CITY OF HIALEAH
RISK MANAGEMENT DIVISION
MEMORANDUM

To: All Sworn Police
From: Robert Lloyd-Still, Risk Manager RLS
Date: October 31, 2012
Subject: Open Enrollment – COH Self-Funded Plan, HMO, Dental, Vision, GAP (MEDlink IV – Enhanced Plus), AFLAC, Washington National (f/k/a Conseco)

The time is coming when the City of Hialeah conducts its annual open enrollment for the various insurance programs offered through the City: COH Self-Funded Plan, HMO, Dental coverage, Vison coverage, GAP coverage, or the other supplementary programs. During this time, you are able to update the coverages that best fit your needs. With regards to the HMO, AFSCME has executed a contract with Coventry Healthcare to continue with the two benefit options with new rates and with some benefit modifications. The City was reimbursed $88,640.23 for the HMO under the early retiree reinsurance program this year, and the $88,640.23 will be used by increasing the City's HMO contribution by $11.00 monthly for single, double, or family coverage. Under the City's Self-Funded Plan, there are changes to the rates. The new rates for each of the programs are attached. Please note that the GAP Plan is changing into two different options depending on whether you are enrolled in the HMO High Option or the HMO Low Option. Therefore, anyone currently enrolled in the GAP Plan will need to complete a new enrollment form or their coverage in the GAP Plan will terminate as of 12/31/2012.

Dependent Eligibility

The City has been advised to conduct a dependent audit/verification. This is being done in order to manage overall healthcare costs by confirming that only *eligible* dependents are enrolled in the City's health insurance programs. Removing ineligible dependents helps control costs for all plan participants. However, before conducting the dependent audit/verification, the City would like to update its records. **The City is looking to remove any dependents that are no longer eligible for the City's plans, i.e. ineligible spouses because of divorce or ineligible children because of changes in child custody status. Currently there is no penalty for removing ineligible dependents. Should ineligible dependents remain on the plans after a dependent audit/verification, the City would require payment for any past insurance claims that the plans have incurred on behalf of these ineligible dependents. And in the event there is a willful misrepresentation for coverage purposes, the employee would be subject to disciplinary action up to and including termination.**

Anyone who desires to make a change must do so during the open enrollment, and you must remain within that plan until the next open enrollment scheduled by the City of Hialeah. Please see the attached schedule of benefits for the two different options being offered by Coventry Healthcare. Please see the attached summary sheet from United Healthcare that highlights the City's Self-Funded Plan. If you decide to add or remove dependents in the City's Self-Funded Plan, you may do so through the City's Risk Management Office located on the third floor of City Hall. All changes will become effective January 1, 2013. Representatives from Coventry, Humana, American Fidelity, AFLAC, and Washinton National (f/k/a Conseco) will be at City facilities at scheduled times to enroll new members, give out information and answer any questions. Please be sure to check with your supervisor before attending one of the meetings. The schedule is listed below:

The enrollment period will begin on Tuesday, November 13, 2012, and end on Thursday, November 29, 2012 at 4:00 PM. Please note that the period to make insurance changes ends on Thursday, November 29, 2012.

November 13, 2012 through November 16, 2012 – (Each weekday) - City Hall (Employee Lounge) 11:00 AM - 3:00 PM.
November 19, 2012 through November 21, 2012 – (Monday, Tuesday, Wednesday) – Police Department (Training Bldg. Classroom #2) 7:30 AM - 9:30 AM, 1:00 PM – 3:30 PM
November 26, 2012 - Monday - Recreation & Community Services Admin. (Conference Room) 1:30 PM - 4:30 PM
November 27, 2012 - Tuesday - Recreation & Community Services Admin. (Conference Room) 1:30 PM - 4:30 PM
November 28, 2012 - Wednesday - Water & Sewer Department (Lunch Room) 12:30 PM - 3:30 PM
November 29, 2012 – Thursday - Police Department (Training Bldg. Classroom #2) 7:30 AM - 9:30 AM
November 29, 2012 - Thursday - Solid Waste Department (Shape-Up Room) 12:00 PM - 3:30 PM

If you have any questions regarding any of the above information, please call the Risk Management Office at (305) 883-8059 or (305) 883-8048. A Coventry Health Plan representative can be reached at (888) 679-9148, between the hours of 8:30 am - 5:00 pm. Also, if you have questions concerning the dental coverage, you can speak with a Humana representative directly at (800) 342-5209. Please visit the Risk Management Page of the City's website at www.hialeahfl.gov to view the Summary Plan Descriptions and other descriptions or updates regarding the City's different insurance programs. Also, open enrollment is an opportunity to update your beneficiary forms for the City's life insurance programs at Risk Management.

INSURANCE PREMIUMS
SWORN POLICE

Effective 1/1/13

City of Hialeah Self-Funded Plan

	Monthly Premium	City's Contribution	Emp. Pays Monthly	Employee Pays Bi - Weekly
SINGLE	$398.50	$214.33	$184.17	$85.00
DOUBLE	$797.00	$560.83	$236.17	$109.00
FAMILY	$1,268.34	$1,010.51	$257.83	$119.00

Effective 1/1/2013

Coventry Health Care of Florida High Option

	Monthly Premium	City's Contribution	Emp. Pays Monthly	Employee Pays Bi - Weekly
SINGLE	$340.81	$246.80	$94.01	$43.39
DOUBLE	$715.69	$436.06	$279.63	$129.06
FAMILY	$827.47	$625.32	$202.15	$93.30

Effective 1/1/2013

Coventry Health Care of Florida Low Option

	Monthly Premium	City's Contribution	Emp. Pays Monthly	Employee Pays Bi - Weekly
SINGLE	$297.07	$246.80	$50.27	$23.20
DOUBLE	$623.85	$436.06	$187.79	$86.67
FAMILY	$721.28	$625.32	$95.96	$44.29

Effective 1/1/2013

GAP with HMO High Option Bi-Weekly Premiums

	Employee	Employee & Spouse	Employee & Child	Employee & Family
Ages 18-54	$14.10	$25.38	$27.49	$38.77
Ages 55+	$21.15	$38.07	$34.54	$51.46

GAP with HMO Low Option Bi-Weekly Premiums

	Employee	Employee & Spouse	Employee & Child	Employee & Family
Ages 18-54	$18.72	$33.70	$36.50	$51.48
Ages 55+	$28.08	$50.54	$45.86	$68.33

UnitedHealthcare

City of Hialeah Sworn Police

Coverage Period: 01/01/2013 – 12/31/2013

Summary of Benefits and Coverage: What This Plan Covers & What it Costs **Coverage for: Employee + Family** **Plan Type: PS1**

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.myuhc.com or by calling 1-866-873-3903.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network: **$0** Individual / **$0** Family Non-Network: **$750** Individual / **$2,250** Family Does not apply to copays, prescription drugs, and services listed below as "No Charge". Per calendar year.	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. There are no other deductibles.	You don't have to meet deductibles for specific services, but see the Common Medical Events chart for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses?	Network: **$3,000** Individual Non-Network: **$6,000** Individual	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?	Premium, balance-billed charges, health care this plan doesn't cover, and penalties for failure to obtain pre-notification for services, prescription drugs and copays.	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 Common Medical Events chart 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, this plan uses network providers. If you use a non-network provider your cost may be more. For a list of network providers, see **www.myuhc.com** or call 1-866-873-3903 for a list of network providers.	If you use a network doctor or other health care provider, this plan will pay some or all of the costs of covered services. Be aware, your network doctor or hospital may use a non-network provider for some services. Plans use the term 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 don't need a referral to see a specialist.	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 under Services Your Plan Does NOT Cover. See your policy or plan document for additional information about excluded services.

Questions: Call 1-866-873-3903 or visit us at www.myuhc.com. If you aren't clear about any of the terms used in this form, see the Glossary.
You can view the Glossary at www.dol.gov/ebsa/healthreform or call the phone number above to request a copy. **This is only a summary.**
It in no way modifies your benefits as described in your plan documents. Please refer to your plan documents provided by your employer for complete terms of this plan.

Summary of Benefits and Coverage: What This Plan Covers & What it Costs **Coverage for: Employee + Family** **Plan Type: PS1**

- Co-payments (copays) are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- Co-insurance (co-ins) 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 a non-network provider charges more than the allowed amount, you may have to pay the difference. For example, if a non-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 network providers by charging you lower deductibles, co-payments and co-insurance amounts.

