

# SELF FUNDED PPO PLAN MEDICAL BENEFIT SUMMARY

## CHOICE OF PPO OR NON-PPO PROVIDERS

Washoe County has contracted with a Preferred Provider Organization (PPO) of health care providers. When obtaining health care services, a Covered Person has a choice of using providers who are participating in the PPO network or any other Covered Providers of his/her choice (Non-PPO Providers). However, using a Non-PPO Provider could result in higher out-of-pocket expenses.

**PPO Providers** - PPO Providers have agreed to provide services at negotiated rates. When a Covered Person uses a PPO Provider, his/her out-of-pocket expenses may be reduced because the Covered PPO Provider will not balance bill for expenses in excess of the PPO negotiated rate. Example: a PPO surgeon's fee for a tonsillectomy is \$3,000. The PPO negotiated rate for the tonsillectomy is \$1,500. Assuming the calendar year deductible has been met, the Plan would pay 80% of \$1,500 resulting in a payment to the PPO surgeon of \$1,200. The patient's out-of-pocket expense for a PPO tonsillectomy would be \$300 (20% of \$1,500). The PPO surgeon would write-off the \$1,500 as a discount and will not balance bill the patient.

**Non-PPO Providers** - If you receive services from a Non-PPO Provider, your out-of-pocket expenses may be greater because the Non-PPO Provider's fees will be subject to the negotiated rate that would have been allowed to a PPO Provider had you used one. Example: a Non-PPO surgeon's fee for a tonsillectomy is \$3,000. The PPO negotiated rate for the tonsillectomy is \$1,500. Assuming the calendar year deductible has been met, the Plan would pay 80% of \$1,500 resulting in a payment to the Non-PPO surgeon of \$1,200. The patient's out-of-pocket expenses would be \$300 (20% of \$1,500) **PLUS** the Non-PPO Provider can balance bill the patient for the \$1,500 that was in excess of Usual and Customary, making the patient's out-of-pocket expense for a Non-PPO tonsillectomy \$1,800. The amount in excess of Usual and Customary will not go towards the Individual or Family Out-of-Pocket Maximums.

**PREFERRED PROVIDER NETWORK**  
**Hometown Health**  
**(775) 982-5425 or (866) 988-5425**  
[www.hometownhealth.com](http://www.hometownhealth.com)

A complete listing of the PPO Providers is on Hometown Health's (HHP) website at [www.hometownhealth.com](http://www.hometownhealth.com) or you may call Hometown Health's customer service at (775) 982-5425 or (866) 988-5425. It is the responsibility of the Covered Person to verify that the provider is a PPO provider. If you require a specialty provider that is not represented in the PPO Network it is recommended that you contact Utilization Management to receive a pre-determination of benefits before receiving any services. See **Utilization Management Program** section.

**Covered Persons Residing Outside of Hometown Health PPO Service Area** - If you or a covered dependent permanently reside outside of the Hometown Health Self-Funded PPO network, your assigned PPO network is provided by PHCS. A listing of the PHCS Providers can be found at [www.multiplan.com](http://www.multiplan.com) or you may call PHCS customer service at (800) 678-7427.

**NOTE:** It is the Covered Member's responsibility to notify the Plan Sponsor if you or a covered dependent permanently reside outside of the Hometown Health PPO network. Notice is also required when/if you or your covered dependent's permanent residence changes and the PHCS network is no longer applicable.

Non-PPO Provider fees will be subject to the PPO negotiated rates. However, in the following circumstances Non-PPO Provider fees will be subject to the **Usual and Customary** allowance rather than the PPO negotiated rate. See **Definitions** section for **Usual and Customary**.

**Covered Persons Residing Outside of PPO Service Area** - If you permanently reside more than 50 miles from a PPO Provider, your local provider's fees will be covered at the **Usual and Customary** allowance.

**PPO PLAN MEDICAL BENEFIT SUMMARY, continued**

**Emergency Care** - If a Covered Person requires care for a **Medical Emergency** as defined below and is transported by an ambulance or private transportation to a Non-PPO facility, such Non-PPO fees will be subject to **Usual and Customary** instead of the PPO negotiated rate(s). If the **Medical Emergency** results in an inpatient hospitalization that is expected to exceed 3 days, **Utilization Management** will contact the Covered Person's treating physician to request that the **Covered Person** be transferred to the Plan's PPO facility once the treating physician determines his/her patient is medically stable for a safe transfer. If the Covered Person chooses not to transfer when medically stable for transfer, then the Non-PPO facility will be subject to the PPO negotiated rate(s) instead of **Usual and Customary** and may result in a greater out-of-pocket expense for the Covered Person. The treating physician is defined as the admitting physician for the inpatient stay or the physician overseeing the care of the patient during the inpatient stay.

