# DecisionPathHR 2017

# Summary of Benefit Coverage (SBCs)

## ACA Suite MEC Plans

## MEC I

## MEC III

## BPA MVP

## $6,350 Deductible

# Gibson Group Consulting, LLC dba DecisionPathHR- MEC I Plan

Coverage Period: January 1, 2017 - December 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.bpatpa.com or by calling 855-236-3272.

| Important Questions | Answers | Why this Matters: |
|---|---|---|
| What is the overall deductible? | No 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. | |
| Is there an out-of-pocket limit on my expenses? | In Network Out of Pocket maximum is $6,850 per individual and $13,700 per family.<br><br>Out of Network Out of Pocket does not have a maximum. | 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 your health care expenses. |
| What is not included in the out-of-pocket limit? | Premiums, balance-billed charges, Prior Authorization Penalties, and health care this plan does not 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 plan pays? | No. | The chart titled Common Medical Event describes any limits on what the insurer will pay for *specific* covered services, such as office visits. |
| Does this plan use a network of providers? | Yes. For a list of Network Providers, see www.multiplan.com and choose the PPO Option or call 800/277-8973. | By utilizing in network providers, you have access to discounted rates for services. |
| 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 | Yes. | Some of the services this plan doesn't cover are listed in the box titled |

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If you aren't clear about any of the underlined terms in this form, see the Glossary. You can view the Glossary at www.dol.gov/ebsa/healthreform or call 855-236-3272 to request a copy.

| | | |
|---|---|---|
| plan doesn't cover? | | Services Your Plan Does Not Cover. See your policy or plan document for information about excluded services. |

- Copayments are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive this 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.

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

Coverage for: Individual Family | Plan Type: PPO

| Common Medical Event | Services You May Need | Your Cost If You Use a | | Limitations & Exceptions |
|---|---|---|---|---|
| | | Network Provider | Out-Of-Network Provider | |
| If you visit a health care provider's office or clinic | Primary care visit to treat an injury or illness | Not covered. | Not covered | |
| | Specialist visit | Not covered | Not covered | |
| | Other practitioner office visit | Not covered | Not covered | |
| | Preventive care/screening/immunization | No charge | Not covered | |
| If you have a test | Diagnostic test (x-ray, blood work) | Not covered | Not covered | |
| | Imaging (CT/PET scans, MRIs) | Not covered | Not covered | |
| If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.caremark.com | Generic | $10 copay/prescription | Not covered | $1,500 without prior authorization per prescription maximum for pharmacy benefit $3,000 without prior authorization per prescription maximum for mail order benefits. |
| | Preferred Brand | CVS Discount Applied | Not covered | $1,500 without prior authorization per prescription maximum for pharmacy benefit $3,000 without prior authorization per prescription maximum for mail order benefits If the member selects a brand drug when a generic equivalent is available, the member is responsible for the generic copay plus the cost difference between the generic and brand equivalent. |
| | Non Preferred Brand | Not covered | Not covered | |

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| Common Medical Event | Services You May Need | Your Cost If You Use a | | Limitations & Exceptions |
|---|---|---|---|---|
| | | Network Provider | Out-Of-Network Provider | |
| | Specialty drugs | Not covered | Not covered | |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | Not covered | Not covered | |
| | Physician/surgeon fees | Not covered | Not covered | |
| If you need immediate medical attention | Emergency room services | Not covered | Not covered | |
| | Emergency medical transportation | Not covered | Not covered | |
| | Urgent care | Not covered | Not covered | |
| If you have a hospital stay | Facility fee (e.g., hospital room) | Not covered | Not covered | |
| | Physician/surgeon fee | Not covered | Not covered | |
| If you have mental health, behavioral health, or substance abuse needs | Mental/Behavioral health outpatient services | Not covered | Not covered | |
| | Mental/Behavioral health inpatient services | Not covered | Not covered | |
| | Substance use disorder outpatient services | Not covered | Not covered | |
| | Substance use disorder inpatient services | Not covered | Not covered | |
| If you are pregnant | Prenatal and postnatal care | Not covered | Not covered | |
| | Delivery and all inpatient services | Not covered | Not covered | |