Common Medical Event	Services You May Need	Your cost if you use a Network Provider	Your cost if you use a Non-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 copay per visit	30% co-ins	If you receive services in addition to office visit, additional copays, deductibles, or co-ins may apply.
	Specialist visit	$35 copay per visit	30% co-ins	If you receive services in addition to office visit, additional copays, deductibles, or co-ins may apply.
	Other practitioner office visit	10% co-ins per visit of Manipulative (Chiropractic) services	30% co-ins per visit of Manipulative (Chiropractic) services	Manipulative (Chiropractic) services limited to $500 per calendar year. Pre-Notification is required non-network.
	Preventive care / screening / immunization	No Charge	30% co-ins	Includes preventive health services specified in the health care reform law.
If you have a test	Diagnostic test (x-ray, blood work)	10% co-ins	30% co-ins	Network deductible does not apply.
	Imaging (CT / PET scans, MRIs)	10% co-ins	30% co-ins	None
If you need drugs to treat your illness or condition	Tier 1 – Your Lowest-Cost Option	Retail: $10 copay Mail-Order: $20 copay	Retail: $10 copay Mail-Order: Not Covered	Provider means pharmacy for purposes of this section. Retail: Up to a 31 day supply Mail-Order: Up to a 90 day supply You may need to obtain certain drugs,

Summary of Benefits and Coverage: What This Plan Covers & What it Costs **Coverage for: Employee + Family** **Plan Type: PS1**

Common Medical Event	Services You May Need	Your cost if you use a Network Provider	Your cost if you use a Non-Network Provider	Limitations & Exceptions
More information about prescription drug coverage is available at **www.myuhc.com**	Tier 2 – Your Midrange-Cost Option	Retail: $30 copay Mail-Order: $60 copay	Retail: $30 copay Mail-Order: Not Covered	including certain specialty drugs, from a pharmacy designated by us Certain drugs may have a pre-authorization requirement or may result in a higher cost. If you use a non-network Pharmacy, you are responsible for any amount over the allowed amount. You may be required to use a lower-cost drug(s) prior to benefits under your policy being available for certain prescribed drugs. Tier 1 Contraceptives covered at No Charge. See the website listed for information on drugs covered by your plan. Not all drugs are covered.
	Tier 3 – Your Highest-Cost Option	Retail: $50 copay Mail-Order: $100 copay	Retail: $50 copay Mail-Order: Not Covered	
	Tier 4 – Additional High-Cost Option	Not Applicable	Not Applicable	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% co-ins	30% co-ins	None
	Physician / surgeon fees	10% co-ins	30% co-ins	None
If you need immediate medical attention	Emergency room services	$30 copay per visit	$30 copay per visit	Non-Network Pre-Service Notification is required if results in an Inpatient Stay.
	Emergency medical transportation	$25 copay	$25 copay	Pre-service Notification is required for non-emergency ambulance.
	Urgent care	$30 copay per visit	30% co-ins	If you receive services in addition to urgent care, additional copays, deductibles, or co-ins may apply.
If you have a hospital stay	Facility fee (e.g., hospital room)	10% co-ins	30% co-ins	Non-Network Pre-Service Notification is required.
	Physician / surgeon fees	10% co-ins	30% co-ins	None
If you have mental health,	Mental / Behavioral health outpatient	$25 copay per visit	30% co-ins	None

UnitedHealthcare

City of Hialeah Sworn Police

Coverage Period: 01/01/2013 – 12/31/2013

Summary of Benefits and Coverage: What This Plan Covers & What it Costs | **Coverage for: Employee + Family** | **Plan Type: PS1**

Common Medical Event	Services You May Need	Your cost if you use a Network Provider	Your cost if you use a Non-Network Provider	Limitations & Exceptions
behavioral health, or substance abuse needs	services			
	Mental / Behavioral health inpatient services	10% co-ins	30% co-ins	Pre-Notification is required non-network.
	Substance use disorder outpatient services	$25 copay per visit	30% co-ins	None
	Substance use disorder inpatient services	10% co-ins	30% co-ins	Pre-Notification is required non-network.
If you become pregnant	Prenatal and postnatal care	$25 Global Maternity copay	30% co-ins	Additional copays, deductibles, or co-ins may apply. Routine pre-natal care is covered at No Charge.
	Delivery and all inpatient services	10% co-ins	30% co-ins	Additional copays, deductible, co-insurance or Notification may apply.
If you have a recovery or other special health needs	Home health care	10% co-ins	30% co-ins	Limited to 60 days per calendar year. Pre-Notification is required non-network.
	Rehabilitation services	10% co-ins	30% co-ins	Unlimited. Non-Network Pre-Notification required.
	Habilitation services	Not Covered	Not Covered	No coverage for Habilitation services.
	Skilled nursing care	10% co-ins	30% co-ins	Limited to 60 days per calendar year. Limit is combined with IP Rehabilitation Services. Pre-Notification is required non-network.
	Durable medical equipment	10% co-ins	30% co-ins	Non-Network Pre-Notification is required for DME over $1,000.
	Hospice service	10% co-ins	30% co-ins	Non-Network Pre-Notification is required for.
If your child needs dental or eye care	Eye exam	Not Covered	Not Covered	No Coverage for Eye Exams.
	Glasses	Not Covered	Not Covered	No coverage for Glasses.
	Dental check-up	Not Covered	Not Covered	No coverage for Dental check-up.

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/Child)	• Glasses • Habilitation Services • Hearing aids • Infertility Treatment • Long-term care	• Non-emergency care when traveling outside the U.S. • Private-duty nursing • 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.)		

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 1-866-747-1019. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or visit http://www.dol.gov/ebsa, or the U.S. Department of Health and Human

Services at 1-877-267-2323 x61565 or visit http://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 your human resource department or the Employee Benefits Security Administration at 1-866-444-3272 or visit www.dol.gov/ebsa/healthreform.

Additionally, a consumer assistance program may help you file your appeal. A list of states with Consumer Assistance Programs is available at www.dol.gov/ebsa/healthreform and http:///ciio.cms.gov/prgrams/consumer/capgrants/index.html.

Para obtener asistencia en español, llame al número de teléfono en su tarjeta de identificación.
若需要中文协助，请拨打您会员卡上的电话号码
Dine k'ehji shich'i' hadoodzih ninizingo, bee neehozin biniiye nanitinigii number bikaa'igii bich'i' hodiilnih
Para sa tulong sa Tagalog, tawagan ang numero sa iyong

----------*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 $ 6,830**
- **Patient Pays $ 710**

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	$0
Co-pays	$40
Co-insurance	$520
Limits or exclusions	$150
Total	**$710**

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

- **Amount owed to providers:** $5,400
- **Plan Pays $ 4,530**
- **Patient Pays $ 870**

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	$0
Co-pays	$650
Co-insurance	$140
Limits or exclusions	$80
Total	**$870**

Questions and answers about 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 to 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.
- If other than individual coverage, the Patient Pays amount may be more.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how deductibles, co-payments, and co-insurance 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 **co-payments**, **deductibles**, and **co-insurance**. 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 1-866-873-3903 or visit us at www.myuhc.com. If you aren't clear about any of the terms used in this form, see the Glossary.
You can view the Glossary at www.dol.gov/ebsa/healthreform or call the phone number above to request a copy. **This is only a summary**.
It in no way modifies your benefits as described in your plan documents. Please refer to your plan documents provided by your employer for complete terms of this plan.

Coventry Health Care of Florida: FDCOA 2060 $3500

Coverage Period: 01/01/2013 – 12/31/2013

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

Coverage for: EE, EE/Spouse, EE/Child(ren), EE/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.chcflorida.com or by calling 1-866-847-8235.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	In-network: **$3,500** person / **$7,000** family. Applies to inpatient and outpatient hospital services. 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?	Yes. In-network: **$4,500** person / **$9,000** 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 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. See **www.chcflorida.com or call 1-866-847-8235** for a list of participating providers.	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 **1-866-847-8235** or visit us at **www.chcflorida.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 **www.cciio.cms.gov** or call **1-866-847-8235** to request a copy.

OMB Control Numbers 1545-2229, 1210-0147, and 0938-1146

Corrected on May 11, 2012

Coventry Health Care of Florida: FDCOA 2060 $3500

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

Coverage for: EE, EE/Spouse, EE/Child(ren), EE/Family | **Plan Type:** HMO

- **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 participating **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 Co-pay/visit	Not Covered	——none——
	Specialist visit	$60 Co-pay/visit	Not Covered	——none——
	Other practitioner office visit	$60 Co-pay/visit for spinal manipulation	Not Covered	Spinal manipulation is limited to 20 visits per calendar year.
	Preventive care/screening/immunization	$0	Not covered	——none——
If you have a test	Diagnostic test (x-ray, blood work)	$0 Co-pay/visit in physician office	Not Covered	——none——
	Imaging (CT/PET scans, MRIs)	$75 co-pay/visit in Outpatient Diagnostic Center	Not Covered	Preauthorization is required for coverage.

Coventry Health Care of Florida: FDCOA 2060 $3500

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

Coverage for: EE, EE/Spouse, EE/Child(ren), EE/Family | **Plan Type:** HMO

Coverage Period: 01/01/2013 – 12/31/2013

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.chcflorida.com.	Generic drugs	$20/$20 Co-pay (retail/mail order)	Not Covered	Covers up to a 30-day supply (retail prescription); 90-day supply (mail order prescription). Preauthorization is required for some drugs.
	Preferred brand drugs	$45/$90 Co-pay (retail/mail order)	Not Covered	
	Non-preferred brand drugs	$70/$210 Co-pay (retail/mail order)	Not Covered	
	Specialty drugs	20% Co-insurance	Not Covered	$250 out-of-pocket limit per month except for diabetic supplies.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$300 co-pay/visit	Not Covered	——none——
	Physician/surgeon fees	$0	Not Covered	——none——
If you need immediate medical attention	Emergency room services	$300 co-pay/visit	$300 co-pay/visit	Must meet emergency criteria. Co-payment waived if admitted.
	Emergency medical transportation	$0	$0	——none——
	Urgent care	$60 Co-pay/visit	Not Covered	——none——
If you have a hospital stay	Facility fee (e.g., hospital room)	Deductible then 30% Co-insurance	Not Covered	Preauthorization is required for coverage.
	Physician/surgeon fee	Deductible then 30% Co-insurance	Not Covered	——none——
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$60 Co-pay/visit	Not Covered	Preauthorization is required for coverage.
	Mental/Behavioral health inpatient services	Deductible then 30% Co-insurance	Not Covered	
	Substance use disorder outpatient services	$60 Co-pay/visit	Not Covered	
	Substance use disorder inpatient services	Deductible then 30% Co-insurance	Not Covered	
If you are pregnant	Prenatal and postnatal care	$60 Co-pay	Not Covered	Applies to the first visit only.

