Coventry Health & Life Insurance Company: Bronze $10 Copay HMO Plan

Coverage Period : 01/01/2014 - 12/31/2014

Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage for:** Employee, Family **| 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: $5,600/ $11,200 family. Ded. Does not apply to Preventative Care, Primary Care visits, and Convenience Care visits, 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: $6,400 person/ $12,800 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, balanced-billed charges and 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.
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**.

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.

- **Co-payments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** 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 **co-insurance** 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		Limitations & Exceptions
		In Network Provider	Out of Network Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$10 Copay / visit	Not Covered	None
	Specialist visit	$75 Copay / visit	Not Covered	----------none----------
	Other practitioner office visit	$75 Copay / visit for chiropractic care	Not Covered	Limit: 20 visits / contract year.
	Preventive care/ Screening/Immunization	$0 Copay / visit	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 Copay + 30% Co-ins	Not Covered	Not covered without Prior Authorization. Free-standing facility applies $250 Copay + Deductible
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 Pharmacy $15 Copay / Non Preferred Pharmacy $20 Copay	Not Covered	90 day supply available retail or mail order 3 times Preferred or Non Preferred Pharmacy Copay
	Preferred brand drugs	Preferred Pharmacy $45 Copay / Non Preferred Pharmacy $55 Copay	Not Covered	90 day supply available retail or mail order for 3 times the Preferred or Non Preferred Pharmacy Copay
	Non-preferred brand drugs	Preferred Pharmacy $75 Copay / Non Preferred $85 Copay	Not Covered	90 day supply avialable retail or mail order for 3 times the Preferred or Non Preferred Pharmacy Copay

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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.	Specialty drugs	Preferred Speciatly Drug 30% Co-ins ; Non Preferred Specialty Drug 40% Co-ins.	Not Covered	Prior Authorization required. Limit: 30 day supply
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% Co-ins	Not Covered	Not covered without Prior Authorization.
	Physician/surgeon fees	30% Co-ins	Not Covered	Not covered without Prior Authorization.
If you need immediate medical attention	Emergency room services	$500 Copay / visit	Not Covered	Must meet emergency criteria.
	Emergency medical transportation	30% Co-ins	Not Covered	Must meet emergency criteria.
	Urgent care	$75 Copay / visit	Not Covered	Must meet urgent care criteria.
If you have a hospital stay	Facility fee (e.g., hospital room)	$500 Copay / Admit + 30% Co-ins	Not Covered	Not covered without Prior Authorization.
	Physician/surgeon fee	30% Co-ins	Not Covered	Not covered without Prior Authorization
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$75 Copay / visit	Not Covered	Not covered without Prior Authorization.
	Mental/Behavioral health inpatient services	$500 Copay / Admit + 30% Co-ins	Not Covered	Not covered without Prior Authorization.
	Substance use disorder outpatient services	$75 Copay / visit	Not Covered	Not covered without Prior Authorization.
	Substance use disorder inpatient services	$500 Copay / Admit 30% Co-ins	Not Covered	Not covered without Prior Authorization.
If you are pregnant	Prenatal and postnatal care	$0 Copay / visit	Not Covered	----------none----------
	Delivery and all inpatient services	One time $500 Copay	Not Covered	Not covered without Prior Authorization.
If you need help recovering or have other special health needs	Home health care	30% Co-ins	Not Covered	Not covered without Prior Authorization.
	Rehabilitation services	Inpatient 30% Co-ins Outpatient 30% Co-ins	Inpatient Not Covered Outpatient Not Covered	Not covered without Prior Authorization. Outpatient Limit: 30 visits/ therapy/ condition/ benefit year

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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	Habilitation services	30% Co-ins	Not Covered	Not covered without Prior Authorization. Covered members birth to age 19; 30 visits / contract year.
	Skilled nursing care	30% Co-ins	Not Covered	Not covered without Prior Authorization; Limit: 100 days / contract year.
	Durable medical equipment	30% Co-ins	Not Covered	Not covered without Prior Authorization.
	Hospice Service	30% Co-ins	Not Covered	Not covered without Prior Authorization.
If your child needs dental or eye care	Eye exam	$0 Copay	Not Covered	One routine eye exam / benefit year
	Glasses	$0 Copay	Not Covered	One pair standard eyeglass lenses or contact lenses / benefit year; one frame every benefit year.
	Dental check-up	Not Covered	Not Covered	Not required due to Stand Alone Dental Product (SADP)

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.)

