

# Ambetter from Coordinated Care Corporation: Ambetter Balanced Care 2 (2016) + Vision

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

Coverage Period: 01/01/2016 - 12/31/2016

Coverage for: Individual/Family | 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 <http://ambetter.coordinatedcarehealth.com/> or by calling 877-687-1197, TTY/TDD 877-941-9238

| Important Questions                                       | Answers  | Why this Matters:   |
|---|--|---|
| What is the overall <u>deductible</u> ?                   | <b>\$6,500</b> individual / <b>\$13,000</b> family. Does not apply to preventive care.                       | 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 plan 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>deductible</u> .  |
| Are there other <u>deductibles</u> for specific services? | No   | You don't have to meet <u>deductibles</u> for specific services, but see the chart starting on page 2 for other costs for services this plan covers.  |
| Is there an <u>out-of-pocket-limit</u> on my expenses?    | Yes, for network providers <b>\$6,500</b> individual/ <b>\$13,000</b> family. No, for non-network providers. | 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 <u>out-of-pocket limit</u> ?  | Premiums, balance-billed charges, and non-network services this plan doesn't cover.                          | 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 <i>specific</i> covered services, such as office visits.  |
| Does this plan use a <u>network</u> of <u>providers</u> ? | Yes. See <a href="#">Find a Provider</a> or call 1-877-687-1197 for a list of participating providers.       | 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> . |
| Do I need a referral to see a <u>specialist</u> ?         | Yes  | This plan will pay some or all of the costs to see a <u>specialist</u> for covered services but only if you have the plan's permission before you see the <u>specialist</u> .   |
| 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 <u>excluded services</u> .   |

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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.cciio.cms.gov](http://www.cciio.cms.gov) or call 877-687-1197, TTY/TDD 877-941-9238 to request a copy.

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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 in-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 & Exceptions                        |
|--|--|---|---|---|
| If you visit a health care <b>provider's</b> office or clinic  | Primary care visit to treat an injury or illness | \$30 Copay/visit                            | Not covered                                     | -----None-----                                  |
|  | Specialist visit                                 | \$60 Copay/visit                            | Not covered                                     | Prior approval required.                        |
|  | Other practitioner office visit                  | \$30 Copay/visit                            | Not covered                                     | -----None-----                                  |
|  | Preventive care/screening/immunization           | No Charge                                   | Not covered                                     | -----None-----                                  |
| If you have a test   | Diagnostic test (x-ray, blood work)              | No charge after deductible                  | Not covered                                     | Prior approval required.                        |
|  | Imaging (CT/PET scans, MRIs)                     | No charge after deductible                  | Not covered                                     | Prior approval required                         |
| If you need drugs to treat your illness or condition<br><br>More information about <b>prescription drug coverage</b> is available at <a href="#">Preferred Drug List</a> . | Generic drugs                                    | \$15 Copay                                  | Not covered                                     | -----None-----                                  |
|  | Preferred brand drugs                            | \$50 Copay                                  | Not covered                                     | Prior approval required.                        |
|  | Non-preferred brand drugs                        | No charge after deductible                  | Not covered                                     | Prior approval required. Subject to deductible. |
|  | Specialty drugs                                  | No charge after deductible                  | Not covered                                     |   |
| If you have outpatient surgery   | Facility fee (e.g., ambulatory surgery center)   | No charge after deductible                  | Not covered                                     | Prior approval required.                        |
|  | Physician/surgeon fees                           | No charge after deductible                  | Not covered                                     | Prior approval required                         |