Questions: Call **1-866-847-8235** or visit us at **www.chcflorida.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 **www.cciio.cms.gov** or call **1-866-847-8235** to request a copy.

Coventry Health Care of Florida: FDCOA 2060 $3500

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

Coverage for: EE, EE/Spouse, EE/Child(ren), EE/Family | **Plan Type:** HMO

Coverage Period: 01/01/2013 – 12/31/2013

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
	Delivery and all inpatient services	Deductible then 30% Co-insurance	Not Covered	Preauthorization is required for coverage.
If you need help recovering or have other special health needs	Home health care	$0	Not Covered	Preauthorization is required for coverage. Limited to 60 visits/year.
	Rehabilitation services	Inpatient: Deductible then 30% Co-insurance; Outpatient: $60 Co-pay/visit	Not Covered	Preauthorization is required for inpatient coverage. Coverage is limited to 30 inpatient days and 60 visits/year, combined for all therapies.
	Habilitation services	Not Covered	Not Covered	Excluded Service
	Skilled nursing care	$100 Co-pay/day for the first 5 days	Not Covered	Preauthorization is required for coverage. Limited to 30 days/year.
	Durable medical equipment	$50 Co-pay	Not Covered	Preauthorization is required for coverage.
	Hospice service	$0	Not Covered	Preauthorization is required for coverage. Limited to 210 days/lifetime.
If your child needs dental or eye care	Eye exam	$0	Not Covered	Limited to routine screenings in the PCP office.
	Glasses	$29 Co-pay single vision frames	Not Covered	Coverage is limited to one pair of glasses per year.
	Dental check-up	$0	Not Covered	Coverage is limited to one cleaning every 6 months.

Excluded Services & Other Covered Services:

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

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- 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
- Dental care (adult)
- Routine eye care (adult)
- Routine foot care (if prescribed for diabetics)

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 **1-866-847-8235**. 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:

For group health coverage subject to ERISA, you may contact **1-866-847-8235**. 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 Florida Department of Financial Services Division of Consumer Services, 200 E. Gaines St., Tallahassee, FL, 32399-0322, **1-877-693-5236**. www.myfloridacfo.com/Division/Consumers/NeedOurHelp.htm.

For non-federal governmental group health plans and church plans that are group health plans, you may contact **1-866-847-8235** or your state department of insurance at Florida Department of Financial Services Division of Consumer Services, 200 E. Gaines St., Tallahassee, FL, 32399-0322, **1-877-693-5236**. www.myfloridacfo.com/Division/Consumers/NeedOurHelp.htm.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-866-847-8235.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-847-8235.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-866-847-8235.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-866-847-8235.

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** $3,441
- **Patient pays** $4,099

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	$158
Coinsurance	$291
Limits or exclusions	$150
Total	**$4,099**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $3,123
- **Patient pays** $2,277

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	$0
Copays	$2,238
Coinsurance	$0
Limits or exclusions	$39
Total	**$2,277**

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 **1-866-847-8235** or visit us at **www.chcflorida.com**.
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Opcion Alta

Coventry Health Care of Florida: FDCOA2060 $3500

Duración de la póliza: 01/01/2013 – 12/31/2013

Resumen de beneficios y cobertura: Lo que cubre el plan y los precios **Cobertura de:** EE, EE/Cónyuge, EE/Hijo(s), EE/Familia | **Tipo de plan:** HMO

Éste es solo un resumen. Si desea más información sobre la cobertura y los precios, puede obtener los documentos del plan o términos de la póliza en www.chcflorida.com o llamando al **1-866-847-8235**

Preguntas importantes	Respuestas	¿Por qué es importante?
¿Qué es el deducible general?	Proveedores participantes: **$3,500** individual / **$7,000** familia Se aplica a los servicios hospitalarios y ambulatorios de hospitales. Proveedores non-participantes: No cubierto	Usted paga todos los costos hasta llegar al monto del **deducible** antes de que el plan comience a pagar los servicios cubiertos que reciba. Revise su póliza o documento del plan y vea cuándo comienza de nuevo el **deducible** (generalmente, no siempre, el 1 de enero). Vea en la tabla (página 2) cuánto paga por servicios cubiertos después de pagar el **deducible**.
¿Hay otros deducibles para servicios específicos?	No.	No tiene que pagar **deducibles** por servicios específicos, pero vea en la tabla que comienza en la página 2 otros costos de servicios cubiertos por este plan.
¿Hay un límite para los gastos de mi bolsillo?	Sí. Proveedores participantes: **$4,500** individual / **$9,000** familia Proveedores non-participantes: No cubierto	El **límite de gastos del bolsillo** es lo máximo que usted pagaría en un período de cobertura (generalmente un año) por la parte del gasto que le corresponde a usted por los servicios cubiertos. Este límite le ayuda a planificar sus gastos médicos.
¿Cuáles son las expensas que no cuentan para el límite de gastos del bolsillo?	Los primas y atención médica que este plan no cubre.	Aunque usted pague estos costos, ellos no cuentan para su **límite de gastos del bolsillo**.
¿Hay un límite anual general para lo que paga el plan?	No.	La tabla de la página 2 describe los límites sobre los que el plan pagará los servicios cubiertos *específicos*, tales como las visitas al consultorio.
¿Tiene este plan una red de proveedores?	Sí. Vea **www.chcflorida.com o llame al 1-866-847-8235** para una lista de proveedores participantes.	Si va a un médico o **proveedor** de atención médica dentro de la red, el plan paga algunos o todos los costos de servicios cubiertos. Tenga en cuenta que su médico u hospital de la red puede usar un **proveedor** fuera de la red para algunos servicios. Los planes usan el término dentro de la red, **preferido** o participante para los **proveedores** incluidos en su **red**. Vea la tabla de la página 2 para saber cómo el plan paga a los diferentes tipos de **proveedores**.

Preguntas: Llame al **1-866-847-8235** o visite www.chcflorida.com.

Si no entiende alguno de los términos en negritas, consulte el Glosario en **www.cciio.cms.gov** o llame al **1-866-847-8235** y pida una copia.

Coventry Health Care of Florida: FDCOA2060 $3500

Duración de la póliza: 01/01/2013 – 12/31/2013

Resumen de beneficios y cobertura: Lo que cubre el plan y los precios **Cobertura de:** EE, EE/Cónyuge, EE/Hijo(s), EE/Familia | **Tipo de plan:** HMO

¿Necesito un referido para ver un especialista?	No.	Puede ver al **especialista** que seleccione sin necesidad de un permiso del plan.
¿Hay algúnservicio(s) que el plan no cubra?	Sí.	Algunos servicios no cubiertos por el plan aparecen en la página 4. Vea su póliza o documento del plan para más información sobre los **servicios excluidos**.

Número de control OMB 1545-2229
1210-0147 y 0938-1146
Corrected on May 11, 2012

- **Copago** es una cantidad fija (por ejemplo $15) que usted paga por los servicios médicos cubiertos, generalmente al momento de recibirlos.
- **Coseguro** es la parte que le corresponde pagar a *usted* por un servicio cubierto, que es un porcentaje de la **cantidad aprobada** para dicho servicio. Por ejemplo, si la **cantidad aprobada** por el plan para pasar la noche en el hospital es $1,000, su coseguro será el 20% de esa cantidad o sea $200. Esta cantidad puede cambiar si usted aún no ha pagado el **deducible**.
- El pago del plan por los servicios cubiertos está basado en la **cantidad aprobada**. Si un **proveedor** fuera de la red (que no pertenece a la red del plan) le cobra más de la **cantidad aprobada**, usted tendrá que pagar la diferencia. Por ejemplo, en un hospital que no pertenece a la red le cobran por pasar la noche internado $1,500 la **cantidad aprobada** es $1,000, usted tendrá que pagar la diferencia de $500 (conocida como **saldo de facturación**.)
- El plan puede animarlo a que use **proveedores** _____ cobrándole **deducibles**, **copagos** o **coseguro** más bajos.

Eventos médicos comunes	Los servicios que podría necesitar	Sus costos si usted usa proveedores participantes	Sus costos si usted usa proveedores no participantes	Limitaciones y excepciones
Si se atiende en la clínica o consultorio del proveedor médico	Consulta con su médico principal para tratar una condición o herida	$20 de copago/visita	No cubierto	ninguna
	Consulta con un especialista	$60 de copago/visita	No cubierto	ninguna
	Consulta con otro proveedor de la salud	$60 de copago/visita (atención quiropráctica)	No cubierto	Cobertura limitada a 20 visitas/año.
	Servicios preventivos/evaluaciones/vacunas	$0	No cubierto	ninguna
Si tiene que hacerse un examen	Exámenes de diagnóstico (radiografías, análisis de sangre)	$0 de copago/visita al consultorio del médico	No cubierto	ninguna
	Imágenes (CT/PET scan, MRI)	$75 de copago/visita al centro diagnóstico ambulatorio	No cubierto	Necesita autorización previa para cobertura.

Preguntas: Llame al **1-866-847-8235** o visite www.chcflorida.com.
Si no entiende alguno de los términos en negritas, consulte el Glosario en **www.cciio.cms.gov** o llame al **1-866-847-8235** y pida una copia.

