

2013 Summary of Benefits & Coverage for Non-Medicare





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.modot-mshp-cvty.com or by calling 1-800-627-6406 (medical) or 1-877-235-2013 (pharmacy).

Important Questions	Answers	Why this Matters:
What is the overall deductible?	In-network: Individual: \$450. Family: \$1,350. Out-of-network: Individual: \$450 Family: \$1,350 Does not apply to preventive care, medical and pharmacy copayments, non-covered services or amounts above the allowed amount for Out-of-Network service.	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>deductibles</u> .
Are there other deductibles for specific services?	Yes. Pharmacy: \$100	You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this plan begins to pay for these services.
Is there an out-of-pocket limit on my expenses?	Yes. In-network: Individual: \$1,275 Family: \$3,825 Out-of-network: Individual: \$2,100 Family: \$6,300.	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 out-of-pocket limit?	Pharmacy deductible, medical and pharmacy co-pays, pharmacy co-insurance, costs above the allowed amount, non-covered services and supplies, utilization review penalties	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 specific covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of participating providers, see www.modot-mshp-cvty.com or call 1-800-627-6406 (medical) or 1-877-235-2013 (pharmacy).	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> .

SBC Name: 400_20087

Questions: Call 1-800-627-6406 (medical) or 1-877-235-2013 (pharmacy) or visit us at www.modot-mshp-cvty.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.modot-mshp-cvty.com or call 1-800-627-6406 (medical) or 1-877-235-2013 (pharmacy) to request a copy.

Do I need a referral to see a specialist?	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 in Services Your Plan Does Not Cover. See your policy or plan document for information about excluded services .



- **Co-payments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** 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 **co-insurance** 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 preferred **providers** by charging you lower **deductibles**, **co-payments** and **co-insurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use an		Limitations & Exceptions
		In-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	\$25 co-pay per visit Co-pay limited to office visit only. All other services subject to deductible then 10% co-insurance.	deductible then 20% co-insurance of allowed amount	None
	Specialist visit			
	Other practitioner office visit			
	Preventive care/screening/immunization	\$0 co-pay per visit	Not Covered	Limitations are based on the American Cancer Society and the Centers for Disease Control and Prevention recommendations.
If you have a test	Diagnostic test (x-ray, blood work)	deductible then 10% co-insurance	deductible then 20% co-insurance of allowed amount	None
	Imaging (CT/PET scans, MRIs)			Preauthorization is required.

Common Medical Event	Services You May Need	Your cost if you use an		Limitations & Exceptions
		In-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.modot-mshp-cvty.com or call 1-877-235-2013.	Generic drugs	pharmacy deductible then 30% co-insurance with a \$5 minimum co-pay	Not covered	Certain drugs require step therapy, quantity limits, and/or prior authorization. Some drugs are excluded from coverage.
	Preferred brand drugs	pharmacy deductible then 30% co-insurance of the brand cost plus the difference between the cost of brand and generic		
	Non-preferred brand drugs			
	Specialty drugs	pharmacy deductible then 30% co-insurance with a \$5 minimum co-pay		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	deductible then 10% co-insurance	deductible then 20% co-insurance of allowed amount	Preauthorization is required.
	Physician/surgeon fees			
If you need immediate medical attention	Emergency room services	\$75 co-pay then deductible then 10% co-insurance	\$75 co-pay then deductible then 10% co-insurance	Co-pay is waived if patient is admitted or if due to accidental injury. Must meet emergency criteria. If does not meet emergency criteria, a 20% co-insurance of allowed amount would apply for out-of-network services.
	Emergency medical transportation	deductible then 10% co-insurance	deductible then 10% co-insurance	Services are excluded if they do not meet emergency criteria.
	Urgent care	\$25 Copayment for office visit. Other services applied toward deductible then 10% co-insurance	deductible then 10% co-insurance	Must meet urgent care criteria. If does not meet urgent criteria, a 20% co-insurance of allowed amount would apply for out-of-network services.

Common Medical Event	Services You May Need	Your cost if you use an		Limitations & Exceptions
		In-network Provider	Out-of-network Provider	
If you have a hospital stay	Facility fee (e.g., hospital room)	deductible then 10% co-insurance	deductible then 20% co-insurance of allowed amount	Preauthorization is required unless Emergency admission. Failure to preauthorize will result in additional charge equal to 20% of allowed amount up to \$1,000 for out-of-network services.
	Physician/surgeon fee			
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	Office visit: \$25 co-pay; Outpatient hospital: deductible then 10% co-insurance	deductible then 20% co-insurance of allowed amount	Preauthorization may be required.
	Mental/Behavioral health inpatient services	deductible then 10% co-insurance		Preauthorization is required unless Emergency admission. Failure to preauthorize will result in additional charge equal to 20% of allowed amount up to \$1,000 for out-of-network services.
	Substance use disorder outpatient services	Office visit: \$25 co-pay; Outpatient hospital: deductible then 10% co-insurance		Preauthorization may be required.
	Substance use disorder inpatient services	deductible then 10% co-insurance		Preauthorization is required unless Emergency admission. Failure to preauthorize will result in additional charge equal to 20% of allowed amount up to \$1,000 for out-of-network services.
If you are pregnant	Prenatal and postnatal care	\$25 co-pay first visit only	deductible then 20% co-insurance of allowed amount	None