- Child/Dental Check-up
- Cosmetic Surgery
- Dental Care (Adult)
- Infertility Treatment
- 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
- Chiropractic Care

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 insurance protection you might get from 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:** $2,220
- **You pay:** $5,320

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**

You pay:

Deductibles	$5,100
Co-pays	$20
Coinsurance	$0
Limits or exclusions	$200
Total	**$5,320**

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

- **Amount owed to providers:** $5,400
- **Plan pays:** $3,020
- **You pay:** $2,380

Sample care costs:

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

You pay:

Deductibles	$700
Co-pays	$1,600
Coinsurance	$0
Limits or exclusions	$80
Total	**$2,380**

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.

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Coventry Health & Life Insurance Company: Bronze Deductible Only PPO HSA Eligible

Coverage Period : 01/01/2014 - 12/31/2014

Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage for:** Employee, 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: $6,300 individual/ $12,600 family. Deductible does not apply to Preventative Care.	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: $6,300 individual/ $12,600 family Out of Network: Unlimited	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 and 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.
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**.

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- **Co-payments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** 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 **co-insurance** 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		Limitations & Exceptions
		In Network Provider	Out of Network Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	0% Co-ins	20% Coinsurance (Co-ins).	None
	Specialist visit	0% Co-ins	20% Co-ins	----------none----------
	Other practitioner office visit	0% Co-ins / visit for chiropractic care	20% Co-ins	Limit: 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)	0% Co-ins x-ray 0% Co-ins lab	20% Co-ins x-ray 20% Co-ins lab	----------none----------
	Imaging (CT/PET scans, MRIs)	0% Co-ins	$250 Coapy + 20% Co-ins	Not covered without Prior Authorization. Out of network:Free-standing facility 20% Co-ins + Ded.
If you need drugs to treat your illness or condition. More information about prescription drug coverage is available at www.chcde.com.	Generic drugs	Deductible	Not Covered	Quantiy Limits may apply
	Preferred brand drugs	Deductible	Not Covered	Quantity Limit and Prior Authorization may apply
	Non-preferred brand drugs	Deductible	Not Covered	Quantity Limits and Prior Authorization may apply
	Specialty drugs	Deductible	Not Covered	Prior Authorization required
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% Co-ins	20% Co-ins	Not covered without Prior Authorization.
	Physician/surgeon fees	0% Co-ins	20% Co-ins	Not covered without Prior Authorization.

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.

