State of Ohio: Ohio Med PPO

Coverage Period: 07/01/2014 – 6/30/2015

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

Coverage for: All Coverage Tiers | **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.myuhc.com** or by calling **1-877-440-5977** (for UHC); or at **www.MedMutualStateOhioEmployee.com** or by calling **1-800-822-1152** (for Medical Mutual).

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**Network: $200** Individual/**$400** Family **Out-of-Network: $400** Individual/**$800** Family Does not apply to copays, network preventive care, or prescription drugs.	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; July 1st for this plan). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
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?	Yes. **Network: $1,500** Individual/**$3,000** Family **Out-of-Network: $3,000** Individual/**$6,000** 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, amounts greater than maximum benefits, penalties for failure to obtain preauthorization of services, prescription drugs, 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 network of providers?	Yes. See **www.MedMutualStateOhioEmployee.com** or call **1-800-822-1152** for a list of Medical Mutual network providers, or see **www.myuhc.com** or call **1-877-440-5977** for a list of UHC network providers.	If you use a network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your 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 don't need a referral to see a specialist.	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**.

Questions: Call **1-800-409-1205** or visit us at **das.ohio.gov/benefits**.
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.dol.gov/ebsa/healthreform or call **1-800-409-1205** to request a copy.

- **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 a		Limitations & Exceptions
		Network Provider	Out-of-Network Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 copay/visit	$30 copay/visit, then 40% coinsurance	No deductible applies to in-network services. Copays do not apply toward deductible.
	Specialist visit	$20 copay/visit	$30 copay/visit, then 40% coinsurance	No deductible applies to in-network services. Copays do not apply toward deductible.
	Other practitioner office visit	20% coinsurance for chiropractor; acupuncture is not covered	40% coinsurance for chiropractor; acupuncture is not covered	——————none——————
	Preventive care/ screening/immunization	No charge	**Office visits** $30 copay/visit, then 40% coinsurance up to age 21; not covered if age 22-40; $30 copay/visit if age 40 or over **Other** 40% coinsurance	No deductible for in-network preventive care. Routine physical and routine mammogram limited to once per plan year (in- and out-of-network combined). Frequency and age limitations may apply.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	——————none——————
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	——————none——————

Common Medical Event	Services You May Need	Your Cost If You Use a		Limitations & Exceptions
		Network Provider	Out-of-Network Provider	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at **www.mycatamaranrx.com**.	Generic drugs	**Retail: 30-day supply** $10 copay/ prescription **Retail: 90-day supply** $30 copay/ prescription **Mail-Order** $25 copay/90-day supply	Not covered	No charge for generic oral contraceptives (retail and mail-order available). No charge for certain diabetic and tobacco cessation medications if plan requirements are met. Some generics are categorized as "single-source" and may result in a brand copay of $25. A single-source generic drug is more expensive than other generics because the drug is generally made by only one pharmaceutical company (often the brand-name manufacturer). Once the drug is produced by multiple pharmaceutical companies, it may be moved to the generic copay level. Drugs not listed in the formulary, investigational drugs, and drugs in clinical trials are not covered.
	Preferred brand-name drugs	**Retail: 30-day supply** $25 copay/ prescription **Retail: 90-day supply** $75 copay/ prescription **Mail-Order** $62.50 copay/90-day supply	Not covered	No charge for preferred brand oral contraceptives when a generic is not available (retail and mail-order available). No charge for certain diabetic and tobacco cessation medications if plan requirements are met. Drugs not listed in the formulary, investigational drugs, and drugs in clinical trials are not covered.
	Non-preferred brand-name drugs	**Retail: 30-day supply** $50 copay/ prescription **Retail: 90-day supply** $150 copay/ prescription **Mail-Order** $125 copay/90-day supply	Not covered	If brand-name medication is requested when generic equivalent is available, you will pay the difference in price in addition to your copay. No charge for non-preferred brand oral contraceptives when a generic is not available (retail and mail-order available). No charge for certain diabetic medications if plan requirements are met. Drugs not listed in the formulary, investigational drugs, and drugs in clinical trials are not covered.

