Delaware County Employee Health Plan: Delaware County Government

Coverage Period: 01/01/2017-12/31/2017

Summary of Benefits & Coverage: What this Plan Covers & Costs **Coverage for:** Employee/Dependents | **Plan Type:** Cost Plus HSA

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.gpatpa.com or by calling 765-741-3397.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$3,000** person/**$6,000** family Level I & Level II PPO & Non-PPO Preventive services do not apply towards the deductible.	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. $4,000** person/**$8,000** family Level I & Level II PPO & Non-PPO	This **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; charges in excess of UCR (Usual, Customary & Reasonable); health care this plan doesn't cover and any noncompliance penalties.	Even though you pay these expenses, they do not count toward the **out-of-pocket limit.**
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 *specific* covered services, such as office visits.
Does this plan use a network of providers?	**Yes**, for Level II Providers. See page 2 for an explanation of Level I & Level II Providers. Visit www.multiplan.com or call 1-888-611-7427 for a list of participating physicians.	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 hospital or in-network doctor 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 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 5. See your plan document for additional information about **excluded services.**

Questions: Call 765-741-3397 or visit us at www.gpatpa.com
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 or call 765-741-3397 to request a copy.

- **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 PHCS **providers** for Level II services by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.
- Level I Providers include but are not limited to: Hospitals (Inpatient and Outpatient treatment); Inpatient Facilities (such as Rehabilitation Facilities, Skilled Nursing Facilities and Hospice); Inpatient and Outpatient Facilities of Mental Disorders, Chemical Dependency, Drug and Substance Abuse; Ambulatory Surgery Centers and Dialysis Clinics
- Level II Providers are Physicians and all other Providers of service not defined as a Level I Provider.

Common Medical Event	Services You May Need	Your Cost If You Use a Level I Provider	Your Cost If You Use a Level II PPO Provider	Your Cost If You Use a Level II Non-PPO Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	N/A	10% coinsurance	30% coinsurance	Deductible waived for female sterilization & all FDA approved female contraceptive methods. Chiropractic services limited to 12 visits per calendar year. Non-PPO charges are subject to UCR fees.
	Specialist visit	N/A	10% coinsurance	30% coinsurance	
	Other practitioner office visit	N/A	10% coinsurance	30% coinsurance	
	Preventive care/screening/ immunization	0% coinsurance; deductible waived	0% coinsurance; deductible waived	0% coinsurance; deductible waived	See your plan document for additional benefit information & limitations. Level I charges based on Allowable Claims Limits. Non-PPO charges are subject to UCR fees.
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance	10% coinsurance	30% coinsurance	Benefit applies to MRIs, CTs & PET Scans billed by One Call Care Management. Level I charges based

Common Medical Event	Services You May Need	Your Cost If You Use a Level I Provider	Your Cost If You Use a Level II PPO Provider	Your Cost If You Use a Level II Non-PPO Provider	Limitations & Exceptions
	Imaging (CT/PET scans, MRIs)	10% coinsurance	10% coinsurance	30% coinsurance	on Allowable Claims Limits. Non-PPO charges are subject to UCR fees.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.express-scripts.com	Generic drugs	Deductible then 10% coinsurance			Covers a 30 day supply for Retail/90 day supply for Mail Order/30 day supply for Specialty. See your plan document for information about drugs that require prior authorization & drugs that are excluded.
	Preferred brand drugs	Deductible then 10% coinsurance			
	Non-preferred brand drugs	Deductible then 10% coinsurance			
	Specialty drugs	Deductible then 10% coinsurance			
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	N/A	N/A	Level I charges based on Allowable Claims Limits. Non-PPO charges are subject to UCR fees.
	Physician/surgeon fees	N/A	10% coinsurance	30% coinsurance	
If you need immediate medical attention	Emergency room services	10% coinsurance	10% coinsurance	30% coinsurance	UR notification required if admitted inpatient. Level I charges based on Allowable Claims Limits. Non-PPO charges are subject to UCR fees.
	Emergency medical transportation	10% coinsurance	10% coinsurance	30% coinsurance	UR notification required for non-emergency transports. Level I charges based on Allowable Claims Limits. Non-PPO charges are subject to UCR fees.
	Urgent care	N/A	10% coinsurance	30% coinsurance	Non-PPO charges are subject to UCR fees.
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	N/A	N/A	UR notification required. Level I charges based on Allowable Claims Limits. Non-PPO charges are

