



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.consociate.com or by calling **1-800-798-2422**.

Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u> ?	\$1,000 person / \$3,000 family for Tier 1, Tier II and Tier III.	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 <u>deductibles</u> 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 <u>out-of-pocket limit</u> on my expenses?	Yes. \$1,000 person / \$3,000 family for Tier 1 and Tier II and \$3,000 person / \$6,000 family for Tier III.	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 <u>out-of-pocket limit</u> ?	Premiums, deductibles, balance-billed charges, copayments, charges in excess of any maximums, pre-certification penalties and health care this plan doesn't cover.	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.	This plan will pay for covered services only up to this limit during each coverage period, even if your own need is greater. You're responsible for all expenses above this limit. The chart starting on page 2 describes specific coverage limits, such as limits on the number of office visits.
Does this plan use a <u>network of providers</u> ?	Yes. See www.healthlink.com or call 1-800-624-2356 for a list of participating providers.	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 <u>specialist</u> ?	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 on page 5. See your policy or plan document for additional information about excluded services .

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Employees of Jackson County Government Group Health Care Plan

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

Coverage Period: 12/01/2014 – 11/30/2015
 Coverage for: Employee + Dependents | Plan Type: PPO



- **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 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			Limitations & Exceptions
		Tier I Providers	Tier II Providers	Tier III Providers	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$20/visit		40% coinsurance	none
	Specialist visit	\$20/visit		40% coinsurance	none
	Other practitioner office visit	10% coinsurance		40% coinsurance	none
	Preventive care / screening / immunization	\$20/visit		40% coinsurance	Limited to \$300 per calendar year maximum, then deductible and coinsurance. NOTE: Immunizations for covered persons over age 16 are only covered if performed at the Jackson County Health Department.
If you have a test	Diagnostic test (x-ray, blood work)	No charge		40% coinsurance	none
	Imaging (CT/PET scans, MRIs)	10% coinsurance		40% coinsurance	Pre-certification required.

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		Tier I Providers	Tier II Providers	Tier III Providers	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.mycatamaranrx.com .	Generic drugs	\$10/prescription (retail) and \$20/prescription (mail order)	25% coinsurance not less than \$25/prescription or more than \$50/prescription (retail) and 25% coinsurance not less than \$50/prescription or more \$100/prescription (mail order)	25% coinsurance after copayment	Covers up to 30-day supply (retail prescription); 90-day supply (mail order prescription).
	Formulary Brand drugs				
	Non-Formulary Brand drugs				
	Specialty drugs	Covered under major medical if not available through pharmacy program			Please see Prescription Drug Benefit section within your Plan Document for details.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	40% coinsurance	Pre-certification is required.	
	Physician/surgeon fees	10% coinsurance	40% coinsurance	Pre-certification is required.	
If you need immediate medical attention	Emergency room services	\$50/visit			none
	Emergency medical transportation	10% coinsurance			none
	Urgent care	10% coinsurance	40% coinsurance	Pre-certification is required.	
	Facility fee (e.g., hospital room)	10% coinsurance	40% coinsurance	Pre-certification is required.	
If you have a hospital stay	Physician/surgeon fee	10% coinsurance	40% coinsurance	Pre-certification is required.	

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		Tier I Providers	Tier II Providers	Tier III Providers	
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	10% coinsurance		40% coinsurance	Pre-certification is required.
	Mental/Behavioral health inpatient services	10% coinsurance		40% coinsurance	Pre-certification is required.
	Substance use disorder outpatient services	10% coinsurance		40% coinsurance	Pre-certification is required.
	Substance use disorder inpatient services	10% coinsurance		40% coinsurance	Pre-certification is required.
	Prenatal and postnatal care	10% coinsurance		40% coinsurance	Pre-certification is required. Included in global fee.
If you are pregnant	Delivery and all inpatient services	10% coinsurance		40% coinsurance	Pre-certification is required.
	Home health care	10% coinsurance		40% coinsurance	Pre-certification is required. Limited to 100 visits per calendar year.
If you need help recovering or have other special health needs	Rehabilitation services	10% coinsurance		40% coinsurance	Pre-certification is required.
	Habilitation services	10% coinsurance		40% coinsurance	Pre-certification is required. Physical therapy is limited to 24 visits per calendar year.
	Skilled nursing care	10% coinsurance		40% coinsurance	Pre-certification is required.
	Durable medical equipment	10% coinsurance		40% coinsurance	Pre-certification is required on durable medical equipment over \$500. Limited to the lesser of the purchase price or the total anticipated rental charge.
	Hospice service	10% coinsurance		40% coinsurance	Pre-certification is required.
If your child needs dental or eye care	Eye exam		\$20/visit		Member must have vision coverage.
	Glasses			\$20/frames and \$20/lenses	Limited to \$200 per calendar year for all vision expenses. Member must have vision coverage.

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		Tier I Providers	Tier II Providers	Tier III Providers	
	Dental check-up		No charge		Limited to \$1,500 per calendar year for all tiers combined. Member must have dental coverage.

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.)					
<ul style="list-style-type: none"> • Acupuncture • Bariatric surgery • Cosmetic surgery 	<ul style="list-style-type: none"> • Hearing aids • Long-term care • Non-emergency care when traveling outside the U.S. 	<ul style="list-style-type: none"> • Routine foot 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.)					
<ul style="list-style-type: none"> • Chiropractic care (10 visit per calendar year for all tiers combined) • Dental care (\$1,500 per calendar year for all tiers combined. Dental coverage must be elected) 	<ul style="list-style-type: none"> • Infertility treatment (see plan document) • Private-duty nursing 	<ul style="list-style-type: none"> • Routine eye care (vision coverage must be elected) 			

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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 1-800-798-2422. 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.ccio.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 plan at 1-800-798-2422. You can also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

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.

Having a baby (normal delivery)

- Amount owed to providers: \$7,540
- Plan pays \$5,660
- Patient pays \$1,880

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	\$730
Limits or exclusions	\$150
Total	\$1,880

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

- Amount owed to providers: \$5,400
- Plan pays \$3,340
- Patient pays \$2,060

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	\$1,000
Copays	\$820
Coinsurance	\$160
Limits or exclusions	\$80
Total	\$2,060



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.

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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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