

City of Chester Employee Benefits Plan

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

Coverage Period: 07/01/2014 - 06/30/2015
 Coverage for: **Plan Participant** 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 <http://www.medcost.com/> or by calling 1-800-795-1023.

Important Questions	Answers		Why this Matters:
	In-Network	Non-Network	
What is the overall <u>deductible</u>?	\$1,500 / person \$4,500 / family Does not apply to most In-Network office visits, preventative care, and prescription drugs		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 1 st). See the chart starting on page 2 for how much you pay for covered services after you meet the deductible .
Are there other <u>deductibles</u> for specific services?	Yes, dental - \$50 / person (3 per family)		You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
Is there an <u>out-of-pocket limit</u> on my expenses?	Yes \$6,200 / person \$12,700 / family	\$8,400 / person \$15,900 / family	The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the costs 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, balanced-billed charges, health care this plan doesn't cover, prescription drug co-pays, and penalties		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 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>?	Yes. See http://www.medcost.com/ or call 1-800-795-1023 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 provider .
Do I need a referral to see a <u>specialist</u>?	No		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 .

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OMB Control Numbers 1545-2229,
1210-0147, and 0938-1146

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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 participating **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	Non-Network Provider	
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$20 co-pay	50% co-insurance	Co-insurance applies after deductible.
	Specialist visit	\$50 co-pay	50% co-insurance	Co-insurance applies after deductible.
	Other practitioner office visit - chiropractor	30% co-insurance	50% co-insurance	Co-insurance applies after deductible. Maximum \$50 each visit and 24 visits in a calendar year.
	Preventive care/screening/immunization	No charge	No charge	Deductible waived.
If you have a test	Diagnostic test (x-ray, blood work)	30% co-insurance	50% co-insurance	Co-insurance applies after deductible.
	Imaging (CT/PET scans, MRIs)	30% co-insurance	50% co-insurance	Co-insurance applies after deductible.
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.mbstpa.com .	Generic drugs	\$10 co-pay Retail \$25 co-pay Mail Order		Covers up to a 30-day supply (retail prescription) or 90 day supply (mail order prescription). FDA approved contraceptives, certain smoking cessation products, and over-the-counter preventive medications (with prescription) are covered at 100%.
	Preferred brand drugs	\$30 co-pay Retail \$75 co-pay Mail Order		
	Non-preferred brand drugs	\$50 co-pay Retail \$125 co-pay Mail Order		
	Specialty drugs	\$75 co-pay		Covers up to a 30-day supply.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% co-insurance	50% co-insurance	Co-insurance applies after deductible.
	Physician/surgeon fees	30% co-insurance	50% co-insurance	Co-insurance applies after deductible.

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		In-Network Provider	Non-Network Provider	
If you need immediate medical attention	Emergency room services	\$100 co-pay, then 30% co-insurance	\$100 co-pay, then 30% co-insurance	Co-insurance applies after deductible.
	Emergency medical transportation	30% co-insurance	30% co-insurance	Co-insurance applies after deductible.
	Urgent care			Co-insurance applies after deductible.
	- Primary	\$20 co-pay	50% co-insurance	
- Specialist	\$50 co-pay	50% co-insurance		
If you have a hospital stay	Facility fee (e.g., hospital room)	30% co-insurance	50% co-insurance	Co-insurance applies after deductible. Precertification required.
	Physician/surgeon fee	30% co-insurance	50% co-insurance	Co-insurance applies after deductible.
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services			Co-insurance applies after deductible.
	- Facility	30% co-insurance	50% co-insurance	
	- Physician	\$20 co-pay	50% co-insurance	
	Mental/Behavioral health inpatient services	30% co-insurance	50% co-insurance	Co-insurance applies after deductible. Precertification required.
	Substance use disorder outpatient services			Co-insurance applies after deductible.
- Facility	30% co-insurance	50% co-insurance		
- Physician	\$20 co-pay	50% co-insurance		
Substance use disorder inpatient services	30% co-insurance	50% co-insurance	Co-insurance applies after deductible. Precertification required.	
If you are pregnant	Prenatal and postnatal care	30% co-insurance	50% co-insurance	Co-insurance applies after deductible.
	Delivery and all inpatient services	30% co-insurance	50% co-insurance	Co-insurance applies after deductible. Includes birthing centers.

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		In-Network Provider	Non-Network Provider	
If you need help recovering or have other special health needs	Home health care	30% co-insurance	50% co-insurance	Co-insurance applies after deductible. Non-Network maximum 100 visits / calendar year.
	Rehabilitation services – cardiac	30% co-insurance	50% co-insurance	Co-insurance applies after deductible.
	Habilitation services	30% co-insurance	50% co-insurance	Co-insurance applies after deductible. Includes speech, physical, and occupational. No visit limit for speech. Maximum 40 visits / condition for Physical and Occupational only.
	Skilled nursing care	30% co-insurance	30% co-insurance	Co-insurance applies after deductible. Maximum 60 days / calendar year.
	Durable medical equipment	30% co-insurance	50% co-insurance	Co-insurance applies after deductible.
	Hospice service	30% co-insurance	50% co-insurance	Co-insurance applies after deductible.
If your child needs dental or eye care	Eye exam	Not applicable	Not applicable	No coverage
	Glasses	Not applicable	Not applicable	No coverage
	Dental check-up	No charge	No charge	Deductible waived.

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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](#).)

<ul style="list-style-type: none">• Acupuncture• Bariatric surgery• Cosmetic surgery	<ul style="list-style-type: none">• Hearing aids• Infertility treatment• Long-term care• Non-emergency care when traveling outside the U.S.	<ul style="list-style-type: none">• Routine eye care (Adult)• Weight loss programs
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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.)

<ul style="list-style-type: none">• Dental care (adult)	<ul style="list-style-type: none">• Private-duty nursing	<ul style="list-style-type: none">• Routine foot care
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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 Group's Phone #(919) 715-9782. 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: the claims administrator, MBS; P. O. Box 25987; Winston-Salem, NC; 27114-5987; or <http://www.medcost.com>. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Additionally a consumer assistance program can help you file your appeal. Contact North Carolina Department of Insurance; Health Insurance Smart NC; 430 N. Salisbury Street; Raleigh, NC 27603 or 1-877-885-0231 or <http://www.ncdoi.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.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-795-1023

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-795-1023

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-795-1023

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-795-1023

—————*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 **\$4,600**
- Patient pays **\$2,940**

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	\$1,000
Co-pays	\$50
Co-insurance	\$1,890
Limits or exclusions	\$0
Total	\$2,940

*Assumed generic filled 2 times through mail order
 **Assumed services provided at independent facility

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

- Amount owed to providers: **\$5,400**
- Plan pays **\$3,800**
- Patient pays **\$1,600**

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	\$1,000
Co-pays	\$480
Co-insurance	\$120
Limits or exclusions	\$0
Total	\$1,600

*Assumed Insulin (Preferred) filled 4x through mail order
 **Assumed 4 PCP visits & 2 Specialist visits
 ***Assumed 4 visits nutritional counseling as any other condition, included in office ancillary
 ****Assumed services provided at independent facility

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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