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

Coverage for: Individual Family | Plan Type: PPO

| Common Medical Event | Services You May Need | Your Cost If You Use a | | Limitations & Exceptions |
|---|---|---|---|---|
| | | Network Provider | Out-Of-Network Provider | |
| If you need help recovering or have other special health needs | Home health care | Not covered | Not covered | |
| | Rehabilitation services | Not covered | Not covered | |
| | Habilitation services | Not covered | Not covered | |
| | Skilled nursing care | Not covered | Not covered | |
| | Durable medical equipment | Not covered | Not covered | |
| | Hospice service | Not covered | Not covered | |
| If your child needs dental or eye care | Eye exam | No charge | No charge | Exam only covered and member may choose any physician. |
| | Glasses | Not covered | Not covered | Not covered. |
| | Dental check-up | No charge | No charge | Coverage limited to children as part of required preventive care services. Exam only covered and member may choose any provider. |

## 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
- Bariatric surgery
- Dental Care
- Chiropractic Care
- Hearing Aids
- Long Term Care
- Non-Emergency Care When Traveling Outside the US
- Private-duty Nursing
- Routine Foot Care
- Weight Loss Programs
- Infertility Treatment
- Routine Eye Care Adult

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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 855-236-3272. 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 the plan at 855-236-3272. 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.

## Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). 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.*

# 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 pre-existing 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.

# Gibson Group Consulting, LLC dba DecisionPathHR - MEC III Plan

Coverage Period: January 1, 2017 - December 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.bpatpa.com or by calling 855-236-3272.

| Important Questions | Answers | Why this Matters: |
|---|---|---|
| What is the overall deductible? | No 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. | |
| Is there an out-of-pocket limit on my expenses? | In Network Out of Pocket maximum is $6,850 per individual and $13,700 per family.<br><br>Out of Network Out of Pocket does not have a maximum. | 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 your health care expenses. |
| What is not included in the out-of-pocket limit? | Premiums, balance-billed charges, Prior Authorization Penalties, and health care this plan does not 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 plan pays? | No. | The chart titled Common Medical Event describes any limits on what the insurer will pay for *specific* covered services, such as office visits. |
| Does this plan use a network of providers? | Yes. For a list of Network Providers, see www.multiplan.com and choose the PPO Option or call 800/277-8973. | By utilizing in network providers, you have access to discounted rates for services. |
| 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 | Yes. | Some of the services this plan doesn't cover are listed in the box titled |

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| | | |
|---|---|---|
| plan doesn't cover? | | Services Your Plan Does Not Cover. See your policy or plan document for information about excluded services. |

- Copayments are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive this 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.

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

Coverage for: Individual Family | Plan Type: PPO

| Common Medical Event | Services You May Need | Your Cost If You Use a | | Limitations & Exceptions |
|---|---|---|---|---|
| | | Network Provider | Out-Of-Network Provider | |
| If you visit a health care provider's office or clinic | Primary care visit to treat an injury or illness | $20 copay/visit | Not covered | Max 3 Visits per calendar year. |
| | Specialist visit | $50 copay/visit | Not covered | Max 3 Visits per calendar year. |
| | Other practitioner office visit | Not covered | Not covered | |
| | Preventive care/screening/immunization | No charge | Not covered | |
| If you have a test | Diagnostic test (x-ray, blood work) | $50 copay/visit | Not covered | In office, max 5 services per calendar year. |
| | Imaging (CT/PET scans, MRIs) | $200 copay/visit | Not covered | Max 1 Cat-Scan, 1 MRI per calendar year. |
| If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.caremark.com | Generic | Retail: $15 copay/prescription Mail: $37.5 copay/prescription | Not covered | $1,500 without prior authorization per prescription maximum for pharmacy benefit $3,000 without prior authorization per prescription maximum for mail order benefits. |
| | Preferred Brand | Retail: $25 copay/prescription Mail: $62.5 copay/prescription | Not covered | $1,500 without prior authorization per prescription maximum for pharmacy benefit $3,000 without prior authorization per prescription maximum for mail order benefits If the member selects a brand drug when a generic equivalent is available, the member is responsible for the generic copay plus the cost difference between the generic and brand equivalent. |
| | Non Preferred Brand | Retail: $75 copay/prescription Mail: $187.5 copay/prescription | Not covered | $1,500 without prior authorization per |

