Monterey Bay Public Employees Trust – EPO Plan

Coverage Period: 4/1/2016 – 3/31/2017

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.mbpet.net or by calling 1-888-742-3380.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$** 400 person/ $1,200 family; Waived for inpatient and outpatient hospital charges at Centers of Excellence and Hospitals of Distinction.	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. See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**. Does not apply to preventive care and prescription drugs.
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 preferred contract providers $1,400 person/$4,200 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. Deductibles, copayments, and coinsurance amounts are included in the out-of-pocket limit. Prescription drugs have a separate out-of-pocket limit (see page 3). **There is no coverage for non-contract providers.**
What is not included in the out–of–pocket limit?	Balance-billed charges, health care this plan doesn't cover, charges from non-contracted providers and penalties for failure to obtain pre-authorization of services.	Even though you pay these expenses, they don't count toward the **out–of–pocket limit**. Prescription drugs, Dental and Vision, are included in non-covered charges that do not accrue towards the medical plan out-of-pocket limit. (See plan booklet.)
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 visit**s.**
Does this plan use a network of providers?	Yes. For list of **preferred providers**, see www.mbpet.net or call **1-888-742-3380**.	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 starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	Yes. You must choose a Primary Care Physician. All written referrals must go through the PCP and be approved by the Network Manager.	This plan will pay some or all of the costs to see a **specialist** for covered services but only if you have the plan's written permission before you see the **specialist.** You do not need permission to access an Ob-Gyn.
Are there services this plan doesn't cover?	Yes.	Some services this plan doesn't cover are listed on page 6. See your *Plan Description Booklet* for additional information about **medical plan exclusions**.

Questions: Call 1-888-742-3380 or visit us at www.mbpet.net**.**
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.mbpet.net or call 1-888-742-3380 to request a copy.

- **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 plan's **allowed amount** for an overnight hospital stay is $1,000, your **co-insurance** 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 to treat an injury or illness	$20 Copayment	You are responsible for all charges	No coverage out-of-network. Applies to covered plan benefits only. See *Plan Booklet* for What is Not Covered.
	Specialist visit	$20 Copayment	You are responsible for all charges	
	Other practitioner office visit	$20 Copayment	You are responsible for all charges	
	Preventive care/screening/ immunization	No charge	You are responsible for all charges	Applies to covered plan benefits only.
	Chiropractic office	$10 copayment	You are responsible for all charges.	45 visit maximum per calendar year. Applies to covered plan benefits only.
If you have a test	Diagnostic test (x-ray, blood work)	20% Coinsurance	You are responsible for all charges	Applies to covered plan benefits only.
	Imaging (CT/PET scans, MRIs)	20% Coinsurance	You are responsible for all charges	CT, PET and MRI must be pre-certified or you are responsible for all charges. Applies to covered plan benefits only.

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 More information about **prescription drug coverage** is available at www.mbpet.net	Generic drugs	$10 Copayment at all other network pharmacies. Mail order: $20 copayment	The trust does not provide any coverage at non-network pharmacies. You are responsible for the full retail cost.	30 day supply retail 90 day supply mail order $0 copayment and 90 day supply at CVS. Copayments and coinsurances apply to a $5,200 individual out-of-pocket limit and a family out-of-pocket limit of $9,000.
	Preferred brand drugs	$30 Copayment. Mail order: $60 copayment		30 day supply retail 90 day supply mail order Copayments and coinsurances apply to a $5,200 individual out-of-pocket limit and a family out-of pocket limit of $9,000.
	Non-preferred brand drugs	$50 Copayment. Mail order: $100 copayment		30 day supply retail 90 day supply mail order Copayments and coinsurances apply to a $5,200 individual out-of-pocket limit and a family out of pocket limit of $9,000
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% Coinsurance at network facilities	You are responsible for all charges	Coinsurance reduced to 10% at Monterey Bay Area Contracted Hospitals 25% increase to participant coinsurance if precertification requirement is not met (except in emergencies). Maximum benefit Amounts apply for certain procedures. See *Plan Booklet.*
	Physician/surgeon fees	20% Coinsurance	You are responsible for all charges	
If you need immediate medical attention	Emergency room services	$200 copay then 20% Coinsurance	$200 copay then 20% coinsurance	Coinsurance reduced to 10% at Monterey Bay Area Contracted Hospitals
	Emergency medical transportation	20% Coinsurance	Charges in excess of 80% UCR	Applies to covered plan benefits only.
	Urgent care	20% Coinsurance	You are responsible for all charges	Applies to covered plan benefits only.

