

# Deschutes County Employee Benefit Plan: Standard Plan

Coverage Period: 08/01/2016 - 07/31/2017

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

Coverage for: Individual, Family | 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.ebms.com](http://www.ebms.com) or by calling 1-866-268-3625.

Important Questions	Answers	Why this Matters
<b>What is the overall <u>deductible</u>?</b>	<b>\$500</b> per covered person; <b>\$1,500</b> per family unit. Does not apply to office visits, allergy injections, alternative care, naturopathic treatment, outpatient diagnostic lab and x-ray, outpatient mental health & chemical dependency, preventive care, colonoscopy / sigmoidoscopy, prescription drugs, and vision services.	You must pay all the costs up to the <b><u>deductible</u></b> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <b><u>deductible</u></b> 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 <b><u>deductible</u></b> .
<b>Are there other <u>deductibles</u> for specific services?</b>	No.	You don't have to meet <b><u>deductibles</u></b> for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
<b>Is there an <u>out-of-pocket limit</u> on my expenses?</b>	Yes. <b>Medical - Participating Provider: \$2,000</b> per covered person; <b>\$6,000</b> per family unit. <b>Non-Participating Provider: \$4,000</b> per covered person; <b>\$12,000</b> per family unit. <b>Prescription Drugs: \$1,200</b> per covered person; <b>\$3,600</b> per family unit.	The <b><u>out-of-pocket</u></b> 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.
<b>What is not included in the <u>out-of-pocket limit</u>?</b>	Prescription drugs, cost containment penalties, premiums, balance-billed charges (unless balanced billing is prohibited), and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <b><u>out-of-pocket limit</u></b> .
<b>Is there an overall annual limit on what the plan pays?</b>	Yes. <b>Vision Care:</b> Benefit maximums apply to vision hardware expenses for Covered Persons age 19 & older.	This plan will pay for covered services only up to this limit during each coverage period, even if your own need is greater. You're responsible for all expenses above this limit.
<b>Does this plan use a <u>network of providers</u>?</b>	Yes. For a list of <b>network providers</b> , see <a href="http://www.ebms.com">www.ebms.com</a> or call 1-866-268-3625.	If you use a participating doctor or other health care <b><u>provider</u></b> , this plan will pay some or all of the costs of covered services. Be aware, your participating doctor or hospital may use a non-participating <b><u>provider</u></b> for some services. Plans use the term participating, network, or preferred for <b><u>providers</u></b> in their <b><u>network</u></b> . See the chart starting on page 2 for how this plan pays different kinds of <b><u>providers</u></b> .

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Do I need a referral to see a <u>specialist</u> ?	No.	You can see the <u>specialist</u> 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 policy or plan document for additional information about excluded services.

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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 participating **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$25 copayment, deductible waived	\$25 copayment then 20% coinsurance, deductible waived	<i>The office visit copayment includes the visit charge only. All other services performed during the office visit are payable per normal Plan provisions.</i>
	Specialist visit			
	Other practitioner office visit: Alternative Care	\$15 copayment, deductible waived for acupuncture, massage therapy, and chiropractic care		Alternative care services are limited to a combined maximum of \$1,500 per calendar year; massage therapy (alone) also has a limit of \$45 per visit.
	Naturopathic treatment	\$25 copayment, deductible waived	\$25 copayment then 20% coinsurance, deductible waived	
Preventive care screenings/immunizations	No Cost	20% coinsurance, deductible waived	————— <i>none</i> —————	

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If you have a test	Diagnostic test (x-ray, blood work)	<i>Inpatient:</i> 20% coinsurance after deductible	<i>Inpatient:</i> 40% coinsurance after deductible	<i>Diagnostic colonoscopy/sigmoidoscopy</i> if performed at a participating provider: No Cost; if performed at a non-participating provider: 20% coinsurance, deductible waived.
	Imaging (CT/PET scans, MRIs)	<i>Outpatient:</i> 20% coinsurance, deductible waived	<i>Outpatient:</i> 40% coinsurance, deductible waived	
If you need drugs to treat your illness or condition: More information about <u>prescription drug coverage</u> is available at <a href="http://www.ebms.com">www.ebms.com</a>	Generic drugs	\$20 copayment (retail); \$40 copayment (mail order)		Coverage is limited to 34-day supply per retail prescription or available up to a 100-day supply per mail order prescription.  Retail prescriptions purchased at a non-participating pharmacy or when the member's ID card is not used must be manually submitted and will be subject to a 50% copayment.
	Formulary drugs	20% copayment or \$50 up to a maximum of \$100, whichever is greater (retail); 20% copayment or \$100 up to a maximum of \$200, whichever is greater (mail order)		
	Non-Formulary drugs	20% copayment or \$75 up to a maximum of \$125, whichever is greater (retail); 20% copayment or \$150 up to a maximum of \$300, whichever is greater (mail order)		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance after deductible	40% coinsurance after deductible	_____none_____
	Physician/surgeon fees			
If you need immediate medical attention	Emergency room services	\$100 copayment then 20% coinsurance after deductible <i>(the ER copayment is waived if admitted)</i>		<i>Pre-notification is required within 2 business days after an admission from the ER to avoid a penalty. There is no coverage for non-emergency use of the Emergency Room.</i>
	Emergency medical transportation	20% coinsurance after deductible		Coverage is limited to 400 miles per condition.
	Urgent care Facility	20% coinsurance after deductible	40% coinsurance after deductible	<i>The office visit copayment includes the visit charge only. All other services performed during the office visit are payable per normal Plan provisions.</i>
Office	\$25 copayment, deductible waived	\$25 copayment then 20% coinsurance, deductible waived		

