### Important Questions

#### What is the overall **deductible**?
- **In network:** IN-UPG: $350 person $700/family
- Doesn’t apply: provider visits, outpatient surgery, hospitalization, mental health, pregnancy, rehabilitation
- **IN:** $350 person/$700 family
- Doesn’t apply: provider visits, outpatient mental health, outpatient rehabilitation
- **Out of network:** $700 person/$1,400 family applies to all OON services

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 **deductibles**.

#### Are there other **deductibles** for specific services?
- **No**

You don’t have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.

#### Is there an **out-of-pocket limit** on my expenses?
- **In network:** Yes. $3,500 person $7,000 family
- Out of network: Yes. $7,000 person $14,000 family

The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.

#### What is not included in the **out-of-pocket limit**?
- **Premiums, balance-billed charges, health care this plan does not cover, prescription drugs, vision**

Even though you pay these expenses, they don’t count toward the out-of-pocket limit.

#### Is there an overall annual limit on what the plan pays?
- **No**

The chart starting on page 2 describes any limits on what the plan will pay for **specific** covered services, such as office visits.

#### Does this plan use a **network** of **providers**?
- **Yes**
- For a list of in-network providers, see www.chcva.com or call 1-800-627-4872.

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.
Coventry Health Care of Virginia, Inc.: UVA Postdocs Low Premium Plan

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

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

<table>
<thead>
<tr>
<th>Are there services this plan doesn't cover?</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Some of the services this plan doesn’t cover are listed on page 5. See your policy or plan document for additional information about excluded services.</td>
<td></td>
</tr>
</tbody>
</table>

Co-payments are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.

Co-insurance is your share of the costs of a covered service, calculated as a percent of the allowed amount for the service. For example, if the plan’s allowed amount for an overnight hospital stay is $1,000, your co-insurance payment of 20% would be $200. This may change if you haven’t met your deductible.

The amount the plan pays for covered services is based on the allowed amount. If an out-of-network provider charges more than the allowed amount, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the allowed amount is $1,000, you may have to pay the $500 difference. (This is called balance billing.)

This plan may encourage you to use In network providers by charging you lower deductibles, copayments and coinsurance amounts.

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>Your cost if you use a In network (UVA/UPG) Provider</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you visit a health care provider’s office or clinic</td>
<td>Primary care visit to treat an injury or illness</td>
<td>$10 co-pay/visit</td>
<td>none</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>$20 co-pay/visit</td>
<td>none</td>
</tr>
<tr>
<td></td>
<td>Other practitioner office visit</td>
<td>$40 co-pay/visit</td>
<td>Chiropractic care is limited to 26 visits per benefit year</td>
</tr>
<tr>
<td></td>
<td>Preventive care/Screening/Immunization</td>
<td>$0</td>
<td>none</td>
</tr>
<tr>
<td>If you have a test</td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>20% co-ins x-ray 20% co-ins lab</td>
<td>none</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>20% co-ins</td>
<td>Requires preauthorization (preauth)</td>
</tr>
</tbody>
</table>

Questions: Call 1-800-627-4872 or visit us at www.chcva.com.

If you aren’t clear about any of the underlined terms used in this form, see the Glossary.

You can view the Glossary at http://cciio.cms.gov/resources/files/Files2/02102012/uniform-glossary-final.pdf or call 1-800-627-4872 to request a copy.
## Common Medical Event

### Services You May Need

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>In network (UVA/UPG) Provider</th>
<th>In network Provider</th>
<th>Out of network Provider</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Generic drugs</td>
<td>$6 co-pay/fill retail, $14 co-pay/fill mail</td>
<td>$6 co-pay/fill retail, $14 co-pay/fill mail</td>
<td>Not Covered</td>
<td>31-day supply retail/90-day supply mail order, preauth. may be required for coverage</td>
</tr>
<tr>
<td>Preferred brand drugs</td>
<td>$24 co-pay/fill or 20% up to $100 max retail, $56 co-pay/fill or 20% up to $300 max mail</td>
<td>$24 co-pay/fill or 20% up to $100 max retail, $56 co-pay/fill or 20% up to $300 max mail</td>
<td>Not Covered</td>
<td>31-day supply retail/90-day supply mail order, preauth. may be required for coverage</td>
</tr>
<tr>
<td>Non-preferred brand drugs</td>
<td>$48 co-pay/fill or 20% up to $100 max retail, $112 co-pay/fill or 20% up to $300 max mail</td>
<td>$48 co-pay/fill or 20% up to $100 max retail, $112 co-pay/fill or 20% up to $300 max mail</td>
<td>Not Covered</td>
<td>31-day supply retail/90-day supply mail order, preauth. may be required for coverage</td>
</tr>
<tr>
<td>Speciality drugs</td>
<td>$50 co-pay/fill or 20% up to $100 max</td>
<td>$50 co-pay/fill or 20% co-insurance up to $100 max</td>
<td>Not Covered</td>
<td>Limited to 31-day supply per fill, preauth. required for coverage</td>
</tr>
</tbody>
</table>

