Coventry: Silver $15 Copay HMO Atlanta PD

Coverage Period : 01/01/2017 - 12/31/2017

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

Coverage for: Individual/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.coventryone.com or by calling (866) 364-5663.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network: **$3,500** Individual (Ind)/ **$7,000** Family (Fam). Does not apply to: Certain Office Visits, Preventive Care, Urgent Care 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?	Yes, for prescription drugs per member In-Network: **$500.** There are no other specific deductibles.	You must pay all of the costs for these services up to the specific **deductible** amount before this plan begins to pay for these services.
Is there an out-of-pocket limit on my expenses?	In-Network: Yes, **$7,000** Ind/ **$14,000** Fam Out-of-Network: Not Covered	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, health care this plan does not cover	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes For a list of Participating providers, visit www.coventryone.com or call (866) 364-5663.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes	Some of the services this plan doesn't cover are listed on page 4. See your policy or plan document for additional information about **excluded services**.

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

Common Medical Event	Services You May Need	Your Cost If You Use a In-Network Provider	Your Cost If You Use a Out-of-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$15 co-payment (co-pay)/visit deductible waived (dw)	Not Covered	----------none----------
	Specialist visit	$75 co-pay/visit dw	Not Covered	----------none----------
	Other practitioner office visit	30% co-insurance (co-ins) chiropractor	Not Covered	Limited to 20 visits for Chiropractic care.
	Preventive care/ Screening/Immunization	No Charge	Not Covered	Age and frequency schedules may apply.
If you have a test	Diagnostic test (x-ray, blood work)	30% co-ins x-ray 30% co-ins lab	Not Covered x-ray Not Covered lab	----------none----------
	Imaging (CT/PET scans, MRIs)	$250 co-pay/service + 30% co-ins	Not Covered	Prior authorization may be required, please see plan documents.
If you need drugs to treat your illness or condition. More information about **prescription drug coverage** is available at www.coventryone.com.	Generic drugs	$5 co-pay/Retail dw, $12.50 co-pay/Mail dw, Tier 1A; $15 co-pay/Retail dw, $37.50 co-pay/Mail dw, Tier 1	Not Covered	Covers up to a 30 day supply (retail prescription), 31 -90 day supply (mail order prescription). Non-Preferred Generic same benefit as Non-Preferred Brand.

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.coventryone.com.	Preferred brand drugs	Tier 2: $45 co-pay/Retail, $112.50 co-pay/Mail	Not Covered	Covers up to a 30 day supply (retail prescription), 31 -90 day supply (mail order prescription).
	Non-preferred brand drugs	Tier 3: $80 co-pay/Retail, $200 co-pay/Mail	Not Covered	Covers up to a 30 day supply (retail prescription), 31 -90 day supply (mail order prescription).
	Specialty drugs	Tier 4: 40% co-ins/Retail; Tier 5: 50% co-ins/Retail	Not Covered	Prior authorization may be required, please see plan documents. Covers up to a 30 day supply (retail prescription). Mail order Tier 4 and 5 Not Covered.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$250 co-pay/service + 30% co-ins	Not Covered	Prior authorization may be required, please see plan documents.
	Physician/surgeon fees	30% co-ins	Not Covered	----------none----------
If you need immediate medical attention	Emergency room services	30% co-ins	30% co-ins	Out-of-Network (OON) emergency room services cost-share same as In-Network.
	Emergency medical transportation	30% co-ins	30% co-ins	Prior authorization may be required, please see plan documents. OON cost-share same as In-Network.
	Urgent care	$75 co-pay/visit dw	Not Covered	----------none----------
If you have a hospital stay	Facility fee (e.g., hospital room)	$500 co-pay/admit + 30% co-ins	Not Covered	Prior authorization may be required, please see plan documents.
	Physician/surgeon fee	30% co-ins	Not Covered	----------none----------
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$75 co-pay/visit dw	Not Covered	----------none----------
	Mental/Behavioral health inpatient services	$500 co-pay/admit + 30% co-ins	Not Covered	Prior authorization may be required, please see plan documents.
	Substance use disorder outpatient services	$75 co-pay/visit dw	Not Covered	----------none----------
	Substance use disorder inpatient services	$500 co-pay/admit + 30% co-ins	Not Covered	Prior authorization may be required, please see plan documents.

