Coventry Health & Life Insurance Company: Gold $0 Copay PPO

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

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

Coverage for: EE, EE+One, EE+Spouse, EE+Child(ren), Family | **Plan Type:** PPO

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: **$1,250** person/ **$2,500** family. Does not apply to Preventive Care, Primary Care, Convenience Care, Urgent Care visits, Ambulance Transportation services, First 5 Specialist Care visits and First 3 Emergency Care visits. Out of Network: **$4,900** person/ **$9,800** family	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?	Separate Pharmacy Deductible **$250** Individual/ **$500** Family; Does not apply to Generic Drugs	You must pay all of the costs for these services up to the specific **deductible** amount before this plan begins to pay for these services.
Is there an out-of-pocket limit on my expenses?	In Network: Yes **$5,000** person/ **$10,000** family Out of Network: Yes **$10,000** person/ **$20,000** family	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, balanced-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, visit www.chcde.com then click "Find a Doctor" 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.

Questions: Call 1-800-833-7423 or visit us at www.chcde.com.
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at http://www.cms.gov/CCIIO/resources/files/downloads/uniform-glossary-final.pdf or call 1-800-833-7423 to request a copy.

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Important Questions	Answers	Why This Matters:
Are there services this plan doesn't cover?	Yes	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **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	$0 Copay / visit	20% Co-ins	----------none----------
	Specialist visit	$50 Copay per visit	20% Co-ins	----------none----------
	Other practitioner office visit	$50 Copay per visit	20% Co-ins	20 visits / contract year
	Preventive care/ Screening/Immunization	$0 Copay / visit	20% Co-ins	----------none----------
If you have a test	Diagnostic test (x-ray, blood work)	20% Co-ins x-ray 20% Co-ins lab	30% Co-ins x-ray 30% Co-ins lab	----------none----------
	Imaging (CT/PET scans, MRIs)	20% Co-ins	$250 Copay plus 30% Co-ins	Not covered without Prior Authorization.

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.	Generic drugs	Preferred Generic: Preferred pharmacy $3 Copay per fill / Non-Preferred pharmacy $5 Copay per fill; Generic: $5 Copay per fill / Non-Preferred pharmacy $10 Copay per fill	Not Covered	90 day supply available retail or mail order for 2 times the preferred or non-preferred pharmacy copay
	Preferred brand drugs	Preferred pharmacy $30 Copay Retail per fill / Non-preferred pharmacy $40 Copay Retail per fill	Not Covered	90 day supply available retail or mail order for 2 times the preferred or non-preferred pharmacy copay
	Non-preferred brand drugs	Preferred pharmacy $60 Copay Retail per fill / Non-preferred pharmacy $75 Copay Retail per fill	Not Covered	90 day supply available retail or mail order for 2 times the preferred or non-preferred pharmacy copay
	Specialty drugs	Preferred Specialty Drugs: Ded. plus 20% Co-ins per fill ; Non-Preferred Specialty Drugs Ded. plus 30% Co-ins per fill	Not Covered	Prior Authorization and quantity limits may apply.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% Co-ins	30% Co-ins	Not covered without Prior Authorization.
	Physician/surgeon fees	20% Co-ins	30% Co-ins	Not covered without Prior Authorization.

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 immediate medical attention	Emergency room services	$250 Copay per visit	$250 Copay per visit	Must meet emergency criteria.
	Emergency medical transportation	$500 Copay / service	$500 Copay / service	Must meet emergency criteria.
	Urgent care	$75 Copay / visit	20% Co-ins	Must meet urgent care criteria.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% Co-ins / admit	$1,000 Copay plus 30% Co-ins	Not covered without Prior Authorization.
	Physician/surgeon fee	20% Co-ins / admit	30% Co-ins	Not covered without Prior Authorization
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$50 Copay per visit	20% Co-ins	Some services may require Prior Authorization for coverage.
	Mental/Behavioral health inpatient services	20% Co-ins / admit	$1,000 Copay / plus 30% Co-ins	Not covered without Prior Authorization.
	Substance use disorder outpatient services	$50 Copay per visit	20% Co-ins	Some services may require Prior Authorization for coverage.
	Substance use disorder inpatient services	20% Co-ins / admit	$1,000 Copay / plus 30% Co-ins	Not covered without Prior Authorization.
If you are pregnant	Prenatal and postnatal care	$0 Copay / for pregnancy	20% Co-ins	----------none----------
	Delivery and all inpatient services	20% Co-ins / admit plus $250 Copay / pregnancy	$1,000 Copay / plus 30% Co-ins	Not covered without Prior Authorization.
If you need help recovering or have other special health needs	Home health care	20% Co-ins / visit	30% Co-ins	Not covered without Prior Authorization.
	Rehabilitation services	Inpatient 20% Co-ins / admit Outpatient 20% Co-ins visit	Inpatient $1,000 Copay / plus 30% Co-ins Outpatient 30% Co-ins	Not Covered without Prior Authorization
	Habilitation services	20% Co-ins / visit	30% Co-ins	Not covered without Prior Authorization. 30 Outpatient therapy visits / conditions/ contract year.
	Skilled nursing care	20% Co-ins / admit	30% Co-ins	Not covered without Prior Authorization. 100 days / contract year

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	Durable medical equipment	20% Co-ins	30% Co-ins	Not covered without Prior Authorization. Limited to once every 2 years for irreparable damage and/or normal wear.
	Hospice Service	20% Co-ins / visit	30% Co-ins	Not covered without Prior Authorization.
If your child needs dental or eye care	Eye exam	$0	20% Out of Network Rate	One routine eye examination / contract year
	Glasses	$0	20% Out of Network Rate	One pair standard eyeglass lenses or contact lenses / contract year; one frame contract year.
	Dental check-up	Covered	Covered	Deductible & OOP Max combined with medical deductible does not apply to preventive & diagnostic services. Coverage for children under age 19.

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.)

- Cosmetic surgery
- Dental care (Adult)
- Hearing aids
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- 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.)

- Acupuncture
- Bariatric surgery
- Child/Dental check-up
- Chiropractic care
- Infertility treatment

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 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** $5,230
- **Patient pays** $2,310

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	$1,300
Copays	$10
Coinsurance	$800
Limits or exclusions	$200
Total	**$2,310**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $4,020
- **Patient pays** $1,380

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	$100
Copays	$1,200
Coinsurance	$0
Limits or exclusions	$80
Total	**$1,380**

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.