| Common Medical Event | Services You May Need | Your Cost If You Use a | | Limitations & Exceptions |
|---|---|---|---|---|
| | | Network Provider | Out-Of-Network Provider | |
| | | | | prescription maximum for pharmacy benefit $3,000 without prior authorization per prescription maximum for mail order benefits If the member selects a brand drug when a generic equivalent is available, the member is responsible for the generic copay plus the cost difference between the generic and brand equivalent. |
| | Specialty Drugs | Not Covered | Not covered | |
| | Facility fee (e.g., ambulatory surgery center) | Not covered | Not covered | |
| | Physician/surgeon fees | Not covered | Not covered | |
| If you have outpatient surgery | Emergency room services | Not covered | Not covered | |
| | Emergency medical transportation | Not covered | Not covered | |
| If you need immediate medical attention | Urgent care | $50 Copay/visit | Not covered | Max 3 visits per calendar year. |
| | Facility fee (e.g., hospital room) | Not covered | Not covered | |
| | Physician/surgeon fee | Not covered | Not covered | |
| If you have a hospital stay | Mental/Behavioral health outpatient services | Not covered | Not covered | |
| | Mental/Behavioral health inpatient services | Not covered | Not covered | |

| Common Medical Event | Services You May Need | Your Cost If You Use a | | Limitations & Exceptions |
|---|---|---|---|---|
| | | Network Provider | Out-Of-Network Provider | |
| If you have mental health, behavioral health, or substance abuse needs | Substance use disorder outpatient services | Not covered | Not covered | |
| | Substance use disorder inpatient services | Not covered | Not covered | |
| | Prenatal and postnatal care | Not covered | Not covered | |
| | Delivery and all inpatient services | Not covered | Not covered | |
| If you are pregnant | Home health care | Not covered | Not covered | |
| | Rehabilitation services | Not covered | Not covered | |
| If you need help recovering or have other special health needs | Habilitation services | Not covered | Not covered | |
| | Skilled nursing care | Not covered | Not covered | |
| | Durable medical equipment | Not covered | Not covered | |
| | Hospice service | Not covered | Not covered | |
| | Eye exam | No charge | No charge | Exam only covered and member may choose any physician. |
| | Glasses | Not covered | Not covered | Not covered. |
| If your child needs dental or eye care | Dental check-up | No charge | No charge | Coverage limited to children as part of required preventive care services. Exam only covered and member may choose any provider. |

## 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
- Bariatric surgery
- Dental Care
- Chiropractic Care
- Hearing Aids
- Long Term Care
- Non-Emergency Care When Traveling Outside the US
- Private-duty Nursing
- Routine Foot Care
- Weight Loss Programs
- Infertility Treatment
- Routine Eye Care Adult

## Your Rights to Continue Coverage:

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For more information on your rights to continue coverage, contact the plan at 855-236-3272. 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.

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## Does this Coverage Provide Minimum Essential Coverage?

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- 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.

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## 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.

# Plan H (6350 Deductible/100% Plan)

**Coverage Period:** 1/1/2017-12/31/2017 **Summary of Benefits and Coverage: What this Plan Covers & What it Costs**
**Coverage for: Employee, Spouse, 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.bpatpa.com or by calling 1-800-277-8973

| Important Questions | Answers | Why this Matters: |
|---|---|---|
| **What is the overall deductible?** | Participating providers, $6,350 person; $12,700 family; Non Par providers, $12,700 person; $25,400 family; Does not apply to preventive care/Co-pays. | For the services applicable, you must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. Check your 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. For Participating providers $6,350 person/$12,700 family. For Non Par providers $25,400 person/$50,800 family | 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, Prescription Drugs, balance-billed charges, health care this plan does not cover. | 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 a list of Network Providers, see www.multiplan.com/search/search-2.cfm?originator=84451. | 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 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 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 the 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. |

**Questions:** Call 1-877-353-0633 or visit us at **www.bpatpa.com**
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OMB Control Numbers 1545-2229, 1210-0147, and 0938-1146
Released on April 23, 2013 (corrected)

# Plan H (6350 Deductible/100% Plan)

**Coverage Period:** 1/1/2017-12/31/2017 **Summary of Benefits and Coverage: What this Plan Covers & What it Costs**
**Coverage for: Employee, Spouse, Family| Plan Type: PPO**