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If you have a hospital stay	Facility fee (e.g., hospital room)	\$100 copayment then 20% coinsurance after deductible	\$100 copayment then 40% coinsurance after deductible	<i>Pre-notification is required prior to any inpatient admission to avoid a penalty. The inpatient admission copayment applies per admission.</i>
	Physician/surgeon fee	20% coinsurance after deductible	40% coinsurance after deductible	————— <i>none</i> —————
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	\$25 copayment, deductible waived	\$25 copayment then 20% coinsurance, deductible waived	————— <i>none</i> —————
	Mental/Behavioral health inpatient services	20% coinsurance after deductible	40% coinsurance after deductible	<i>Pre-notification is required prior to any inpatient admission to avoid a penalty.</i>
	Substance use disorder outpatient services	\$25 copayment, deductible waived	\$25 copayment then 20% coinsurance, deductible waived	————— <i>none</i> —————
	Substance use disorder inpatient services	20% coinsurance after deductible	40% coinsurance after deductible	<i>Pre-notification is required prior to any inpatient admission to avoid a penalty.</i>
If you are pregnant	Prenatal and postnatal care	\$25 copayment, deductible waived	\$25 copayment then 20% coinsurance, deductible waived	<i>Pre-notification is required for any inpatient maternity admission that exceeds 48 hours following a vaginal delivery or 96 hours following a cesarean section, to avoid a penalty.</i>
	Delivery and all inpatient services	20% coinsurance after deductible	40% coinsurance after deductible	The \$100 inpatient admission copayment will apply to the facility charge (per admission).
If you need help recovering or have other special health needs	Home health care	20% coinsurance after deductible	40% coinsurance after deductible	Coverage is limited to a maximum of 2 visits per day and 180 visits per calendar year.
	Rehabilitation services	20% coinsurance after deductible	40% coinsurance after deductible	<i>Pre-notification is required prior to any inpatient admission to avoid a penalty. Inpatient is limited to 30 days per calendar year. Outpatient includes physical, occupational, speech, &amp; vision therapy and is limited to 30 visits per calendar year. An additional 30 visits may be available for head or spinal injury, cardiovascular accident, stroke or other major injury.</i>
	Habilitation services			

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	Skilled nursing care	20% coinsurance after deductible	40% coinsurance after deductible	<i>Pre-notification is required prior to any inpatient admission to avoid a penalty.</i>
	Durable medical equipment	20% coinsurance after deductible	40% coinsurance after deductible	Reimbursement based on rental charge; <i>option to purchase requires prior approval.</i>
	Hospice service	20% coinsurance after deductible	40% coinsurance after deductible	<i>Pre-notification is required prior to any inpatient admission to avoid a penalty.</i>
<b>If your child needs dental or eye care</b>	Eye exam	No Cost (age 18 & under)		Coverage is limited to one exam per calendar year.
	Glasses	No Cost (age 18 & under)		Coverage is limited to one set of lenses/frames per calendar year or a 12-month supply of disposable contact lenses in lieu of glasses.
	Dental check-up	Not Covered		Benefits may be available through a separate plan election.

## 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 <u>excluded services</u> .)		
<ul style="list-style-type: none"> <li>Bariatric surgery</li> <li>Cosmetic surgery</li> <li>Dental care (<i>Benefits may be available through a separate plan election.</i>)</li> </ul>	<ul style="list-style-type: none"> <li>Infertility treatment</li> <li>Long-term care</li> <li>Non-emergency care when traveling outside the U.S.</li> </ul>	<ul style="list-style-type: none"> <li>Private-duty nursing</li> <li>Routine foot care</li> <li>Weight loss programs</li> </ul>
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.)		
<ul style="list-style-type: none"> <li>Acupuncture</li> <li>Chiropractic care</li> </ul>	<ul style="list-style-type: none"> <li>Hearing aids</li> </ul>	<ul style="list-style-type: none"> <li>Routine eye care</li> </ul>

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### 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 1-866-268-3625. 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](http://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](http://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: Employee Benefits Management Services, Inc. (EBMS) at 1-800-777-3575 or [www.ebms.com](http://www.ebms.com). You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform).

Additionally, a consumer assistance program can help you file your appeal. A list of states with Consumer Assistance Programs is available at [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform) and <http://cciio.cms.gov/prgrams/consumer/capgrants/index.html>.

### 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 **1-866-268-3625**.

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

#### 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	\$500
Copays	\$120
Coinsurance	\$1,350
Limits or exclusions	\$150
<b>Total</b>	<b>\$2,120</b>

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

- **Amount owed to providers: \$5,400**
- **Plan pays \$3,570**
- **Patient pays \$1,830**

#### 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	\$500
Copays	\$1,010
Coinsurance	\$240
Limits or exclusions	\$80
<b>Total</b>	<b>\$1,830</b>

## HHS COVERAGE EXAMPLE CALCULATOR

*This Plan has elected to use the U. S. Department of Health and Human Services (HHS) coverage calculator. These coverage examples are not an accurate reflection of the benefits under your plan.*

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## 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 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.

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