Ector County Health Benefit Plan

Summary of Benefits and Coverage: What this plan covers and what it costs

Coverage Period: 10/1/2016 – 9/30/2017
Coverage for: All Levels **Plan Type:** PPO

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.groupresources.com or by calling (800) 749-9963.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$441** employee **$882** employee + one dependent **$1,333** family Does not apply to prescription drugs, home health care, hospice care, or routine/preventive services	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 to see 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?	**$3,057** person	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, balance-billed charges, deductibles, co-payments, penalties, and health care this plan doesn't 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 this plan use a network of providers?	Yes. See www.pbhn.org or www.multiplan.com for a list of participating providers	If you use an in-network doctor or other health care **provider**, this plan will pay a higher portion 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**.

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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 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 health 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 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 an In-network Provider	Your cost if you use an Out-of-network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit or Specialist visit to treat an injury or illness	10% coinsurance PBHN 20% coinsurance PPO 30% coinsurance out of area	40% coinsurance	---none---
	Other practitioner office visit	10% coinsurance PBHN 20% coinsurance PPO 30% coinsurance out of area for chiropractic or acupuncture	40% coinsurance for chiropractic or acupuncture	Coverage limited to 26 visits per calendar year for chiropractic
	Preventive care/screening/immunization	No charge for first $300 then 10% coinsurance PBHN physician 20% coinsurance PBHN facility 20% coinsurance PPO 30% coinsurance out of area	40% coinsurance	Gardasil vaccine is not covered
If you have a test	Diagnostic test (x-ray, blood work) and Imaging (CT/PET scans, MRIs)	10% coinsurance PBHN physician 20% coinsurance PBHN facility 20% coinsurance PPO 30% coinsurance out of area	40% coinsurance	---none---

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If you need drugs to treat your Illness or condition For more information about drug coverage, visit www.medtrakservices.com or call (800) 771-4648	Generic drugs	$6 retail (30) - $12 retail (90) $12 mail order (90)	Not covered	Covers up to a 30-day or 90 day supply retail and a 90 day supply mail order
	Preferred brand drugs	$30 retail (30) - $60 retail (90) $60 mail order (90)	Not covered	
	Prescription drugs costing $250 or more retail/$750 or more mail order	$60 retail (30) - $120 retail (90) $120 mail order (90)	Not covered	
	Prescription drugs costing $1,000 or more retail/$3,000 or more mail order	$60 plus 30% of retail cost (30) $120 plus 30% of retail cost (90) $120 plus 30% of mail order cost (90)	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance PBHN 20% coinsurance PPO 30% coinsurance out of area	40% coinsurance	---none---
	Physician/surgeon fees	10% coinsurance PBHN 20% coinsurance PPO 30% coinsurance out of area	40% coinsurance	---none---
If you need immediate medical attention	Emergency room services	10% coinsurance PBHN physician 20% coinsurance PBHN facility 20% coinsurance PPO 30% coinsurance out of area	40% coinsurance	---none---
	Emergency medical transportation	20% coinsurance PBHN 20% coinsurance PPO 20% out of area	20% coinsurance	---none---
	Urgent care	10% coinsurance PBHN 20% coinsurance PPO 30% coinsurance out of area	40% coinsurance	---none---
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance PBHN 20% coinsurance PPO 30% coinsurance out of area	40% coinsurance	Must be pre-certified or a $500 penalty applies
	Physician/surgeon fees	10% coinsurance PBHN 20% coinsurance PPO 30% coinsurance out of area	40% coinsurance	--none---

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Common Medical Event	Services You May Need	Your cost if you use an In-network Provider	Out-of-network Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services Substance use disorder outpatient services	10% coinsurance PBHN physician 20% coinsurance PBHN facility 20% coinsurance PPO 30% coinsurance out of area	40% coinsurance	---none---
	Mental/Behavioral health inpatient services Substance use disorder inpatient services	10% coinsurance PBHN physician 20% coinsurance PBHN facility 20% coinsurance PPO 30% coinsurance out of area	40% coinsurance	Must be pre-certified or a $500 penalty applies
If you are pregnant	Prenatal and postnatal care	10% coinsurance PBHN 20% coinsurance PPO 30% coinsurance out of area	40% coinsurance	---none---
	Delivery and all inpatient services	10% coinsurance PBHN physician 20% coinsurance PBHN facility 20% coinsurance PPO 30% coinsurance out of area	40% coinsurance	---none---
If you need help recovering or have other special health needs	Home health care	No charge	No charge	---none---
	Rehabilitation services or Habilitation services	10% coinsurance PBHN physician 20% coinsurance PBHN facility 20% coinsurance PPO 30% coinsurance out of area	40% coinsurance	Coverage limited to 50 visits per calendar year per type of therapy
	Skilled nursing care	10% coinsurance PBHN physician 20% coinsurance PBHN facility 20% coinsurance PPO 30% coinsurance out of area	40% coinsurance	Coverage limited to 60 days per calendar year
	Durable medical equipment	10% coinsurance PBHN physician 20% coinsurance PBHN facility 20% coinsurance PPO 30% coinsurance out of area	40% coinsurance	Letter of medical necessity is required
	Hospice service	No charge	No charge	---none---

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	Not covered	Not covered	---none---
	Glasses	Not covered	Not covered	---none---
	Dental check-up	Not covered by medical plan		---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
- Hearing aids
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult)
- 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.)

- Acupuncture
- Chiropractic care (Limited to 26 visits per calendar year)
- Cosmetic surgery (Covered only when required due to illness or injury and when performed within 12 months of such illness or injury, or because of congenital birth defects, trauma, tumors, or developmental deformities)
- Dental care (Adult – limited to emergency repair of accidental injury to sound natural teeth including the replacement of such teeth or setting of a jaw fractured or dislocated in an accident when treatment is received within six months of such accident; cutting procedures in the oral cavity for tumors or cysts of the jawbone; treatment of fractures and traumatic dislocations of the jawbone; cutting procedures on gums or mouth tissues needed to treat a disease; and the removal of impacted teeth)
- Infertility treatment (Covered only if plan criteria are met)
- Private duty nursing (Covered only when medically necessary – prior approval is required)

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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 (800) 749-9963. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at (866) 444-3272 or www.dol.gov/ebsa, or the U.S. Department of health and Human Services at (877) 267-2323, ext 61565 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 either:

Group Resources
3080 Premiere Parkway
Suite 100
Duluth, GA 30097-4904
(770) 623-8383

Or

Employee Benefits Security Administration
(866) 444-3272
www.dol.gov/ebsa/healthreform

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

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About these Coverage Examples:

These examples show how this plan might cover medical care in two situations. Use these examples to see, in general, how much insurance protection you might get from 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 also will be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

▪ **Amount owed to providers:**	$7540
▪ **Plan pays**	$5580
▪ **Patient pays**	$1960

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	$880
Copays	$10
Coinsurance	$920
Limits or exclusions	$150
Total	**$1960**

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

▪ **Amount owed to providers:**	$5400
▪ **Plan pays**	$4490
▪ **Patient pays**	$910

Sample care costs:

Prescriptions	$2900
Medical equipment & supplies	$1300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5400**

Patient pays:

Deductibles	$440
Copays	$190
Coinsurance	$200
Limits or exclusions	$80
Total	**$910**

Questions and answers about 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 to the U.S. Department of Health and Human Services (HHS), and aren't specific to a particular geographic area or health plan.
- Patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same policy 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 these conditions 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 Summaries of Coverage for other plans, you'll find the same coverage examples. When you compare plans, check the "You Pay" box for 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 copays, deductibles, and coinsurance. You also should 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.