

City of Chester Employee Benefits Plan

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

Coverage Period: 07/01/2013 - 06/30/2014
 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 www.mbstpa.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>?	\$1,000 / person \$3,000 / family Does not apply most In-Network office visits, preventative care and prescription drugs	\$1,000 / person \$3,000 / family	You must pay all the costs up to the <u>deductible</u> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <u>deductible</u> 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 <u>deductible</u> .
Are there other <u>deductibles</u> for specific services?	Yes, dental		You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this plan begins to pay for these services.
Is there an <u>out-of-pocket limit</u> on my expenses?	Yes \$3,500 / person \$7,000 / family	\$4,500 / person \$9,000 / family	The <u>out-of-pocket limit</u> 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, deductibles, co-pays, and penalties		Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Is there an overall annual limit on what the plan pays?	Yes \$2,000,000		This plan will pay for covered services only up to this limit during each coverage period, even if your own need is greater. You're responsible for all expenses above this limit. The chart starting on page 2 described <i>specific</i> coverage limits, such as limited on the number of 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 <u>provider</u> , 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 <u>provider</u> for some services. Plans use the term in-network, preferred, or participating for <u>providers</u> in their <u>network</u> . See the chart starting on page 2 for how this plan pays different kinds of <u>provider</u> .
Do I need a referral to see a <u>specialist</u>?	No		You can see the <u>specialist</u> 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 4. See your policy or plan document for additional information about <u>excluded services</u> .

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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, deductible waived	50% co-insurance after deductible	None
	Specialist visit	\$50 co-pay, deductible waived	50% co-insurance after deductible	None
	Other practitioner office visit - chiropractor	30% co-insurance	50% co-insurance	Subject to deductible; maximum \$50 each visit and 24 visits in a alendar 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	Subject to deductible
	Imaging (CT/PET scans, MRIs)	30% co-insurance	50% co-insurance	Subject to deductible
If you need drugs to treat your illness or condition More information about prescription drug coverage 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); 90 day supply (mail order prescription)
	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	Subject to deductible
	Physician/surgeon fees	30% co-insurance	50% co-insurance	Subject to deductible

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Common Medical Event	Services You May Need	Your cost if you use an		Limitations & Exceptions
		In-Network Provider	Non-Network Provider	
If you need immediate medical attention	Emergency room services	\$100 co-pay, then 30% co-insurance	50% co-insurance	Co-insurance amounts subject to deductible
	Emergency medical transportation	30% co-insurance	30% co-insurance	Subject to deductible
	Urgent care	\$20 co-pay, deductible waived	50% co-insurance after deductible	None
If you have a hospital stay	Facility fee (e.g., hospital room)	30% co-insurance	50% co-insurance	Subject to deductible; precertification required
	Physician/surgeon fee	30% co-insurance	50% co-insurance	Subject to deductible
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services - facility - physician	30% co-insurance \$20 co-pay	50% co-insurance 50% co-insurance	Co-insurance amounts subject to deductible
	Mental/Behavioral health inpatient services	30% co-insurance	50% co-insurance	Subject to deductible; precertification required
	Substance use disorder outpatient services - facility - physician	30% co-insurance \$20 co-pay	50% co-insurance 50% co-insurance	Co-insurance amounts subject to deductible
	Substance use disorder inpatient services	30% co-insurance	50% co-insurance	Subject to deductible; precertification required
If you are pregnant	Prenatal and postnatal care	30% co-insurance	50% co-insurance	Subject to deductible
	Delivery and all inpatient services	30% co-insurance	50% co-insurance	Subject to deductible; includes birthing centers
If you need help recovering or have other special health needs	Home health care	30% co-insurance	50% co-insurance	Subject to deductible; Non-Network maximum 100 visits / calendar year
	Rehabilitation services – cardiac	30% co-insurance	50% co-insurance	Subject to deductible
	Habilitation services	30% co-insurance	50% co-insurance	Includes physical and occupational; maximum 40 visits / condition
	Skilled nursing care	30% co-insurance	30% co-insurance	Subject to deductible; maximum 60 days / calendar year
	Durable medical equipment	30% co-insurance	50% co-insurance	Subject to deductible
	Hospice service	30% co-insurance	50% co-insurance	Subject to 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 #(803) 581-2123. 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>.

Language Access Services:

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

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 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

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwüijigo 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	\$400
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

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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.

*Generated 06/04/2013
Based on preliminary Schedule of Benefits*

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