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	0% Co-ins	0% Co-ins	Must meet emergency criteria.
	Emergency medical transportation	0% Co-ins	0% Co-ins	Must meet emergency criteria.
	Urgent care	0% Co-ins	20% Co-ins	Must meet urgent care criteria.
If you have a hospital stay	Facility fee (e.g., hospital room)	0% Co-ins	$1,000 Admit + 20% Co-ins	Not covered without Prior Authorization.
	Physician/surgeon fee	0% Co-ins	20% Co-ins	Not covered without Prior Authorization
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	0% Co-ins	20% Co-ins	Not covered without Prior Authorization.
	Mental/Behavioral health inpatient services	0% Co-ins	$1,000 Admit + 20% Co-ins	Not covered without Prior Authorization.
	Substance use disorder outpatient services	0% Co-ins	20% Co-ins	Not covered without Prior Authorization.
	Substance use disorder inpatient services	0% Co-ins	$1,000 Admit + 20% Co-ins	Not covered without Prior Authorization.
If you are pregnant	Prenatal and postnatal care	$0 Copay / visit	20% Co-ins	----------none----------
	Delivery and all inpatient services	0% Co-ins	20% Co-ins	Not covered without Prior Authorization.
If you need help recovering or have other special health needs	Home health care	0% Co-ins	20% Co-ins	Not covered without Prior Authorization.
	Rehabilitation services	Inpatient 0% Co-ins Outpatient 0% Co-ins	Inpatient $1,000 Admit + 20% Co-ins Outpatient 20% Co-ins	Not covered without Prior Authorization. Outpatient Limit: 30 visits per therapy per condition per benefit year
	Habilitation services	0% Co-ins	20% Co-ins	Not covered without Prior Authorization. Covered members birth to age 19; 30 visits / contract year.
	Skilled nursing care	0% Co-ins	20% Co-ins	Not covered without Prior Authorization; Limit: 100 days / contract year.
	Durable medical equipment	0% Co-ins	20% Co-ins	Not covered without Prior Authorization.
	Hospice Service	0% Co-ins	20% Co-ins	Not covered without Prior Authorization.

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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 your child needs dental or eye care	Eye exam	$0 Copay	20% Usual and Customary Charges.	One routine eye exam / benefit year
	Glasses	$0 Copay	20% Usual and Customary Charges.	One pair standard eyeglass lenses or contact lenses / benefit year; one frame every benefit year.
	Dental check-up	Not Covered	Not Covered	Not required due to Stand Alone Dental Product (SADP)

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.)

- Child/Dental Check-up
- Cosmetic Surgery
- Dental Care (Adult)
- Infertility Treatment
- 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
- Chiropractic Care

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.

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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.*———————

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.

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 insurance protection you might get from 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:** $2,240
- **You pay:** $5,300

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**

You pay:

Deductibles	$5,100
Co-pays	$0
Coinsurance	$0
Limits or exclusions	$200
Total	**$5,300**

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

- **Amount owed to providers:** $5,400
- **Plan pays:** $4,520
- **You pay:** $880

Sample care costs:

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

You pay:

Deductibles	$800
Co-pays	$0
Coinsurance	$0
Limits or exclusions	$80
Total	**$880**

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.

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.

Coventry Health & Life Insurance Company: Silver $10 Copay HMO Plan

Coverage Period : 01/01/2014 - 12/31/2014

Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage for:** Employee, Family **| 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: $2,000 individual/ $4,000 family. Deductible does not apply to Preventative Care, Primary Care, First Specialist Care visit, Urgent Care and First Emergency Room visit. 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?	Separate Pharmacy Deductible $1,000 Individual / $2,000 Family	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: $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, balanced-billed charges and 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.
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**.

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.

- **Co-payments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** 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 **co-insurance** 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		Limitations & Exceptions
		In Network Provider	Out of Network Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$10 Copay / visit	Not Covered	None
	Specialist visit	$75 Copay / visit	Not Covered	----------none----------
	Other practitioner office visit	$75 Copay / visit for chiropractic care	Not Covered	Limit: 20 visits / contract year.
	Preventive care/ Screening/Immunization	$0 Copay / visit	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)	$500 Copay + 30% Co-ins	Not Covered	Not covered without Prior Authorization. Free-standing facility applies $500 Copay + Ded.
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 $5 Copay / Non Preferred Pharmacy $15 Copay; Generic: Preferred Pharmacy $15 Copay / Non Preferred Pharmacy $20 Copay	Not Covered	Pharmacy Deductible does not apply to generics. 90 day supply available retail or mail order for 3 times the Preferred or Non Preferred Pharmacy Copay.

