

Medical Benefit Preferred Plan: Town of Gilbert

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

Coverage Period: 07/01/2016 – 06/30/2017

Coverage for: All Tiers | Plan Type: EPO

 **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.MayoClinicHealthSolutions.com or by calling 1-866-465-5148.

Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u> ?	\$500 person/ \$1,000 family	See the chart starting on page 2 for your costs for services this plan covers.
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> 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. \$2,000 person/ \$4,000 family	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 limit</u> ?	The <u>out-of-pocket limit</u> does not include charges that are not covered services and co-pays for non-formulary prescription drugs.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
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 <u>network of providers</u> ?	Yes. For a list of <u>in-network providers</u> , see www.MayoClinicHealthSolutions.com or call 1-866-465-5148.	If you use an in-network doctor or other health care <u>provider</u> , 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 <u>provider</u> for some services. Plans use the term in-network, <u>preferred</u> , or participating for <u>providers</u> in their <u>network</u> . See the chart starting on page 2 for how this plan pays different kinds of <u>providers</u> .
Do I need a referral to see a <u>specialist</u> ?	No.	You can see the <u>specialist</u> 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 5. See your plan document for additional information about <u>excluded services</u> .

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

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	Adult primary care, general physician or OB/GYN: \$20 copay/visit Child primary care provider: \$10 copay/visit	Not covered	Child primary care applies to members age 13 and under; adult primary care applies to members age 14 and older.
	Specialist visit	\$35 copay/visit	Not covered	—————none—————
	Other practitioner office visit	20% coinsurance after deductible	Not covered	For chiropractic care: limit 20 visits per coverage year. For vision care: limit one exam per member per coverage year.
	Preventive care/screening/immunization	No charge	Not covered	See Summary Benefit Description for preventive care schedule.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance after deductible	Not covered	—————none—————
	Imaging (CT/PET scans, MRIs)	20% coinsurance after deductible	Emergency room: 20% coinsurance after deductible	—————none—————

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If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.MayoClinicHealthSolutions.com .	Preferred Generic drugs	\$10 copay/prescription (retail) \$30 copay/prescription (mail service)	Not covered, except in emergencies	Covers up to a 34-day supply (retail); up to 102-day supply (mail service). Prior authorization required for certain drugs. If diabetic supplies are filled on the same day as an insulin prescription, there is no copay for diabetic supplies. With no insulin fill, the applicable copay is charged.
	Generic drugs	\$20 copay/prescription (retail) \$60 copay/prescription (mail service)		
	Brand drugs	\$50 copay/prescription (retail) \$150 copay/prescription (mail service)		
	Non-formulary drugs	\$75 copay/prescription (retail) \$225 copay/prescription (mail service)		
	Specialty drugs	\$100 copay/prescription (retail) \$300 copay/prescription (mail service)		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance after deductible	Not covered	Prior authorization required for certain services.
	Physician/surgeon fees	20% coinsurance after deductible	Not covered	Prior authorization required for certain services.
If you need immediate medical attention	Emergency room services	\$200 copay/visit	\$200 copay/visit	Copay waived if admitted to the hospital Notification required within 48 hours.
	Emergency medical transportation	20% coinsurance after deductible	20% coinsurance after deductible	Prior authorization required for non-emergency medical transportation.
	Urgent care	\$50 copay/visit	\$50 copay/visit	—————none—————
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance after deductible	Not covered	Prior authorization required.
	Physician/surgeon fee	20% coinsurance after deductible	Not covered	Prior authorization required.

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If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	\$20 copay/visit	Not covered	_____none_____
	Mental/Behavioral health inpatient services	20% coinsurance after deductible	Not covered	Prior authorization required.
	Substance use disorder outpatient services	\$20 copay/visit	Not covered	_____none_____
	Substance use disorder inpatient services	20% coinsurance after deductible	Not covered	Prior authorization required.
If you are pregnant	Prenatal and postnatal care	Initial visit: \$20 copay Other visits: No charge	Not covered	_____none_____
	Delivery and all inpatient services	20% coinsurance after deductible	Not covered	Prior authorization may be required for stays exceeding 48 hours (vaginal deliveries) or 96 hours (caesarian deliveries).
If you need help recovering or have other special health needs	Home health care	20% coinsurance after deductible	Not covered	Prior authorization required.
	Rehabilitation services	20% coinsurance after deductible	Not covered	Limit 90 days per coverage year. Prior authorization required.
	Habilitation services	20% coinsurance after deductible	Not covered	
	Skilled nursing care	20% coinsurance after deductible	Not covered	Limit 90 days per coverage year. Prior authorization required.
	Durable medical equipment	20% coinsurance after deductible	Not covered	Prior authorization required for items over \$750 or rentals exceeding 4 months.
	Hospice service	20% coinsurance after deductible	Not covered	Prior authorization required.
If your child needs dental or eye care	Eye exam	No charge	Not covered	Limit one exam per member per coverage year.
	Glasses	Not covered	Not covered	_____none_____

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Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
	Dental check-up	Not covered	Not covered	—————none—————

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.)

- Cosmetic surgery
- Dental Care (Adults) (Routine)
- 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.)

- Acupuncture
- Bariatric Surgery
- Chiropractic Care
- 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 1-866-465-5148. 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:

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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: the plan at 1-866-465-5148. You may also contact 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.

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.**

—————*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 \$6,060
- Patient pays \$1,480

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	\$500
Copays	\$40
Coinsurance	\$790
Limits or exclusions	\$150
Total	\$1,480

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

- Amount owed to providers: \$5,400
- Plan pays \$4,080
- Patient pays \$1,320

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	\$370
Copays	\$870
Coinsurance	\$0
Limits or exclusions	\$80
Total	\$1,320

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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.

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