HRA
Health Reinsurance Association

Options PPO Portability Plan

Coverage Period: 01/01/2016 /12/31/2016

Summary of Benefits and Coverage: What This Plan Covers & What it Costs **Coverage for: Member & 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 the Health Reinsurance Association (HRA) at 1-800-842-0004.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network: **$1,500** Individual / **$3,000** Family Non-Network: **$3,000** Individual / **$6,000** Family Per calendar year. Does not apply to copays, prescription drugs, and services listed below as "No Charge".	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?	Yes, Prescription drugs: **$250** Individual / **$500** Family	You must pay all the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
Is there an out-of-pocket limit on my expenses?	Network: **$7,500** Individual / **$15,000** Family Non-Network: **$15,000** Individual / **$30,000** 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?	Premium, prescription drug copays, balance-billed charges, health care this plan doesn't cover and penalties for failure to obtain for services.	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. There is a lifetime maximum of **$1,500,000**	The Common Medical Events chart 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, this plan uses network providers. If you use a non-network provider your cost may be more. For a list of network providers, see **www.myuhc.com** or call 1-866-873-3903 for a list of network providers.	If you use a network doctor or other health care provider, this plan will pay some or all of the costs of covered services. Be aware, your network doctor or hospital may use a non-network provider for some services. Plans use the term 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?	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 plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed under Services Your Plan Does NOT Cover. See your policy or plan document for additional information about excluded services.

- Co-payments (copays) are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- Co-insurance (co-ins) 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 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, co-payments and co-insurance amounts.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Network Provider	Non-Network Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% co-ins, after ded.	40% co-ins, after ded.	None
	Specialist visit	20% co-ins, after ded.	40% co-ins, after ded.	None
	Other practitioner office visit	20% co-ins, after ded. for Manipulative (Chiropractic) services	40% co-ins, after ded. for Manipulative (Chiropractic) services	Limited to 20 visits of Manipulative (Chiropractic) services per calendar year.
	Preventive care / screening / immunization	20% co-ins, after ded.	40% co-ins, after ded.	None
If you have a test	Diagnostic test (x-ray, blood work)	20% co-ins, after ded.	40% co-ins, after ded.	None
	Imaging (CT / PET scans, MRIs)	20% co-ins, after ded.	40% co-ins, after ded.	None

If you need drugs to treat your illness or condition More information about prescription drug coverage is available at **www.myuhc.com**	Tier 1 – Your Lowest-Cost Option Generic drugs	Retail: $10 copay, after ded. Mail-Order: $20 copay, after ded.	Retail: $10 copay, after ded. Mail-Order: $20 copay, after ded.	Provider means pharmacy for purposes of this section. Retail: Up to a 31 day supply Mail-Order: Up to a 90 day supply You may need to obtain certain drugs, including certain specialty drugs, from a pharmacy designated by us. Certain drugs may have a Pre-Notification requirement or may result in a higher cost. If you use a non-network Pharmacy, you are responsible for any amount over the allowed amount. You may be required to use a lower-cost drug(s) prior to benefits under your policy being available for certain prescribed drugs. Tier 1 Contraceptives covered at No Charge. See the website listed for information on drugs covered by your plan. Not all drugs are covered.
	Tier 2 – Your Midrange-Cost Option Preferred brand name drugs	Retail: $25 copay, after ded. Mail-Order: $50 copay, after ded.	Retail: $25 copay, after ded. Mail-Order: $50 copay, after ded.	
	Tier 3 – Your Highest-Cost Option Non-preferred brand name drugs	Retail: $40 copay, after ded. Mail-Order: $80 copay, after ded.	Retail: $40 copay, after ded. Mail-Order: $80 copay, after ded.	
	Tier 4 – Additional High-Cost Options Specialty drugs	Not Applicable	Not Applicable	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% co-ins, after ded.	40% co-ins, after ded.	None
	Physician / surgeon fees	20% co-ins, after ded.	40% co-ins, after ded.	None
If you need immediate medical attention	Emergency room services	20% co-ins, after ded.	40% co-ins, after ded.	Pre-authorization is required if you are confined in a Hospital. Penalty for failure to authorize a Covered Service: The combined penalty amount for the Facility Benefit and the Admitting Physician Benefit will be the lesser of 50% of