### If you need drugs to treat your illness or condition


- If you need immediate medical attention:
  - **Emergency room services**: 20% co-ins, 20% co-ins, 40% co-ins, Must meet emergency criteria
  - **Emergency medical transportation**: 20 co-ins, 20 co-ins, 40% co-ins, Must meet emergency criteria
  - **Urgent care**: $40 co-pay/visit, $40 co-pay/visit, $40 co-pay/visit, Must meet urgent care criteria

### If you have outpatient surgery

- **Facility fee (e.g., ambulatory surgery center)**: 20% co-ins, 20% co-ins, 40% co-ins, Requires preauth
- **Physician/surgeon fees**: 20% co-ins, 20% co-ins, 40% co-ins, Requires preauth

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**Questions**: Call 1-800-627-4872 or visit us at www.chcva.com.

If you aren’t clear about any of the underlined terms used in this form, see the Glossary.

### Coventry Health Care of Virginia, Inc.: UVA Postdocs Low Premium Plan

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

**Coverage for:** EE, EE/Sp., EE/1Ch., EE/Children, Fam.

**Plan Type:** POS

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>In network (UVA/UPG) Provider</th>
<th>In network Provider</th>
<th>Out of network Provider</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>20% co-ins</td>
<td>20% co-ins</td>
<td>40% co-ins</td>
<td>Requires preauth</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fee</td>
<td>20% co-ins</td>
<td>20% co-ins</td>
<td>40% co-ins</td>
<td>Requires preauth</td>
</tr>
<tr>
<td>If you have mental health, behavioral health, or substance abuse needs</td>
<td>Mental/Behavioral health outpatient services</td>
<td>$10 co-pay/visit</td>
<td>$20 co-pay/visit</td>
<td>40% co-ins</td>
<td>Requires preauth</td>
</tr>
<tr>
<td></td>
<td>Mental/Behavioral health inpatient services</td>
<td>20% co-ins</td>
<td>20% co-ins</td>
<td>40% co-ins</td>
<td>Requires preauth</td>
</tr>
<tr>
<td></td>
<td>Substance use disorder outpatient services</td>
<td>$10 co-pay/visit</td>
<td>$20 co-pay/visit</td>
<td>40% co-ins</td>
<td>Requires preauth</td>
</tr>
<tr>
<td></td>
<td>Substance use disorder inpatient services</td>
<td>20% co-ins</td>
<td>20% co-ins</td>
<td>40% co-ins</td>
<td>Requires preauth</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Prenatal and postnatal care</td>
<td>$10 co-pay</td>
<td>20% co-ins</td>
<td>40% co-ins</td>
<td>Co-pay applies to the first visit only</td>
</tr>
<tr>
<td></td>
<td>Delivery and all inpatient services</td>
<td>20% co-ins</td>
<td>20% co-ins</td>
<td>40% co-ins</td>
<td>------------------------</td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Home health care</td>
<td>20% co-ins</td>
<td>20% co-ins</td>
<td>40% co-ins</td>
<td>Limited: 90 visits/year, requires preauth</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>20% co-ins</td>
<td>Inpatient 20% co-ins</td>
<td>Inpatient 40% co-ins</td>
<td>Limited: 40 inpatient/40 outpatient days/year, requires preauth</td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>Excluded Service</td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care (facility)</td>
<td>20% co-ins</td>
<td>20% co-ins</td>
<td>40% co-ins</td>
<td>Limited: 120 days/year, requires preauth</td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment</td>
<td>20% co-ins</td>
<td>20% co-ins</td>
<td>40% co-ins</td>
<td>Purchase over $500/all rental require preauth</td>
</tr>
</tbody>
</table>

**SNO:** 1054681  
**SBC Name:** 002_79942 002_8953 002_9634  
**Questions:** Call 1-800-627-4872 or visit us at www.chcva.com. 
If you aren't clear about any of the underlined terms used in this form, see the Glossary. 
### Common Medical Event:

#### Services You May Need

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>In network (UVA/UPG) Provider</th>
<th>In network Provider</th>
<th>Out of network Provider</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Hospice Services</td>
<td>20% co-ins</td>
<td>20% co-ins</td>
<td>40% co-ins</td>
<td>Requires preauth</td>
</tr>
<tr>
<td>If your child needs dental or eye care</td>
<td>Eye exam</td>
<td>$0</td>
<td>$0</td>
<td>40% co-in</td>
<td>Limited: routine screenings by PCPs</td>
</tr>
<tr>
<td></td>
<td>Glasses</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>Excluded Service</td>
</tr>
<tr>
<td></td>
<td>Dental check-up</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>Excluded Service</td>
</tr>
</tbody>
</table>

### Excluded Services & Other Covered Services:

#### Services Your Plan Does NOT Cover (This isn’t a complete list. Check your policy for others.)

- Acupuncture
- Child/Glasses
- Habilitation services
- Long-Term Care
- Weight Loss Programs
- Bariatric Surgery
- Cosmetic Surgery
- Hearing Aids
- Private-Duty Nursing
- Child/Dental Check-up
- Dental Care (Adult)
- Infertility Treatment
- Routine Foot Care

#### Other Covered Services (This isn’t a complete list. Check your policy for other covered services and your costs for these services.)

- Chiropractic Care
- Non-Emergency Care when Traveling Outside the U.S.
- Routine Eye Care (Adult)
Your Rights to Continue Coverage:

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

For more information on your rights to continue coverage, contact the plan at 1-800-627-4872. 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 Appeals and Grievances:

For group health coverage subject to ERISA, you may contact 1-800-627-4872. 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 Office of the Managed Care Ombudsman Bureau of Insurance P.O. Box 1157 Richmond, VA 23218 877-310-6560 (Toll Free) E-Mail: ombudsman@scc.virginia.gov.

For non-federal governmental group health plans and church plans that are group health plans, you may contact 1-800-627-4872 or your state department of insurance at Office of the Managed Care Ombudsman Bureau of Insurance P.O. Box 1157 Richmond, VA 23218 877-310-6560 (Toll Free) E-Mail: ombudsman@scc.virginia.gov.

Additionally, a consumer assistance program can help you file your appeal. Contact Virginia State Corporation Commission Life & Health Division, Bureau of Insurance P.O. Box 1157 Richmond, VA 23218 (877) 310-6560 http://www.scc.virginia.gov/boi bureauofinsurance@scc.virginia.gov.

Language Access Services:

Spanish (Espanol): Para obtener asistencia en Espanol, llame al 1-800-627-4872.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-627-4872.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-627-4872.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijjigo holne' 1-800-627-4872.

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

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much insurance protection you might get from different plans.

This is not a cost estimator.

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

See the next page for important information about these examples.

### Having a baby (normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays:** $6,320
- **You pay:** $1,220

**Sample care costs:**

<table>
<thead>
<tr>
<th>Item</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital charges (mother)</td>
<td>$2,700</td>
</tr>
<tr>
<td>Routine Obstetric Care</td>
<td>$2,100</td>
</tr>
<tr>
<td>Hospital Charges (baby)</td>
<td>$900</td>
</tr>
<tr>
<td>Anesthesia</td>
<td>$900</td>
</tr>
<tr>
<td>Laboratory tests</td>
<td>$500</td>
</tr>
<tr>
<td>Prescriptions</td>
<td>$200</td>
</tr>
<tr>
<td>Radiology</td>
<td>$200</td>
</tr>
<tr>
<td>Vaccines, other preventive</td>
<td>$40</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$7,540</strong></td>
</tr>
</tbody>
</table>

**You pay:**

- **Deductibles**: $0
- **Co-pays**: $20
- **Coinsurance**: $1,000
- **Limits or exclusions**: $200

**Total**: $1,220

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

- **Amount owed to providers:** $5,400
- **Plan pays:** $3,960
- **You pay:** $1,440

**Sample care costs:**

<table>
<thead>
<tr>
<th>Item</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prescriptions</td>
<td>$2,900</td>
</tr>
<tr>
<td>Medical equipment and supplies</td>
<td>$1,300</td>
</tr>
<tr>
<td>Office Visits and Procedures</td>
<td>$700</td>
</tr>
<tr>
<td>Education</td>
<td>$300</td>
</tr>
<tr>
<td>Laboratory tests</td>
<td>$100</td>
</tr>
<tr>
<td>Vaccine, other preventive</td>
<td>$100</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$5,400</strong></td>
</tr>
</tbody>
</table>

**You pay:**

- **Deductibles**: $0
- **Co-pays**: $1,300
- **Coinsurance**: $80
- **Limits or exclusions**: $60

**Total**: $1,440

Note: These numbers assume the patient is participating in our diabetes wellness program. If you have diabetes and do not participate in the wellness program, your costs may be higher. For more information about the diabetes wellness program, please contact: 1-800-627-4872
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.