# Piedmont Community Health Plan: LCS1500 OptNG

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

**Summary of Benefits and Coverage:** What this Plan Covers & What it Costs **Coverage for:** All Coverage Tiers | **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 at www.pchp.net or by calling 1-800-400-7247. Note: The Uniform Glossary can be accessed at www.cciio.cms.gov

| Important Questions | Answers | Why this Matters: |
|---|---|---|
| **What is the overall deductible?** | **$1,500** individual **/ $3,000** family in-network<br>**$2,500** individual **/ $5,000** family out-of-network<br>Does not apply to preventive care or to covered services subject to a copayment rather than coinsurance.<br>Copayments do not count toward the **deductible**. | 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?** | 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 out–of–pocket limit on my expenses?** | Yes. **$2,500** individual **/ $5,000** family in-network<br>**$5,000** individual **/ $10,000** family out-of-network | The medical **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?** | Premiums, balance-billed charges, charges in excess of any benefit limitations, and health care this plan doesn't cover. | Even though you pay these expenses, they don't count toward the medical **out-of-pocket limit**. |
| **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 network of providers?** | Yes. See www.pchp.net **or call 1-800-400-7247** for a list of in-network 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 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 on page 5. See your policy or plan document for additional information about **excluded services**. |

- **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 in-network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

| Common Medical Event | Services You May Need | Your Cost If You Use an In-Network Provider | Your Cost If You Use an Out-of-Network Provider | Limitations & Exceptions |
|---|---|---|---|---|
| **If you visit a health care provider's office or clinic** | Primary care visit to treat an injury or illness | $25 copay/visit | 40% coinsurance | Doctor office labs covered at No Charge after office visit copay. |
| | Specialist visit | $45 copay/visit | 40% coinsurance | Doctor office labs covered at No Charge after office visit copay. |
| | Other practitioner office visit | $45 copay/visit | 40% coinsurance | Chiropractic maintenance therapy is Not Covered. Acupuncture is Not Covered. |
| | Preventive care/screening/immunization | No charge | 40% coinsurance | ————————none———————— |
| **If you have a test** | Diagnostic test (x-ray, blood work) | 20% coinsurance | 40% coinsurance | Doctor office labs covered at No Charge after office visit copay. |
| | Imaging (CT/PET scans, MRIs) | 20% coinsurance | 40% coinsurance | Pre-authorization required. |

| Common Medical Event | Services You May Need | Your Cost If You Use an In-Network Provider | Your Cost If You Use an Out-of-Network Provider | Limitations & Exceptions |
|---|---|---|---|---|
| **If you need drugs to treat your illness or condition**<br><br>More information about **prescription drug coverage** is available from Script Care at 1-888-810-9010 or visit www.scriptcare.com. | Generic drugs | 40%, between $20 & $50 (retail)<br>40%, between $60 & $125 (mail order) | 40%, between $20 & $50 (retail)<br>40%, between $60 & $125 (mail order) | Copays are per prescription; any one prescription is limited to a 30 day or 90 day supply depending on type.<br><br>Separate prescription drug **out-of-pocket limit** of $4,100 individual / $8,200 family per year applies.<br><br>Mandatory mail-order for maintenance Rx after 4 retail fills. Prior Authorization required for prescriptions exceeding $2,000.<br><br>Mandatory Generic: If members fill a brand name drug when a generic is available, member will pay the brand copay plus the difference between the cost of the brand and generic.<br><br>If a drug is purchased from an Out-of-Network Provider, the amount payable in excess of the copayment will be the ingredient cost and dispensing fee. |
| | Preferred brand drugs | 40%, between $20 & $100 (retail)<br>40%, between $60 & $300 (mail order) | 40%, between $20 & $100 (retail)<br>40%, between $60 & $300 (mail order) | |
| | Non-preferred brand drugs | 40%, between $20 & $100 (retail)<br>40%, between $60 & $300 (mail order) | 40%, between $20 & $100 (retail)<br>40%, between $60 & $300 (mail order) | |
| | Specialty drugs - Must be filled through the SCL Specialty Pharmacy after one retail fill.<br><br>[Diabetic meds/supplies (excluding insulin) - Must be filled through the SCL Diabetic Program after one retail fill (40%, between $60 & $300 brand; 40% between $60 & $125 generic)] | 40%, between $20 & $100 (SCL Specialty Brand)<br>40% between $20 & $50 (SCL Specialty Generic) | 40%, between $20 & $100 (SCL Specialty Brand)<br>40% between $20 & $50 (SCL Specialty Generic) | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 20% coinsurance | 40% coinsurance | Pre-authorization required. Covered as Out-of-Network without pre-auth. |
| | Physician/surgeon fees | 20% coinsurance | 40% coinsurance | |
| **If you need immediate medical attention** | Emergency room services | $200 copay/visit | $200 copay/visit | If not an actual emergency, covered at 40% coinsurance after deductible. ER copay waived if admitted; then subject to inpatient coinsurance. |
| | Emergency medical transportation | 20% coinsurance | 20% coinsurance | |
| | Urgent care | $45 copay/visit | $45 copay/visit | |

