# Gundersen Health Plan: MN N4 Minnesota Individual Plan

**Coverage Period: 01/01/2014 - 12/31/2014**

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

**Coverage for: Individual | Plan Type: HMO**

**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.gundersenhealthplan.org or by calling 1-800-897-1923.

| Important Questions | Answers | Why this Matters: |
|---|---|---|
| What is the overall **deductible**? | **$3500** Ind/ **$7000** Fam Per benefit year | 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 **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 **$3500** Ind/ **$7000** Fam Per benefit year | 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, balanced billed charges and any health care this plan does not 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 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 the plan use a **network** of **providers**? | Yes See www.glhealthplan.org for a list of participating doctors and hospitals | 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 **network specialist** | You can see the **specialist** you choose without permission from this plan. |
| Are there services this plan does not 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**. |

- 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 participating **providers** by charging you lower **deductibles**, **co-payments** and **co-insurance** amounts.

| Common Medical Event | Services you May Need | Your cost if you use a Participating Provider | Limitations & Exceptions |
|---|---|---|---|
| **If you visit a health care provider's office or clinic** | Primary care visit to treat an injury or illness | $40 Copayment | *none* |
| | Specialist visit | $40 Copayment | No need for a referral within the network. |
| | Other practitioner office visit | $40 Copayment | *none* |
| | Preventive care / screening / immunization | $0 Cost Share | Benefit is limited to preventive care guidelines. Refer to the wellness section of the certificate. (Preventive care) |
| **If you have a test** | Diagnostic test (x-ray, blood work) | Deductible | *none* |
| | Imaging (CT/PET scans, MRIs) | Deductible | *none* |
| **If you need drugs to treat your illness or condition** | Generic drugs | $5 Copayment | *none* |
| | Preferred brand drugs | $45 Copayment | *none* |
| | Non-preferred brand drugs | $100 Copayment | *none* |
| | Specialty drugs (e.g., chemotherapy) | 50% Coinsurance | *none* |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | Deductible | *none* |
| | Physician/surgeon fees | $40 Copayment | *none* |

| Common Medical Event | Services you May Need | Your cost if you use a Participating Provider | Limitations & Exceptions |
|---|---|---|---|
| **If you need immediate medical attention** | Emergency room services | $150 Copayment | Emergency room copayment waived if admitted. |
| | Emergency medical transportation | Deductible | *none* |
| | Urgent care | $40 Copayment | Limited to care, provided by a participating provider, or by a non-participating provider outside the service area. |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | Deductible | *none* |
| | Physician/surgeon fees | Deductible | *none* |
| **If you have mental health, behavioral health, or substance abuse needs** | Mental/behavioral health outpatient services | $40 Copayment | *none* |
| | Mental/behavioral health inpatient services | Deductible | *none* |
| | Substance abuse disorder outpatient services | $40 Copayment | *none* |
| | Substance abuse disorder inpatient services | Deductible | *none* |
| **If you become pregnant** | Prenatal and postnatal care | Deductible | *none* |
| | Delivery and all inpatient services | Deductible | *none* |

| Common Medical Event | Services you May Need | Your cost if you use a Participating Provider | Limitations & Exceptions |
|---|---|---|---|
| **If you have a recovery or other special health need** | Home health care | $40 Copayment | Limited to 120 visits per benefit year. Prior authorization is required. Applicable cost sharing may apply after the copayment. |
| | Rehabilitation services | $40 Copayment | Prior authorization is required after 20 visits per therapy discipline (physical, speech, occupational) per benefit year. |
| | Habilitation services | $40 Copayment | Prior authorization required after 20 visits per therapy discipline (physical, speech, occupational) per benefit year. |
| | Skilled nursing care | Deductible | Limited to 120 days per confinement (medical or surgical condition). This benefit is combined with the Swing Bed Care benefit. Prior authorization is required. |
| | Durable medical equipment | Deductible | Prior authorization required for all rentals and purchases and repairs over $1,000. |
| | Hospice Services | Deductible | Limited to 30 visits. |
| **If your child needs dental or eye care** | Eye Exam | $0 Cost Share | Routine eye exams limited to one per benefit year. |
| | Glasses | $0 Cost Share | For children under the age of 19. Limited coverage. Refer to the Certificate of Coverage. |
| | Dental check-up | Not Covered | *none* |

## Excluded Services & Other Covered Services:

| Services Your Plan Does NOT Cover (This isn't a complete list. Check you policy or plan document for other **excluded services**.) | | |
|---|---|---|
| • Bariatric surgery | • Non-emergency care when traveling outside of the U.S. | • Cosmetic surgery |
| • Dental care (adult) | • Infertility treatment | • Long-term care |
| • Private-duty nursing | • Routine foot care | • Weight loss programs |
| • Acupuncture | | |

| 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.) | | |
|---|---|---|
| • Routine eye care (adult) | • Chiropractic care | • Hearing aids |

## 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 1-800-897-1923. 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: 1-800-897-1923.

## 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: $7540
- Plan pays: $3890
- Patient pays: $3650

**Sample care costs:**

| | |
|---|---|
| Hospital charges (mother) | $2700 |
| Routine obstetric care | $2100 |
| Hospital charges (baby) | $900 |
| Anesthesia | $900 |
| Laboratory tests | $500 |
| Prescriptions | $200 |
| Radiology | $200 |
| Vaccines, other preventive | $40 |
| Total | $7540 |

**Patient pays:**

| | |
|---|---|
| Deductibles | $3500 |
| Co-pays | $0 |
| Co-insurance | $0 |
| Limits or exclusions | $150 |
| Total | $3650 |

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

- Amount owed to providers: $5400
- Plan pays: $1820
- Patient pays: $3580

**Sample care costs:**

| | |
|---|---|
| Prescriptions | $2900 |
| Medical Equipment and Supplies | $1300 |
| Office Visits and Procedures | $700 |
| Education | $300 |
| Laboratory tests | $100 |
| Vaccines, other preventive | $100 |
| Total | $5400 |

**Patient pays:**

| | |
|---|---|
| Deductibles | $3500 |
| Co-pays | $0 |
| Co-insurance | $0 |
| Limits or exclusions | $80 |
| Total | $3580 |

## 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.