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.	Preferred brand drugs	Preferred Pharmacy $45 Copay/ Non Preferred Pharmacy $55 Copay	Not Covered	Pharmacy Deductible of $1,000 Individual / $2,000 Family applies. 90 day supply available for 3 times the Preferred or Non Preferred Copay
	Non-preferred brand drugs	Preferred Pharmacy $75 Copay / Non Preferred $85 Copay	Not Covered	Pharmacy Deductible of $1,000 Individual / $2,000 Family applies. 90 day supply available for 3 times the Preferred or Non Preferred Copay
	Specialty drugs	Preferred Speciatly Drug 30% Co-ins ; Non Preferred Specialy Drug 40% Co-ins.	Not Covered	Pharmacy Deductible of $1,000 Individual / $2,000 Family applies. Limit: 30 day supply
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% Co-ins	Not Covered	Not covered without Prior Authorization.
	Physician/surgeon fees	30% Co-ins	Not Covered	Not covered without Prior Authorization.
If you need immediate medical attention	Emergency room services	$500 Copay / visit	Not Covered	Must meet emergency criteria.
	Emergency medical transportation	30% Co-ins	Not Covered	Must meet emergency criteria.
	Urgent care	$75 Copay / visit	Not Covered	Must meet urgent care criteria.
If you have a hospital stay	Facility fee (e.g., hospital room)	$500 Copay / Admit + 30% Co-ins	Not Covered	Not covered without Prior Authorization.
	Physician/surgeon fee	30% Co-ins	Not Covered	Not covered without Prior Authorization.
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$75 Copay / visit	Not Covered	Not covered without Prior Authorization.
	Mental/Behavioral health inpatient services	$500 Copay / Admit + 30% Co-ins	Not Covered	Not covered without Prior Authorization.
	Substance use disorder outpatient services	$75 Copay / visit	Not Covered	Not covered without Prior Authorization.
	Substance use disorder inpatient services	$500 Copay / Admit + 30% Co-ins	Not Covered	Not covered without Prior Authorization.
If you are pregnant	Prenatal and postnatal care	$0 Copay	Not Covered	----------none----------

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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 are pregnant	Delivery and all inpatient services	One time $500 Copay	Not Covered	Not covered without Prior Authorization.
If you need help recovering or have other special health needs	Home health care	30% Co-ins	Not Covered	Not covered without Prior Authorization.
	Rehabilitation services	Inpatient 30% Co-ins Outpatient 30% Co-ins	Inpatient Not Covered Outpatient Not Covered	Not covered without Prior Authorization. Outpatient Limit: 30 visits/ therapy/ condition/ benefit year
	Habilitation services	30% Co-ins	Not Covered	Not covered without Prior Authorization. Covered members birth to age 19; 30 visits / contract year.
	Skilled nursing care	30% Co-ins	Not Covered	Not covered without Prior Authorization; Limit: 100 days / contract year.
	Durable medical equipment	30% Co-ins	Not Covered	Not covered without Prior Authorization.
	Hospice Service	30% Co-ins	Not Covered	Not covered without Prior Authorization.
If your child needs dental or eye care	Eye exam	$0 Copay	Not Covered	One routine eye exam / benefit year
	Glasses	$0 Copay	Not Covered	One pair standard eyeglass lenses or contact lenses / benefit year; one frame every benefit year.
	Dental check-up	Not Covered	Not Covered	Not required due to Stand Alone Dental Product (SADP)

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.)

- Child/Dental Check-up
- Cosmetic Surgery
- Dental Care (Adult)
- Infertility Treatment
- 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
- Chiropractic Care

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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.**

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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.*——————

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These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much insurance protection you might get from 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:** $4,040
- **You pay:** $3,500

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**

You pay:

Deductibles	$2,000
Co-pays	$500
Coinsurance	$800
Limits or exclusions	$200
Total	**$3,500**

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

- **Amount owed to providers:** $5,400
- **Plan pays:** $3,520
- **You pay:** $1,880

Sample care costs:

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

You pay:

Deductibles	$100
Co-pays	$1,700
Coinsurance	$0
Limits or exclusions	$80
Total	**$1,880**

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: 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.

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.

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.

