subject to Kansas and Missouri mandates. For more information regarding any limitations, exclusions or defined terms, please ask for a copy of the Mental Health Rider and the CoventryOne Policy.

Covered Services are as follows:

Mental Health Benefits

- Inpatient treatment subject to the Hospital Inpatient Deductible, Copayment and/or Coinsurance as listed in the Benefit Summary. Limited to ninety (90) days per Calendar Year.
- Outpatient treatment subject to the Specialty Physician Deductible, Copayment and/or Coinsurance as listed in the Benefit Summary.

Chemical Dependency Benefits

- Inpatient treatment subject to the Hospital Inpatient Deductible, Copayment and/or Coinsurance as listed in the Benefit Summary. Limited to twenty-one (21) days per Calendar Year.
- Outpatient treatment subject to the Specialty Physician Deductible, Copayment and/or Coinsurance as listed in the Benefit Summary. Limited to twenty-six (26) Visits per Calendar Year.
- Medical or Social Setting Detoxification subject to the Hospital Inpatient Deductible, Copayment and/or Coinsurance as listed in the Benefit Summary. Limited to six (6) days per Calendar Year.

Exclusions and Limitations

Pre-Existing Conditions Limitation

The Plan will not provide Coverage to the Insured for any expenses incurred for a condition (whether physical or mental), regardless of the condition, for which medical advice, diagnosis, care or treatment was recommended or received within the [six (6) – sixty (60)] month period ending on the Insured's effective date. Benefits for a Pre-Existing Condition are not payable until the Insured's coverage under this Policy has been in force for [zero (0) - twelve (12)] consecutive months. Once the Pre-Existing Condition Exclusion Period expires, the Insured's condition may be Covered if it is otherwise Covered under this Policy.

General Exclusions

Unless otherwise stated in the CoventryOne Policy or any applicable Riders attached to the Policy, the following items are excluded from Coverage. For more information regarding any terms used in the exclusions presented below, please see Section 1, the Defined Terms of the CoventryOne Policy.

- 1) Any service or supply that is provided by a Provider not in accordance with the Plan's utilization management policies and procedures, except that Emergency Services shall be Covered in accordance with the terms and conditions set forth in this Policy;
- 2) Any service or supply that is not Medically Necessary;
- 3) Any service or supply that is not a Covered Service or that is directly or indirectly a result of receiving a non-Covered Service;
- 4) Any service or supply for which You have no financial liability or that was provided at no charge; those services for which the Insured has no legal obligation to pay or for which a charge would not ordinarily be made in the absence of Coverage under the Policy;
- 5) Procedures and treatments that the Plan determines and defines to be Experimental or Investigational;
- 6) Court-ordered services or services that are a condition of probation or parole;
- 7) Those services otherwise Covered under the Policy, but rendered after the date Coverage under the Policy terminates, including services for medical conditions arising prior to the date individual Coverage under the Policy terminates; and

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- 8) Those services rendered outside the scope of a Participating or Non-Participating Provider's license, rendered by a Provider with the same legal residence as the Insured, or rendered by a person who is a member of the Insured's family, including Spouse, brother, sister, parent, step-parent, child or step-child

Specifically excluded services include, but are not limited to, the following:

- Acupuncture - Those acupuncture services and associated expenses that include, but are not limited to, the treatment of certain painful conditions or for anesthesia purposes are not Covered;
- Allergy Services - Those non-Physician allergy services or associated expenses relating to an allergic condition including, but not limited to, installation of air filters, air purifiers, or air ventilation system cleaning;
- Alternative Therapies - Alternative therapies including, but not limited to, aquatic, recreational, wilderness, educational, music or sleep therapies and any related diagnostic testing;
- Ambulance Service - Non-Emergency and non-medically appropriate ambulance services are excluded regardless of who requested the services, including ambulance transport due to the absence of other transportation for the Insured;
- Augmentative Communication Devices – Devices including but not limited to, those used to assist hearing impaired, or physically or developmentally disabled Insureds;
- Autopsy - Those services and associated expenses related to the performance of autopsies, and also post-mortem genetic studies;
- Behavior modification;
- Biofeedback;
- Blood and Blood Products - The cost of whole blood and blood products replacement to a blood bank;
- Blood Storage - Those services and associated expenses related to personal blood storage, unless associated with a scheduled surgery. Additionally, fetal cord blood harvesting and storage is not a Covered service;
- Braces and supports needed for athletic participation or employment;
- Charges resulting from Your failure to appropriately cancel a scheduled appointment;
- Cochlear Implants and related services;
- Cosmetic Services and Surgery - Those services, associated expenses, or complications resulting from Cosmetic Surgery, which alters appearance but does not restore or improve impaired physical function. Removal or replacement of a breast implant that was initially done for augmentation or for cosmetic purposes;
- Counseling Services and treatment related to religious counseling, marital/relationship counseling, vocational or employment counseling, and sex therapy are not Covered Services;
- Custodial Care, domiciliary care, private duty nursing, respite care or rest care. This includes care that assists the Insured in the Activities of Daily Living like walking, getting in and out of bed, bathing, dressing, feeding and using the toilet; preparation of special diets and supervision of medication that is usually self-administered regardless of who orders the services;
- Dental Services - Those dental services provided by a Doctor of Dental Surgery, “D.D.S.,” a Doctor of Medical Dentistry “D.M.D.” or a Physician licensed to perform dental-related oral surgical procedures, including services for overbite or underbite, services related to surgery for cutting through the lower or upper jaw bone, and services for the surgical treatment of temporomandibular joint disorder (“TMJ”), whether the services are considered to be medical or dental in nature except as provided in the “Covered Services” Section of this Policy. Dental x-rays, supplies and appliances (including occlusal splints and orthodontia). The diagnosis and treatment for TMJ and craniomandibular joint disease is not Covered unless by an attached Rider. Removal of dentiginous cysts, mandibular tori and odontoid cysts are excluded as they are dental in origin;
- Also excluded from coverage are dental services when such services are directly related to an accidental injury. This includes but is not limited to treatment of natural teeth and the purchase, repair or replacement of dental prostheses needed as a direct result of an accidental injury. Removal of teeth, including any prophylactic extractions, as a complication of radionecrosis is not a Covered Service.
- Dental Surgery and Implants - Upper and lower jaw bone surgery and dental implants (including that related to the temporomandibular and craniomandibular joint). Dental implants are excluded.;
- Medical services and expenses incurred for learning disabilities, developmental delays, mental retardation, and autistic disorders.
- Durable Medical Equipment (“DME”) - Electronically controlled cooling compression therapy devices (such as polar ice packs, Ice Man Cool Therapy, or Cryo-cuff); home blood pressure monitoring devices; home oximetry units; home traction units; replacement for changes due to obesity; preventive or routine maintenance due to normal wear and tear or negligence of items owned by the Insured; personal comfort items, including breast pumps, air conditioners, humidifiers and dehumidifiers, even though prescribed by a Physician, unless defined as Covered Services;
- Educational Services Those educational services for remedial education including, but not limited to, evaluation or treatment of learning disabilities, minimal brain dysfunction, cerebral palsy, mental retardation, developmental and learning disorders and behavioral training;
- Equipment or services for use in altering air quality or temperature;
- Educational testing or psychological testing, unless part of a treatment program for Covered Services;

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Elective or Voluntary Enhancement - Elective or voluntary enhancement procedures, services, and medications (growth hormone and testosterone), including, but not limited to: weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging, mental performance, salabrasion, chemosurgery, laser surgery or other skin abrasion procedures associated with the removal of scars, tattoos, or actinic changes. In addition, service performed for the treatment of acne scarring, even when the medical or surgical treatment has been provided by the Plan;

Eligible Expenses - Any otherwise Eligible Expenses that exceed the maximum allowance or benefit limit;

Enteral Feeding Food Supplement - The cost of outpatient enteral tube feedings or formula and supplies except when used for PKU or any other amino and organic acid inherited disease is not Covered, except as defined as a Covered Service;

Examinations - Those physical, psychiatric or psychological examinations or testing, vaccinations, immunizations or treatments when such services are for purposes of obtaining, maintaining or otherwise relating to career, camp, sports, education, travel, employment, insurance, marriage or adoption. Also excluded are routine immunizations for college, and services relating to judicial or administrative proceedings or orders which are conducted for purposes of medical research or to obtain or maintain a license of any type;

Exercise equipment, hot tubs and pools;

Eye Glasses and Contact Lenses - Those charges incurred in connection with the provision or fitting of eye glasses or contact lenses, except as specifically provided in the Covered Services Section;

Food or food supplements;

Foot Care – Foot care in connection with corns, calluses, flat feet, fallen arches or chronic foot strain. Medical or surgical treatment of onychomycosis (nail fungus) is also excluded, except as specifically provided for a diabetic Insured;

Growth Hormone – Growth hormone therapy for any condition, except in children less than 18 years of age who have been appropriately diagnosed to have an actual growth hormone deficiency according to clinical guidelines used by the Plan;