Coventry Health Care of Florida: FDCOA2060 $3500

Duración de la póliza: 01/01/2013 – 12/31/2013

Resumen de beneficios y cobertura: Lo que cubre el plan y los precios **Cobertura de:** EE, EE/Cónyuge, EE/Hijo(s), EE/Familia | **Tipo de plan:** HMO

Eventos médicos comunes	Los servicios que podría necesitar	Sus costos si usted usa proveedores participantes	Sus costos si usted usa proveedores no participantes	Limitaciones y excepciones
Si necesita un medicamento Para más información sobre la **cobertura de medicamentos** visite www.chcflorida.com.	Medicamentos genéricos	$20 de copago (minorista); $20 de copago (pedido por correo)	No cubierto	Cubre hasta un suministro de 30-días (minorista) y un suministro de 90 días (pedido por correo). Necesita autorización previa para algunos medicamentos.
	Medicamentos de marca preferidos	$45 de copago (minorista); $90 de copago (pedido por correo)	No cubierto	
	Medicamentos de marca no preferidos	$70 de copago (minorista); $210 de copago (pedido por correo)	No cubierto	
	Medicamentos especiales	20% de coseguro	No cubierto	$250 de límite de gastos del bolsillo mensual excepto en suministros para diabéticos.
Si le hacen una cirugía ambulatoria	Arancel del centro (clínica)	$300 de copago/visita	No cubierto	ninguna
	Tarifa del médico/cirujano	$0	No cubierto	ninguna

Coventry Health Care of Florida: FDCOA2060 $3500

Duración de la póliza: 01/01/2013 – 12/31/2013

Resumen de beneficios y cobertura: Lo que cubre el plan y los precios **Cobertura de:** EE, EE/Cónyuge, EE/Hijo(s), EE/Familia | **Tipo de plan:** HMO

Eventos médicos comunes	Los servicios que podría necesitar	Sus costos si usted usa proveedores participantes	Sus costos si usted usa proveedores no participantes	Limitaciones y excepciones
Si necesita atención inmediata	Servicios de la sala de emergencias	$300 de copago/visita	$300 de copago/visita	Debe cumplir criterios de emergencia. Sin copago si lo ingresan.
	Traslado médico de emergencia	$0	$0	ninguna
	Cuidado urgente	$60 de copago/visita	No cubierto	ninguna
Si lo admiten al hospital	Arancel del hospital (habitación)	Deducible y luego 30% de coseguro	No cubierto	Necesita autorización previa para cobertura.
	Tarifa del médico/cirujano	Deducible y luego 30% de coseguro	No cubierto	ninguna
Si tiene problemas psiquiátricos, de conducta o de abuso de sustancias	Servicios ambulatorios de salud mental y de la conducta	$60 de copago/visita	No cubierto	Necesita autorización previa para cobertura.
	Servicios de salud mental y de la conducta para pacientes internados	Deducible y luego 30% de coseguro	No cubierto	
	Tratamiento ambulatorio para el abuso de sustancias	$60 de copago/visita	No cubierto	
	Tratamiento para el abuso de sustancias para pacientes internados	Deducible y luego 30% de coseguro	No cubierto	
Si está embarazada	Cuidados prenatales y post parto	$60 de copago	No cubierto	Corresponde solo a la primera visita.
	Parto y todos los servicios de internación	Deducible y luego 30% de coseguro	No cubierto	Necesita autorización previa para cobertura.

Coventry Health Care of Florida: FDCOA2060 $3500

Duración de la póliza: 01/01/2013 – 12/31/2013

Resumen de beneficios y cobertura: Lo que cubre el plan y los precios **Cobertura de:** EE, EE/Cónyuge, EE/Hijo(s), EE/Familia | **Tipo de plan:** HMO

Eventos médicos comunes	Los servicios que podría necesitar	Sus costos si usted usa proveedores participantes	Sus costos si usted usa proveedores no participantes	Limitaciones y excepciones
Si necesita servicios de recuperación u otras necesidades especiales	Cuidado de la salud en el hogar	$0	No cubierto	Necesita autorización previa para cobertura. Cobertura limitada a 60 visitas/año.
	Servicios de rehabilitación	Pacientes internados: Deducible y luego 30% de coseguro Servicios de consulta externa: $60 de copago/visita	No cubierto	Necesita autorización previa para cobertura. Cobertura limitada a 60 visitas/año.
	Servicios de recuperación de las habilidades	No cubierto	No cubierto	Servicio excluido
	Cuidado de enfermería especializado	$100 de copago/días, 1-5 días	No cubierto	Necesita autorización previa para cobertura. Cobertura limitada a 30 días/año.
	Equipo médico duradero	$50 de copago	No cubierto	Necesita autorización previa para cobertura.
	Cuidado de hospicio	$0	No cubierto	Necesita autorización previa para cobertura. Cobertura limitada a 210 días/de por vida.
Si su hijo necesita servicios dentales o de la vista	Examen de la vista	$0	No cubierto	Limitado al pruebas de detección de rutina en el consultorio del PCP.
	Anteojos	$29 de copago por marcos monofocales	No cubierto	Cobertura limitada a un par de anteojos anual.
	Consulta dental	$0	No cubierto	Cobertura limitada a una limpieza cada 6 meses.

Servicios excluidos y otros servicios cubiertos:

Los servicios que su plan NO cubre. (Esta es una lista parcial. Consulte los documentos del plan para más información.)

- Acupuntura
- Cirugía bariátrica
- Cirugía estética
- Aparatos auditivos
- Tratamiento de infertilidad
- Cuidados prolongados
- Atención que no sea de emergencia al viajar fuera de EE.UU.
- Atención de enfermería privada
- Programas para bajar de peso

Otros servicios cubiertos. (Esta es una lista parcial. Consulte los documentos del plan para otros servicios cubiertos y sus precios.)

- Atención de quiropráctico
- Atención dental (Adulto)
- Atención rutinaria de la vista (Adulto)
- Atención rutinaria del pie (si se receta a diabéticos)

Su derecho para continuar con la cobertura:

Si pierde la cobertura bajo el plan, dependiendo de las circunstancias, las leyes federales y estatales pueden brindarle protecciones que le permiten tener cobertura de salud. Tales derechos pueden ser limitados en duración y se le exigirá que usted pague una **prima**, que puede ser significativamente mayor que la prima que paga al estar cubierto por el plan. También puede aplicare otras limitaciones en sus derechos para continuar la cobertura.
Para más información sobre sus derechos para continuar la cobertura, comuníquese con el plan al **1-866-847-8235**. También puede llamar al departamento de seguros de su estado, al Departamento del Trabajo de EE.UU., a la Administración para la Seguridad de los Beneficios del Trabajador al 1-866-444-3272 o www.dol.gov/ebsa, o al Departamento de Salud y Servicios Humanos de EE.UU. al 1-877-267-2323 ext.61565 o www.cciio.cms.gov.

Su derecho a presentar una queja o una apelación:

Si tiene una queja o no está satisfecho con una negación de cobertura por reclamaciones hechas bajo su plan, puede **apelar** o presentar una **queja formal**. Para preguntar sobre sus derechos, este aviso o solicitar ayuda, puede llamar al: plan al **1-866-847-8235**. También puede llamar al departamento de seguros de su estado, al Departamento del Trabajo de EE.UU., a la Administración para la Seguridad de los Beneficios del Trabajador al 1-866-444-3272 o www.dol.gov/ebsa/healthreform, o al Departamento de Salud y Servicios Humanos de EE.UU. al 1-877-267-2323 ext.61565 o www.cciio.cms.gov.

Servicios de acceso a idiomas:

Spanish (Español): Para obtener asistencia en Español, llame al 1-866-847-8235.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-847-8235.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-866-847-8235.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-866-847-8235.

Para ejemplos sobre cómo este plan paga por los servicios en una situación médica específica consulte la página siguiente.

Sobre los ejemplos de cobertura:

Estos ejemplos le muestran cómo cubriría el plan los servicios en situaciones distintas. Úselos para tener una idea de cuánta cobertura económica podría obtener el paciente del ejemplo de los distintos planes.

Ésta no es una herramienta de cálculo de costos

No use estos ejemplos para calcular los costos reales de su plan. Los servicios médicos que usted reciba y los precios pueden ser distintos a los mencionados en los ejemplos.

Para información importante sobre estos ejemplos, consulte la página siguiente.

Nacimiento
(parto normal)

- **El proveedor cobra:** $7,540
- **El plan paga:** $3,441
- **Usted paga:** $4,099

Ejemplos de los costos:

El costo del hospital (madre)	$2,700
Atención de rutina del obstetra	$2,100
El costo del hospital (bebe)	$900
Anestesia	$900
Análisis de laboratorio	$500
Medicamentos	$200
Radiografías	$200
Vacunas y otros servicios preventivos	$40
Total	**$7,540**

El paciente paga:

Deducibles	$3,500
Copagos	$158
Coseguro	$291
Límites o exclusiones	$150
Total	**$4,099**

Control de la diabetes (control rutinario de la enfermedad)

- **El proveedor cobra:** $5,400
- **El plan paga:** $3,123
- **Usted paga:** $2,277

Ejemplo de los costos:

Medicamentos	$2,900
Equipo médico e insumos	$1,300
Visitas al consultorios y procedimientos médicos	$700
Educación sobre el cuidado	$300
Análisis de laboratorio	$100
Vacunas y otros servicios preventivos	$100
Total	**$5,400**

El paciente paga:

Deducibles	$0
Copagos	$2,238
Coseguro	$0
Límites o exclusiones	$39
Total	**$2,277**

Preguntas y respuestas sobre los ejemplos mencionados:

¿Qué conceptos se presuponen de estos ejemplos?