A **Medical Emergency** is a situation which arises suddenly and which either poses a serious threat or causes serious impairment of bodily functions and which requires immediate medical attention or hospitalization. This includes conditions arising as the result of accidental bodily injury and any of the following conditions or symptoms: acute severe abdominal pains, poisoning, vomiting, acute chest pains (angina, suspected heart attack, coronary, pneumothorax), shortness of breath, asthma, allergic reaction to drugs, angioneurotic edema, convulsions, coma, syncope, fainting, shock, hemorrhage, acute urinary retention, epistaxis (severe nose bleed), or high fever of at least 104 degrees.

**Unavailable Services** - If a Covered Person requires a specialty provider that is not represented in the PPO Network such Non-PPO specialist fees will be covered using **Usual and Customary**, rather than the PPO negotiated rate. Before seeking specialty care from a Non-PPO Provider it is recommended that you, or the physician referring you to a Non-PPO Provider, contact Utilization Management to receive a pre-determination of benefits. See the **Utilization Management Program** section for additional information.

**Ancillary Services** - Services of a Non-PPO ancillary provider's fees (i.e. emergency room Physician, urgent care Physician, radiologist, pathologist, on-call Physician) will be covered using **Usual and Customary** rather than the PPO negotiated rate if such services are received while a Covered Person is being treated in a PPO emergency room, PPO Urgent Care Facility, PPO Ambulatory Surgery Center or confined in a PPO hospital facility.

**EXAMPLE OF HOW YOUR OUT-OF-POCKET EXPENSES** can be greater if you use the services of a Non-PPO Provider. John and Peter both had the same surgery performed, except Peter went to a Non-PPO Ambulatory Surgery Center.

John had outpatient surgery at a Preferred <b>PPO</b> Ambulatory Surgical Center. John's out-of-pocket expense was \$ 0.00.		Peter had outpatient surgery at a <b>Non-PPO</b> Ambulatory Surgical Center. Peter's out-of-pocket expense was \$4,575.26.	
<b>PPO Provider</b>		<b>Non-PPO Provider</b>	
Billed Amount	\$5,725.00	Billed Amount	\$5,725.00
PPO Negotiated Rate (Allowed Amount)	\$1,437.18	Negotiated Rate (Allowed Amount)	\$1,437.18
PPO Provider Discount <b>Not</b> Patient Responsibility	\$4,287.82	In excess of negotiated rate Patient Responsibility	\$4,287.82
Allowed Amount	\$1,437.18	Allowed Amount	\$1,437.18
Plan Pays 80% when using a Preferred Ambulatory Surgery Center	\$1,149.74	Plan Pays 80% of Negotiated rate (Allowable Amount)	\$1,149.74
<b>Patient Out-of-Pocket (Patient responsibility)</b> 20% of \$1,437.18	<b>\$287.44</b>	<b>Patient Out-of-Pocket (Patient responsibility)</b> 20% of \$1,437.18 PLUS \$4,287.82 in excess of negotiated rate.	<b>\$4,575.26</b>

**PPO PLAN MEDICAL BENEFIT SUMMARY, continued**

	<b>PPO In-Network</b>	<b>Non-PPO Out-of-Network</b>
<b>LIFETIME MAXIMUM</b>	Unlimited	
<b>MEDICAL DEDUCTIBLE MAXIMUM – Calendar Year</b>		
Individual Medical Deductible	\$ 375	
Family Medical Deductible	\$ 750	
<b>MEDICAL &amp; PRESCRIPTION OUT-OF-POCKET MAXIMUM Calendar Year</b>		
Individual Out-of-Pocket	\$ 3,450	\$ 6,675
Family Out-of-Pocket	\$ 6,900	\$ 13,350

**MEDICAL DEDUCTIBLE MAXIMUM**

**Individual Medical Deductible** - The Individual Deductible (\$375) is an amount which a Covered Person must contribute toward payment of eligible medical expenses each Calendar Year.

**Family Medical Deductible** - If eligible medical expenses equal to the Family Maximum Deductible (\$750) are incurred collectively by family members during a Calendar Year and are applied towards the Individual Deductible, then the Family Maximum Deductible is satisfied. For purposes of satisfying the Family Deductible, a “family” includes a covered Employee/Retiree, his Covered Spouse/Domestic Partner and/or Covered Dependent child(ren). No individual can have more than the \$375 Individual Deductible applied towards the Family Deductible.

If both the Covered Member and a Covered Spouse/Domestic Partner are employed by Washoe County and both are eligible and enrolled in the same PPO Plan, eligible expenses will be combined when calculating the family deductible.

**Deductible Carry-Over** - Eligible Expenses incurred in the last 3 months of a Calendar Year and applied toward that year’s Individual Deductible can be carried forward and applied toward the Covered Person’s Individual Deductible for the next Calendar Year.