Coventry Health & Life Insurance Company: Silver $10 Copay PPO Plan

Coverage Period : 01/01/2014 - 12/31/2014

Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage for:** Employee, 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: $2,000/ $4,000 family. Ded. does not apply to Preventative and Primary Care, First Specialist Office visit, Urgent Care and First Emergency Room visit. Out of Network: $5,300/ $10,600	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 of $1,000/ Individual; $2,000/ Family	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: $6,350 person/ $12,700 family Out of Network: Unlimited	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 and 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.
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**.

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.

- **Co-payments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** 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 **co-insurance** 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		Limitations & Exceptions
		In Network Provider	Out of Network Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$10 Copay / visit	20% Coinsurance (Co-ins)	None
	Specialist visit	$75 Copay / visit	20% Co-ins .	----------none----------
	Other practitioner office visit	$75 Copay / visit for chiropractic care	20% Co-ins	Limit: 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)	30% Co-ins x-ray 30% Co-ins lab	35% Co-ins x-ray 35% Co-ins lab	----------none----------
	Imaging (CT/PET scans, MRIs)	$500 Copay + 30% Co-ins	$750 Copay + 35% Co-ins	Not covered without Prior Authorization. Free-standing facility: In Network $500 Copay + Deductible
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 Pharmacy $5 Copay/ Non Preferred Pharmacy $15 Copay	Not Covered	Pharmacy Deductible does not apply to Generic Drugs. 90 day supply avialable retail or mail order for 3 times the Preferred/Non Preferred Pharmacy Copay
	Preferred brand drugs	Preferred Pharmacy $45 Copay / Non Preferred Pharmacy $55 Copay	Not Covered	Deductible $1,000/ Individual / $2,000 Family applies. 90 day supply avialable retail or mail order for 3 times the Preferred/ Non Preferred Pharmacy Copay

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.

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	Preferred Pharmacy $75 Copay / Non Preferred Pharmacy $85 Copay.	Not Covered	Deductible $1,000/ Individual / $2,000/Family applies. 90 day supply avialable retial or mail order for 3 times the Preferred/Non Preferred Pharmacy Copay
	Specialty drugs	Preferred Pharmacy 30% Co-ins / Non Preferred Pharmacy 40% Co-ins.	Not Covered	Deductible $1,000/ Individual / $2,000/ Family applies; Limit: 30 day supply
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% Co-ins	35% Co-ins	Not covered without Prior Authorization.
	Physician/surgeon fees	30% Co-ins	35% Co-ins	Not covered without Prior Authorization.
If you need immediate medical attention	Emergency room services	$500 Copay / visit	$500 Copay / visit	Must meet emergency criteria.
	Emergency medical transportation	30% Co-ins	35% Co-ins	Must meet emergency criteria.
	Urgent care	$75 Copay / visit	35% Co-ins	Must meet urgent care criteria.
If you have a hospital stay	Facility fee (e.g., hospital room)	$500 Copay / Admit + / 30% Co-ins	$1,000 Admit + Ded. / 35% Co-ins	Not covered without Prior Authorization.
	Physician/surgeon fee	30% Co-ins	35% Co-ins	Not covered without Prior Authorization
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$75 Copay / visit	35% Co-ins	Not covered without Prior Authorization.
	Mental/Behavioral health inpatient services	$500 Copay / Admit + 30% Co-ins	$1,000 Admit + 35% Co-ins	Not covered without Prior Authorization.
	Substance use disorder outpatient services	$75 Copay / visit	35% Co-ins	Not covered without Prior Authorization.
	Substance use disorder inpatient services	$500 Copay / Admit + / 30% Co-ins	$1,000 Admit + Ded. / 35% Co-ins	Not covered without Prior Authorization.
If you are pregnant	Prenatal and postnatal care	$0 Copay / visit	35% Co-ins	----------none----------
	Delivery and all inpatient services	One time $500 Copay	35% Co-ins	Not covered without Prior Authorization.
If you need help recovering or have other special health needs	Home health care	30% Co-ins	35% Co-ins	Not covered without Prior Authorization.