				the scheduled benefit or $500.
	Emergency medical transportation	20% co-ins, after ded.	40% co-ins, after ded.	The plan will pay up to the maximum allowable charges under the Department of Public Health.
	Urgent care	20% co-ins, after ded.	40% co-ins, after ded.	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% co-ins, after ded.	40% co-ins, after ded.	None
	Physician / surgeon fees	20% co-ins, after ded.	40% co-ins, after ded.	None
If you have mental health, behavioral health, or substance abuse needs	Mental / Behavioral health outpatient services	20% co-ins, after ded.	40% co-ins, after ded.	None
	Mental / Behavioral health inpatient services	20% co-ins, after ded.	40% co-ins, after ded.	None
	Substance use disorder outpatient services	20% co-ins, after ded.	40% co-ins, after ded.	None
	Substance use disorder inpatient services	20% co-ins, after ded.	40% co-ins, after ded.	None
If you become pregnant	Prenatal and postnatal care	20% co-ins, after ded.	40% co-ins, after ded.	None
	Delivery and all inpatient services	20% co-ins, after ded.	40% co-ins, after ded.	None
If you have a recovery or other special health needs	Home health care	20% co-ins, after ded.	40% co-ins, after ded.	Limited to 80 visits per calendar year. Pre-Notification is required non-network.
	Rehabilitation services	20% co-ins, after ded.	40% co-ins, after ded.	Any combination of outpatient rehabilitation services is limited to 30 visits per calendar year.
	Habilitation services	Not Covered	Not Covered	Not Covered
	Skilled nursing care	20% co-ins, after ded.	40% co-ins, after ded.	Limited to 120 days per calendar year.

				Pre-Notification is required non-network.
	Durable medical equipment	20% co-ins, after ded.	40% co-ins, after ded.	None
	Hospice service	20% co-ins, after ded.	40% co-ins, after ded.	Limited to 60 days per calendar year.
If your child needs dental or eye care	Eye exam	20% co-ins, after ded.	40% co-ins, after ded.	Limited to 1 exam every 2 years. Eye refractions are not covered.
	Glasses	Not Covered	Not Covered	No coverage for Glasses.
	Dental check-up	Not Covered	Not Covered	No coverage for Dental check-up.

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 • Dental Care (Adult/Child)	• Glasses • Long-term care • Weight Loss Programs	• Non-emergency care when traveling outside the U.S. • Routine eye care (Adult) • 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 - may be covered with limitations • Hearing aids - may be covered with limitations	• Infertility Treatment- may be covered with limitations	• Private-duty nursing- may be covered with limitations

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 Member Service number listed on the back of your ID card or visit www.myuhc.com.

Additionally, a consumer assistance program may help you file your appeal. A list of states with Consumer Assistance Programs is available at www.dol.gov/ebsa/healthreform and http://cciio.cms.gov/programs/consumer/capgrants/index.html.

Para obtener asistencia en español, llame al número de teléfono en su tarjeta de identificación.
若需要中文协助，请拨打您会员卡上的电话号码
Dine k'ehji shich'i' hadoodzih ninizingo, bee neehozin biniiye nanitinigii number bikaa'igii bich'i' hodiilnih
Para sa tulong sa Tagalog, tawagan ang numero sa iyong

----------*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** $4,840
- ☐ **Patient Pays** $2,700

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	$1,500
Co-pays	$0
Co-insurance	$1,000
Limits or exclusions	$200
Total	**$2,700**

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

- ☐ **Amount owed to providers:** $5,400
- ☐ **Plan Pays** $3,220
- ☐ **Patient Pays** $2,180

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	$1,500
Co-pays	$600
Co-insurance	$0
Limits or exclusions	$80
Total	**$2,180**

Questions and answers about 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 to 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.
- If other than individual coverage, the Patient Pays amount may be more.

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.

Questions: Call HRA at 1-800-842-0004. If you aren't clear about any of the terms used in this form, see the Glossary.
You can view the Glossary at www.dol.gov/ebsa/healthreform or call the phone number above to request a copy. **This is only a summary**.
It in no way modifies your benefits as described in your plan documents. Please refer to your plan documents provided by HRA for complete terms of this plan.