

Blue Lake Rancheria Self-Insured Health Plan

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

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

Coverage for: Individual, +Spouse, +Child(ren), +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 by calling 1-707-668-5101 extension 1045.

| Important Questions | Answers | Why this Matters: |
|---|---|---|
| What is the overall <u>deductible</u> ? | \$500 person / \$1,000 spouse/child(ren)/family. Doesn't apply to preventive care and prescription drugs. | You must pay all the costs up to the <u>deductible</u> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <u>deductible</u> 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 <u>deductible</u> . |
| Are there other <u>deductibles</u> for specific services? | Yes. \$50 for dental coverage, except bi-annual cleanings & exam. There are no other specific <u>deductibles</u> . | You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this plan begins to pay for these services. |
| Is there an <u>out-of-pocket limit</u> on my expenses? | Yes. \$40,000 annually per individual. | The <u>out-of-pocket limit</u> 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. Grandfathered plans under the ACA are not required to place a limit out-of-pocket expenses, but we have voluntarily established a limit. |
| What is not included in the <u>out-of-pocket limit</u> ? | Premiums, balance-billed charges and health care this plan doesn't cover. | Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> . |
| 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 <i>specific</i> covered services, such as office visits. |
| Does this plan use a <u>network of providers</u> ? | Yes. See www.humboldtIPA.com or call 1-707-443-4563 for a list of participating providers. | If you use an in-network doctor or other health care <u>provider</u> , 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 <u>provider</u> for some services. Plans use the term in-network, <u>preferred</u> , or participating for <u>providers</u> in their <u>network</u> . See the chart starting on page 2 for how this plan pays different kinds of <u>providers</u> . |
| Do I need a referral to see a <u>specialist</u> ? | No. You don't need a referral to see a specialist. | You can see the <u>specialist</u> you choose without permission from this plan. |

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| | | |
|---|------|---|
| 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 . |
|---|------|---|



- **Copayments** are fixed dollar amounts (for example, \$30) 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 provider's office or clinic | Primary care visit to treat an injury or illness | \$30 copay/visit | 40% coinsurance | Waive deductible and copay when using international medical care benefit and receive 10% share of cost savings. |
| | Specialist visit | \$40 copay/visit | 40% coinsurance | Waive deductible and copay when using international medical care benefit and receive 10% share of cost savings. |
| | Other practitioner office visit, including chiropractic, acupuncture, occupational and physical therapy. | \$30 copay/visit | 40% coinsurance | Chiropractic care and acupuncture are limited to a combined maximum of \$2,500 per plan year. Waive deductible and copay when using international medical care benefit and receive 10% share of cost savings. |
| | Preventive care/screening/immunization | No charge/deductible | No charge/deductible | —————none————— |

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|---|--|--|---|--|
| If you have a test | Diagnostic test (x-ray, blood work) | \$30 copay/test | Not covered | —————none————— |
| | Imaging (CT/PET scans, MRIs) | \$30 copay/test | Not covered | —————none————— |
| If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.optum.com . | Generic drugs | \$10 copay/prescription (retail) and \$20 copay/prescription (mail order) | Not covered | Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription). |
| | Preferred brand drugs | \$40 copay/prescription (retail) and \$80 copay/prescription (mail order) | Not covered | Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription). |
| | Non-preferred brand drugs | \$70 copay/prescription (retail) and \$140 copay/prescription (mail order) | Not covered | Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription). |
| | Specialty drugs | 50% coinsurance | Not covered | —————none————— |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | 20% coinsurance | 40% coinsurance | Waive deductible and copay when using international medical care benefit and receive 10% share of cost savings. |
| | Physician/surgeon fees | 20% coinsurance | 40% coinsurance | Cosmetic/reconstruction surgery. Waive deductible and copay when using international medical care benefit and receive 10% share of cost savings. |
| If you need immediate medical attention | Emergency room & ambulance services | 20% coinsurance | 20% coinsurance | —————none————— |
| | Emergency medical transportation | 20% coinsurance | 20% coinsurance | —————none————— |
| | Urgent care | \$40 copay | 20% coinsurance | —————none————— |

