Independent Health

Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services

Coverage Period:

Genesee County: Health & Wellness 5/10 Plan (GC66)

Coverage for: 1/1/2018 – 12/31/2018 | **Plan Type:** PPO

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this ____ (called the premium) will be provided separately.

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, please contact your Human Resources Department. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at http://www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf.or call 1-800-257-2753 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**In-Network**: $0 **Out-of-Network**: $150 Individual / $300 Family	Generally, you must pay all of the costs from providers up to the deductible amount before the plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered deductible?	**Yes**	Preventive care. This plan covers items and services even if you haven't met the deductible amount. But a copayment or coinsurance may apply.
Are there other deductibles for specific services?	**No**	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	**In-Network**: $0 **Out-of-Network**: $1,250 Individual / $2,500 Family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Cost Containment Penalties, Premiums, Balance-billed Charges (unless balance billing is prohibited), health care services this plan doesn't cover	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider	Yes. See www.independenthealth.com for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist	No	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$15 copay	20% coinsurance after Deductible	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
	Specialist visit	$15 copay	20% coinsurance after Deductible	--None--
	Preventive care/screening/ immunization	No charge	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
`If you have a test	Diagnostic test (x-ray, blood work)	X-Ray: $15 copay Laboratory: No charge	20% coinsurance after Deductible	--None--
	Imaging (CT/PET scans, MRIs)	$15 copay	20% coinsurance after Deductible	Member Precertification may be required. Failure to obtain precertification could result in up to 50% reduction in eligible expenses for each instance.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.pbdrx.com	Generic drugs / Tier 1	Retail: $5 copay Mail Order: $5 copay	Not covered.	Must be filled at a participating pharmacy. Retail: 30 day supply Mail Order: 90 day supply
	Preferred brand drugs / Tier 2	Retail: $10 copay Mail Order: $10 copay	Not covered.	Must be filled at a participating pharmacy. Retail: 30 day supply Mail Order: 90 day supply
	Non-preferred brand drugs / Tier 3	Retail: $10 copay Mail Order: $10 copay	Not covered.	Must be filled at a participating pharmacy. Retail: 30 day supply Mail Order: 90 day supply
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$50 copay	20% coinsurance after Deductible	Member Precertification may be required. Failure to obtain precertification could result in up to 50% reduction in eligible expenses for each instance.

* For more information about limitations and exceptions, please contact your Human Resources Department.

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Physician/surgeon fees	No charge	20% coinsurance after Deductible	Member Precertification may be required. Failure to obtain precertification could result in up to 50% reduction in eligible expenses each instance.
If you need immediate medical attention	Emergency room care	$50 copay	Covered as in-network benefit	Copayment waived if admitted
	Emergency medical transportation	$75 copay	Covered as in-network benefit	Must be deemed medically necessary. Wheelchair van transportation is not covered.
	Urgent care	$15 copay	Not Applicable	Coverage based on Participating After Hours Urgent Care Center
If you have a hospital stay	Facility fee (e.g., hospital room)	$250 copay	20% coinsurance after Deductible	Maximum 1 copay per individual/ 2 copays per family per year. Member Precertification may be required. Failure to obtain precertification could result in up to a 50% reduction of the eligible expenses up to a maximum of $500 for each instance.
	Physician/surgeon fees	No charge	20% coinsurance after Deductible	Member Precertification may be required. Failure to obtain precertification could result in up to a 50% reduction of the eligible expenses up to a maximum of $500 for each instance.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$15 copay	20% coinsurance after Deductible	-None-
	Inpatient services	$250 copay	20% coinsurance after Deductible	Maximum 1 copay per individual/ 2 copays per family per year. Member Precertification may be required. Failure to obtain precertification could result in up to a 50% reduction of the eligible expenses up to a maximum of $500 for each instance.
If you are pregnant	Office visits	No charge after initial diagnosis	20% coinsurance after Deductible	Cost sharing does not apply for preventative services. If a visit is unrelated to Pregnancy, member liability may apply based on services rendered.

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Childbirth/delivery professional services	No charge	20% coinsurance after Deductible	Member Precertification may be required for Home Births. Failure to obtain precertification could result in up to a 50% reduction of the eligible expenses up to a maximum of $500 for each instance.
	Childbirth/delivery facility services	No charge	20% coinsurance after Deductible	Member Precertification may be required. Failure to obtain precertification could result in up to a 50% reduction of the eligible expenses up to a maximum of $500 for each instance.
If you need help recovering or have other special health needs	Home health care	$15 copay	20% coinsurance after Deductible	Up to 365 visits per plan year. In and Out-of-Network combined equal total benefit.
	Rehabilitation services	$15 copay	20% coinsurance after Deductible	Up to 20 visits per plan year (combined). In and Out-of-Network combined equal total benefit.
	Habilitation services	Not covered.	Not covered.	-None-
	Skilled nursing care	$0 copay	20% coinsurance after Deductible	Up to 120 days per plan year. In and Out-of-Network combined equal total benefit. Member Precertification may be required. Failure to obtain precertification could result in up to a 50% reduction of the eligible expenses up to a maximum of $500 for each instance.
	Durable medical equipment	$15 copay	20% coinsurance after Deductible	Member Precertification may be required. Failure to obtain precertification could result in up to 50% reduction in eligible expenses for each instance.
	Hospice services	No charge	20% coinsurance after Deductible	Hospice services shall include supplies & drugs.
If your child needs dental or eye care	Children's eye exam	Not covered.	Not covered.	
	Children's glasses	Not covered.	Not covered.	
	Children's dental check-up	Not covered.	Not covered.	-None-

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Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)		
• Acupuncture	• Dental care (Adult)	• Non-Emergency care when traveling outside the US
• Bariatric surgery	• Hearing aids	• Routine eye care (Adult)
• Cosmetic Surgery	• Long-term care	• Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Chiropractic care	• Private-duty nursing	
• Infertility treatment	• Routine foot care	

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Department of Health and Human Services, Center for Consumer Information and Insurance Oversight at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. You may also contact: Independent Health at 1-800-257-2753.

Does this plan provide Minimum Essential Coverage? **Yes**
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? **Yes**
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:
Spanish (Español): Para obtener asistencia en Español, llame al 1-800-257-2753.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-257-2753.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码1-800-257-2753.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-257-2753.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

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About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$0
Specialist copayment	$15
Hospital (facility) copayment	$250
Other coinsurance	20%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care*)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit *(anesthesia)*

Total Example Cost	**$12,731**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$150
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$210**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$0
Specialist copayment	$15
Hospital (facility) copayment	$250
Other coinsurance	20%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$7,389**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$35
Coinsurance	$115
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$205**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$0
Specialist copayment	$15
Hospital (facility) copayment	$250
Other coinsurance	20%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$1,925**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$150
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$150**

The plan would be responsible for the other costs of these EXAMPLE covered services.