| Common Medical Event | Services You May Need | Your Cost If You Use an In-Network Provider | Your Cost If You Use an Out-of-Network Provider | Limitations & Exceptions |
|---|---|---|---|---|
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 20% coinsurance | 40% coinsurance | Pre-authorization required. Covered as Out-of-Network without pre-auth. |
| | Physician/surgeon fee | 20% coinsurance | 40% coinsurance | |
| **If you have mental health, behavioral health, or substance abuse needs** | Mental/Behavioral health outpatient services | $25 copay/office visit and 20% coinsurance other outpatient services | 40% coinsurance | Doctor office labs covered at No Charge after office visit copay. Pre-authorization required for any inpatient or outpatient facility services. Pre-authorization required for any services and office visits from Out-of-Network providers. Covered as Out-of-Network without pre-authorization. |
| | Mental/Behavioral health inpatient services | 20% coinsurance | 40% coinsurance | |
| | Substance use disorder outpatient services | $25 copay/office visit and 20% coinsurance other outpatient services | 40% coinsurance | |
| | Substance use disorder inpatient services | 20% coinsurance | 40% coinsurance | |
| **If you are pregnant** | Prenatal and postnatal care | $45 copay | 40% coinsurance | Prenatal care is covered at $0 copay. Routine labs covered at No Charge. |
| | Delivery and all inpatient services | 20% coinsurance | 40% coinsurance | Pregnancy for a dependent child is Not Covered. |
| **If you need help recovering or have other special health needs** | Home health care | 20% coinsurance | 40% coinsurance | Limited to 100 visits per year. Pre-authorization required. |
| | Rehabilitation services | 20% coinsurance | 40% coinsurance | Pre-authorization required. |
| | Habilitation services | Not Covered | Not Covered | Habilitation services are Not Covered. |
| | Skilled nursing care | 20% coinsurance | 40% coinsurance | Pre-authorization required. |
| | Durable medical equipment | 20% coinsurance | 40% coinsurance | Pre-authorization required. |
| | Hospice service | 20% coinsurance | 40% coinsurance | Pre-authorization required. |
| **If your child needs dental or eye care** | Eye exam | Not Covered | Not Covered | Routine eye exam is Not Covered for children. |
| | Glasses | Not Covered | Not Covered | Glasses and routine dental check-ups Not Covered for children. |
| | Dental check-up | Not Covered | Not Covered | |

## 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.)**

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult) (except for accidental injury)
- Glasses
- Habilitation services
- Hearing aids
- Infertility treatment
- Long-term care
- Routine eye care (Adult)
- Routine foot care (unless you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes)
- 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.)**

- Chiropractic care (maintenance therapy services are Not Covered)
- Non-emergency care when traveling outside the U.S. (covered as Out-of-Network and subject to balance billing)
- Private-duty nursing

## 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 1-800-400-7247. 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, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or 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 Piedmont Community Health Plan at 1-800-400-7247 (434-947-4463 if local) or visit www.pchp.net. You may also contact the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or visit www.dol.gov/ebsa/healthreform. For prescription drug information, contact Script Care at 1-888-810-9010 or visit www.scriptcare.com.

## 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.*

## 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. These examples were completed using the cost sharing for the Employee Only (Individual) coverage tier.

**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** $5,170
- **Patient pays** $2,370

**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 |
| Copays | $70 |
| Coinsurance | $600 |
| Limits or exclusions | $200 |
| **Total** | **$2,370** |

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

- **Amount owed to providers:** $5,400
- **Plan pays** $2,820
- **Patient pays** $ 2,580

**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 | $0 |
| Copays | $1,300 |
| Coinsurance | $1,200 |
| Limits or exclusions | $80 |
| **Total** | **$2,580** |

# 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.