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| 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 have a hospital stay | Facility fee (e.g., hospital room) | 20% coinsurance | 40% coinsurance | Waive deductible and copay when using international medical care benefit and receive 10% share of cost savings. |
| | Physician/surgeon fee | 20% coinsurance | 40% coinsurance | Waive deductible and copay when using international medical care benefit and receive 10% share of cost savings. |
| If you have mental health, behavioral health, or substance abuse needs | Mental/Behavioral health outpatient services | \$30 copay/office visit and 20% coinsurance for other outpatient services | 40% coinsurance | —————none————— |
| | Mental/Behavioral health inpatient services | 20% coinsurance | 40% coinsurance | —————none————— |
| | Substance use disorder outpatient services | \$30 copay/office visit and 20% coinsurance for other outpatient services | 40% coinsurance | —————none————— |
| | Substance use disorder inpatient services | 20% coinsurance | 40% coinsurance | —————none————— |
| If you are pregnant | Prenatal and postnatal care | 20% coinsurance | 40% coinsurance | —————none————— |
| | Delivery and all inpatient services | 20% coinsurance | 40% coinsurance | —————none————— |
| If you need help recovering or have other special health needs | Home health care | 20% coinsurance | 40% coinsurance | —————none————— |
| | Rehabilitation services | 20% coinsurance | 40% coinsurance | —————none————— |
| | Habilitation services | 20% coinsurance | 40% coinsurance | —————none————— |
| | Skilled nursing care | 20% coinsurance | 40% coinsurance | —————none————— |
| | Durable medical equipment | 20% coinsurance | 40% coinsurance | —————none————— |
| | Hospice service | 20% coinsurance | 40% coinsurance | —————none————— |

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|---|-----------------------|---|---|--------------------------|
| If you or your child needs dental or eye care More information about <u>eye care</u> is available at www.VSP.com . | Eye exam | Not covered | Not covered | Not covered. |
| | Glasses/Contact Lens | Not covered | Not covered | Not covered. |
| | Dental check-up | \$50 deductible | Not covered | _____none_____ |

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.)

- Bariatric surgery
- Cosmetic surgery
- Infertility treatment
- Long-term care
- Private-duty nursing
- Routine foot care

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.)

- Acupuncture
- Chiropractic care
- Dental care (Adult)
- Hearing aids
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult)
- Weight loss programs

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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 [contact number]. 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: Humboldt Independent Practice Association, 2662 Harris St., Eureka, CA 95503. A Claimant whose claim for benefits or authorization is denied by the Contract Administrator may, within sixty (60) days after receipt of denial of the claim: require a review upon written request to Contract Administrator; review pertinent documents; and submit issues and comments in writing.

The Plan shall notify the Claimant of its decision on review within sixty (60) days after receipt of a request for review. Notice of the decision on review shall be in writing and shall include specific reasons for the decision with specific references to the pertinent Plan provision on which the decision is based. Such decision shall be final and binding upon all persons involved and upon the Employer.

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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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 \$5,232
- Patient pays \$2,308

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 | \$1,000 |
| Copays | \$0 |
| Coinsurance | \$1308 |
| Limits or exclusions | \$0 |
| Total | \$2,308 |

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

- Amount owed to providers: \$5,400
- Plan pays \$3,920
- Patient pays \$1,480

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 | \$500 |
| Copays | \$0 |
| Coinsurance | \$980 |
| Limits or exclusions | \$80 |
| Total | \$1,480 |

Note: These numbers assume the patient is participating in our diabetes wellness program. If you have diabetes and do not participate in the wellness program, your costs may be higher. For more information about the diabetes wellness program, please contact: www.humboldtIPA.com or 707-443-4563.

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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 or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

- ✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

- ✗ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

- ✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

- ✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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