

# Washington Fire Comm'rs Assn Health Care Benefits Plan—Traditional

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

Coverage Period: 1/1/2017-12/31/2017

Coverage for: Individual + 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 plan document at [www.trustedplans.com](http://www.trustedplans.com) or by calling 1-800-426-9786.

Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u> ?	\$50 person/\$150 family. Does not apply to basic benefits, preventive care, outpatient prescription drugs and vision services.	You must pay all the costs up to the <b>deductible</b> amount before this plan begins to pay for covered services you use. Check your plan document to see when the <b>deductible</b> 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 <b>deductible</b> .
Are there other <u>deductibles</u> for specific services?	No	You don't have to meet <b>deductibles</b> 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. \$425 person/\$1,275 family. For outpatient prescription drugs: \$2,000 person/\$4,000 family.	The <b>out-of-pocket limit</b> 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, balance-billed charges, healthcare this plan doesn't cover, vision hardware ("for all others") coinsurance.	Even though you pay these expenses, they don't count toward the <b>out-of-pocket limit</b> .
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 specific covered services, such as office visits.
Does this plan use a <u>network</u> of <u>providers</u> ?	No	This plan treats <b>providers</b> the same in determining payment for the same services.
Do I need a referral to see a <u>specialist</u> ?	No	You can see the <b>specialist</b> 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 plan document for additional information about <b>excluded services</b> .

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- **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**.)

Your cost sharing does not depend on whether a provider is in a network.

Common Medical Event	Services You May Need	Your Cost If You Are an Employee	Your Cost If You Are a Dependent	Limitations & Exceptions
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	No charge		Deductible waived for employees. Deductible waived for dependents only if office visit due to an Injury.
	Specialist visit			
	Other practitioner office visit	No charge		Deductible waived for employees. Deductible waived for dependents for massage therapy and chiropractic care only. Acupuncture and massage therapy are limited to 16 visits/year each; chiropractic care is limited to 50% Coinsurance and 30 visits/year.
	Preventive care/screening/immunization	No charge		Deductible waived.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	No charge*	Deductible waived for employees. Deductible is waived for tests due to Dependent's Injury. *If tests are due to Dependent's Illness, paid in full up to \$100, then 80% Coinsurance after deductible.
	Imaging (CT/PET scans, MRIs)			

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<p><b>If you need drugs to treat your illness or condition</b></p> <p>More information about <u>prescription drug coverage</u> is available at <a href="http://www.maxor.com/maxorplus">www.maxor.com/maxorplus</a>.</p>	Generic drugs	<p><u>Preferred Providers:</u> Retail or Mail-Order: No charge</p> <p><u>Non-Preferred Providers:</u> Retail or Mail-Order: No charge</p>	<p><u>Preferred Providers:</u> Retail: \$10/Prescription Mail-Order: \$20/Prescription</p> <p><u>Non-Preferred Providers:</u> Retail (Only)**: 50% Coinsurance</p>	<p>Deductible waived for all drugs.</p> <p>Retail: Limited to a 34-day supply. Mail-Order: Limited to a 90-day supply.</p> <p>Limitations on Dependent Coverage: **No mail-order coverage from Non-Preferred Providers for Dependents.</p>
	Preferred brand drugs	<p><u>Preferred Providers:</u> Retail or Mail-Order: No charge</p>	<p><u>Preferred Providers:</u> Retail: \$15/Prescription Mail-Order: \$30/Prescription</p>	<p>No coverage for Dependents eligible for Medicare.</p>
	Non-preferred brand drugs	<p><u>Non-Preferred Providers:</u> Retail or Mail-Order: No charge</p>	<p><u>Non-Preferred Providers:</u> Retail (Only)**: 50% Coinsurance</p>	
	Specialty drugs	Same as any other drug.		Limited to a 34-day supply.
<p><b>If you have outpatient surgery</b></p>	Facility fee (e.g., ambulatory surgery center)	No charge		Deductible waived.
	Physician/surgeon fees	No charge		Deductible waived for employees only.
<p><b>If you need immediate medical attention</b></p>	Emergency room services	No charge	\$50/Visit	Deductible waived. Dependent's Copay is waived if admitted to Hospital.
	Emergency medical transportation	Paid in full up to \$150, then 80% Coinsurance		Deductible waived.
	Urgent care	No charge		Deductible waived for employees. Deductible waived for dependents only if visit due to an Injury.
<p><b>If you have a hospital stay</b></p>	Facility fee (e.g., hospital room)	No charge		Deductible waived for first 365 days/ Lifetime. After 365 days, 80% coinsurance after deductible.
	Physician/surgeon fee	No charge		Deductible waived for employees only.

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If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	No charge		Deductible waived for employees only.
	Mental/Behavioral health inpatient services	No charge		Deductible waived.
	Substance use disorder outpatient services	No charge		Deductible waived for employees only.
	Substance use disorder inpatient services	No charge		Deductible waived.
If you are pregnant	Prenatal and postnatal care	No charge		Deductible waived for employees only. Limited to employee & spouse only.
	Delivery and all inpatient services	No charge		Deductible waived. Limited to employee & spouse only.
If you need help recovering or have other special health needs	Home health care	No charge		Limited to 130 visits/year.
	Rehabilitation services	No charge		Inpatient: Deductible waived. Outpatient: Deductible waived for employees only.
	Habilitation services	No charge		Inpatient: Deductible waived. Outpatient: Deductible waived for employees only.
	Skilled nursing care	No charge		Deductible waived for employees only. Limited to 365 days/ Lifetime.
	Durable medical equipment	80% Coinsurance		-----none-----
	Hospice service	No charge		Limited to 6 mo. of care/ year.
If your child needs dental or eye care	Eye exam	No charge		Deductible waived. Limited to 1 exam/ year.
	Glasses	20% Coinsurance		Deductible waived. Limited to 1 pair/ 2 years.
	Dental check-up	Not covered		This Plan does not cover dental care.

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## Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your plan document for other <u>excluded services</u> .)		
• Bariatric Surgery	• Cosmetic Surgery	• Dental Care (Adult & Child)
• Infertility Treatment	• Long-Term Care	• Private-Duty Nursing
• Routine Foot Care	• Weight Loss Programs	• Non-emergent care when traveling outside the U.S.
Other Covered Services (This isn't a complete list. Check your plan document for other covered services and your costs for these services.)		
• Acupuncture	• Chiropractic Care	• Hearing Aids
• Routine Eye Care (Adult & Child)		

## 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: TPSC at (800) 426-9786 or visit us at [www.trustedplans.com](http://www.trustedplans.com). You may also contact the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform), 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: TPSC at (800) 426-9786 or visit us at [www.trustedplans.com](http://www.trustedplans.com); or refer to the appeals processes in the CLAIMS PROCEDURES section of your plan document. You may also contact the U.S. Department of Labor's Employee Benefit Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://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 does provide minimum essential coverage.**

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### 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 1-800-426-9786.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-426-9786.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码1-800-426-9786.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-426-9786.

-----*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 \$7,510
- Patient pays \$ 30

#### 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
<b>Total</b>	<b>\$7,540</b>

#### Patient pays:

Deductibles	\$0
Copays	\$0
Coinsurance	\$0
Limits or exclusions	\$30
<b>Total</b>	<b>\$30</b>

### Managing type 2 diabetes

(routine maintenance of a well-controlled condition)

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

#### 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
<b>Total</b>	<b>\$5,400</b>

#### Patient pays:

Deductibles	\$50
Copays	\$0
Coinsurance	\$250
Limits or exclusions	\$40
<b>Total</b>	<b>\$340</b>

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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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