

# Redwood Empire Municipal Insurance Fund

## EPO 500

Coverage Period: Begins on or after 07/01/2016

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

**Coverage for:**  
Individual + Spouse + Children

**Plan Type:**  
EPO



**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 <https://www.healthcomp.com> or by calling 1(800) 442-7247.

Important Questions	Answers	Why this Matters:
<b>What is the overall <u>deductible</u>?</b>	\$500 per person / \$1,500 family Doesn't apply to: urgent care, organ transplant travel meals and lodging, office visits, second surgical opinions, preventive services, mental health in an office setting, substance abuse in an office setting, hospice care, bariatric travel expenses and diabetes education.	You must pay all 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 1 <sup>st</sup> ). See the Common Medical Events section for how much you pay for covered services after you meet the <u>deductible</u> .
<b>Are there other <u>deductibles</u> for specific services?</b>	No.	You don't have to meet <u>deductibles</u> for specific services, but see the Common Medical Events section for other costs for services this plan covers.
<b>Is there an <u>out-of-pocket limit</u> on my expenses?</b>	Yes. Medical: \$3,400 per person; \$6,800 two party; \$10,000 family Prescription Drug: \$1,600 per person; \$3,200 family	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.
<b>What is not included in the <u>out-of-pocket limit</u>?</b>	Premiums, utilization management program penalties, 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> .
<b>Is there an overall annual limit on what the plan pays?</b>	No.	The Common Medical Events section describes <i>specific</i> coverage limits, such as limits on the number of office visits.
<b>Does this plan use a <u>network</u> of <u>providers</u>?</b>	Yes. See <a href="http://www.healthcomp.com">www.healthcomp.com</a> or call 1(800) 442-7247 for a list of <u>network providers</u> .	If you use a <u>network</u> doctor or other health care <u>provider</u> , this plan will pay some or all of the costs of covered services. Be aware, your <u>network</u> doctor or hospital may use a non-network <u>provider</u> for some services. Plans use the term <u>network</u> , <u>preferred</u> , or participating for <u>providers</u> in their <u>network</u> . See the Common Medical Events section for how this plan pays different kinds of <u>providers</u> .

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Important Questions	Answers	Why this Matters:
<b>Do I need a referral to see a <u>specialist</u>?</b>	No. You don't need a referral to see a <u>specialist</u> .	You can see the <u>specialist</u> you choose without permission from this plan.
<b>Are there services this plan doesn't cover?</b>	Yes.	Some of the services this plan doesn't cover are listed in the Excluded Services and Other Covered Services section. See your policy or plan document for additional information about <u>excluded services</u> .



- 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 cost of a covered service, calculated as a percent of the allowed amount for the service. For example, if the plan's allowed amount of 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 a non-network provider charges more than the allowed amount, you may have to pay the difference. For example, if a non-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 network providers by charging you lower deductibles, copayments and coinsurance amounts.

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Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider *	Limitations & Exceptions
<b>If you visit a health care provider's office or clinic</b>	Primary care visit to treat an injury or illness	\$30 copay/visit	Not covered	Copay applies to office visit charges only. Additional services billed at the time of the visit may be subject to deductible and applicable coinsurance.
	Specialist visit	\$40 copay/visit	Not covered	Copay applies to office visit charges only. Additional services billed at the time of the visit may be subject to deductible and applicable coinsurance.
	Other practitioner office visit	Acupuncture or Chiropractic care: 10% coinsurance	Acupuncture or Chiropractic care: Not covered	Acupuncture: 12 visits per plan year. Chiropractic care: 24 visits per plan year combined with occupational therapy and physical therapy.
	Preventive care/screening/immunization	No charge	Not covered	As defined by the Patient Protection Affordable Care Act.
<b>If you have a test</b>	Diagnostic test (x-ray, blood work)	10% coinsurance	Not covered	None.
	Imaging (CT/PET scans, MRIs)	10% coinsurance	Not covered	Subject to utilization review.

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<b>If you need drugs to treat your illness or condition</b>  More information about <u>prescription drug coverage</u> is available at <a href="http://www.envisionrx.com">www.envisionrx.com</a>	Tier 1 – Typically Generic	Retail: \$15 Mail order: \$23	Retail: \$15 plus all charges in excess of allowable charge Mail order: Not covered	Retail is limited to a 30 day supply. Mail order is limited to a 90 day supply.
	Tier 2 - Preferred Brand Name Drugs	Retail: \$35 Mail order: \$53	Retail: \$35 plus all charges in excess of allowable charge Mail order: Not covered	Retail is limited to a 30 day supply. Mail order is limited to a 90 day supply.
	Tier 3 - Non-Preferred Brand Name Drugs	Retail: \$50 Mail order: \$75	Retail: \$50 plus all charges in excess of allowable charge Mail order: Not covered	Retail is limited to a 30 day supply. Mail order is limited to a 90 day supply.
	Tier 4 – Typically Specialty Drugs (includes self-administered injectable drugs, except insulin)	Mail order: \$150	Not covered	Limited to a 30 day supply.

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Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider *	Limitations & Exceptions
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	Not covered	Certain surgeries are subject to utilization review.
	Physician/surgeon fees	10% coinsurance	Not covered	None.
<b>If you need immediate medical attention</b>	Emergency room services	\$150 copay/visit	\$150 copay/visit	Copay waived if admitted. This is for the hospital facility charge only. The emergency room physician may be separate.
	Emergency medical transportation	10% coinsurance	10% coinsurance	None.
	Urgent care	\$30 copay/visit	\$30 copay/visit	None.
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	10% coinsurance	Not covered	Subject to utilization review for inpatient services and certain outpatient services; waived for emergency admissions.
	Physician/surgeon fee	10% coinsurance	Not covered	None.