- **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 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 to treat an injury or illness | Deductible, then Plan pays 100% | Deductible, then 50% co-insurance | Non-network Plan payments are based on 140% of Medicare allowed amount. Patient may be balance billed. |
| | Specialist visit | Deductible, then Plan pays 100% | Deductible, then 50% co-insurance | Non-network Plan payments are based on 140% of Medicare allowed amount. Patient may be balance billed. |
| | Other practitioner office visit | Deductible, then Plan pays 100% | Deductible, then 50% co-insurance | Non-network Plan payments are based on 140% of Medicare allowed amount. Patient may be balance billed. |
| | Preventive care/screening/immunization | Plan pays 100% | No Benefit | |
| **If you have a test** | Diagnostic test (x-ray, blood work) | Deductible, then Plan pays 100% | Deductible, then 50% co-insurance | Non-network Plan payments are based on 140% of Medicare allowed amount. Patient may be balance billed. |
| | Imaging (CT/PET scans, MRIs) | Deductible, then Plan pays 100% | Deductible, then 50% co-insurance | Non-network Plan payments are based on 140% of Medicare allowed amount. Patient may be balance billed. |



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# Plan H (6350 Deductible/100% Plan)

**Coverage Period:** 1/1/2017-12/31/2017 **Summary of Benefits and Coverage: What this Plan Covers & What it Costs**
**Coverage for: Employee, Spouse, Family| Plan Type: PPO**

| 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 need drugs to treat your illness or condition**<br><br>More information about **prescription drug coverage** is available at www.rxedo.com | Generic drugs | Deductible, then Plan pays 100%, both retail and mail order | No Benefit | Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription) |
| | Preferred brand drugs | Deductible, then Plan pays 100%, both retail and mail order | No Benefit | Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription) |
| | Non-preferred brand drugs | Deductible, then Plan pays 100%, both retail and mail order | No Benefit | Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription) |
| | Specialty drugs | Deductible, then Plan pays 100% | No Benefit | Covers 30-day supply |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | Deductible, then Plan pays 100% | Deductible, then 50% co-insurance | Non-network Plan payments are based on 140% of Medicare allowed amount. Patient may be balance billed. |
| | Physician/surgeon fees | Deductible, then Plan pays 100% | Deductible, then 50% co-insurance | Non-network Plan payments are based on 140% of Medicare allowed amount. Patient may be balance billed. |
| **If you need immediate medical attention** | Emergency room services | Deductible, then Plan pays 100% | Deductible, then 50% co-insurance | Based on plan provisions |
| | Emergency medical transportation | Deductible, then Plan pays 100% | Deductible, then 50% co-insurance | Non-network Plan payments are based on 140% of Medicare allowed amount. Patient may be balance billed. |
| | Urgent care | Deductible, then Plan pays 100% | Deductible, then 50% co-insurance | Non-network Plan payments are based on 140% of Medicare allowed amount. Patient may be balance billed. |



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# Plan H (6350 Deductible/100% Plan)

**Coverage Period:** 1/1/2017-12/31/2017 **Summary of Benefits and Coverage: What this Plan Covers & What it Costs**
**Coverage for: Employee, Spouse, Family| Plan Type: PPO**

| 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 have a hospital stay** | Facility fee (e.g., hospital room) | Deductible, then Plan pays 100% | Deductible, then 50% co-insurance | Non-network Plan payments are based on 140% of Medicare allowed amount. Patient may be balance billed. |
| | Physician/surgeon fee | Deductible, then Plan pays 100% | Deductible, then 50% co-insurance | Non-network Plan payments are based on 140% of Medicare allowed amount. Patient may be balance billed. |
| **If you have mental health, behavioral health, or substance abuse needs** | Mental/Behavioral health outpatient services | Deductible, then Plan pays 100% | Deductible, then 50% co-insurance | Non-network Plan payments are based on 140% of Medicare allowed amount. Patient may be balance billed. |
| | Mental/Behavioral health inpatient services | Deductible, then Plan pays 100% | Deductible, then 50% co-insurance | Non-network Plan payments are based on 140% of Medicare allowed amount. Patient may be balance billed. |
| | Substance use disorder outpatient services | Deductible, then Plan pays 100% | Deductible, then 50% co-insurance | Non-network Plan payments are based on 140% of Medicare allowed amount. Patient may be balance billed. |
| | Substance use disorder inpatient services | Deductible, then Plan pays 100% | Deductible, then 50% co-insurance | Non-network Plan payments are based on 140% of Medicare allowed amount. Patient may be balance billed. |
| **If you are pregnant** | Prenatal and postnatal care | Deductible, then Plan pays 100% | Deductible, then 50% co-insurance | Non-network Plan payments are based on 140% of Medicare allowed amount. Patient may be balance billed. |
| | Delivery and all inpatient services | Deductible, then Plan pays 100% | Deductible, then 50% co-insurance | Non-network Plan payments are based on 140% of Medicare allowed amount. Patient may be balance billed. |



