

City of Hannibal and Board of Public Works: Medical Plan

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

Coverage Period: 01/01/2018 - 12/31/2018

Coverage for: Individual/Family | Plan Type: PPO



This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document by calling 1-800-365-9036.

Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u> ?	HMO Providers \$200 Individual / \$400 Family Network providers \$200 Individual / \$400 Family Non-Network providers \$200 Individual / \$400 Family Does not apply to preventive care and prescription drugs. Co-insurance and co-pays don't count toward the deductible .	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 <u>deductibles</u> 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 <u>out-of-pocket limit</u> on my expenses?	Yes. HMO Providers \$200 Individual / \$400 Family Network providers \$550 Individual / \$1,100 Family Non-Network providers \$1,250 Individual / \$2,500 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 <u>out-of-pocket limit</u> ?	Prescription Co-payments, Penalties for failing to follow pre-certification procedures, Amounts in excess of the reasonable and customary limit/maximum allowed amount, Expenses not covered under the plan, Premiums, balance-billed charges, and health care this plan doesn't 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 <u>network of providers</u> ?	Yes.	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 <u>specialist</u> ?	No.	You can see the specialist you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 4. See your policy or plan document for additional information about excluded services .

Questions: Call 1-800-365-9036.

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

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

Common Medical Event	Services You May Need	Your Cost If You Use HMO Providers	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	0% Co-Insurance	10% Co-Insurance	30% Co-Insurance	---none---
	Specialist visit	0% Co-Insurance	10% Co-Insurance	30% Co-Insurance	---none---
	Other practitioner office visit	0% Co-Insurance	10% Co-Insurance	30% Co-Insurance	Chiropractic Calendar Year Maximum 26 visits.
	Preventive care/screening/immunization	No Charge	No Charge	30% Co-Insurance	---none---
If you have a test	Diagnostic test (x-ray, blood work)	0% Co-Insurance	10% Co-Insurance	30% Co-Insurance	---none---
	Imaging (CT/PET scans, MRIs)	0% Co-Insurance	10% Co-Insurance	30% Co-Insurance	---none---
If you need drugs to treat your illness or condition More information about prescription drug coverage by contacting MedTrak Services at 1-800-894-0794 .	Generic drugs	25% Co-Pay Retail 25% Co-Pay Mail Order/Prescription	25% Co-Pay Retail 25% Co-Pay Mail Order/Prescription	Not Covered	Refer to your Plan Document for further information
	Preferred brand drugs	25% Co-Pay Retail 25% Co-Pay Mail Order/Prescription	25% Co-Pay Retail 25% Co-Pay Mail Order/Prescription	Not Covered	Refer to your Plan Document for further information
	Non-preferred brand drugs	25% Co-Pay Retail 25% Co-Pay Mail Order/Prescription	25% Co-Pay Retail 25% Co-Pay Mail Order/Prescription	Not Covered	Refer to your Plan Document for further information
	Specialty drugs	25% Co-Pay Retail 25% Co-Pay Mail Order/Prescription	25% Co-Pay Retail 25% Co-Pay Mail Order/Prescription	Not Covered	Subject to \$2,500 Pharmacy Out-of-Pocket. Refer to your Plan Document for further information.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% Co-Insurance	10% Co-Insurance	30% Co-Insurance	---none---
	Physician/surgeon fees	0% Co-Insurance	10% Co-Insurance	30% Co-Insurance	---none---