- Los costos no incluyen las **primas**.
- Los ejemplos de costos están basados en los promedios nacionales provenientes del Departamento de Salud y Servicios Humanos de los EE.UU. y que no son específicos para una zona geográfica o un plan.
- La afección del paciente no es una condición excluida ni preexistente.
- Todos los servicios y tratamientos empezaron y terminaron en el mismo período de cobertura.
- No hay otros gastos médicos para ningún miembro cubierto por este plan.
- Los gastos del bolsillo están basados solamente en el tratamiento del problema mencionado en el ejemplo.
- El paciente recibió todos los servicios de **proveedores** de la red del plan. Si el paciente hubiese recibido los servicios de **proveedores** fuera de la red, los costos hubieran sido más altos.

¿Qué muestra el ejemplo?

En cada ejemplo usted verá cómo suman los **deducibles**, **copagos** y **coseguro**. También le ayudan a ver cuáles son los gastos que tendrá que pagar usted porque no están cubiertos o porque el pago es limitado.

¿Contempla el ejemplo mis propias necesidades?

✘ **No.** Los tratamientos que mencionamos son solo ejemplos. El tratamiento que usted podría recibir para esta condición tal vez sea distinto, según cuál sea el consejo de su médico, su edad, la gravedad de su caso y otros factores.

¿Puede el ejemplo predecir mis gastos futuros?

✘ **No.** Los ejemplos de cobertura **no** son herramientas de cálculo de costos. Usted no puede usar el ejemplo para estimar el costo del cuidado de su condición. El ejemplo es únicamente para fines comparativos. Sus costos reales dependerán de los servicios que reciba, del precio del **proveedor** y del reembolso que autorice el plan.

¿Puedo usar los ejemplos para comparar los planes?

✓ **Sí.** Cuando usted se fija en el Resumen de Beneficios y Cobertura de otros planes, encontrará los mismos ejemplos de cobertura. Cuando compare los planes, fíjese en el casillero titulado "Usted paga" de cada ejemplo. Cuanto más bajo el número, mayor será la cobertura ofrecida por el plan.

¿Debo tener en cuenta otros costos al comparar los planes?

✓ **Sí.** Un gasto importante es lo que paga de **prima**. Por lo general, cuanto más baja sea la **prima** mayores serán los gastos de su bolsillo, como los **copagos**, **deducibles** y **coseguro**. También debe tener en cuenta las contribuciones a cuentas tales como las Cuentas de Ahorros Médicos (HSA), Acuerdos de Gastos Flexibles (FSA) o las Cuentas de Reembolsos Médicos (HRA) que le ayudan con los gastos del bolsillo.

Coventry Health Care of Florida: FDCOAX4-40 $5000

Coverage Period: 01/01/2013 – 12/31/2013

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

Coverage for: EE, EE/Spouse, EE/Child(ren), EE/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.chcflorida.com or by calling 1-866-847-8235.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	In-network: **$5,000** per person Applies to inpatient and outpatient hospital services. 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?	Yes. In-network: **$10,000** person / **$20,000** 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 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. See **www.chcflorida.com or call 1-866-847-8235** for a list of participating providers.	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 **1-866-847-8235** or visit us at **www.chcflorida.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 www.cciio.cms.gov or call **1-866-847-8235** to request a copy.

OMB Control Numbers 1545-2229, 1210-0147, and 0938-1146

Corrected on May 11, 2012

Coventry Health Care of Florida: FDCOAX4-40 $5000

Coverage Period: 01/01/2013 – 12/31/2013

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

Coverage for: EE, EE/Spouse, EE/Child(ren), EE/Family | **Plan Type:** HMO

- **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 participating **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$10 Co-pay/visit	Not Covered	——none——
	Specialist visit	$80 Co-pay/visit	Not Covered	——none——
	Other practitioner office visit	$80 Co-pay/visit for spinal manipulation	Not Covered	Spinal manipulation is limited to 20 visits per calendar year.
	Preventive care/screening/immunization	$0	Not covered	——none——
If you have a test	Diagnostic test (x-ray, blood work)	$0 Co-pay/visit in physician office	Not Covered	——none——
	Imaging (CT/PET scans, MRIs)	$80 co-pay/visit in Outpatient Diagnostic Center	Not Covered	Preauthorization is required for coverage.

Coventry Health Care of Florida: FDCOAX4-40 $5000

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

Coverage for: EE, EE/Spouse, EE/Child(ren), EE/Family | **Plan Type:** HMO

Coverage Period: 01/01/2013 – 12/31/2013

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.chcflorida.com.	Generic drugs	$10/$10 Co-pay (retail/mail order)	Not Covered	Includes $3 Co-pay/$3 Co-pay prescription (Retail/Mail Order) for select generic drugs. Covers up to a 30-day supply (retail prescription); 90-day supply (mail order prescription). Preauthorization is required for some drugs.
	Preferred brand drugs	$45/$90 Co-pay (retail/mail order)	Not Covered	
	Non-preferred brand drugs	$70/$210 Co-pay (retail/mail order)	Not Covered	
	Specialty drugs	20% Co-insurance	Not Covered	$250 out-of-pocket limit per month except for diabetic supplies.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$250 co-pay/visit	Not Covered	——none——
	Physician/surgeon fees	$0	Not Covered	——none——
If you need immediate medical attention	Emergency room services	$300 co-pay/visit	$300 co-pay/visit	Must meet emergency criteria. Co-payment waived if admitted.
	Emergency medical transportation	$0	$0	——none——
	Urgent care	$50 Co-pay/visit	Not Covered	——none——
If you have a hospital stay	Facility fee (e.g., hospital room)	Deductible then 40% Co-insurance	Not Covered	Preauthorization is required for coverage.
	Physician/surgeon fee	Deductible then 40% Co-insurance	Not Covered	——none——
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$80 Co-pay/visit	Not Covered	Preauthorization is required for coverage.
	Mental/Behavioral health inpatient services	Deductible then 40% Co-insurance	Not Covered	
	Substance use disorder outpatient services	$80 Co-pay/visit	Not Covered	
	Substance use disorder inpatient services	Deductible then 40% Co-insurance	Not Covered	
If you are pregnant	Prenatal and postnatal care	$80 Co-pay	Not Covered	Applies to the first visit only.

Questions: Call **1-866-847-8235** or visit us at **www.chcflorida.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 **www.cciio.cms.gov** or call **1-866-847-8235** to request a copy.

Coventry Health Care of Florida: FDCOAX4-40 $5000

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

Coverage for: EE, EE/Spouse, EE/Child(ren), EE/Family | **Plan Type:** HMO

Coverage Period: 01/01/2013 – 12/31/2013

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
	Delivery and all inpatient services	Deductible then 40% Co-insurance	Not Covered	Preauthorization is required for coverage.
If you need help recovering or have other special health needs	Home health care	$0	Not Covered	Preauthorization is required for coverage. Limited to 60 visits/year.
	Rehabilitation services	Inpatient: Deductible then 40% Co-insurance; Outpatient: $80 Co-pay/visit	Not Covered	Preauthorization is required for inpatient coverage. Coverage is limited to 30 inpatient days and 60 visits/year, combined for all therapies.
	Habilitation services	Not Covered	Not Covered	Excluded Service
	Skilled nursing care	$100 Co-pay/day for the first 5 days	Not Covered	Preauthorization is required for coverage. Limited to 30 days/year.
	Durable medical equipment	$0	Not Covered	Preauthorization is required for coverage.
	Hospice service	$0	Not Covered	Preauthorization is required for coverage. Limited to 210 days/lifetime.
If your child needs dental or eye care	Eye exam	$0	Not Covered	Limited to routine screenings in the PCP office.
	Glasses	$29 Co-pay single vision frames	Not Covered	Coverage is limited to one pair of glasses per year.
	Dental check-up	$0	Not Covered	Coverage is limited to one cleaning every 6 months.

Excluded Services & Other Covered Services:

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

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- 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
- Dental care (adult)
- Routine eye care (adult)
- Routine foot care (if prescribed for diabetics)

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 **1-866-847-8235**. 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:

For group health coverage subject to ERISA, you may contact **1-866-847-8235**. 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 Florida Department of Financial Services Division of Consumer Services, 200 E. Gaines St., Tallahassee, FL, 32399-0322, **1-877-693-5236**. www.myfloridacfo.com/Division/Consumers/NeedOurHelp.htm.

For non-federal governmental group health plans and church plans that are group health plans, you may contact **1-866-847-8235** or your state department of insurance at Florida Department of Financial Services Division of Consumer Services, 200 E. Gaines St., Tallahassee, FL, 32399-0322, **1-877-693-5236**. www.myfloridacfo.com/Division/Consumers/NeedOurHelp.htm.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-866-847-8235.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-847-8235.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-866-847-8235.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-866-847-8235.

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** $2,743
- **Patient pays** $4,797

Sample care costs:

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

Patient pays:

Deductibles	$4,471
Copays	$175
Coinsurance	$0
Limits or exclusions	$150
Total	**$4,797**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $3,454
- **Patient pays** $1,946

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	$0
Copays	$1,907
Coinsurance	$0
Limits or exclusions	$39
Total	**$1,946**

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.