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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	Rehabilitation services	Inpatient 30% Co-ins Outpatient 30% Co-ins	Inpatient 35% Co-ins Outpatient 35% Co-ins	Not covered without Prior Authorization. Outpatient Limit: 30 visits/therapy/ condition / benefit year
	Habilitation services	30% Co-ins	35% Co-ins	Not covered without Prior Authorization. Covered members birth to age 19; 30 visits / contract year.
	Skilled nursing care	30% Co-ins	35% Co-ins	Not covered without Prior Authorization; Limit: 100 days / contract year.
	Durable medical equipment	30% Co-ins	35% Co-ins	Not covered without Prior Authorization.
	Hospice Service	30% Co-ins	35% Co-ins	Not covered without Prior Authorization.
If your child needs dental or eye care	Eye exam	$0 Copay	20% Usual and Customary Charges.	One routine eye exam / benefit year
	Glasses	$0 Copay	20% Usual and Customary Charges.	One pair standard eyeglass lenses or contact lenses / benefit year; one frame every benefit year.
	Dental check-up	Not Covered	Not Covered	Not required due to Stand Alone Dental Product (SADP)

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.)

- Child/Dental Check-up
- Cosmetic Surgery
- Dental Care (Adult)
- Infertility Treatment
- 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
- Chiropractic Care

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

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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.

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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 insurance protection you might get from 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:** $4,040
- **You pay:** $3,500

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**

You pay:

Deductibles	$2,000
Co-pays	$500
Coinsurance	$800
Limits or exclusions	$200
Total	**$3,500**

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

- **Amount owed to providers:** $5,400
- **Plan pays:** $3,520
- **You pay:** $1,880

Sample care costs:

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

You pay:

Deductibles	$100
Co-pays	$1,700
Coinsurance	$0
Limits or exclusions	$80
Total	**$1,880**

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.

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Coventry Health & Life Insurance Company: Gold $0 Copay HMO Plan

Coverage Period : 01/01/2014 - 12/31/2014

Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage for:** Employee, 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/ $2,500 family. Deductible does not apply to Preventative Care, Primary Care, First 5 Specialist Office visits, Urgent Care and First 3 Emergency Room visits. 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?	Separate Pharmacy Deductible $250 Individual/ $500 Family	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: $5,000 person/ $10,000 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, balanced-billed charges and 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.
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**.

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- **Co-payments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** 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 **co-insurance** 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		Limitations & Exceptions
		In Network Provider	Out of Network Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$0 Copay / visit	Not Covered	None
	Specialist visit	$50 Copay / visit	Not Covered	----------none----------
	Other practitioner office visit	$50 Copay / visit for chiropractic care	Not Covered	Limit: 20 visits / contract year.
	Preventive care/ Screening/Immunization	$0 Copay / visit	Not Covered	----------none----------
If you have a test	Diagnostic test (x-ray, blood work)	20% Co-ins x-ray 20% Co-ins lab	Not Covered x-ray Not Covered lab	----------none----------
	Imaging (CT/PET scans, MRIs)	20% Co-ins	Not Covered	Not covered without Prior Authorization.
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 / Non Preferred Pharmacy $5 Copay ; Generic: Preferred Pharmacy $5 Copay / Non Preferred Pharmacy $10 Copay	Not Covered	Pharmacy deductible does not apply to generic drugs. 90 day supply available retail or mail order for 3 times the Preferred or Non Preferred Pharmacy Copay
	Preferred brand drugs	Preferred Pharmacy $30 Copay/ Non Preferred Pharmacy $40 Copay	Not Covered	Pharmacy Deductible $250 Individual/ $500 Family applies. 90 day supply available retail or mail order for 3 times the Preferred or Non Preferred Copay