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If you need immediate medical attention	Emergency room services	0% Co-Insurance	0% Co-Insurance	0% Co-Insurance	---none---
	Emergency medical transportation	0% Co-Insurance	0% Co-Insurance	0% Network Benefits Apply	---none---
	Urgent care	0% Co-Insurance	10% Co-Insurance	30% Co-Insurance	---none---
If you have a hospital stay	Facility fee (e.g., hospital room)	0% Co-Insurance	10% Co-Insurance	30% Co-Insurance	Non-compliance penalty of \$500 per occurrence.
	Physician/surgeon fee	0% Co-Insurance	10% Co-Insurance	30% Co-Insurance	---none---
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	0% Co-Insurance	10% Co-Insurance	30% Co-Insurance	---none---
	Mental/Behavioral health inpatient services	0% Co-Insurance	10% Co-Insurance	30% Co-Insurance	Non-compliance penalty of \$500 per occurrence.
	Substance use disorder outpatient services	0% Co-Insurance	10% Co-Insurance	30% Co-Insurance	---none---
	Substance use disorder inpatient services	0% Co-Insurance	10% Co-Insurance	30% Co-Insurance	Non-compliance penalty of \$500 per occurrence.
If you are pregnant	Prenatal and postnatal care	0% Co-Insurance	10% Co-Insurance	30% Co-Insurance	Except as required under Preventive Care Services.
	Delivery and all inpatient services	0% Co-Insurance	10% Co-Insurance	30% Co-Insurance	Non-compliance penalty of \$500 per occurrence.
If you need help recovering or have other special health needs	Home health care	0% Co-Insurance	10% Co-Insurance	30% Co-Insurance	Calendar Year Maximum 100 days. One visit equals 4 hours.
	Rehabilitation services	0% Co-Insurance	10% Co-Insurance	30% Co-Insurance	---none---
	Habilitation services	0% Co-Insurance	10% Co-Insurance	30% Co-Insurance	---none---
	Skilled nursing care	0% Co-Insurance	10% Co-Insurance	30% Co-Insurance	Calendar Year Maximum 70 days. Must be within 14 days of a 3-day hospital confinement. Non-compliance penalty of \$500 per occurrence.
	Durable medical equipment	0% Co-Insurance	10% Co-Insurance	30% Co-Insurance	---none---
	Hospice service	0% Co-Insurance	10% Co-Insurance	30% Co-Insurance	Hospice: Calendar Year Maximum 70 days. Bereavement: Within 6 months of death.
If your child needs dental or eye care	Eye exam	Not Covered	Not Covered	Not Covered	Vision Screening only as required under Preventive Care services for children.
	Glasses	Not Covered	Not Covered	Not Covered	---none---
	Dental check-up	Not Covered	Not Covered	Not Covered	Coverage available under separate election of Dental Plan.

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Excluded Services & Other Covered Services:

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

- Acupuncture
- Bariatric Surgery
- Cosmetic Surgery
- Dental Care (Adult)
- Hearing Aids
- Infertility Treatment
- Long-Term Care
- Non-emergency Care when traveling outside the U.S.
- Routine Eye Care (Adult)
- Routine Foot Care
- Weight Loss Programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Chiropractic Care
- Private-duty Nursing

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 **1-800-365-9036**. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at **1-866-444-3272** or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at **1-877-267-2323 x61565** or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For more information, contact **1-800-365-9036**. 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/healthreform.

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Does this Coverage Provide Minimum Essential Coverage?

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

Does this Coverage Meet the Minimum Value Standard?

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

Language Access Services:

Group Health Plans must provide the SBC in a culturally and linguistically appropriate manner when the SBC is sent to an address in a county where 10% or more of the population are literate only in the same non-English language. The 10% or more determination is based on American Community Survey Data published by the U.S. Census Bureau and currently includes the following languages: Spanish, Tagalog, Chinese and Navajo.

[Spanish (Español): Para obtener asistencia en Español, llame al 1-800-365-9036]

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-365-9036]

[Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-365-9036]

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiiijigo holne' 1-800-365-9036]

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

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About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much 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 \$6,840
- Patient pays \$700

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	\$200
Copays	\$0
Coinsurance	\$350
Limits or exclusions	\$150
Total	\$700

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

- Amount owed to providers: \$5,400
- Plan pays \$4,770
- Patient pays \$630

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	\$200
Copays	\$0
Coinsurance	\$350
Limits or exclusions	\$80
Total	\$630

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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.