Opcion Baja

Coventry Health Care of Florida: FDCOAX4-40 $5000

Duración de la póliza: 01/01/2013 – 12/31/2013

Resumen de beneficios y cobertura: Lo que cubre el plan y los precios **Cobertura de:** EE, EE/Cónyuge, EE/Hijo(s), EE/Familia | **Tipo de plan:** HMO

Éste es solo un resumen. Si desea más información sobre la cobertura y los precios, puede obtener los documentos del plan o términos de la póliza en www.chcflorida.com o llamando al **1-866-847-8235**

Preguntas importantes	Respuestas	¿Por qué es importante?
¿Qué es el deducible general?	Proveedores participantes: **$5,000** individual Se aplica a los servicios hospitalarios y ambulatorios de hospitales. Proveedores non-participantes: No cubierto	Usted paga todos los costos hasta llegar al monto del **deducible** antes de que el plan comience a pagar los servicios cubiertos que reciba. Revise su póliza o documento del plan y vea cuándo comienza de nuevo el **deducible** (generalmente, no siempre, el 1 de enero). Vea en la tabla (página 2) cuánto paga por servicios cubiertos después de pagar el **deducible**.
¿Hay otros deducibles para servicios específicos?	No.	No tiene que pagar **deducibles** por servicios específicos, pero vea en la tabla que comienza en la página 2 otros costos de servicios cubiertos por este plan.
¿Hay un límite para los gastos de mi bolsillo?	Sí. Proveedores participantes: **$10,000** individual / **$20,000** familia Proveedores non-participantes: No cubierto	El **límite de gastos del bolsillo** es lo máximo que usted pagaría en un período de cobertura (generalmente un año) por la parte del gasto que le corresponde a usted por los servicios cubiertos. Este límite le ayuda a planificar sus gastos médicos.
¿Cuáles son las expensas que no cuentan para el límite de gastos del bolsillo?	Los primas y atención médica que este plan no cubre.	Aunque usted pague estos costos, ellos no cuentan para su **límite de gastos del bolsillo**.
¿Hay un límite anual general para lo que paga el plan?	No.	La tabla de la página 2 describe los límites sobre los que el plan pagará los servicios cubiertos *específicos*, tales como las visitas al consultorio.
¿Tiene este plan una red de proveedores?	Sí. Vea **www.chcflorida.com o llame al 1-866-847-8235** para una lista de proveedores participantes.	Si va a un médico o **proveedor** de atención médica dentro de la red, el plan paga algunos o todos los costos de servicios cubiertos. Tenga en cuenta que su médico u hospital de la red puede usar un **proveedor** fuera de la red para algunos servicios. Los planes usan el término dentro de la red, **preferido** o participante para los **proveedores** incluidos en su **red**. Vea la tabla de la página 2 para saber cómo el plan paga a los diferentes tipos de **proveedores**.
¿Necesito un referido	No.	Puede ver al **especialista** que seleccione sin necesidad de un permiso del plan.

Preguntas: Llame al **1-866-847-8235** o visite www.chcflorida.com.

Si no entiende alguno de los términos en negritas, consulte el Glosario en www.cciio.cms.gov o llame al **1-866-847-8235** y pida una copia.

para ver un especialista?		
¿Hay algúnservicio(s) que el plan no cubra?	Sí.	Algunos servicios no cubiertos por el plan aparecen en la página 4. Vea su póliza o documento del plan para más información sobre los **servicios excluidos**.

Número de control OMB 1545-2229
1210-0147 y 0938-1146
Corrected on May 11, 2012

- **Copago** es una cantidad fija (por ejemplo $15) que usted paga por los servicios médicos cubiertos, generalmente al momento de recibirlos.
- **Coseguro** es la parte que le corresponde pagar a *usted* por un servicio cubierto, que es un porcentaje de la **cantidad aprobada** para dicho servicio. Por ejemplo, si la **cantidad aprobada** por el plan para pasar la noche en el hospital es $1,000, su coseguro será el 20% de esa cantidad o sea $200. Esta cantidad puede cambiar si usted aún no ha pagado el **deducible**.
- El pago del plan por los servicios cubiertos está basado en la **cantidad aprobada**. Si un **proveedor** fuera de la red (que no pertenece a la red del plan) le cobra más de la **cantidad aprobada**, usted tendrá que pagar la diferencia. Por ejemplo, en un hospital que no pertenece a la red le cobran por pasar la noche internado $1,500 la **cantidad aprobada** es $1,000, usted tendrá que pagar la diferencia de $500 (conocida como **saldo de facturación**.)
- El plan puede animarlo a que use **proveedores** _____ cobrándole **deducibles**, **copagos** o **coseguro** más bajos.

Eventos médicos comunes	Los servicios que podría necesitar	Sus costos si usted usa proveedores participantes	Sus costos si usted usa proveedores no participantes	Limitaciones y excepciones
Si se atiende en la clínica o consultorio del proveedor médico	Consulta con su médico principal para tratar una condición o herida	$10 de copago/visita	No cubierto	ninguna
	Consulta con un especialista	$80 de copago/visita	No cubierto	ninguna
	Consulta con otro proveedor de la salud	$80 de copago/visita (atención quiropráctica)	No cubierto	Cobertura limitada a 20 visitas/año.
	Servicios preventivos/evaluaciones/vacunas	$0	No cubierto	ninguna
Si tiene que hacerse un examen	Exámenes de diagnóstico (radiografías, análisis de sangre)	$0 de copago/visita al consultorio del médico	No cubierto	ninguna
	Imágenes (CT/PET scan, MRI)	$80 de copago/visita al centro diagnóstico ambulatorio	No cubierto	Necesita autorización previa para cobertura.

Preguntas: Llame al **1-866-847-8235** o visite **www.chcflorida.com**.
Si no entiende alguno de los términos en negritas, consulte el Glosario en **www.cciio.cms.gov** o llame al **1-866-847-8235** y pida una copia.

Coventry Health Care of Florida: FDCOAX4-40 $5000

Duración de la póliza: 01/01/2013 – 12/31/2013

Resumen de beneficios y cobertura: Lo que cubre el plan y los precios **Cobertura de:** EE, EE/Cónyuge, EE/Hijo(s), EE/Familia | **Tipo de plan:** HMO

Eventos médicos comunes	Los servicios que podría necesitar	Sus costos si usted usa proveedores participantes	Sus costos si usted usa proveedores no participantes	Limitaciones y excepciones
Si necesita un medicamento Para más información sobre la **cobertura de medicamentos** visite www.chcflorida.com.	Medicamentos genéricos	$10 de copago (minorista); $10 de copago (pedido por correo)	No cubierto	Incluye recita $3 copago por medicamentos genéricos selectos. Cubre hasta un suministro de 30-días (minorista) y un suministro de 90 días (pedido por correo). Necesita autorización previa para algunos medicamentos.
	Medicamentos de marca preferidos	$45 de copago (minorista); $90 de copago (pedido por correo)	No cubierto	
	Medicamentos de marca no preferidos	$70 de copago (minorista); $210 de copago (pedido por correo)	No cubierto	
	Medicamentos especiales	20% de coseguro	No cubierto	$250 de límite de gastos del bolsillo mensual excepto en suministros para diabéticos.
Si le hacen una cirugía ambulatoria	Arancel del centro (clínica)	$250 de copago/visita	No cubierto	ninguna
	Tarifa del médico/cirujano	$0	No cubierto	ninguna

Coventry Health Care of Florida: FDCOAX4-40 $5000

Duración de la póliza: 01/01/2013 – 12/31/2013

Resumen de beneficios y cobertura: Lo que cubre el plan y los precios **Cobertura de:** EE, EE/Cónyuge, EE/Hijo(s), EE/Familia | **Tipo de plan:** HMO

Eventos médicos comunes	Los servicios que podría necesitar	Sus costos si usted usa proveedores participantes	Sus costos si usted usa proveedores no participantes	Limitaciones y excepciones
Si necesita atención inmediata	Servicios de la sala de emergencias	$300 de copago/visita	$300 de copago/visita	Debe cumplir criterios de emergencia. Sin copago si lo ingresan.
	Traslado médico de emergencia	$0	$0	ninguna
	Cuidado urgente	$50 de copago/visita	No cubierto	ninguna
Si lo admiten al hospital	Arancel del hospital (habitación)	Deducible y luego 40% de coseguro	No cubierto	Necesita autorización previa para cobertura.
	Tarifa del médico/cirujano	Deducible y luego 40% de coseguro	No cubierto	ninguna
Si tiene problemas psiquiátricos, de conducta o de abuso de sustancias	Servicios ambulatorios de salud mental y de la conducta	$80 de copago/visita	No cubierto	Necesita autorización previa para cobertura.
	Servicios de salud mental y de la conducta para pacientes internados	Deducible y luego 40% de coseguro	No cubierto	
	Tratamiento ambulatorio para el abuso de sustancias	$80 de copago/visita	No cubierto	
	Tratamiento para el abuso de sustancias para pacientes internados	Deducible y luego 40% de coseguro	No cubierto	
Si está embarazada	Cuidados prenatales y post parto	$80 de copago	No cubierto	Corresponde solo a la primera visita.
	Parto y todos los servicios de internación	Deducible y luego 40% de coseguro	No cubierto	Necesita autorización previa para cobertura.