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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	Preferred Pharmacy $60 Copay / Non Preferred Pharmacy $75 Copay	Not Covered	Pharmacy Deductible $250 Individual/ $500 Family applies. 90 day supply avialable retail or mail order for 3 times the Preferred or Non Preferred Pharmacy Copay
	Specialty drugs	Preferred Specialty Drug 20% Co-ins ; Non Preferred Specialy Drug 30% Co-ins.	Not Covered	Limit: 30 day supply
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% Co-ins	Not Covered	Not covered without Prior Authorization.
	Physician/surgeon fees	20% Co-ins	Not Covered	Not covered without Prior Authorization.
If you need immediate medical attention	Emergency room services	$250 Copay / visit	Not Covered	Must meet emergency criteria.
	Emergency medical transportation	$500 Copay / visit	Not Covered	Must meet emergency criteria.
	Urgent care	$75 Copay / visit	Not Covered	Must meet urgent care criteria.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% Co-ins	Not Covered	Not covered without Prior Authorization.
	Physician/surgeon fee	20% Co-ins	Not Covered	Not covered without Prior Authorization
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	20% Co-ins	Not Covered	Not covered without Prior Authorization.
	Mental/Behavioral health inpatient services	20% Co-ins	Not Covered	Not covered without Prior Authorization.
	Substance use disorder outpatient services	20% Co-ins	Not Covered	Not covered without Prior Authorization.
	Substance use disorder inpatient services	20% Co-ins	Not Covered	Not covered without Prior Authorization.
If you are pregnant	Prenatal and postnatal care	$0 Copay / visit	Not Covered	----------none----------
	Delivery and all inpatient services	One time $250 Copay	Not Covered	Not covered without Prior Authorization.

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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	20% Co-ins	Not Covered	Not covered without Prior Authorization.
	Rehabilitation services	Inpatient 20% Co-ins Outpatient 20% Co-ins	Inpatient Not Covered Outpatient Not Covered	Not covered without Prior Authorization. Outpatient Limit: 30 visits/ therapy/ condition/ benefit year
	Habilitation services	20% Co-ins	Not Covered	Not covered without Prior Authorization. Covered members birth to age 19; 30 visits / contract year.
	Skilled nursing care	20% Co-ins	Not Covered	Not covered without Prior Authorization; Limit: 100 days / contract year.
	Durable medical equipment	20% Co-ins	Not Covered	Not covered without Prior Authorization.
	Hospice Service	20% Co-ins	Not Covered	Not covered without Prior Authorization.
If your child needs dental or eye care	Eye exam	$0 Copay	Not Covered	One routine eye exam / benefit year
	Glasses	$0 Copay	Not Covered	One pair standard eyeglass lenses or contact lenses / benefit year; one frame every benefit year.
	Dental check-up	Not Covered	Not Covered	Not required due to Stand Alone Dental Product (SADP)

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.)

- Child/Dental Check-up
- Cosmetic Surgery
- Dental Care (Adult)
- Infertility Treatment
- 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
- Chiropractic Care

Your Rights to Continue Coverage:

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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.

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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:

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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.

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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 insurance protection you might get from 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
- **You pay:** $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**

You pay:

Deductibles	$1,300
Co-pays	$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
- **You pay:** $1,380

Sample care costs:

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

You pay:

Deductibles	$100
Co-pays	$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.

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.

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

Coverage Period : 01/01/2014 - 12/31/2014

Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage for:** Employee, 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/ $2,500 family. Ded. does not apply to Preventative and Primary Care, First 5 Specialist Office visits, Urgent Care and First 3 Emergency Room visits. Out of Network: $4,900/ $9,800	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	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: $5,000 person/ $10,000 family Out of Network: Unlimited	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 and 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.
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**.