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)	20% Coinsurance at network facilities	You are responsible for all charges	Coinsurance reduced to 10% at Monterey Bay Area Contracted Hospitals. 25% increase to participant coinsurance if precertification requirement is not met (except in emergencies). Maximum benefit Amounts apply for certain procedures. See *Plan Booklet.*
	Physician/surgeon fee	20% Coinsurance	You are responsible for all charges	
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	No charge for the first 5 visits; $20 Copay thereafter	You are responsible for all charges	Benefits are provided through Claremont Behavioral Services. Applies to covered plan benefits only.
	Mental/Behavioral health inpatient services	20% Coinsurance at network facilities	You are responsible for all charges	Coinsurance reduced to 10% at Monterey Bay Area Contracted Hospitals. 25% increase to participant coinsurance if precertification requirement is not met (except in emergencies). Maximum of 2 treatment programs per lifetime.
	Substance use disorder outpatient services	20% Coinsurance	You are responsible for all charges	Benefits are provided through Claremont Behavioral Services. Applies to covered plan benefits only.
	Substance use disorder inpatient services	20% Coinsurance	You are responsible for all charges	Coinsurance reduced to 10% at Monterey Bay Area Contracted Hospitals. 25% increase to participant coinsurance if precertification requirement is not met (except in emergencies). .
If you are pregnant	Prenatal and postnatal care	20% Coinsurance	You are responsible for all charges.	No charge for well baby care and immunizations covered under the Affordable Care Act. Applies to covered plan benefits only.

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
	Delivery and all inpatient services	20% Coinsurance	You are responsible for all charges.	Co-insurance reduced to 10% at Monterey Bay Area Contracted Hospitals. 25% increase to participant coinsurance if precertification requirement is not met (except in emergencies). Applies to covered plan benefits only.
If you need help recovering or have other special health needs	Home health care	20% Coinsurance	You are responsible for all charges	Applies to covered plan benefits only.
	Rehabilitation services	20% Coinsurance	You are responsible for all charges	Applies to covered plan benefits only.
	Habilitation services	Not Covered	Not Covered	
	Skilled nursing care	20% Coinsurance	You are responsible for all charges	100 day calendar year maximum. Precertification required. Applies to covered plan benefits only.
	Durable medical equipment	20% Coinsurance	You are responsible for all charges	Preauthorization is required. See Booklet for replacement limitations.
	Hospice service	20% Coinsurance	You are responsible for all charges	Maximum lifetime benefit of $7,500. Bereavement counseling limited to 2 visits. Precertification required. Applies to covered plan benefits only.
If your child needs dental or eye care	Eye exam	**Under age 19 years:** No charge for preventative care eye exam. **Ages 19 years and over:**		See "Vision Service Plan brochure" for full Benefit Schedule.
	Glasses			See "Vision Service Plan brochure" for full Benefit Schedule.
	Dental check-up	No charge for preventative services. You are responsible for charges exceeding 70% of Premier contract allowance.		Contract allowance benefits increases 10% with at least one annual dental visit. You are responsible for charges exceeding the annual limit. See "Delta Dental brochure" for full Benefit Schedule.

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
- Cosmetic Surgery
- Dental Care (Adult)
- Hearing Aids (requires precertification
- Infertility Treatment
- Long Term Care
- Medically Unnecessary Care
- Private Duty Nurse
- Routine Eye 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
- Chiropractic Care
- Non-Emergency care when traveling outside of U.S.
- Routine Foot Care

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 (888)-742-3380. You may also contact your state insurance department 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 Department of Health and Human Services Health Insurance Assistance Team at 1-888-393-2789. You can also contact HS&BA at (831) 757-1711.Additionally, a consumer assistance program can help you file your appeal. Contact the Department of Managed Health Care Help Center in your state.

Language Access Services:

Written translations are available in the following languages within 7 business days by contacting plan representatives at the phone numbers below:
Spanish (Español): Para obtener asistencia en Español, llame al 1-888-742-3380

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** $6,390
- **Patient pays** $1,150

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	$400
Co-pays	$0
Co-insurance	$600
Limits or exclusions	$150
Total	**$1,150**

Note: This example excludes any hospital charges to the newborn.

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

- **Amount owed to providers:** $5,400
- **Plan pays** $4,320
- **Patient pays** $ 1,080

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	$400
Co-pays	$430
Co-insurance	$170
Limits or exclusions	$80
Total	**$1,080**

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**, **co-payments**, and **co-insurance** 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 **co-payments**, **deductibles**, and **co-insurance**. 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.