Coventry Health Care of Florida: FDCOAX4-40 $5000

Duración de la póliza: 01/01/2013 – 12/31/2013

Resumen de beneficios y cobertura: Lo que cubre el plan y los precios **Cobertura de:** EE, EE/Cónyuge, EE/Hijo(s), EE/Familia | **Tipo de plan:** HMO

Eventos médicos comunes	Los servicios que podría necesitar	Sus costos si usted usa proveedores participantes	Sus costos si usted usa proveedores no participantes	Limitaciones y excepciones
Si necesita servicios de recuperación u otras necesidades especiales	Cuidado de la salud en el hogar	$0	No cubierto	Necesita autorización previa para cobertura. Cobertura limitada a 60 visitas/año.
	Servicios de rehabilitación	Pacientes internados: Deducible y luego 40% de coseguro Servicios de consulta externa: $80 de copago/visita	No cubierto	Necesita autorización previa para cobertura. Cobertura limitada a 60 visitas/año.
	Servicios de recuperación de las habilidades	No cubierto	No cubierto	Servicio excluido
	Cuidado de enfermería especializado	$100 de copago/días, 1-5 días	No cubierto	Necesita autorización previa para cobertura. Cobertura limitada a 30 días/año.
	Equipo médico duradero	$0	No cubierto	Necesita autorización previa para cobertura.
	Cuidado de hospicio	$0	No cubierto	Necesita autorización previa para cobertura. Cobertura limitada a 210 días/de por vida.
Si su hijo necesita servicios dentales o de la vista	Examen de la vista	$0	No cubierto	Limitado al pruebas de detección de rutina en el consultorio del PCP.
	Anteojos	$29 de copago por marcos monofocales	No cubierto	Cobertura limitada a un par de anteojos anual.
	Consulta dental	$0	No cubierto	Cobertura limitada a una limpieza cada 6 meses.

Servicios excluidos y otros servicios cubiertos:

Los servicios que su plan NO cubre. (Esta es una lista parcial. Consulte los documentos del plan para más información.)

- Acupuntura
- Cirugía bariátrica
- Cirugía estética
- Aparatos auditivos
- Tratamiento de infertilidad
- Cuidados prolongados
- Atención que no sea de emergencia al viajar fuera de EE.UU.
- Atención de enfermería privada
- Programas para bajar de peso

Otros servicios cubiertos. (Esta es una lista parcial. Consulte los documentos del plan para otros servicios cubiertos y sus precios.)

- Atención de quiropráctico
- Atención dental (Adulto)
- Atención rutinaria de la vista (Adulto)
- Atención rutinaria del pie (si se receta a diabéticos)

Su derecho para continuar con la cobertura:

Si pierde la cobertura bajo el plan, dependiendo de las circunstancias, las leyes federales y estatales pueden brindarle protecciones que le permiten tener cobertura de salud. Tales derechos pueden ser limitados en duración y se le exigirá que usted pague una **prima**, que puede ser significativamente mayor que la prima que paga al estar cubierto por el plan. También puede aplicare otras limitaciones en sus derechos para continuar la cobertura. Para más información sobre sus derechos para continuar la cobertura, comuníquese con el plan al **1-866-847-8235**. También puede llamar al departamento de seguros de su estado, al Departamento del Trabajo de EE.UU., a la Administración para la Seguridad de los Beneficios del Trabajador al 1-866-444-3272 o www.dol.gov/ebsa, o al Departamento de Salud y Servicios Humanos de EE.UU. al 1-877-267-2323 ext.61565 o www.cciio.cms.gov.

Su derecho a presentar una queja o una apelación:

Si tiene una queja o no está satisfecho con una negación de cobertura por reclamaciones hechas bajo su plan, puede **apelar** o presentar una **queja formal**. Para preguntar sobre sus derechos, este aviso o solicitar ayuda, puede llamar al: plan al **1-866-847-8235**. También puede llamar al departamento de seguros de su estado, al Departamento del Trabajo de EE.UU., a la Administración para la Seguridad de los Beneficios del Trabajador al 1-866-444-3272 o www.dol.gov/ebsa/healthreform, o al Departamento de Salud y Servicios Humanos de EE.UU. al 1-877-267-2323 ext.61565 o www.cciio.cms.gov.

Servicios de acceso a idiomas:

Spanish (Español): Para obtener asistencia en Español, llame al 1-866-847-8235.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-847-8235.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-866-847-8235.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-866-847-8235.

Para ejemplos sobre cómo este plan paga por los servicios en una situación médica específica consulte la página siguiente.

Preguntas: Llame al **1-866-847-8235** o visite **www.chcflorida.com**.
Si no entiende alguno de los términos en negritas, consulte el Glosario en **www.cciio.cms.gov** o llame al **1-866-847-8235** y pida una copia.

Sobre los ejemplos de cobertura:

Estos ejemplos le muestran cómo cubriría el plan los servicios en situaciones distintas. Úselos para tener una idea de cuánta cobertura económica podría obtener el paciente del ejemplo de los distintos planes.

Ésta no es una herramienta de cálculo de costos

No use estos ejemplos para calcular los costos reales de su plan. Los servicios médicos que usted reciba y los precios pueden ser distintos a los mencionados en los ejemplos.

Para información importante sobre estos ejemplos, consulte la página siguiente.

Nacimiento
(parto normal)

- **El proveedor cobra:** $7,540
- **El plan paga:** $2,743
- **Usted paga:** $4,797

Ejemplos de los costos:

El costo del hospital (madre)	$2,700
Atención de rutina del obstetra	$2,100
El costo del hospital (bebe)	$900
Anestesia	$900
Análisis de laboratorio	$500
Medicamentos	$200
Radiografías	$200
Vacunas y otros servicios preventivos	$40
Total	**$7,540**

El paciente paga:

Deducibles	$4,471
Copagos	$175
Coseguro	$0
Límites o exclusiones	$150
Total	**$4,797**

Control de la diabetes (control rutinario de la enfermedad)

- **El proveedor cobra:** $5,400
- **El plan paga:** $3,454
- **Usted paga:** $1,946

Ejemplo de los costos:

Medicamentos	$2,900
Equipo médico e insumos	$1,300
Visitas al consultorios y procedimientos médicos	$700
Educación sobre el cuidado	$300
Análisis de laboratorio	$100
Vacunas y otros servicios preventivos	$100
Total	**$5,400**

El paciente paga:

Deducibles	$0
Copagos	$1,907
Coseguro	$0
Límites o exclusiones	$39
Total	**$1,946**

Preguntas y respuestas sobre los ejemplos mencionados:

¿Qué conceptos se presuponen de estos ejemplos?

- Los costos no incluyen las **primas**.
- Los ejemplos de costos están basados en los promedios nacionales provenientes del Departamento de Salud y Servicios Humanos de los EE.UU. y que no son específicos para una zona geográfica o un plan.
- La afección del paciente no es una condición excluida ni preexistente.
- Todos los servicios y tratamientos empezaron y terminaron en el mismo período de cobertura.
- No hay otros gastos médicos para ningún miembro cubierto por este plan.
- Los gastos del bolsillo están basados solamente en el tratamiento del problema mencionado en el ejemplo.
- El paciente recibió todos los servicios de **proveedores** de la red del plan. Si el paciente hubiese recibido los servicios de **proveedores** fuera de la red, los costos hubieran sido más altos.

¿Qué muestra el ejemplo?

En cada ejemplo usted verá cómo suman los **deducibles**, **copagos** y **coseguro**. También le ayudan a ver cuáles son los gastos que tendrá que pagar usted porque no están cubiertos o porque el pago es limitado.

¿Contempla el ejemplo mis propias necesidades?

✘ **No.** Los tratamientos que mencionamos son solo ejemplos. El tratamiento que usted podría recibir para esta condición tal vez sea distinto, según cuál sea el consejo de su médico, su edad, la gravedad de su caso y otros factores.

¿Puede el ejemplo predecir mis gastos futuros?

✘ **No.** Los ejemplos de cobertura **no** son herramientas de cálculo de costos. Usted no puede usar el ejemplo para estimar el costo del cuidado de su condición. El ejemplo es únicamente para fines comparativos. Sus costos reales dependerán de los servicios que reciba, del precio del **proveedor** y del reembolso que autorice el plan.

¿Puedo usar los ejemplos para comparar los planes?

✓ **Sí.** Cuando usted se fija en el Resumen de Beneficios y Cobertura de otros planes, encontrará los mismos ejemplos de cobertura. Cuando compare los planes, fíjese en el casillero titulado "Usted paga" de cada ejemplo. Cuanto más bajo el número, mayor será la cobertura ofrecida por el plan.

¿Debo tener en cuenta otros costos al comparar los planes?

✓ **Sí.** Un gasto importante es lo que paga de **prima**. Por lo general, cuanto más baja sea la **prima** mayores serán los gastos de su bolsillo, como los **copagos**, **deducibles** y **coseguro**. También debe tener en cuenta las contribuciones a cuentas tales como las Cuentas de Ahorros Médicos (HSA), Acuerdos de Gastos Flexibles (FSA) o las Cuentas de Reembolsos Médicos (HRA) que le ayudan con los gastos del bolsillo.