Common Medical Event	Services You May Need	Your Cost If You Use a Level I Provider	Your Cost If You Use a Level II PPO Provider	Your Cost If You Use a Level II Non-PPO Provider	Limitations & Exceptions
	Physician/surgeon fee	N/A	10% coinsurance	30% coinsurance	subject to UCR fees.
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health inpatient & outpatient services	10% coinsurance	10% coinsurance	30% coinsurance	UR notification required if admitted inpatient. Level I charges based on Allowable Claims Limits. Non-PPO charges are subject to UCR fees.
	Substance use disorder inpatient & outpatient services	10% coinsurance	10% coinsurance	30% coinsurance	
If you are pregnant	Prenatal and postnatal care	N/A	10% coinsurance	30% coinsurance	Contact UR for coordination of prenatal care. Level I charges based on Allowable Claims Limits. UR notification required if admitted inpatient. Non-PPO charges are subject to UCR fees.
	Delivery and all inpatient services	10% coinsurance	10% coinsurance	30% coinsurance	
If you need help recovering or have other special health needs	Home health care	10% coinsurance	10% coinsurance	30% coinsurance	Services limited per calendar year to 60 combined visits for Physical/Occupational Therapy, 20 visits for Speech Therapy, 60 days for Skilled Nursing Facilities & 60 days for Rehabilitation Facilities. Treatment of developmental delays may not be covered. See your plan document for additional information about **excluded services.** Contact UR for coordination of care for Home Health care & Outpatient Hospice. UR notification required if admitted inpatient. Level I charges based on Allowable Claims Limits. Non-PPO charges are subject to UCR fees.
	Rehabilitation services	10% coinsurance	10% coinsurance	30% coinsurance	
	Habilitation services	10% coinsurance	10% coinsurance	30% coinsurance	
	Skilled nursing care	10% coinsurance	10% coinsurance	30% coinsurance	
	Durable medical equipment	10% coinsurance	10% coinsurance	30% coinsurance	
	Hospice service	10% coinsurance	10% coinsurance	30% coinsurance	
If your child needs dental or eye care	Eye exam	N/A	0% coinsurance; deductible waived	0% coinsurance; deductible waived	Vision Screenings covered to age 19. Non-PPO charges are subject to UCR fees.
	Glasses	Not Covered			Not Covered

Common Medical Event	Services You May Need	Your Cost If You Use a Level I Provider	Your Cost If You Use a Level II PPO Provider	Your Cost If You Use a Level II Non-PPO Provider	Limitations & Exceptions
	Dental check-up	Not Covered			Not Covered

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
- Care outside the U.S. when travel is specifically for medical care
- Charges not medically necessary
- Cosmetic Surgery
- Dental Care
- Hearing Aids
- Infertility Treatment
- Long Term Care
- 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.)

- Bariatric Surgery (morbid obesity only)
- Chiropractic Care
- Medical Services incurred while traveling outside the U.S. **only** if a medical emergency, subject to medical necessity and approved AMA procedure
- Private Duty Nursing (related to Home Health only)
- Routine eye care (screening to age 19)

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 765-741-3397. 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: 800-827-7223 or the Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or 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.

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** $3,950
- **Patient pays** $3,590

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	$3,000
Copays	$0
Coinsurance	$440
Limits or exclusions	$150
Total	**$3,590**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $2,100
- **Patient pays** $3,300

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	$3,000
Copays	$0
Coinsurance	$220
Limits or exclusions	$80
Total	**$3,300**

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.