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- **Co-payments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** 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 **co-insurance** 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		Limitations & Exceptions
		In Network Provider	Out of Network Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$0 Copay / visit	20% Coinsurance (Co-ins)	None
	Specialist visit	$50 Copay / visit	20% Co-ins	----------none----------
	Other practitioner office visit	$50 Copay / visit for chiropractic care	20% Co-ins	Limit: 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 +30% Co-ins	Not covered without Prior Authorization. In-network Free-standing facility $250 Copay
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 / Non-Preferred Pharmacy $5 Copay; Generic:Preferred Pharmacy $5 Copay / Non-Preferred Pharmacy $10 Copay	Not Covered	90 day supply avialable retail or mail order for 3 times the Preferred/Non Preferred Pharmacy Copay
	Preferred brand drugs	Preferred Pharmacy $30 Copay / Non Preferred Pharmacy $40 Copay	Not Covered	Deductible $250 Individual / $500 Family applies. 90 day supply available retail or mail order for 3 times Preferred / Non Preferred Pharamacy Copay

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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	Preferred Pharmacy $60 Copay / Non Preferred Pharmacy $75 Copay	Not Covered	Deductible $250 Individual / $500 Family. 90 day supply avialable retail or mail order for 3 times the Preferred/ non preferred Pharmacy Copay
	Specialty drugs	Preferred Pharmacy 20% Co-ins / Non Preferred Pharmacy 30% Co-ins.	Not Covered	Deductible $250 Individual / $500 Family applies. Prior Authorization required. Limit: 30 day supply
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.
If you need immediate medical attention	Emergency room services	$250 Copay / visit	$250 Copay / visit	Must meet emergency criteria.
	Emergency medical transportation	$500 Copay / visit	$500 Copay	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	$1,000 Admit + 30% Co-ins	Not covered without Prior Authorization.
	Physician/surgeon fee	20% Co-ins	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 / visit	20% Co-ins	Not covered without Prior Authorization.
	Mental/Behavioral health inpatient services	20% Co-ins	$1,000 Admit + 30% Co-ins	Not covered without Prior Authorization.
	Substance use disorder outpatient services	$50 Copay / visit	20% Co-ins	Not covered without Prior Authorization.
	Substance use disorder inpatient services	20% Co-ins	$1,000 Admit + 30% Co-ins	Not covered without Prior Authorization.
If you are pregnant	Prenatal and postnatal care	$0 Copay / visit	20% Co-ins	----------none----------
	Delivery and all inpatient services	One time $250 Copay	20% Co-ins	Not covered without Prior Authorization.
If you need help recovering or have other special health needs	Home health care	20% Co-ins	30% Co-ins	Not covered without Prior Authorization.

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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	Rehabilitation services	Inpatient 20% Co-ins Outpatient 20% Co-ins	Inpatient 30% Co-ins Outpatient 30% Co-ins	Not covered without Prior Authorization. Outpatient Limit: 30 visits / therapy / condition / benefit year
	Habilitation services	20% Co-ins	30% Co-ins	Not covered without Prior Authorization. Covered members birth to age 19; 30 visits / contract year.
	Skilled nursing care	20% Co-ins	30% Co-ins	Not covered without Prior Authorization; Limit: 100 days / contract year.
	Durable medical equipment	20% Co-ins	30% Co-ins	Not covered without Prior Authorization.
	Hospice Service	20% Co-ins	30% Co-ins	Not covered without Prior Authorization.
If your child needs dental or eye care	Eye exam	$0 Copay	20% of Out of Network Rate	One routine eye exam / benefit year
	Glasses	$0 Copay	Not Covered	One pair standard eyeglass lenses or contact lenses / benefit year; one frame every benefit year.
	Dental check-up	Not Covered	Not Covered	Not required due to Stand Alone Dental Product (SADP)

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.)

- Child/Dental Check-up
- Cosmetic Surgery
- Dental Care (Adult)
- Infertility Treatment
- 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
- Chiropractic Care

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

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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.

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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 insurance protection you might get from 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:** $5,810
- **You pay:** $1,730

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**

You pay:

Deductibles	$1,300
Co-pays	$30
Coinsurance	$200
Limits or exclusions	$200
Total	**$1,730**

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

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

Sample care costs:

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

You pay:

Deductibles	$100
Co-pays	$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.

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