Coventry Health Care of Delaware, Inc.: Bronze $10 Copay HMO Plan

Coverage Period : 01/01/2015 - 12/31/2015

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

Coverage for: EE, EE/Sp., EE/1Ch., EE/Children, Fam. | **Plan Type:** HMO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.chcde.com or by calling 1-800-833-7423.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-network: **$5,550** person **$11,100** family, doesn't apply: PCP visits, preventive care, pediatric dental preventive/diagnostic, pediatric vision Out-of-network: Not Covered	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** 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 **deductible**.
Are there other deductibles for specific services?	No	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses?	In-network: Yes **$6,350** person **$12,700** family Out-of-network: Not Covered	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, health care this plan does not cover	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes For a list of in-network providers, see www.chcde.com or call 1-800-833-7423.	If you use an in-network doctor or other health care **provider**, 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 **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No	You can see the **specialist** 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 4. See your policy or plan document for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use In-network **providers** by charging you lower **deductibles, copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a In-network Provider	Your Cost If You Use a Out-of-network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$10 co-payment (co-pay)/visit	Not Covered	----------none----------
	Specialist visit	$75 co-pay/visit	Not Covered	----------none----------
	Other practitioner office visit	$75 co-pay/visit chiropractor	Not Covered	Limited: 20 visits/year
	Preventive care/ Screening/Immunization	No Charge	Not Covered	----------none----------
If you have a test	Diagnostic test (x-ray, blood work)	30% co-ins x-ray 30% co-ins lab	Not Covered x-ray Not Covered lab	----------none----------
	Imaging (CT/PET scans, MRIs)	$250 co-pay/service + 30% co-ins	Not Covered	Not covered without preauthorization (preauth)
If you need drugs to treat your illness or condition. More information about **prescription drug coverage** is available at www.chcde.com.	Generic drugs	$15 co-pay/fill preferred retail, $20 co-pay/fill non-preferred retail, $30 co-pay/fill mail	Not Covered	Limited: 31 day supply retail, 90 day supply mail, may require preauth
	Preferred brand drugs	$45 co-pay/fill preferred retail, $55 co-pay/fill non-preferred retail, $90 co-pay/fill mail	Not Covered	Limited: 31 day supply retail, 90 day supply mail, may require preauth

Common Medical Event	Services You May Need	Your Cost If You Use a In-network Provider	Your Cost If You Use a Out-of-network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition. More information about **prescription drug coverage** is available at www.chcde.com.	Non-preferred brand drugs	$75 co-pay/fill preferred retail, $85 co-pay/fill non-preferred retail, $150 co-pay/fill mail	Not Covered	Limited: 31 day supply retail, 90 day supply mail, may require preauth
	Specialty drugs	Preferred: 30% co-ins, Non-preferred: 40% co-ins	Not Covered	Limited: 31 day supply, not covered without preauth
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% co-ins	Not Covered	Not covered without preauth
	Physician/surgeon fees	30% co-ins	Not Covered	Not covered without preauth
If you need immediate medical attention	Emergency room services	$500 co-pay/visit	$500 co-pay/visit	----------none----------
	Emergency medical transportation	30% co-ins	30% co-ins	----------none----------
	Urgent care	$75 co-pay/visit	Not Covered	----------none----------
If you have a hospital stay	Facility fee (e.g., hospital room)	$500 co-pay/admit + 30% co-ins	Not Covered	Not covered without preauth
	Physician/surgeon fee	30% co-ins	Not Covered	Not covered without preauth
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$75 co-pay/visit	Not Covered	Not covered without preauth
	Mental/Behavioral health inpatient services	$500 co-pay/admit + 30% co-ins	Not Covered	Not covered without preauth
	Substance use disorder outpatient services	$75 co-pay/visit	Not Covered	Not covered without preauth
	Substance use disorder inpatient services	$500 co-pay/admit + 30% co-ins	Not Covered	Not covered without preauth
If you are pregnant	Prenatal and postnatal care	No Charge	Not Covered	----------none----------
	Delivery and all inpatient services	$500 co-pay/admit + 30% co-ins	Not Covered	----------none----------