| 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 & Exceptions                                   |
|---|--|---|---|--|
| <b>If you need immediate medical attention</b>                                | Emergency room services                      | No charge after deductible /visit           | No charge after deductible /visit               | -----None-----   |
|   | Emergency medical transportation             | No charge after deductible                  | No charge after deductible                      | -----None-----   |
|   | Urgent care                                  | \$100 Copay                                 | Not covered                                     | -----None-----   |
| <b>If you have a hospital stay</b>  | Facility fee (e.g., hospital room)           | No charge after deductible                  | Not covered                                     | Prior approval required                                    |
|   | Physician/surgeon fee                        | No charge after deductible                  | Not covered                                     | Prior approval required.                                   |
| <b>If you have mental health, behavioral health, or substance abuse needs</b> | Mental/Behavioral health outpatient services | \$30 Copay/visit                            | Not covered                                     | Prior approval required                                    |
|   | Mental/Behavioral health inpatient services  | No charge after deductible                  | Not covered                                     | Prior approval required                                    |
|   | Substance use disorder outpatient services   | \$30 Copay/visit                            | Not covered                                     | Prior approval required                                    |
|   | Substance use disorder inpatient services    | No charge after deductible                  | Not covered                                     | Prior approval required.                                   |
| <b>If you are pregnant</b>  | Prenatal and postnatal care                  | \$30 Copay/visit                            | Not covered                                     | Prior approval required.                                   |
|   | Delivery and all inpatient services          | No charge after deductible                  | Not covered                                     | Prior approval required                                    |
| <b>If you need help recovering or have other special health needs</b>         | Home health care                             | No charge after deductible                  | Not covered                                     | Prior approval required. 130 Visit(s) per Year             |
|   | Rehabilitation services                      | No charge after deductible                  | Not covered                                     | Prior approval required. 25 Visit(s) per year.             |
|   | Habilitation services                        | No charge after deductible                  | Not covered                                     | Prior approval required. 25 Visit(s) per benefit per year. |
|   | Skilled nursing care                         | No charge after deductible                  | Not covered                                     | Prior approval required. 60 Days per year in a facility.   |
|   | Durable medical equipment                    | No charge after deductible                  | Not covered                                     | Prior approval required.                                   |
|   | Hospice service                              | No charge after deductible                  | Not covered                                     | Prior approval required. 14 Days per Lifetime              |

| 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 & Exceptions   |
|--|-----------------------|---|---|--|
| If your child needs dental or eye care | Eye exam              | \$0 Copay/visit                             | Not covered                                     | 1 Visit(s) per year.   |
|  | Glasses               | \$0 Copay/pair                              | Not covered                                     | 1 Item(s) per year. 1 pair of lenses or 1 pair of frames per year. |
|  | 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.)

- Bariatric surgery
- Long-term care
- Weight loss programs
- Cosmetic surgery
- Non-emergency care when traveling outside the U.S.
- Dental care
- Private-duty nursing

### 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.)

- Abortion services (Not limited based on federal funding)
- Hearing aids (Coverage for cochlear implants only)
- Routine foot care (For diabetes treatment)
- Acupuncture (Limited to 12 visits per year. Unlimited visits for chemical dependency treatment)
- Infertility treatment (Coverage for the diagnosis of infertility only)
- Chiropractic care (Limited to 10 specialists' visits per year)
- Routine eye care

## Your Rights to Continue Coverage

Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay your **premium**. There are exceptions, however, such as if:

- You commit fraud
- The insurer stops offering services in the State
- You move outside the coverage area

For more information on your rights to continue coverage, contact the insurer at 877-687-1197, TTY/TDD 877-941-9238. You may also contact your state insurance department at Consumer Advocacy/SHIBA Office of the Insurance Commissioner, 5000 Capitol Blvd., SE, Turnwater, WA 98501, Phone No. (800) 562-6900 or (360) 725-7080

## 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: Consumer Advocacy/SHIBA Office of the Insurance Commissioner, 5000 Capitol Blvd., SE, Turnwater, WA 98501, Phone No. (800) 562-6900 or (360) 725-7080

## 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.**

## Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 877-687-1197, TTY/TDD 877-941-9238

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*To see examples of how this plan might cover costs for a sample medical situation, see below.*

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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** \$2,120
- **Patient pays** \$5,420

#### 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           |
| <b>Total</b>               | <b>\$7,540</b> |

#### Patient pays

|                      |                |
|----------------------|----------------|
| Deductibles          | \$5,200        |
| Copays               | \$20           |
| Coinsurance          | \$0            |
| Limits or exclusions | \$200          |
| <b>Total</b>         | <b>\$5,420</b> |

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

- **Amount owed to providers:** \$5,400
- **Plan pays** \$2,320
- **Patient pays** \$3,080

#### 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          |
| <b>Total</b>                   | <b>\$5,400</b> |

#### Patient pays

|                      |                |
|----------------------|----------------|
| Deductibles          | \$2,400        |
| Copays               | \$600          |
| Coinsurance          | \$0            |
| Limits or exclusions | \$80           |
| <b>Total</b>         | <b>\$3,080</b> |

## 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 Examples 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.

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