PGRMA HEALTH BENEFIT PLAN/PGRMA

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

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

Coverage for: All eligible employees | **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. lpgov.org or by calling 1-888-578-5555:

Important Questions	Answers	Why this Matters:
What is the overall deductible?	$**750.00** individual/**3** family. Does not apply to Preventative care, prescription drugs and some outpatient services. Out-of-network co-insurance and co-payments don't 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. For participating providers only, **$3,500** person/**3** family.	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 the covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, out of network co-insurance, deductibles, co-payments 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	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.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 services 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	$15.00 co-pay/visit	40% co-insurance	none
	Specialist visit	20% co-insurance	40% co-insurance	none
	Other practitioner office visit	20% co-insurance	40% co-insurance	none
	Preventive care/screening/immunization	No charge	40% co-insurance	none
If you have a test	Diagnostic test (x-ray, blood work)	20% co-insurance	40% co-insurance	Test performed in a hospital or surgery center are subject to the hospital benefits
	Imaging (CT/PET scans, MRIs)	20% co-insurance	40% co-insurance	Test performed in a hospital or surgery center are subject to the hospital benefits
If you need drugs to treat your illness or condition	Generic drugs	$15.00 co-pay retail/$30.00 mail-order	Not covered	Covers up to a 30 day supply (retail prescription); 31-90 day supply (mail-order prescription).
	Preferred brand drugs	$30.00 co-pay retail/$60.00 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	

If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% co-insurance	40% co-insurance	These services require pre-certification, failure to obtain pre-certification will result in the denial of your claims.
	Physician/surgeon fees	20% co-insurance	40% 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	$50.00 co-payment then 20% co-insurance	$100.00 co-payment then 40% 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	20% co-insurance	20% co-insurance	none
	Urgent care	20% co-insurance	40% co-insurance	none
If you have a hospital stay	Facility fee (e.g., hospital room)	20% co-insurance	$250.00 co-pay then 40% co-insurance	These services require pre-certification, failure to obtain pre-certification will result in the denial of your claims
	Physician/surgeon fee	20% co-insurance	40% 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	$15.00 co-payment	40% co-insurance	none
	Mental/Behavioral health inpatient services	20% co-insurance	40% 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	$15.00 co-payment	40% co-insurance	none
	Substance use disorder inpatient services	20% co-insurance	40% co-insurance	These services require pre-certification, failure to obtain pre-certification will result in the denial of your claims
If you are pregnant	Prenatal and postnatal care	20% co-insurance	40% co-insurance	none
	Delivery and all inpatient services	20% co-insurance	40% co-insurance	

If you need help recovering or have other special health needs	Home health care	20% co-insurance	40% co-insurance	These services require pre-certification, failure to obtain pre-certification will result in the denial of your claims
	Rehabilitation services	20% co-insurance	40% co-insurance	These services require pre-certification, failure to obtain pre-certification will result in the denial of your claims
	Habilitation services	20% co-insurance	40% co-insurance	These services require pre-certification, failure to obtain pre-certification will result in the denial of your claims
	Skilled nursing care	20% co-insurance	40% co-insurance	These services require pre-certification, failure to obtain pre-certification will result in the denial of your claims
	Durable medical equipment	20% co-insurance	40% co-insurance	These services require pre-certification, failure to obtain pre-certification will result in the denial of your claims
	Hospice service	20% co-insurance	40% 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:

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.**

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

- **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**

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** $4832.00
- **Patient pays** $2708.00

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	$1500
Co-pays	$0
Co-insurance	$1208
Limits or exclusions	$0
Total	**$2708**

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

- **Amount owed to providers:** $4,100
- **Plan pays** $2708.00
- **Patient pays** $1392.00

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	$750
Co-pays	$0
Co-insurance	$642
Limits or exclusions	$0
Total	**$1392**

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.