Common Medical Event	Services You May Need	Your Cost If You Use a		Limitations & Exceptions
		Network Provider	Out-of-Network Provider	
	Specialty drugs	See your costs above for preferred and non-preferred brand-name drugs	Not covered	Some specialized medications must be obtained from the specialty pharmacy through Catamaran after your first fill. For additional information, visit **das.ohio.gov/prescriptiondrug**.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	————————none————————
	Physician/surgeon fees	20% coinsurance	40% coinsurance	————————none————————
If you need immediate medical attention	Emergency room services	$75 copay/visit; copay waived if admitted, then 20% coinsurance	$75 copay/visit; copay waived if admitted, then 20% coinsurance	————————none————————
	Emergency medical transportation	20% coinsurance	20% coinsurance	No deductible applies.
	Urgent care	$25 copay	$30 copay, then 40% coinsurance	No deductible applies to in-network services. Copays do not apply toward deductible.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Preauthorization required for out-of-network care. $350 penalty may apply for failure to preauthorize.
	Physician/surgeon fee	20% coinsurance	40% coinsurance	————————none————————
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$20 copay/office visit	$30 copay/office visit, then 40% coinsurance	No deductible applies to in-network services. Copays do not apply toward deductible. More information can be found at **www.liveandworkwell.com**.
	Mental/Behavioral health inpatient services	20% coinsurance	40% coinsurance after deductible	Out-of-network copay does not apply toward deductible. $350 penalty may apply for failure to preauthorize. More information can be found at **www.liveandworkwell.com**.
	Substance use disorder outpatient services	$20 copay/office visit	$30 copay/office visit, then 40% coinsurance	No deductible applies to in-network services. Copays do not apply toward deductible. More information can be found at **www.liveandworkwell.com**.
	Substance use disorder inpatient services	20% coinsurance	40% coinsurance after deductible	Out-of-network copay does not apply toward deductible. $350 penalty may apply for failure to preauthorize. More information can be found at **www.liveandworkwell.com**.

Common Medical Event	Services You May Need	Your Cost If You Use a		Limitations & Exceptions
		Network Provider	Out-of-Network Provider	
If you are pregnant	Prenatal and postnatal care	No charge for initial visit, then 20% coinsurance	$30 copay/office visit, then 40% coinsurance	Deductible does not apply for initial in-network visit. Out-of-network copay does not apply toward deductible.
	Delivery and all inpatient services	20% coinsurance	40% coinsurance	————————none————————
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	Must be noncustodial. Limited to 100 visits/plan year or 180 days (whichever is greater), in- and out-of-network combined. Preauthorization required five business days before receiving services for out-of-network care. Financial penalty may apply or no benefit will be provided for failure to preauthorize.
	Rehabilitation services	20% coinsurance	40% coinsurance	————————none————————
	Habilitation services	20% coinsurance; office visit copay may apply	40% coinsurance: office visit copay may apply	Coverage limited to diagnosis only of Autism Spectrum Disorder.
If you need help recovering or have other special health needs	Skilled nursing care	20% coinsurance for first 180 days/plan year, then 40% coinsurance	20% coinsurance for first 180 days/plan year, then 40% coinsurance	Must be noncustodial. Must follow a hospital confinement or to avoid a hospitalization which would otherwise be necessary. Preauthorization for out-of-network care required and no benefit will be provided for failure to preauthorize.
	Durable medical equipment	20% coinsurance	40% coinsurance	————————none————————
	Hospice service	No charge	No charge	————————none————————
If your child needs dental or eye care	Eye exam	No charge	$30 copay/office visit, then 40% coinsurance	Covered up to age 21 if in-network without deductible if eye exam is part of a preventive care/wellness examination. Out-of-network copay does not apply to deductible.
	Glasses	Not covered	Not covered	————————none————————
	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.)

- Acupuncture
- Cosmetic surgery
- Dental care (Adult + Child)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult)
- Routine foot care (unless medically necessary as a result of diabetes)
- 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 (medically necessary only)
- Chiropractic care
- Hearing aids (participant pays 20% coinsurance for covered accident, illness, or injury; natural hearing loss covered at 50% coinsurance up to $1,000 and limited to once per lifetime)

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 **1-800-409-1205, option 5**. 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 questions about your rights, this notice, or assistance, you can visit **www.myuhc.com** or call **1-877-440-5977** (for UHC); or visit **www.MedMutual.com** or call **1-800-822-1152** (for Medical Mutual). You can also contact the Department of Labor's Employee Benefits Security Administration at **1-866-444-EBSA (3272)** or visit **www.dol.gov/ebsa/healthreform**. Additionally, a consumer assistance program can help you file your appeal. A list of states with Consumer Assistance Programs is available at www.dol.gov/ebsa/healthreform.

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.

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** $6,040
- **Patient pays** $1,500

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	$1,100
Limits or exclusions	$200
Total	**$1,500**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $4,220
- **Patient pays** $1,180

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	$600
Coinsurance	$300
Limits or exclusions	$80
Total	**$1,180**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs assume individual coverage.
- 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.

Questions: Call **1-800-409-1205** or visit us at **das.ohio.gov/benefits**.
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