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	Prenatal and postnatal care	Prenatal: No Charge, Postnatal and Delivery: 30% co-ins	Not Covered	----------none----------
	Delivery and all inpatient services	$500 co-pay/admit + 30% co-ins	Not Covered	----------none----------
If you need help recovering or have other special health needs	Home health care	30% co-ins	Not Covered	Limited to 120 visits.
	Rehabilitation services	Inpatient $500 co-pay/admit + 30% co-ins Outpatient 30% co-ins	Inpatient Not Covered Outpatient Not Covered	Prior authorization may be required, please see plan documents. Limited to 40 visits for Physical Therapy and Occupational Therapy combined, 40 visits for Speech Therapy.
	Habilitation services	30% co-ins	Not Covered	Limited to 40 visits for Physical Therapy and Occupational Therapy combined, 40 visits for Speech Therapy.
	Skilled nursing care	30% co-ins	Not Covered	Prior authorization may be required, please see plan documents. Limited to 60 days per calendar year.
	Durable medical equipment	50% co-ins	Not Covered	Prior authorization may be required, please see plan documents.
	Hospice Service	30% co-ins	Not Covered	Prior authorization may be required, please see plan documents.
If your child needs dental or eye care	Eye exam	No Charge	Not Covered	Limited to 1 exam per calendar year age 0-19.
	Glasses	No Charge	Not Covered	Limited to 1 set of frames and 1 set of contact lenses or eyeglass lenses per calendar year age 0-19.
	Dental check-up	No Charge	Not Covered	Limited to 2 exams per calendar year.

Excluded Services & Other Covered Services:

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

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Hearing aids
- 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.)

- Chiropractic care

Your Rights to Continue Coverage:

Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay your **premium**. There are exceptions, however, such as if:

- You commit fraud
- The insurer stops offering services in the State
- You move outside the coverage area

For more information on your rights to continue coverage, contact the insurer at (866) 364-5663. You may also contact your state insurance department at Office of Insurance and Safety Fire Commissioner - Seventh Floor, West Tower, Floyd Building, Martin Luther King, Jr. Drive, Atlanta, GA 30333, 404-656-2070.

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:

Office of Insurance and Safety Fire Commissioner - Seventh Floor, West Tower, Floyd Building, Martin Luther King, Jr. Drive, Atlanta, GA 30333, 404-656-2070

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 <u>does meet</u> the minimum value standard for the benefits it provides.

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

About these Coverage Examples:

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

This is not a cost estimator.

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

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $3,340
- **Patient pays** $4,200

Sample care costs:

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

Patient pays:

Deductibles	$3,500
Copays	$500
Coinsurance	$0
Limits or exclusions	$200
Total	**$4,200**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $2,720
- **Patient pays** $2,680

Sample care costs:

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

Patient pays:

Deductibles	$2,400
Copays	$200
Coinsurance	$0
Limits or exclusions	$80
Total	**$2,680**

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.

Addendum

Assistive Technology

Persons using assistive technology may not be able to fully access the following information. For assistance, please call (866) 364-5663.

Smartphone or Tablet

To view documents from your smartphone or tablet, the free WinZip app is required. It may be available from your App Store.

Non-Discrimination

Aetna complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. Aetna does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

Aetna:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact our Civil Rights Coordinator.

If you believe that Aetna has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with our Civil Rights Coordinator at:

Address: P.O. Box 14462, Lexington, KY 40512
Telephone: **1-800-648-7817 (TTY: 711)**, Fax: **1-859-425-3379**
Email: CRCoordinator@aetna.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services,

200 Independence Avenue, SW Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 800-537-7697 (TDD).

Complaint forms are available at **http://www.hhs.gov/ocr/office/file/index.html**.

Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies, including Aetna Life Insurance Company, Coventry Health Care plans and their affiliates.

Language Assistance

TTY: 711

For Language assistance in English call (866) 364-5663 at no cost. (English)

Para obtener asistencia lingüística en español, llame sin cargo al (866) 364-5663. (Spanish)

欲取得繁體中文語言協助, 請撥打 (866) 364-5663, 無需付費。 (Chinese)

Pour une assistance linguistique en français appeler le (866) 364-5663 sans frais. (French)

Para sa tulong sa wika na nasa Tagalog, tawagan ang (866) 364-5663 nang walang bayad. (Tagalog)

T'áá shí shizaad k'ehjí bee shíká a'doowoł nínízingo ĮDiné k'ehjíÓ kojį' t'áá jíík'e hólne' (866) 364-5663 (Navajo)

Benötigen Sie Hilfe oder Informationen in deutscher Sprache? Rufen Sie uns kostenlos unter der Nummer (866) 364-5663 an. (German)

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للمساعدة في (اللغة العربية) ، الرجاء الاتصال على الرقم المجاني (866) 364-5663. (Arabic)

ငွေကုန်ကျခံစရာမလိုဘဲ (မြန်မာဘာသာစကား)ဖြင့် ဘာသာစကားအကူအညီရယူရန် (866) 364-5663 ကို ခေါ်ဆိုပါ။ (Burmese)

ᎾᏍᎩᎾ ᏕᏠᏂᎯᏍᏗ ᏗᏂᏍᏕᎵᏍᎩ ᎾᏞᎢ (ᏕᏠᏂᎯᏍᏗ) ᏫᏓᎳᏫᎢᏍ (866) 364-5663 ᎤᎾᎢ ᎪᎱᏍᏗ ᏧᎬᏩᎶᏗ ᏂᎨᏒᎾ. (Cherokee)

