Summary of Benefits and Coverage: What this Plan Covers & What it Costs Coverage for: You & Dependent | Plan Type: HDHP



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 from your employer or by calling 309-973-2112.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	\$3,000 person, \$9,000 family	You must pay all the costs up to the <u>deductible</u> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <u>deductible</u> 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 <u>deductible</u> .
Are there other deductibles for specific services?	No	You must pay all of the costs for these services up to the specific <b>deductible</b> amount before this plan begins to pay for these services.
Is there an <u>out-of-</u> <u>pocket limit</u> on my expenses?	No for participating providers For non-participating hospitals there is no limit.	The <u>out-of-pocket limit</u> 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 <u>out-of-pocket</u> <u>limit?</u>	Premiums, non-PPO Hospitals, amounts over R&C, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <b>out-of-pocket limit</b> .
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 <i>specific</i> covered services, such as office visits.
Does this plan use a network of providers?	Yes. Refer to your ID card, or view networks at www.mutualmedical.com	If you use an in-network doctor or other health care <b>provider</b> , 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 <b>provider</b> for some services. Plans use the term in-network, <b>preferred</b> , or participating for <b>providers</b> in their <b>network</b> . See the chart starting on page 2 for how this plan pays different kinds of <b>providers</b> .
Do I need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the <b>specialist</b> 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 <b>excluded services</b> .

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

Questions: Call 1-800-448-4689 or visit us at www.mutualmedical.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 309-973-2112 to request a copy.

Summary of Benefits and Coverage: What this Plan Covers & What it Costs Coverage for: You & Dependent | Plan Type: HDHP



- Copayments are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- <u>Coinsurance</u> is *your* share of the costs of a covered service, calculated as a percent of the <u>allowed amount</u> for the service. For example, if the plan's <u>allowed amount</u> for an overnight hospital stay is \$1,000, your <u>coinsurance</u> payment of 20% would be \$200. This may change if you haven't met your <u>deductible</u>.
- The amount the plan pays for covered services is based on the <u>allowed amount</u>. If an out-of-network <u>provider</u> charges more than the <u>allowed amount</u>, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the <u>allowed amount</u> is \$1,000, you may have to pay the \$500 difference. (This is called <u>balance billing</u>.)
- 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
	Primary care visit to treat an injury or illness	\$0 after deductible	\$0 after deductible	Expenses over UCR for Non PPO
If you visit a health care provider's office	Specialist visit	\$0 after deductible	\$0 after deductible	Expenses over UCR for Non PPO
or clinic	Other practitioner office visit	\$0 after deductible	\$0 after deductible	Expenses over UCR for Non PPO
	Preventive care/screening/immunization	See Plan	See Plan	
If you have a test	Diagnostic test (x-ray, blood work)	\$0 co-pay	See Plan	Non-PPO/UCR may apply
If you have a test	Imaging (CT/PET scans, MRIs)	\$0 co-pay	See Plan	Non-PPO/UCR may apply
If you need drugs to	Generic drugs	\$0 after deductible	Not covered	Maintenance/Mandatory Mail-order
treat your illness or	Preferred brand drugs	\$0 after deductible	Not covered	Maintenance/Mandatory Mail-order
condition  More information	Non-preferred brand drugs	\$0 after deductible	Not covered	PDST applies; Maintenance/Mandatory Mail-order
about <u>prescription</u> <u>drug coverage</u> is available at <u>www.medco.com</u>	Specialty drugs	\$0 after deductible	Not covered	PDST applies

Questions: Call 1-800-448-4689 or visit us at www.mutualmedical.com.

Summary of Benefits and Coverage: What this Plan Covers & What it Costs 
Coverage for: You & Dependent | Plan Type: HDHP