**Common Injury Deductible** - If two or more family members sustain injury simultaneously during the same accident, only the amount of one deductible per calendar year will need to be satisfied by any or all such family members on account of such accident to qualify any of them for an Allowance on covered medical expenses arising from such accident.

**MEDICAL & PRESCRIPTION OUT-OF-POCKET MAXIMUM**

**Individual Out-of-Pocket Maximum** - Except as noted, a Covered Person will not be required to pay more than \$3,450 for In-Network services or \$6,675 for Out-of-network services in any Calendar Year toward his share of Eligible Expenses that are not paid by the Plan. Once he has paid the Out-of-Pocket Maximum, his Eligible Expenses will be paid at 100% for the balance of the Calendar Year except for the amounts/expenses listed below under **NOTE**.

**Family Out-of-Pocket Maximum** - The Out-of-Pocket Maximum applies “collectively” to a Covered Family. Except as noted, a Covered Family (Employee and his/her Dependents) will not be required to pay more than \$6,900 for In-network services or \$13,350 for Out-of-network services in any Calendar Year toward their share of Eligible Expenses. Once the family has paid their Family Out-of-Pocket Maximum, their Eligible Expenses will be paid at 100% for the balance of the Calendar Year, except for the amounts/expenses listed below under **NOTE**.

If both the Covered Member and a Covered Spouse/Domestic Partner are employed by Washoe County and both are eligible and enrolled in the same PPO Plan, eligible expenses will be combined when calculating the family Out-of-Pocket Maximum.

**NOTE:** The out-of-pocket maximums do not apply to or include:

- 1) amounts in excess of Usual, Customary and Reasonable as determined by the Plan;
- 2) expenses which become the Covered Person’s responsibility for failure to comply with the requirements of the Utilization Management Program;
- 3) expenses which become the Covered Person’s responsibility for services not covered by the Plan.

## SELF FUNDED PPO PLAN SCHEDULE OF BENEFIT PERCENTAGES

**IMPORTANT INFORMATION REGARDING NON-PPO ALLOWABLES (U&C)** - Except where expressly stated otherwise, where rates have been negotiated with providers participating in the PPO Network, such rates will apply to PPO Providers and will be used as the Plan's Usual and Customary (U&C) allowable for Non-PPO Providers. Non-PPO charges that are in excess of U&C will not be applied towards the Out-of-Pocket Maximum and will be the Covered Person's patient responsibility.

It is important to read the entire Plan Document. The Medical Benefit Summary section provides only the highlights of the Plan and should not be relied on to determine the extent to which a service or benefit is covered or excluded. See the **ELIGIBLE MEDICAL EXPENSES, MEDICAL LIMITATIONS AND EXCLUSIONS AND GENERAL EXCLUSIONS** sections for more information.

ELIGIBLE MEDICAL EXPENSES	Calendar Year Deductible (CYD)	PPO In-Network	Non-PPO Out-of-Network
<b>BILLED CHARGES ARE SUBJECT TO</b>	<b>PPO Network Rates (U&amp;C) See Important Information Above</b>		
<b>Ambulance</b>	Yes	80%	80%
<b>Ambulatory Surgical Center (ASC)</b>	Yes	80%	80% of U&C
<b>Acupuncture / Acupressure</b>	Yes	80%	80% of U&C
<b>Autism Spectrum Disorder, Limited to 1,200 total hours of therapy per Calendar Year</b>	Yes	80%	80% of U&C
<b>Behavioral Health Services</b> (Mental Health and Substance Abuse)			
Outpatient Physician Visit	No/Yes	\$25 co-pay	80% of U&C
Inpatient Physician Visit	Yes	80%	80% of U&C
Inpatient Facility	Yes	80%	\$500 co-pay + 80% of U&C
<b>Chiropractic Care</b> , up to 25 visits per Calendar Year.	Yes	80%	80% of U&C
<b>Diabetes Education</b>	Yes	80%	80% of U&C
<b>Diagnostic Lab &amp; X-ray</b>	Yes	80%	80% of U&C
<b>Durable Medical Equipment</b>	Yes	80%	80% of U&C
<b>Genetic Counseling and Testing</b>			
BRCA Counseling	No	100%	80% of U&C
BRCA1 and BRCA2 test	No	100%	80% of U&C
ApoE Counseling and test	Yes	80%	80% of U&C
Pregnancy specific counseling and tests	Yes	80%	80% of U&C
All other Genetic Counseling and Testing, not specifically listed, up to \$1,000 per Calendar Year.	Yes	80%	80% of U&C
<b>NOTE: See Genetic Counseling and Testing and Pregnancy under the ELIGIBLE MEDICAL EXPENSES for additional information.</b>			
<b>Hearing Aid and Related Exam</b> , limited to one (1) hearing aid per ear and one (1) exam every 36 months.	Yes	80%	80% of U&C

