



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.lpgov.org or by calling 1-888-578-5555:

Important Questions	Answers	Why this Matters:
What is the overall deductible?	\$0	See the chart starting on page 2 for your costs for services this plan covers.
Are there other deductibles for specific services?	Yes, \$5,000.00 for out of network expenses and \$250.00/person for prescription.	You must pay all of these 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?	This plan has no out-of-pocket limit	There's no limit on how much you could pay during a coverage period for your share of the cost of covered services.
What is not included in the out-of-pocket limit?	This plan has no out-of-pocket limit	Not applicable because there's no out-of-pocket limit on your expenses.
Is there an overall annual limit on what the plan	No.	The chart starting on page 2 describes any limits on what the plan will pay for <i>specific</i> covered services, such as office visits.
Does this plan use a network of providers?	Yes, see www.verityhealth.com or call 1-888-578-5555 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 specialist?	No.	You can see the specialist you choose without permission from this plan.
Are there service the plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 4. See your policy or plan document for additional information about excluded services .

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

Common Medical Event	Services You May Need	Your cost if you use an		Limitations & Exceptions
		In-network Provider	Out-of-network Provider	
If you visit a health care provider’s office or clinic	Primary care visit to treat an injury or illness	\$30.00 co-pay/visit	50% co-insurance	none
	Specialist visit	\$40.00 co-pay/visit	50% co-insurance	none
	Other practitioner office visit	\$40.00 co-pay/visit	50% co-insurance	none
	Preventive care/screening/immunization	No charge	Not covered	none
If you have a test	Diagnostic test (x-ray, blood work)	\$30.00 co-pay	50% co-insurance	none
	Imaging (CT/PET scans, MRIs)	Ct-scan \$100.00 co-pay; Pet scan/MRI \$250.00 co-pay	50% co-insurance	These services require pre-certification, failure to obtain pre-certification will result in the denial of your claims.
If you need drugs to treat your illness or condition	Generic drugs	\$20.00 co-pay retail/\$40.00 mail-order	Not covered	Covers up to a 30 day supply (retail prescription); 31-90 day supply (mail-order prescription).
	Preferred brand drugs	\$35.00 co-pay retail/\$70.00 mail-order	Not covered	Covers up to a 30 day supply (retail prescription); 31-90 day supply (mail-order prescription).
	Non-preferred brand drugs	n/a	n/a	none
	Specialty drugs	Same as generic/brand Co-payments above	Not covered	

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PGRMA HEALTH BENEFIT PLAN/PGRMA-Rapides Parish

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

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

Coverage for: All eligible employees | Plan Type: MCO

If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$275.00 co-pay/procedure	50% co-insurance	These services require pre-certification, failure to obtain pre-certification will result in the denial of your claims.
	Physician/surgeon fees	100% coverage	50% co-insurance	These services require pre-certification, failure to obtain pre-certification will result in the denial of your claims
If you need	Emergency room services	\$100.00 co-pay	\$200.00 co-pay then 50% co-insurance	none

	Services You May Need	Your cost if you use an		Limitations & Exceptions
		In-network Provider	Out-of-network Provider	
immediate medical attention	Emergency medical transportation	Ground \$50.00 co-pay, Air \$250.00 co-pay	Ground \$50.00 co-pay, Air \$250.00 co-pay	none
	Urgent care	\$100.00 co-pay	\$200.00 co-pay then 50% co-insurance	none
If you have a hospital stay	Facility fee (e.g., hospital room)	\$350.00 co-pay/day up to 5 days then 100%	\$500.00 co-pay then 50% co-insurance	These services require pre-certification, failure to obtain pre-certification will result in the denial of your claims
	Physician/surgeon fee	100%	50% co-insurance	These services require pre-certification, failure to obtain pre-certification will result in the denial of your claims
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	\$30.00 co-payment	50% co-insurance	none
	Mental/Behavioral health inpatient services	\$300.00 co-pay/day up to 5 days then 100%	50% co-insurance	These services require pre-certification, failure to obtain pre-certification will result in the denial of your claims
	Substance use disorder outpatient services	\$30.00 co-payment	50% co-insurance	none
	Substance use disorder inpatient services	\$300.00 co-pay/day up to 5 days then 100%	50% co-insurance	These services require pre-certification, failure to obtain pre-certification will result in the denial of your claims

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

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

Coverage for: All eligible employees | Plan Type: MCO

If you are pregnant	Prenatal and postnatal care	\$40.00 co-pay/visit up to 10 visits then 100%	50% co-insurance	none
	Delivery and all inpatient services	\$350.00co-pay/day up to 5 days then 100%	50% co-insurance	
If you need help recovering or have other special health needs	Home health care	\$40.00 co-pay/visit	50% co-insurance	These services require pre-certification, failure to obtain pre-certification will result in the denial of your claims
	Rehabilitation services	\$40.00 co-pay/visit	50% co-insurance	These services require pre-certification, failure to obtain pre-certification will result in the denial of your claims
	Habilitation services	\$40.00 co-pay/visit	50% co-insurance	These services require pre-certification, failure to obtain pre-certification will result in the denial of your claims
	Skilled nursing care	\$350.00co-pay/day up to 5 days then 100%	50% co-insurance	These services require pre-certification, failure to obtain pre-certification will result in the denial of your claims
	Durable medical equipment	80% coverage	50% co-insurance	These services require pre-certification, failure to obtain pre-certification will result in the denial of your claims
	Hospice service	100%	50% co-insurance	These services require pre-certification, failure to obtain pre-certification will result in the denial of your claims
If your child needs dental or eye care	Eye exam	100%	Not covered	Limited to one exam per year
	Glasses	Not covered	Not covered	
	Dental check-up	Not covered	Not covered	

Excluded Services & Other Covered Services:

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Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other **excluded services**.)

- Cosmetic Surgery
- Routine foot care
- Infertility Treatment
- Charges not submitted within the plan filing limit of 1 year
- Non-emergency treatment when traveling outside of the U.S.
- Private – duty nursing
- Hearing Aids
- Weight loss programs
- Failure to have approval for services that require authorization as indicated in the plan document
- Charges for hearing aids, batteries or repairs
- Dental care (Adult)
- Dental care (child)

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 (if prescribed and approved)
- Chiropractic care
- Bariatric surgery (when approved for medical necessity)
- Long Term Care
- Routine Eye Care
- Allergy Shots

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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 1-888-578-5555. 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- x 61565 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: CCMSI at 1-888-578-5555.

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.



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** \$5540
- **Patient pays** \$2000

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	\$200
Co-pays	\$1800
Co-insurance	\$0
Limits or exclusions	\$0
Total	\$2000

Managing type 2 diabetes

(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** \$4,100
- **Plan pays** \$3480
- **Patient pays** \$620

Sample care costs:

Prescriptions	\$1,500
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$730
Education	\$290
Laboratory tests	\$140
Vaccines, other preventive	\$140
Total	\$4,100

Patient pays:

Deductibles	\$250
Co-pays	\$110
Co-insurance	\$260
Limits or exclusions	\$0
Total	\$620

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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 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.

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