Common Medical Event	Services You May Need	Your cost if you use an		Limitations & Exceptions	
		In-network Provider	Out-of-network Provider		
	Delivery and all inpatient services	deductible then 10% co-insurance	deductible then 20% co-insurance of allowed amount	Notification required for 48/96 hours for vaginal delivery or cesarean section. Stays beyond these time frames require preauthorization. Failure to preauthorize will result in additional charge equal to 20% of allowed amount up to \$1,000 for out-of-network services.	
If you need help recovering or have other special health needs	Home health care	deductible then 10% co-insurance	deductible then 20% co-insurance of allowed amount	Preauthorization required.	
	Rehabilitation services			Preauthorization is required. Limited to 60 visits per benefit year for physical, speech, and occupational therapies.	
	Habilitation services	Office visit: \$25 co-pay; Outpatient: deductible then 10% co-insurance			
	Skilled nursing care	deductible then 10% co-insurance			Preauthorization required.
	Durable medical equipment				Preauthorization is required for medical equipment over \$1,000.
	Hospice service				Preauthorization required.
If your child needs dental or eye care	Eye exam	Excluded service		Excluded service	
	Glasses				
	Dental check-up				

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 Services/Drugs |
| • Dental Care | • Dental check-up | • Hearing Screenings |
| • Infertility Treatment/Drugs | • Long-Term Care | • Out-of-Network Prescription Drugs |
| • Routine Eye Care | • Routine Foot Care | • Weight Loss Programs/Drugs |

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 with limitations | • Non-Emergency Care when Traveling Outside the U.S. | • Private-Duty Nursing |
| • Hearing Aids for children with developmental delays | | |

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 1-800-627-6406. 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:

For group health coverage subject to ERISA, you may contact 1-800-627-6406. You may also contact, the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform, or your state department of insurance at Illinois Department of

Insurance 320 W. Washington Street Springfield, IL 62767 Consumer Assistance Hotline: 866-445-5364 (Toll-Free) Email: DOI.InfoDesk@illinois.gov Missouri Department of Insurance P.O. Box 690 Jefferson City, MO 76102-0690 800-726-7390 (Toll Free) E-mail: consumeraffairs@insurance.mo.gov.

For non-federal governmental group health plans and church plans that are group health plans, you may contact 1-800-755-3901 or your state department of insurance at Illinois Department of Insurance 320 W. Washington Street Springfield, IL 62767 Consumer Assistance Hotline: 866-445-5364 (Toll-Free) Email: DOI.InfoDesk@illinois.gov Missouri Department of Insurance P.O. Box 690 Jefferson City, MO 76102-0690 800-726-7390 (Toll Free) Email: consumeraffairs@insurance.mo.gov.

Additionally, a consumer assistance program can help you file your appeal. Contact Illinois Department of Insurance 320 W. Washington St, 4th Floor, Springfield, IL 62767 (877) 527-9431 <http://www.insurance.illinois.gov> DOI.Director@illinois.gov Missouri Department of Insurance 301 W. High Street, Room 830 Harry S. Truman State Office Building Jefferson City, MO 65101 (800) 726-7390 www.insurance.mo.gov consumeraffairs@insurance.mo.gov

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-627-6406.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-627-6406.

Chinese (中文): 在西班牙的援助要求, 1-800-627-6406.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijjigo holne' 1-800-627-6406.

—————*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 \$6,440
- Patient pays \$1,100

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
Co-pays	\$30
Co-insurance	\$400
Limits or exclusions	\$200
Total	\$1,100

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

- Amount owed to providers: \$5,600
- Plan pays \$3,500
- Patient pays \$2,100

Sample care costs:

Prescriptions	\$1,500
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$730
Education	\$290
Laboratory tests	\$140
Vaccines, other preventive	\$140
Total	\$5,600

Patient pays:

Deductibles	\$600
Co-pays	\$200
Co-insurance	\$1,100
Limits or exclusions	\$200
Total	\$2,100

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**, **co-payments**, and **co-insurance** 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 **co-payments**, **deductibles**, and **co-insurance**. 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.