Common Medical Event	Services You May Need	Your Cost If You Use a In-network Provider	Your Cost If You Use a Out-of-network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	30% co-ins	Not Covered	Not covered without preauth
	Rehabilitation services	Inpatient $500 co-pay/admit + 30% co-ins Outpatient 30% coins	Inpatient Not Covered Outpatient Not Covered	Outpatient for members 19 and above limited: 30 PT, 30 OT & 30 Speech visits per condition per year, inpatient not covered without preauth
	Habilitation services	30% coins	Not Covered	Limited: members up to age 19
	Skilled nursing care	30% co-ins	Not Coverecd	Limited: 100 days/year, not covered without preauth
	Durable medical equipment	30% co-ins	Not Covered	----------none----------
	Hospice Service	30% co-ins	Not Covered	Not covered without preauth
If your child needs dental or eye care	Eye exam	No Charge	Not Covered	Limited: members under 19
	Glasses	No Charge	Not Covered	Limited: members under 19, one pair standard glasses/year
	Dental check-up	No Charge	Not Covered	Limited: members under 19, 1 x-ray/year, 1 exam/6 months

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

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

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

- Chiropractic care
- Hearing aids
- Infertility treatment
- Private-duty nursing
- Routine eye care (Adult)

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-800-833-7423. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa , or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov .

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact:

For group health coverage subject to ERISA, you may contact 1-800-833-7423. You may also contact, the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform , or your state department of insurance at For group health coverage subject to ERISA, you may contact 1-800-833-7423. You may also contact, the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform , or your state department of insurance at Maryland Insurance Administration Appeals and Grievance Unit 200 St. Paul Place, Suite 2700 Baltimore, MD 21202 410-468-2000 800-492-6116 (Toll Free) Fax: 410-468-2270. For non-federal governmental group health plans and church plans that are group health plans, you may contact 1-800-833-7423 or your state department of insurance at Maryland Insurance Administration Appeals and Grievance Unit 200 St. Paul Place, Suite 2700 Baltimore, MD 21202 410-468-2000 800-492-6116 (Toll Free) Fax: 410-468-2270..

For non-federal governmental group health plans and church plans that are group health plans, you may contact 1-800-833-7423 or your state department of insurance at For group health coverage subject to ERISA, you may contact 1-800-833-7423. You may also contact, the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform , or your state department of insurance at Maryland Insurance Administration Appeals and Grievance Unit 200 St. Paul Place, Suite 2700 Baltimore, MD 21202 410-468-2000 800-492-6116 (Toll Free) Fax: 410-468-2270. For non-federal governmental group health plans and church plans that are group health plans, you may contact 1-800-833-7423 or your state department of insurance at Maryland Insurance Administration Appeals and Grievance Unit 200 St. Paul Place, Suite 2700 Baltimore, MD 21202 410-468-2000 800-492-6116 (Toll Free) Fax: 410-468-2270..

Additionally, a consumer assistance program can help you file your appeal. Contact Maryland Office of the Attorney General Health Education and Advocacy Unit 200 St. Paul Place, 16th Floor Baltimore, MD 21202 (877) 261-8807 http://www.oag.state.md.us/Consumer.HEAU.htm heau@oag.state.md.us

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health**

coverage does meet the minimum value standard for the benefits it provides.

Language Access Services:

Spanish (Espanol): Para obtener asistencia en Espanol, llame al 1-800-833-7423.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-833-7423.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-833-7423.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-833-7423.

———————*To see examples of how this plan might cover costs for a sample medical situation, see the next page.*———————

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $3,270
- **Patient pays** $4,270

Sample care costs:

Hospital charges (mother)	$2,700
Routine Obstetric Care	$2,100
Hospital Charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$4,200
Copays	$0
Coinsurance	$0
Limits or exclusions	$70
Total	**$4,270**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $980
- **Patient pays** $4,420

Sample care costs:

Prescriptions	$2,900
Medical equipment and supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$4,300
Copays	$60
Coinsurance	$0
Limits or exclusions	$60
Total	**$4,420**

Note: These numbers assume the patient is participating in our diabetes wellness program. If you have diabetes and do not participate in the wellness program, your costs may be higher. For more information about the diabetes wellness program, please contact: 1-800-833-7423

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.