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ELIGIBLE MEDICAL EXPENSES	Calendar Year Deductible (CYD)	PPO In-Network	Non-PPO Out-of-Network
<b>BILLED CHARGES ARE SUBJECT TO</b>	<b>PPO Network Rates (U&amp;C) See Important Information Page 8</b>		
<b>Home Health Care</b> , up to 100 visits per Calendar Year	Yes	80%	80% of U&C
<b>Hospice Care</b>	Yes	80%	80% of U&C
<b>Hospital Services</b> Inpatient Services	Yes	80%	\$500 co-pay + 80% of U&C
Emergency Room Services	Yes	\$75 co-pay + 80%	\$75 co-pay + 80% of U&C
Outpatient Services	Yes	80%	80% of U&C
Inpatient Admission to a Non-PPO hospital will result in an additional co-payment of \$500, unless admitted through the emergency room or if you reside more than 50 miles from a PPO hospital. Hospital Emergency Room visit will result in an additional co-payment of \$75 unless admitted to the hospital through the emergency room.			
<b>Newborn Nursery</b>	Yes	80%	\$500 co-pay + 80% of U&C
<b>Orthopedic Shoes</b> , one pair up to \$500 per Calendar Year	Yes	80%	80% of U&C
<b>Orthotics / Shoe Inserts</b> Age 0-17, up to \$300 Lifetime	Yes	80%	80% of U&C
Age 18 and over, up to \$150 Lifetime	Yes	80%	80% of U&C
<b>Physical / Occupational Therapy</b>	Yes	80%	80% of U&C
<b>Physician, Primary Care (PCP)</b> Office Visit Only	No/Yes	\$25 co-pay	80% of U&C
Injection during the PCP office visit, per injection	No/Yes	\$5 co-pay	80% of U&C
Laboratory test during the PCP Office Visit, per test	No/Yes	\$5 co-pay	80% of U&C
X-ray taken during the PCP Office Visit, per test	No/Yes	\$5 co-pay	80% of U&C
All other services rendered during the PCP Office Visit	Yes	80%	80% of U&C
<b>Physicians, All Others</b>	Yes	80%	80% of U&C
<b>Primary Care Physician (PCP)</b> includes Family Practice, General Practice, Gynecology, Internal Medicine and Pediatrics. Specialist physicians include all others unless noted.			
<b>Prescription Drug Program through MaxorPlus</b> Generic	No	\$7 co-pay	
Preferred Brand	No	\$30 co-pay	
Non-Preferred Brand	No	\$50 co-pay	
Specialty Drugs	No	20% co-insurance	
MaxorPlus Specialty Copay Program for Eligible Specialty Drugs	No	Co-pay indicated on applicable manufacturer's coupon	
<b>Maintenance Drugs (mandatory mail-order, ≤ 90-day supply)</b> Generic	No	\$14 co-pay	
Preferred Brand	No	\$60 co-pay	
Non-Preferred Brand	No	\$100 co-pay	

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ELIGIBLE MEDICAL EXPENSES	Calendar Year Deductible (CYD)	PPO In-Network	Non-PPO Out-of-Network
<b>BILLED CHARGES ARE SUBJECT TO</b>	<b>PPO Network Rates (U&amp;C) See Important Information Page 8</b>		
<b>Preventive/Wellness</b>	No	100%	100% of U&C
Preventative/Wellness benefits are healthcare services that are not provided as a result of illness, injury or congenital defect. Any test or procedure done that is related to a known or present condition may not be subject to this benefit and will be processed accordingly. See Appendix A – Preventative Services for additional information.			
<b>Second Surgical Opinion</b>	Yes	80%	80% of U&C
<b>Skilled Nursing Facility</b> , up to 60 days per Calendar Year	Yes	80%	80% of U&C
<b>Speech Therapy</b>	Yes	80%	80% of U&C
<b>Telemedicine Services</b>	No	100%	100% of U&C
<b>Temporomandibular Joint Dysfunction (TMJ) Surgery</b>	Yes	80%	80% of U&C
Non-Surgical services, up to \$500 per Calendar Year	Yes	80%	80% of U&C
Medically accepted non-surgical services, including splints (removable mouth piece), will be subject to a limit of \$500 per calendar year. Dental and orthodontia treatments are covered under the Dental Plan. Refer to the <b>Dental Plan Summary for Benefits and Limitations</b> .			
<b>Urgent Care Centers</b>	Yes	80%	80% of U&C
<b>Weight Loss Surgery</b> , one (1) procedure per Lifetime	Yes	80%	80% of U&C
<b>All Other Eligible Medical Expenses</b>	Yes	80%	80% of U&C