



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.ipmg.com or by calling 1-800-423-1841.

| Important Questions | Answers | Why this Matters: |
|---|---|---|
| What is the overall <u>deductible</u> ? | <p>Network \$1,500 individual \$3,000 family</p> <p>Non-Network-\$ 3,000 individual/\$6,000 family</p> <p>Network and Non-Network deductible apply towards each other.</p> <p>The deductible does not apply to preventive care, urgent care centers, or out-of-pocket</p> | <p>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.</p> |
| Are there other <u>deductibles</u> for specific services? | <p>Yes. \$500 per Inpatient hospital confinements; \$250 per Outpatient Surgery</p> | <p>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.</p> |
| Is there an <u>out-of-pocket limit</u> on my expenses? | <p>Yes. Network \$1,500 individual \$3,000 family</p> <p>Non-Network-\$3,000 individual \$6,000 family</p> <p>Network and Non-Network out of pocket does not apply towards each other.</p> | <p>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.</p> |
| What is not included in the <u>out-of-pocket limit</u> ? | <p>Cost containment penalties, copays, deductibles, amounts over usual and reasonable charges</p> | <p>Even though you pay these expenses, they don't count toward the out-of-pocket limit.</p> |
| Is there an overall annual limit on what the plan pays? | <p>No.</p> | <p>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.</p> |

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Chariton Valley Association Plan 1: IPMG

Coverage Period: 04/01/2016-03/30/2017

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

Coverage for: Individuals + Deps | Plan Type: PPO 1

| | | |
|---|--|---|
| Does this plan use a network of providers? | Yes. For a list of network providers, see www.healthlink.com or call 1-800-624-2356 for a list of network 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 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 4. See your policy or plan document for additional information about excluded services . |



- **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 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 | \$30 copay | 30% coinsurance | —————none————— |
| | Specialist visit | \$60 copay | 30% coinsurance | —————none————— |
| | Other practitioner office visit | \$30 copay | 30% coinsurance | —————none————— |
| | Preventive care/screening/immunization | No charge | 30% coinsurance | —————none————— |
| If you have a test | Diagnostic test (x-ray, blood work) | 10% coinsurance | 30% coinsurance | —————none————— |
| | Imaging (CT/PET scans, MRIs) | 10% coinsurance | 30% coinsurance | —————none————— |

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| Common Medical Event | Services You May Need | Your Cost If You Use a Network Provider | Your Cost If You Use a Non-network Provider | Limitations & Exceptions |
|--|--|--|---|--|
| If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.informrx.com or call 1-800-880-1188. | Generic drugs | \$5 copay retail \$10 copay mail | Not covered | Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription) |
| | Preferred brand drugs | \$40 copay retail \$100 copay mail | Not covered | |
| | Non-preferred brand drugs | \$75 copay retail \$187.50 copay mail | Not covered | |
| | Specialty drugs | \$75 copay retail Not covered mail | Not covered | _____none_____ |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | 10% coinsurance | 30% coinsurance | Prior authorization is required call AHH at 1-866-457-0534 or a \$500 penalty will apply |
| | Physician/surgeon fees | 10% coinsurance | 30% coinsurance | _____none_____ |
| If you need immediate medical attention | Emergency room services | Emergency-\$250 copay then 10% coinsurance Non Emergency-\$250 copay then 10% coinsurance | Emergency-\$250 copay then 10% coinsurance Non Emergency-30% coinsurance | _____none_____ |
| | Emergency medical transportation | 10% coinsurance | 10% coinsurance | _____none_____ |
| | Urgent care | \$75 copay | 30% coinsurance | _____none_____ |
| If you have a hospital stay | Facility fee (e.g., hospital room) | 10% coinsurance | 30% coinsurance | Prior authorization is required call AHH at 1-866-457-0534 or a \$500 penalty will apply |
| | Physician/surgeon fee | 10% coinsurance | 30% coinsurance | _____none_____ |

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|---|--|---|---|---|
| If you have mental health, behavioral health, or substance abuse needs | Mental/Behavioral health outpatient services | 10% coinsurance | 30% coinsurance | —————none————— |
| | Mental/Behavioral health inpatient services | 10% coinsurance | 30% coinsurance | —————none————— |
| | Substance use disorder outpatient services | 10% coinsurance | 30% coinsurance | —————none————— |
| | Substance use disorder inpatient services | 10% coinsurance | 30% coinsurance | —————none————— |
| If you are pregnant | Prenatal and postnatal care | 10% coinsurance | 30% coinsurance | —————none————— |
| | Delivery and all inpatient services | 10% coinsurance | 30% coinsurance | —————none————— |
| If you need help recovering or have other special health needs | Home health care | 10% coinsurance | 30% coinsurance | Limited to 60 days per calendar year. |
| | Rehabilitation services | 10% coinsurance | 30% coinsurance | Speech Therapy 20 visits per Calendar Year/Physical Therapy 20 visits per Calendar Year |
| | Habilitation services | 10% coinsurance | 30% coinsurance | Occupational Therapy-20 visits per Calendar Year |
| | Skilled nursing care | 10% coinsurance | 30% coinsurance | Limited to 60 days per calendar year. |
| | Durable medical equipment | 10% coinsurance | 30% coinsurance | —————none————— |
| | Hospice service | 10% coinsurance | 30% coinsurance | —————none————— |
| If your child needs dental or eye care | Eye exam | \$30 copay | 30% coinsurance | —————none————— |
| | Glasses | Not covered | Not covered | —————none————— |
| | Dental check-up | Not covered | Not covered | —————none————— |

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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 or Child)
- Glasses
- Hearing Aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Non-network prescription drugs
- 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
- 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 1-800-423-1841. 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 contact: IPMG Employee Benefits Services at 1-800-423-1841 or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (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 40% (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 \$4,850
- Patient pays \$2,690

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 (includes IP copay) | \$2,000 |
| Copays | \$10 |
| Coinsurance | \$530 |
| Limits or exclusions | \$150 |
| Total | \$2,690 |

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

- Amount owed to providers: \$5,400
- Plan pays \$3,400
- Patient pays \$2,000

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 | \$1,500 |
| Copays | \$320 |
| Coinsurance | \$100 |
| Limits or exclusions | \$80 |
| Total | \$2,000 |

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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.

THIS IS A GRANDFATHERED HEALTH PLAN

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