Hair analysis, wigs and hair transplants - Those services related to the analysis of hair unless used as a diagnostic tool to determine poisoning. Also excluded are hairstyling, hairpieces and hair prostheses, including those ordered by a Provider;

Home services to help meet personal, family, or domestic needs;

Health and Athletic Club Membership - Any costs of enrollment in a health, athletic or similar club;

Hearing Services and Supplies - Those services and associated expenses for hearing aids, cochlear implants, digital and programmable hearing devices, the examination for prescribing and fitting hearing aids, hearing therapy and any related diagnostic hearing tests;

Household Equipment and Fixtures - Purchase or rental of household equipment such as, but not limited to, fitness equipment, air purifiers, central or unit air conditioners, humidifiers, dehumidifiers, water purifiers, hypo-allergenic pillows, power assist chairs, mattresses or waterbeds and electronic communication devices;

Hypnotherapy and Hypnosis;

Immunizations unless specifically covered under the Policy, including but not limited to immunizations required for travel, school, work-related, Anthrax vaccine and Lyme Disease vaccine. Also excluded are examinations and testing in connection with insurance, obtaining employment, specifically for the purpose of entering school, participating in extracurricular school activities, adoption, immigration and naturalization, or examinations or treatment ordered by a court or an employer; premarital blood testing;

Infertility Services - All diagnostic studies, non-diagnostic services, and certain surgical procedures that are related to diagnosing and/or treating Infertility. Also excluded are expenses incurred for the promotion of conception including, but not limited to, artificial insemination, intracytoplasmic sperm injection (“ICSI”), in vitro or in vivo fertilization, gamete intrafallopian transfer (“GIFT”) procedures, zygote intrafallopian transfer (“ZIFT”) procedures, embryo transport, egg harvesting (collection, storage, preparation), reversal of voluntary sterilization, surrogate parenting, selective reduction, cryo preservation, travel costs, donor eggs or semen and related costs including collection, preparation and storage, non-Medically Necessary amniocentesis (for example, determining sex), other forms of assisted reproductive technology and any Infertility treatment deemed Experimental or Investigational. Additionally, pharmaceutical agents used for the purpose of treating Infertility are not Covered under the terms of the Policy; No legal obligation to pay - Services are excluded for Injuries and Illnesses for which the Plan has no legal obligation to pay (e.g., free clinics, free government programs, court-ordered care, expenses for which a voluntary contribution is requested) or for that portion of any charge which would not be made but for the availability of benefits from the Plan, or for work-related injuries and Illness. Health services and supplies furnished under or as part of a study, grant, or research program;

Maternity Services – Expenses incurred for any condition of or related to pregnancy, unless specifically covered in the Schedule of Benefits. Also excluded are expenses associated with selective reduction during pregnancy.

Maintenance Therapy – Once the maximum therapeutic benefit has been achieved for a given condition, ongoing Maintenance Therapy is not considered Medically Necessary;

Male Gynecomastia – Those services and associated expenses for treatment of male gynecomastia.

Massage Therapy – Those services and associated expenses related to massage therapy;

Medical complications arising directly or indirectly from a non-Covered Service;

Military Health Services - Those services for treatment of military service-related disabilities when the Insured is legally entitled to other Coverage and for which facilities are reasonably available to the Insured; or those services for any Insured who is on active military duty except as required by the Uniformed Services Employment and Reemployment Rights Act; or services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country;

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Miscellaneous Service Charges - Telephone consultations, document processing or copying fees, mailing costs, charges for completion of forms, charges for failure to keep a scheduled appointment (unless the scheduled appointment was for a Mental Health service), any late payment charge, interest charges or other non-medical charges;

Non-Prescription Drugs and Medications - Over-the-counter (“OTC”) drugs and medications incidental to outpatient care and Urgent Care Services are excluded unless specifically stated as Covered in the Covered Services Section of this Policy or as specifically provided in an optional pharmacy Rider;

Nutritional-based Therapy - Nutritional-based therapies except for treatment of PKU and for nutritional deficiencies due to short bowel syndrome and HIV. Oral supplements and/or enteral feedings, either by mouth or by tube, are also excluded;

Newborn home delivery and also the cost of child birth classes;

Obesity Services - Those services and associated expenses for procedures intended primarily for the treatment of obesity and morbid obesity including, but not limited to, gastric bypasses, gastric balloons, stomach stapling, jejunal bypasses, wiring of the jaw, removal of excess skin, including pannus, and services of a similar nature. Services and associated expenses for weight loss programs, nutritional supplements, dietary counseling, appetite suppressants, and supplies of a similar nature;