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<b>If you have mental health, behavioral health, or substance abuse needs</b>	Mental/Behavioral health outpatient services	Office Setting: \$30 copay/visit Outpatient: 10% coinsurance	Not covered	None.
	Mental/Behavioral health inpatient services	10% coinsurance	Not covered	Subject to utilization review for inpatient services and certain outpatient services; waived for emergency admissions.
	Substance use disorder outpatient services	Office Setting: \$30 copay/visit Outpatient: 10% coinsurance	Not covered	None.
	Substance use disorder inpatient services	10% coinsurance	Not covered	Subject to utilization review for inpatient services and certain outpatient services; waived for emergency admissions.
<b>If you are pregnant</b>	Prenatal and postnatal care	Prenatal: No charge Postnatal: \$30 copay/visit	Not covered	None.
	Delivery and all inpatient services	10% coinsurance	Not covered	None.

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Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider *	Limitations & Exceptions
<b>If you need help recovering or have other special health needs</b>	Home health care	10% coinsurance	Not covered	Subject to utilization review. Coverage is limited to a total of 100 visits/plan year (one visit by a home health aide equals four hours or less).
	Rehabilitation services	10% coinsurance	Not covered	24 visits combined for chiropractic care, physical therapy and occupational therapy. Additional visits allowed for physical and occupational therapies if medically necessary.
	Habilitation services	10% coinsurance	Not covered	All rehabilitation and habilitation visits count toward your rehabilitation visit limit where applicable.
	Skilled nursing care	10% coinsurance	Not covered	Subject to utilization review. Coverage is limited to a combined total of 100 days per plan year.
	Durable medical equipment	10% coinsurance	Not covered	May be subject to utilization review.
	Hospice service	No charge	Not covered	None.
<b>If your child needs dental or eye care</b>	Eye exam	Not covered	Not covered	Must enroll in separate vision plan for vision benefits.
	Glasses	Not covered	Not covered	Must enroll in separate vision plan for vision benefits.
	Dental check-up	Not covered	Not covered	Must enroll in separate dental plan for dental benefits.

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### Excluded services & Other Covered Services:

<b>Services your Plan Does Not Cover</b> (This isn't a complete list. Check your policy or plan document for other <u>excluded services</u> .)		
<ul style="list-style-type: none"><li>• Cosmetic surgery</li><li>• Dental care (Adult)</li><li>• Infertility treatment</li></ul>	<ul style="list-style-type: none"><li>• Long-term care</li><li>• Non-emergency care when traveling outside the U.S.</li><li>• Private-duty nursing</li></ul>	<ul style="list-style-type: none"><li>• Routine eye care (Adult)</li><li>• Routine foot care</li><li>• Weight loss programs</li></ul>

<b>Other Covered Services</b> (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)	
<ul style="list-style-type: none"><li>• Acupuncture</li><li>• Bariatric surgery</li></ul>	<ul style="list-style-type: none"><li>• Chiropractic care</li><li>• Hearing aids</li></ul>

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## Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a premium, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at (800) 442-7247. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1 (866) 444-3272 or [www.dol.gov/ebsa](http://www.dol.gov/ebsa), or the U.S. Department of Health and Human Services at 1 (877) 267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov).

## Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact: HealthComp Administrators at 1(800) 442-7247.

## Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as “minimum essential coverage.” **This plan or policy does provide minimum essential coverage.**

## Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

## Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-442-7247.

-----*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)		Managing type 2 diabetes (routine maintenance of a well-controlled condition)	
<ul style="list-style-type: none"> <li>▪ Amount owed to providers: <b>\$7,540</b></li> <li>▪ Plan pays <b>\$6,225</b></li> <li>▪ Patient pays <b>\$1,315</b></li> </ul>		<ul style="list-style-type: none"> <li>▪ Amount owed to providers: <b>\$5,400</b></li> <li>▪ Plan pays <b>\$4,400</b></li> <li>▪ Patient pays <b>\$1,000</b></li> </ul>	
<b>Sample care costs:</b>		<b>Sample care costs:</b>	
Hospital charges (mother)	\$2,700	Prescriptions	\$2,900
Routine Obstetric care	\$2,100	Medical Equipment and Supplies	\$1,300
Hospital Charges (baby)	\$900	Office Visits and Procedures	\$700
Anesthesia	\$900	Education	\$300
Laboratory tests	\$500	Laboratory tests	\$100
Prescriptions	\$200	Vaccines, other preventive	\$100
Radiology	\$200	<b>Total</b>	<b>\$5,400</b>
Vaccines, other preventive	\$40		
<b>Total</b>	<b>\$7,540</b>	<b>Patient Pays:</b>	
		Deductibles	\$500
<b>Patient Pays:</b>		Copays	\$330
Deductible	\$500	Coinsurance	\$90
Copays	\$135	Limits or exclusions	\$80
Coinsurance	\$680	<b>Total</b>	<b>\$1,000</b>
Limits or exclusions	\$0		
<b>Total</b>	<b>\$1,315</b>		

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## Questions and answers about the Coverage Examples:

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### 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 exclusion.
- All services and treatment 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 [network providers](#). If the patient had received care from non-network [providers](#), costs would have been higher.

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### What does a Coverage Example show?

For each treatment situation, the coverage 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.

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### 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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### 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.

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### 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.

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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.

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