Gargaarsa afaan Oromiffa hiikuu argachuuf lakkokkofsa bilbilaa (866) 364-5663 irratti bilisaan bilbilaa. (Cushite)

Bel voor tolk- en vertaaldiensten in het Nederlands gratis naar (866) 364-5663. (Dutch)

Pou jwenn asistans nan lang Kreyòl Ayisyen, rele nimewo (866) 364-5663 gratis. (French Creole)

Για γλωσσική βοήθεια στα Ελληνικά καλέστε το (866) 364-5663 χωρίς χρέωση. (Greek)

ગુજરાતીમાં ભાષામાં સહાય માટે કોઈ પણ ખર્ચ વગર (866) 364-5663 પર કૉલ કરો. (Gujarati)

हिन्दी में भाषा सहायता के लिए, (866) 364-5663 पर मुफ्त कॉल करें। (Hindi)

Yog xav tau kev pab txhais lus Hmoob hu dawb tau rau (866) 364-5663. (Hmong)

Per ricevere assistenza linguistica in italiano, può chiamare gratuitamente (866) 364-5663. (Italian)

日本語で援助をご希望の方は, (866) 364-5663 まで無料でお電話ください。 (Japanese)

လၢတၢ်မၤစၢၤတၢ်ကတိၤကျိာ်အဂိၢ် ကျိာ် ကိး (866) 364-5663 လၢတအိာ်ဒီးတၢ်လၢာ်ဘျာ်လၢာ်စုၤဘဉ် (Karen)

한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 (866) 364-5663 번으로 전화해 주십시오. (Korean)

بۆ وەرگرتنی ڕێنوێنی پێوەندیدار بە زمان بە زمان بە ژمارەی (866) 364-5663 بە خۆڕایی پەیوەندی بکەن. (Kurdish)

ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການແປພາສາລາວ, ກະລຸນາໂທຫາ (866) 364-5663 ໂດຍບໍ່ເສຍຄ່າໂທ. (Laotian)

Ñan bōk jipañ ilo Kajin Majol, kallok (866) 364-5663 ilo ejjelok wōnān. (Marshallese)

សម្រាប់ជំនួយភាសាជាភាសាខ្មែរសូមទូរស័ព្ទទៅកាន់លេខ (866) 364-5663 ដោយឥតគិតថ្លៃ។ (Mon-Khmer, Cambodian)

(नेपाली) मा निःशुल्क भाषा सहायता पाउनका लागि (866) 364-5663 मा फोन गर्नुहोस् । (Nepali)

For språkassistanse på norsk, ring (866) 364-5663 kostnadsfritt. (Norwegian)

Fer Helfe in Deitsch, ruf: (866) 364-5663 aa. Es Aaruf koschtet nix. (Pennsylvania Dutch)

برای راهنمایی به زبان فارسی با شماره (866) 364-5663 بدون هیچ هزینه ای تماس بگیرید . انگلیسی (Persian)

Aby uzyskać pomoc w języku polskim zadzwoń bezpłatnie pod numer (866) 364-5663. (Polish)

Para obter assistência linguística em português ligue para o (866) 364-5663 gratuitamente. (Portuguese)

Pentru asistenţă lingvistică în româneşte telefonaţi la numărul gratuit (866) 364-5663 (Romanian)

Чтобы получить помощь русскоязычного переводчика, позвоните по бесплатному номеру (866) 364-5663. (Russian)

Za jezičnu pomoć na hrvatskom jeziku pozovite besplatan broj (866) 364-5663. (Serbo-Croatian)

Fii yo on heɓu balal e ko yowitii e haala Pular noddee e oo numero ɗoo (866) 364-5663. Njodi woo fawaaki on. (Sudanic-Fulfulde)

Ukihitaji usaidizi katika lugha ya Kiswahili piga simu kwa (866) 364-5663 bila malipo. (Swahili)

สำหรับความช่วยเหลือทางด้านภาษาเป็น ภาษาไทย โทร (866) 364-5663 ฟรีไม่มีค่าใช้จ่าย (Thai)

Kapau ‘oku fiema’u hā tokoni ‘i he lea faka-Tonga telefoni (866) 364-5663 ‘o ‘ikai hā tōtōngi. (Tongan)

Щоб отримати допомогу перекладача української мови, зателефонуйте за безкоштовним номером (866) 364-5663. (Ukrainian)

اُردو میں لسانی معاونت کے لیے (866) 364-5663 پر مفت کال کریں۔ (Urdu)

Để được hỗ trợ ngôn ngữ bằng (ngôn ngữ), hãy gọi miễn phí đến số (866) 364-5663. (Vietnamese)