Occupational Injury - Those services and associated expenses related to the treatment of an occupational Injury or Illness for which the Insured is eligible to receive treatment under any Workers' Compensation or occupational disease laws or benefit plans whether or not You file a claim. If You enter into a settlement giving up Your right to recover future medical benefits under a Workers' Compensation benefit, medical benefits that would have been compensable except for the settlement will not be Covered Services under this Policy;

Oral Surgery Supplies - required as part of an orthodontic treatment program, required for correction of an occlusal defect, encompassing orthognathic or prognathic surgical procedures, or removal of symptomatic bony impacted teeth;

Orthodontia and related services;

Orthotic Appliances, Repairs or Replacement - The replacement costs for changes due to obesity; routine maintenance due to normal wear and tear or negligence of items owned by the Insured; foot or shoe inserts, arch supports, special orthopedic shoes, heel lifts, heel or sole wedges, heel pads, or insoles whether custom-made or prefabricated; also excluded are cranial (head) remodeling band for the treatment of positional non-synostotic plagiocephaly; and other protective head gear;

Over-the-counter supplies such as ACE wraps, elastic supports, finger splints, Orthotics, and braces; also OTC products not requiring a prescription to be dispensed (e.g., aspirin, antacids, cervical collars and pillows, lumbar-sacral supports, back braces, ankle supports, positioning wedges/pillows, herbal products, oxygen, medicated soaps, food supplements, and bandages) are excluded unless specifically stated as Covered in the Covered Services Section of this Policy or as specifically provided in an optional pharmacy Rider;

Personal comfort and convenience items or services such as television, telephone, barber or beauty service, guest service and similar incidental services and supplies;

Prescription Drugs and Medications - Prescription drugs and medications that require a prescription and are dispensed at a Pharmacy for outpatient treatment, except as specifically Covered in the Covered Services Section of this Policy or as specifically provided in an optional pharmacy Rider.

Private Duty Nursing - Private duty nursing services, nursing care on a full-time basis in Your home, or home health aides;

Prosthetic Devices Repairs or Replacement - The replacement costs for any otherwise Covered device, including replacement for changes due to obesity; routine maintenance due to normal wear and tear or negligence of items owned by the Insured;

Private inpatient room, unless Medically Necessary or if a Semi-private room is unavailable;

Reduction or Augmentation Mammoplasty - Reduction or augmentation mammoplasty is excluded unless associated with breast reconstruction surgery following a Medically Necessary mastectomy resulting from cancer;

Reversal of Sterilization Services - Those services and associated expenses related to reversal of voluntary sterilization;

Sex Transformation Services - Services and associated expenses for sex transformation operations regardless of any diagnosis of gender role disorientation or psychosexual orientation, including any treatment or studies related to sex transformation. Also excluded is hormonal support for sex transformation;

Sexual Dysfunction - Any device, implant or self-administered prescription medication for the treatment of sexual dysfunction, including erectile dysfunction, impotence and anorgasmy;

Sleep Studies – Sleep studies provided within the home;

Smoking Cessation - Those services and supplies for smoking cessation programs and treatment of nicotine addiction;

Speech therapy or voice training when prescribed for stuttering or hoarseness;

Sports Related Services - Those services or devices used specifically as safety items or to affect performance primarily in sports-related activities, and all expenses related to physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, and diversion or general motivation including braces and orthotics;

Surrogate motherhood services and supplies, including, but not limited to, all services and supplies relating to the conception and pregnancy of the Insured acting as a surrogate mother;

Transplant Organ Removal - Those services and associated expenses for removal of an organ for the purposes of transplantation from a donor who is not Covered under the Policy unless the recipient is the Insured and the donor's medical Coverage excludes

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reimbursement for organ harvesting;
Transplant services, screening tests, and any related conditions or complications related to organ donation when the Insured is donating organ or tissue to a person not Covered under the Policy;
Transplant Services and associated expenses involving temporary or permanent mechanical or animal organs;
Travel Expenses - Travel or transportation expenses, even though prescribed by a Provider, except as specified in the Covered Services Section;
Treatment for disorders relating to learning, motor skills and communication;
Vision Aids, Associated Services - Those services and associated expenses for orthoptics or vision training, field charting, eye exercises, radial keratotomy, LASIK and other refractive eye surgery, low vision aids and services or other refractive surgery;
Vocational therapy;
Health services resulting from war or an act of war when the Insured is outside of the continental United States; and
Work hardening programs.

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