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 have	Facility fee (e.g., ambulatory surgery center)	0% after deductible	50% +	See Plan Description
outpatient surgery	Physician/surgeon fees	0% after deductible	20% co-insurance	Expenses over UCR for Non PPO
If you need	Emergency room services	\$200 + Deductible	See Plan	See Plan Description
immediate medical	Emergency medical transportation	0% after deductible	0% after deductible	Expenses over UCR for Non PPO
attention	Urgent care	0% after deductible	0% after deductible	Expenses over UCR for Non PPO
If you have a	Facility fee (e.g., hospital room)	0% after deductible	50% +	See Plan Description
hospital stay	Physician/surgeon fee	0% after deductible	0% after deductible	Expenses over UCR for Non PPO
If you have mental	Mental/Behavioral health outpatient services	0% after deductible	0% after deductible	Expenses over UCR for Non PPO
health, behavioral	Mental/Behavioral health inpatient services	0% after deductible	50% +	See Plan Description
health, or substance	Substance use disorder outpatient services	0% after deductible	0% after deductible	Expenses over UCR for Non PPO
abuse needs	Substance use disorder inpatient services	0% after deductible	Non-Covered	See Plan Description
If you are program	Prenatal and postnatal care	0% after deductible	0% after deductible	Expenses over UCR for Non PPO
If you are pregnant	Delivery and all inpatient services	0% after deductible	50% +	See Plan Description

Summary of Benefits and Coverage: What this Plan Covers & What it Costs Coverage for: You & Dependent | Plan Type: HDHP

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 help recovering or have	Home health care	0% after deductible	0% after deductible	Expenses over UCR for Non PPO
other special health needs	Rehabilitation services	0% after deductible	50% after ded.	Expenses over UCR for Non PPO
	Habilitation services	See Plan Document	See Plan	See Plan Document
	Skilled nursing care	Not covered	Not covered	Not covered
	Durable medical equipment	0% after deductible	0% after deductible	Expenses over UCR for Non PPO
	Hospice service	0% after deductible	0% after deductible	Expenses over UCR for Non PPO
Terrore abild not de	Eye exam	Not covered	Not covered	
If your child needs dental or eye care	Glasses	Not covered	Not covered	
delital of cyc care	Dental check-up	Not covered	Not covered	

Summary of Benefits and Coverage: What this Plan Covers & What it Costs Coverage for: You & Dependent | Plan Type: HDHP

#### **Excluded Services & Other Covered Services:**

5	Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)					
•	Acupuncture	Hearing aids	Non-emergency care when traveling outside			
•	Bariatric surgery	Infertility treatment	the U.S.			
•	Cosmetic surgery	Long-term care	• Routine eye care			
•	Dental Care	Most coverage provided outside the United	• Routine foot care			
		States.	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

• Private-duty nursing

Summary of Benefits and Coverage: What this Plan Covers & What it Costs Coverage for: You & Dependent | Plan Type: HDHP

#### **Your Rights to Continue Coverage:**

#### \*\* Group health coverage sample -

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 [contact number]. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or <a href="www.dol.gov/ebsa">www.dol.gov/ebsa</a>, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or <a href="www.cciio.cms.gov">www.cciio.cms.gov</a>.

#### **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 <u>appeal</u> or file a <u>grievance</u>. For questions about your rights, this notice, or assistance, you can contact: Mutual Medical Plans, Inc., 800-448-4689, or Dist 205 at 309-973-2112.

#### **Does this Coverage Provide Minimum Essential Coverage?**

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy** <u>does provide</u>minimum essential coverage.

#### **Does this Coverage Meet the Minimum Value Standard?**

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). This health coverage does meet the minimum value standard for the benefits it provides.

# **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 \$3,600
- **Patient pays** \$3,940

#### 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	\$3,900
Copays	\$0
Coinsurance	\$0
Limits or exclusions	\$40
Total	\$3,940

\*assumed baby covered as dependent \*assumes delivery at Cottage Hospital

#### **Managing type 2 diabetes**

(routine maintenance of a well-controlled condition)

- Amount owed to providers: \$5,400
- Plan pays \$2,000
- Patient pays \$3,400

#### 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	\$3,000
Copays	\$0
Coinsurance	\$0
Limits or exclusions	\$400
Total	\$3,400

### **Questions and answers about the Coverage Examples:**

# What are some of the assumptions behind the Coverage Examples?

- Costs don't include <u>premiums</u>.
- 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 innetwork <u>providers</u>. If the patient had received care from out-of-network <u>providers</u>, costs would have been higher.

## What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how <u>deductibles</u>, <u>copayments</u>, and <u>coinsurance</u> 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 <u>not</u> 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 <u>providers</u> charge, and the reimbursement your health plan allows.

# Can I use Coverage Examples to compare plans?

Yes. When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

# Are there other costs I should consider when comparing plans?

Yes. An important cost is the premium you pay. Generally, the lower your premium, the more you'll pay in out-of-pocket costs, such as copayments, deductibles, and coinsurance. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Questions: Call 1-800-448-4689 or visit us at www.mutualmedical.com.