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**Coverage Period:** 1/1/2017-12/31/2017 **Summary of Benefits and Coverage: What this Plan Covers & What it Costs**
**Coverage for: Employee, Spouse, Family| Plan Type: PPO**

| 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 need help recovering or have other special health needs** | Home health care | Deductible, then Plan pays 100% | Deductible, then 50% co-insurance | Non-network Plan payments are based on 140% of Medicare allowed amount. Patient may be balance billed. |
| | Rehabilitation services | Deductible, then Plan pays 100% | Deductible, then 50% co-insurance | Non-network Plan payments are based on 140% of Medicare allowed amount. Patient may be balance billed. |
| | Habilitation services | Deductible, then Plan pays 100% | Deductible, then 50% co-insurance | Non-network Plan payments are based on 140% of Medicare allowed amount. Patient may be balance billed. |
| | Skilled nursing care | Deductible, then Plan pays 100% | Deductible, then 50% co-insurance | Non-network Plan payments are based on 140% of Medicare allowed amount. Patient may be balance billed. |
| | Durable medical equipment | Deductible, then Plan pays 100% | Deductible, then 50% co-insurance | Non-network Plan payments are based on 140% of Medicare allowed amount. Patient may be balance billed. |
| | Hospice service | Deductible, then Plan pays 100% | Deductible, then 50% co-insurance | Non-network Plan payments are based on 140% of Medicare allowed amount. Patient may be balance billed. |
| **If your child needs dental or eye care** | Eye exam | Plan covers 100% | No Covered | Based on plan provisions |
| | Glasses | Not covered | Not covered | Based on plan provisions |
| | Dental check-up | Not covered | Not covered | Based on plan provisions |

# Plan H (6350 Deductible/100% Plan)

**Coverage Period:** 1/1/2017-12/31/2017 **Summary of Benefits and Coverage: What this Plan Covers & What it Costs**
**Coverage for: Employee, Spouse, Family| Plan Type: PPO**

## 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
- Bariatric Surgery
- Cosmetic Surgery
- Dental care (Adults)
- Hearing Aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S. if travel is for sole purpose of obtaining medical services
- 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.)

- Chiropractic Care
- Private-duty nursing
- Urgent Care

## Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstance, 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 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 800-277-8973. 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, extension 61565 or www.cciio.cms.gov.

## Your Grievance and Appeals Rights:

**Questions:** Call 1-877-353-0633 or visit us at **www.bpatpa.com**
If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.bpatpa.com or call 1-877-353-0633 to request a copy.

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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:

Benefit Plan Administrators, Inc.
Po Box 11746
Roanoke, VA 24022-1746
1-800-277-8973

Department of Labor Employee Benefits Security Administration

1-866-444-EBSA (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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# Plan H (6350 Deductible/100% Plan)

**Coverage Period:** 1/1/2017-12/31/2017 **Summary of Benefits and Coverage: What this Plan Covers & What it Costs**
**Coverage for: Employee, Spouse, Family| Plan Type: PPO**

## 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** $2,190
- **Patient pays** $5,350

**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 | $5,200 |
| Copays | $0 |
| Coinsurance | $0 |
| Limits or exclusions | $150 |
| **Total** | **$5,350** |

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

- **Amount owed to providers:** $5,400
- **Plan pays** $50
- **Patient pays** $5,350

**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 | $5,270 |
| Copays | $0 |
| Coinsurance | $0 |
| Limits or exclusions | $80 |
| **Total** | **$5,350** |



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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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