MEDICAL MUTUAL®

Coverage Maximum
Questions and Answers

General

What is a coverage maximum* plan benefit design?
This means that a coverage maximum will be set for identified services. The coverage maximum is the maximum amount a plan sponsor or employer group will pay for services identified regardless of the provider used or where the service is rendered. Some services will only be covered by the plan for a specified amount.

If a provider's contracted rate is above the coverage maximum, members will be responsible for the amount in excess of the coverage maximum up to the provider's contracted rate, in addition to their normal benefit plan out-of-pocket costs (e.g., deductibles, coinsurance payments). Participating members will have continued access to all network providers, but may choose a provider or facility whose contracted rates match or are below the coverage maximum to get the most out of their benefits and avoid additional out-of-pocket costs.

When is coverage maximum being implemented?
January 1, 2016.

Why is coverage maximum being implemented?
The objective is to encourage members to spend their healthcare dollars effectively without impacting quality of care.

Which services are included in the coverage maximum plan benefit design?
Currently, 40 specific lab services are included in the coverage maximum benefit design. Services rendered in an emergency setting or inpatient hospital/facility and those resulting from outpatient procedures will not be subject to the coverage maximum. A full list of services and their associated coverage maximums is available at Provider.MedMutual.com by selecting Tools & Resources, Provider eServices, ePortal Resources. You must be logged into the secure Provider ePortal to view the coverage maximums, available under the Fee Schedule tab.

How do I know if my patient is participating in a coverage maximum plan benefit design?
Providers were sent letters naming the plan sponsors or employer groups who have elected a coverage maximum plan benefit design in August and November 2015. In addition, the application of coverage maximums will be noted on the Notice of Payment. Members are also being encouraged to talk to their providers about their benefit design.

What are participating members being told about this benefit design?
Medical Mutual is encouraging members to actively participate in deciding where to receive lab services. They are being directed to use My Care Compare, an online tool that provides cost estimates and quality ratings for in-network facilities and providers. The cost estimates provided will allow members to determine if providers' contracted rates match or are below the coverage maximum. To read more about My Care Compare, visit Provider.MedMutual.com and select Tools & Resources, Provider Publications, Mutual News Bulletin, Volume 8, Issue 2 - March, 2015.

*Previously referred to as reference-based pricing.

How can I help my patients make the most of their benefits?
If you order lab work for Medical Mutual members, they may ask where you are sending the test and the associated cost. If the suggested testing facility would require members to incur costs above the coverage maximum, they may ask you to send the test elsewhere.

Members may also ask when scheduling an appointment if they need lab work and, if so, if they can get lab orders in advance. This would allow the member to get the sample drawn and analyzed at a lab provider of their choice.

We encourage you to consider your role in helping members maximize their benefits and minimize out-of-pocket costs. Knowing the costs of the providers you usually refer patients to in advance will result in a productive and beneficial engagement with members. Oftentimes, members follow your recommendation and direction.

Reimbursement

How will I be reimbursed if my contracted rate is BELOW the coverage maximum?
Reimbursement will be the lesser of the contracted rate or coverage maximum. Members will only pay their normal benefit plan out-of-pocket costs (e.g., deductibles, coinsurance payments). These costs will accrue according to the member's deductible and maximum out-of-pocket limits.

How will I be reimbursed if my contracted rate is ABOVE the coverage maximum?
Your reimbursement will be capped at the coverage maximum less any benefit cost-sharing owed by members. It will be your responsibility to bill the member for the difference between the coverage maximum and your contracted rate. The difference paid by the member will not count toward their deductible or out-of-pocket maximum and will be in addition to their normal benefit plan out-of-pocket costs (e.g., deductibles, coinsurance payments).

Are there any exceptions to/exclusions from the coverage maximum plan design reimbursement?
Yes. Exceptions may be available if there are no in-network providers whose contracted rates match or are below the established coverage maximum within 15 miles of the member's permanent residence for urban and suburban areas and 40 miles for rural. Members should contact Customer Care in advance of receiving care. If the member meets the exception requirements, Customer Care may waive the member's responsibility to pay the difference between the coverage maximum and the provider's contracted rate. You would be reimbursed your contracted rate.

Further, services will not be subject to the coverage maximum when delivered:

- In an emergency setting or inpatient hospital/facility
- As part of an outpatient procedure
- By a provider outside the SuperMed® service area