Supplemental Limited Benefit Medical Expense Insurance MEDlink®IV – Enhanced Plus

Summary of Benefit for City of Hialeah

Option 2	
Base Policy	
Maximum In-Hospital Benefits	$4,500 per Covered Person per Calendar Year. Maximum of $13,500 per Calendar Year for all Covered Persons combined.
In-Hospital Ambulance Benefit	Up to $350 per trip for ground transportation or up to $1,000 per trip for air transportation where a Covered Person is Confined as an Inpatient. Limited to one trip per day.
Pre-Existing Period	The Pre-Existing Period is 12 months prior to the effective date of coverage. This product has a Pre-Existing Condition Limitation. The Pre-Existing Condition Limitation will apply only if the Covered Person is subject to a Pre-Existing Condition Limitation under the Other Medical Plan. Therefore, any Pre-Existing Condition Limitation applied to the Major Medical plan would, in effect, limit coverage under this plan.
Outpatient Benefit Rider	
Maximum Outpatient Benefits	$250 per Covered Person per Calendar Day for Covered Outpatient Services.
Outpatient Ambulance Benefit	Up to $350 per trip for ground transportation or up to $1,000 per trip for air transportation where a Covered Person resides less than 18 hours. Limited to one trip per day.
Covered Outpatient Services	
Hospital Emergency Room	Payable up to the Maximum Outpatient Benefit, subject to the Outpatient Benefit Deductible, as shown above.
Urgent Care Facility	Maximum of three Urgent Care visits per Covered Person per Calendar Year. Maximum of six Urgent Care visits per Calendar Year for all Covered Persons combined. Payable up to the Maximum Outpatient Benefit, subject to the Outpatient Benefit Deductible, as shown above.
Outpatient Surgery	Outpatient Surgery in Hospital Outpatient Facility or Freestanding Outpatient Surgery Center. Payable up to the Maximum Outpatient Benefit, subject to the Outpatient Benefit Deductible, as shown above.
Diagnostic Testing	Diagnostic Testing in a Hospital Outpatient Facility or MRI Facility. Payable up to the Maximum Outpatient Benefit, subject to the Outpatient Benefit Deductible, as shown above.
Outpatient Treatment for a Mental or Emotional Disorder in a Hospital Outpatient Facility	Maximum of 30 days of treatment per Covered Person per Calendar Year. Payable up to the Maximum Outpatient Benefit, subject to the Outpatient Benefit Deductible, as shown above.
Cancer Treatment Facility	Payable up to the Maximum Outpatient Benefit, subject to the Outpatient Benefit Deductible, as shown above.
Physical Therapy Facility	Payable up to the Maximum Outpatient Benefit, subject to the Outpatient Benefit Deductible, as shown above.

Premiums*

Bi-Weekly Premiums by Plan				
	Employee	**Employee & Spouse**	**Employee & Child**	**Employee & Family**
Ages 18-54	$14.10	$25.38	$27.49	$38.77
Ages 55+	$21.15	$38.07	$34.54	$51.46

*The Premium and amount of benefits vary dependent upon the plan selected.
Must be used in conjunction with brochure APSB-22133 series

Supplemental Limited Benefit Medical Expense Insurance MEDlink®IV – Enhanced Plus

Summary of Benefit for City of Hialeah

Option 1	
Base Policy	
Maximum In-Hospital Benefits	$10,000 per Covered Person per Confinement.
In-Hospital Ambulance Benefit	Up to $350 per trip for ground transportation or up to $1,000 per trip for air transportation where a Covered Person is Confined as an Inpatient. Limited to one trip per day.
In-Hospital Deductible	$0 per Covered Person per Confinement
Pre-Existing Period	The Pre-Existing Period is 12 months prior to the effective date of coverage. This product has a Pre-Existing Condition Limitation. The Pre-Existing Condition Limitation will apply only if the Covered Person is subject to a Pre-Existing Condition Limitation under the Other Medical Plan. Therefore, any Pre-Existing Condition Limitation applied to the Major Medical plan would, in effect, limit coverage under this plan.
Outpatient Benefit Rider	
Maximum Outpatient Benefits	$250 per Covered Person per Calendar Day for Covered Outpatient Services.
Outpatient Ambulance Benefit	Up to $350 per trip for ground transportation or up to $1,000 per trip for air transportation where a Covered Person resides less than 18 hours. Limited to one trip per day.
Outpatient Deductible	$0 per Covered Person per Calendar Day
Covered Outpatient Services	
Hospital Emergency Room	Payable up to the Maximum Outpatient Benefit, subject to the Outpatient Benefit Deductible, as shown above.
Urgent Care Facility	Maximum of three Urgent Care visits per Covered Person per Calendar Year. Maximum of six Urgent Care visits per Calendar Year for all Covered Person combined. Payable up to the Maximum Outpatient Benefit, subject to the Outpatient Benefit Deductible, as shown above.
Outpatient Surgery	Outpatient Surgery in Hospital Outpatient Facility or Freestanding Outpatient Surgery Center. Payable up to the Maximum Outpatient Benefit, subject to the Outpatient Benefit Deductible, as shown above.
Diagnostic Testing	Diagnostic Testing in a Hospital Outpatient Facility or MRI Facility. Payable up to the Maximum Outpatient Benefit, subject to the Outpatient Benefit Deductible, as shown above.
Outpatient Treatment for a Mental or Emotional Disorder in a Hospital Outpatient Facility	Maximum of 30 days of treatment per Covered Person per Calendar Year. Payable up to the Maximum Outpatient Benefit, subject to the Outpatient Benefit Deductible, as shown above.
Cancer Treatment Facility	Payable up to the Maximum Outpatient Benefit, subject to the Outpatient Benefit Deductible, as shown above.
Physical Therapy Facility	Payable up to the Maximum Outpatient Benefit, subject to the Outpatient Benefit Deductible, as shown above.

Premiums*

Bi-Weekly Premiums by Plan				
	Employee	**Employee & Spouse**	**Employee & Child**	**Employee & Family**
Ages 18-54	$18.72	$33.70	$36.50	$51.48
Ages 55+	$28.08	$50.54	$45.86	$68.33

*The premium and amount of benefits vary dependent upon the plan selected.
Must be used in conjunction with brochure APSB-22133 series

DENTAL AND VISION 2013 RATES
EFFECTIVE 1/1/2013

Dental

Humana DHMO (CS150)

	Monthly Premium	Bi-Weekly Premium
SINGLE	$14.44	$6.66
DOUBLE	$25.26	$11.66
FAMILY	$37.02	$17.09

Humana PPO

	Monthly Premium	Bi-Weekly Premium
SINGLE	$34.56	$15.95
DOUBLE	$67.38	$31.10
FAMILY	$120.04	$55.40

Vision

Humana Visioncare

	Monthly Premium	Bi-Weekly Premium
SINGLE	$6.62	$3.06
DOUBLE	$13.24	$6.11
FAMILY	$17.74	$8.19

HUMANA®
Specialty Benefits

Great News!

New Humana Vision Care Plan for the City of Hialeah Employees

Benefits for employees & family members include:

- Comprehensive Eye Exams at listed co-pays
- Private Practice Providers
- Frames and Lenses at listed co-pays
- Coverage for Contact Lenses
- Discounts for Lasik Surgery
- Newly Expanded Vision Network

Ask us how
YOU CAN ENROLL TODAY!

Please visit our website at
www.humanavisioncare.com

Member Services 800-979-4578

Medicaid and the Children's Health Insurance Program (CHIP)
Offer Free Or Low-Cost Health Coverage To Children And Families

If you are eligible for health coverage from your employer, but are unable to afford the premiums, some States have premium assistance programs that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage, but need assistance in paying their health premiums.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, you can contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, your employer's health plan is required to permit you and your dependents to enroll in the plan – as long as you and your dependents are eligible, but not already enrolled in the employer's plan. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance.**

If you live in one of the following States, you may be eligible for assistance paying your employer health plan premiums. The following list of States is current as of January 31, 2011. You should contact your State for further information on eligibility –

ALABAMA – Medicaid	**CALIFORNIA** – Medicaid
Website: http://www.medicaid.alabama.gov Phone: 1-800-362-1504	Website: http://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx Phone: 1-866-298-8443
ALASKA – Medicaid	**COLORADO** – Medicaid and CHIP
Website: http://health.hss.state.ak.us/dpa/programs/medicaid/ Phone (Outside of Anchorage): 1-888-318-8890 Phone (Anchorage): 907-269-6529	Medicaid Website: http://www.colorado.gov/ Medicaid Phone (In state): 1-800-866-3513 Medicaid Phone (Out of state): 1-800-221-3943 CHIP Website: http:// www.CHPplus.org CHIP Phone: 303-866-3243
ARIZONA – CHIP	
Website: http://www.azahcccs.gov/applicants/default.aspx Phone (Outside of Maricopa County): 1-877-764-5437 Phone (Maricopa County): 602-417-5437	
ARKANSAS – CHIP	**FLORIDA** – Medicaid
Website: http://www.arkidsfirst.com/ Phone: 1-888-474-8275	Website: http://www.fdhc.state.fl.us/Medicaid/index.shtml Phone: 1-877-357-3268

NOTICE ABOUT THE EARLY RETIREE REINSURANCE PROGRAM

You are a plan participant, or are being offered the opportunity to enroll as a plan participant, in an employment-based health plan that is certified for participation in the Early Retiree Reinsurance Program. The Early Retiree Reinsurance Program is a Federal program that was established under the Affordable Care Act. Under the Early Retiree Reinsurance Program, the Federal government reimburses a plan sponsor of an employment-based health plan for some of the costs of health care benefits paid on behalf of, or by, early retirees and certain family members of early retirees participating in the employment-based plan. By law, the program expires on January 1, 2014.

Under the Early Retiree Reinsurance Program, your plan sponsor may choose to use any reimbursements it receives from this program to reduce or offset increases in plan participants' premium contributions, co-payments, deductibles, co-insurance, or other out-of-pocket costs. If the plan sponsor chooses to use the Early Retiree Reinsurance Program reimbursements in this way, you, as a plan participant, may experience changes that may be advantageous to you, in your health plan coverage terms and conditions, for so long as the reimbursements under this program are available and this plan sponsor chooses to use the reimbursements for this purpose. A plan sponsor may also use the Early Retiree Reinsurance Program reimbursements to reduce or offset increases in its own costs for maintaining your health benefits coverage, which may increase the likelihood that it will continue to offer health benefits coverage to its retirees and employees and their families.

If you have received this notice by email, you are responsible for providing a copy of this notice to your family members who are participants in this plan.