

OPERS : PPO and Interim Plan PPO

Coverage Period: 01/01/2017 - 12/31/2017

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

Coverage for: Participant | 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 at www.MedMutual.com/SBC or by calling 1-877-520-6728.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u>?	\$1,000 /single Network \$2,000 /single Non-Network Doesn't apply to coinsurance, copays and network preventive care	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?	Yes, \$200 (brand name prescriptions), \$100 (generic prescriptions)/single	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
Is there an <u>out-of-pocket limit</u> on my expenses?	Yes, \$4,900 /single Network Unlimited /single Non-Network	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 <u>not included</u> in the <u>out-of-pocket limit</u>?	Cost sharing for prescription drugs, 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 <u>annual limit</u> on what the insurer 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, See www.MedMutual.com/SBC or call 1-877-520-6728 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 <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 6. See your policy or plan document for additional information about excluded services .

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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 an In-Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations and Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$15 copay/visit (Medical Home), \$25 copay/visit (PCP)	40% coinsurance	-----none-----
	Specialist visit	\$40 copay/visit	40% coinsurance	-----none-----
	Other practitioner office visit (Chiropractic)	25% coinsurance	40% coinsurance	(10 visits per benefit period)
	Other practitioner office visit (Acupuncture)	Not Covered		Excluded Service
	Preventive care/ screening/ immunization	No charge	40% coinsurance	Must be billed with preventive diagnosis
If you have a test	Diagnostic test (x-ray)	25% coinsurance	30% coinsurance for Pre-Admission Tests; 40% coinsurance after deductible all other tests	-----none-----
	Diagnostic test (blood work)	25% coinsurance	30% coinsurance for Pre-Admission Tests; 40% coinsurance after deductible all other tests	-----none-----
	Imaging (CT/PET scans, MRIs)	25% coinsurance	30% coinsurance for Pre-Admission Tests; 40% coinsurance after deductible all other tests	-----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.express-scripts.com	Generic copay - retail /Rx	20% coinsurance, \$4 min & \$8 max (Preferred); 25% coinsurance \$7 min & \$11 max (Non-preferred)	Does Not Apply	Covers up to a 30-day supply
	Generic copay - home delivery /Rx	20% coinsurance, \$10 min & \$20 max	Does Not Apply	Covers a 61-90 day supply
	Formulary copay - retail /Rx	30% coinsurance, \$30 min & \$60 max (Preferred); 35% coinsurance, \$35 min & \$65 max (Non-preferred)	Does Not Apply	Covers up to a 30-day supply
	Formulary copay - home delivery /Rx	30% coinsurance; \$75 min & \$150 max	Does Not Apply	Covers a 61-90 day supply
	Non-Formulary copay - retail /Rx	Not Covered	Does Not Apply	Excluded Service
	Non-Formulary copay - home delivery /Rx	Not Covered	Does Not Apply	Excluded Service
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	25% coinsurance	40% coinsurance	-----none-----
	Physician/surgeon fees (Outpatient)	25% coinsurance	40% coinsurance	-----none-----
If you need immediate medical attention	Emergency room services	\$150 copay/visit		\$250 copay/visit Non-emergency room services
	Emergency medical transportation	25% coinsurance	30% coinsurance	-----none-----
	Urgent care	\$45 copay/visit	40% coinsurance	-----none-----
If you have a hospital stay	Facility fee (e.g., hospital room)	\$150 copay/confinement, plus deductible, 25% coinsurance	\$250 copay/confinement, plus deductible; 30% coinsurance	(copay applies to all services except Skilled Nursing Facility)
	Physician/ surgeon fee (inpatient)	25% coinsurance	30% coinsurance	-----none-----

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If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	Benefits paid based on corresponding medical benefits		-----none-----
	Mental/Behavioral health inpatient services	Benefits paid based on corresponding medical benefits		-----none-----
	Substance use disorder outpatient services (alcoholism)	Benefits paid based on corresponding medical benefits		-----none-----
	Substance use disorder outpatient services (drug use)	Benefits paid based on corresponding medical benefits		-----none-----
	Substance use disorder inpatient services (alcoholism)	Benefits paid based on corresponding medical benefits		-----none-----
	Substance use disorder inpatient services (drug use)	Benefits paid based on corresponding medical benefits		-----none-----
If you are pregnant	Prenatal and postnatal care	25% coinsurance	40% coinsurance	-----none-----
	Delivery and all inpatient services	\$150 copay/confinement, plus deductible, 25% coinsurance	\$250 copay/confinement, plus deductible; 30% coinsurance	-----none-----

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If you need help recovering or have other special health needs	Home health care	25% coinsurance except no charge first 100 days for Aid/Home Visit/Skilled Nursing/Physical/Speech/Occupational Therapies	30% coinsurance	-----none-----
	Rehabilitation services (Physical Therapy)	25% coinsurance	40% coinsurance	(10 visits, then Medical Review - Professional; unlimited - Institutional)
	Habilitation services (Occupational Therapy)	25% coinsurance	40% coinsurance	-----none-----
	Habilitation services (Speech Therapy)	25% coinsurance	40% coinsurance	(10 visits, then Medical Review - Professional; unlimited - Institutional)
	Skilled nursing care	No charge after deductible	30% coinsurance	365 days per confinement with a 90-day renewal. Covered after a 3-day hospital stay and within 14 days of discharge
	Durable medical equipment	25% coinsurance	40% coinsurance	-----none-----
	Hospice service	No charge after deductible	30% coinsurance	-----none-----
If your child needs dental or eye care	Eye exam (Child)	No charge	40% coinsurance	-----none-----
	Glasses	Not Covered		Excluded Service
	Dental check-up (Child)	Not Covered		Excluded Service

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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
- Cosmetic Surgery
- Dental check-up (Child)
- Dental Care (Adult)
- Glasses
- Hearing Aids
- Infertility Treatment
- Long-Term Care
- Non-Formulary copay - home delivery /Rx
- Non-Formulary copay - retail /Rx
- 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.)

- Bariatric Surgery
- Chiropractic Care
- Non-emergency care when traveling outside the U.S.
- 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 1-877-520-6728. 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.

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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 medical questions about your rights, this notice, or assistance, you can contact: the number on the back of your medical card or visit MedMutual.com/SBC. For prescription drug questions about your rights, this notice or assistance, you can contact the number on the back of your pharmacy card or visit www.express-scripts.com.

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 sample medical situations, 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 **\$4,640**
- Patient Pays **\$2,900**

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	\$1,000
Copays	\$200
Coinsurance	\$1,500
Limits or exclusions	\$200
Total	\$2,900

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

- Amount owed to providers: **\$5,400**
- Plan Pays **\$4,460**
- Patient Pays **\$940**

Sample care cost:

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedure	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
Total	\$5,400

Patient Pays:

Deductibles	\$200
Copays	\$200
Coinsurance	\$500
Limits or exclusions	\$40
Total	\$940

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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 by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- 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 Summaries of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box on 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**.

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