East Carolina Behavioral Health Employee Health Plan; East Carolina Behavioral Health Specialized Services Plan: East Carolina Behavioral Health

Coverage Period: Beginning 7/1/2014

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

Coverage for: All Plans | **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.myhealthplanonline.com or by calling 800-426-8739. The Uniform Glossary can be accessed at www.dol.ebsa/healthreform.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	For network providers $650 person/$1,950 family. For non-network providers $1,300 person/$3,900 family. Does not apply to emergency room care, network outpatient lab or x-ray, allergy testing , serum or injections.	You must pay all of 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 network providers $3,600 person/ $10,800 family. For non-network providers $7,200 person/$21,600 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 covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Deductibles, copayments, cost containment penalties, premiums, chiropractic care, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit** on your expenses.
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. For a list of **network providers**, see	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

	www.medcost.com/LocateAProvider.aspx or call 800-824-7406 (NC residents), or www.vhn.com (VA residents)	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**. These network providers may not be used for some services covered under the Specialized Services Plan.
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 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	30% coinsurance	Surgery is considered outpatient.
	Specialist visit	$40 copay/visit	30% coinsurance	Surgery is considered outpatient. Different benefit may apply for some services covered under the Specialized Services Plan.
	Other practitioner office visit	10% coinsurance for chiropractor	10% coinsurance for chiropractor	Network deductible applies to non-network chiropractic services.
	Preventive care/screening/immunization	$25 copay/visit	30% coinsurance	Coverage is limited to $750 calendar year max. Balance of network charges subject to deductible and coinsurance.

If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance	30% coinsurance	When performed at a free-standing facility. Deductible does not apply to network services. Quest LabCard and One Call discounted rate may apply. Different benefit may apply for some services covered under the Specialized Services Plan.
	Imaging (CT/PET scans, MRIs)	10% coinsurance	30% coinsurance	When performed at a free-standing facility. Deductible does not apply to network services. One Call discounted rate may apply. Different benefit may apply for some services covered under the Specialized Services Plan.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.caremark.com	Generic drugs	$10 copay/prescription (pharmacy), $20 copay/prescription (mail order)	Not covered	Pharmacy is limited to a 30 day supply and mail order is limited to a 90 day supply.
	Preferred brand drugs	$30 copay/prescription (pharmacy), $60 copay/prescription (mail order)		
	Non-preferred brand drugs	$60 copay/prescription (pharmacy), $120 copay/prescription (mail order)		
	Specialty Pharmacy	$60 copay/prescription		Limited to a 30 day supply.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	30% coinsurance	Different benefit may apply for some services covered under the Specialized Services Plan.

	Physician/surgeon fees	10% coinsurance	30% coinsurance	Different benefit may apply for some services covered under the Specialized Services Plan.
If you need immediate medical attention	Emergency room services	$120 copay/visit and 10% coinsurance	$120 copay/visit and 10% coinsurance	Deductible does not apply for true emergency.
	Emergency medical transportation	10% coinsurance	30% coinsurance	---none---
	Urgent care	$40 copay/visit	$40 copay/visit	---none---
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	30% coinsurance	Covered at the semiprivate room rate if available. Precert required or covered charge will be reduced by $500. Different benefit may apply for some services covered under the Specialized Services Plan.
	Physician/surgeon fee	10% coinsurance	30% coinsurance	Different benefit may apply for some services covered under the Specialized Services Plan.
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	10% coinsurance	30% coinsurance	---none---
	Mental/Behavioral health inpatient services	10% coinsurance	30% coinsurance	Covered at the semiprivate room rate if available. Precert required or covered charge will be reduced by $500.
	Substance use disorder outpatient services	10% coinsurance	30% coinsurance	---none---
	Substance use disorder inpatient services	10% coinsurance	30% coinsurance	Covered at the semiprivate room rate if available. Precert required or covered charge will be reduced by $500.
If you are pregnant	Prenatal and postnatal care	$25 copay/visit	30% coinsurance	Dependent daughters not covered.
	Delivery and all inpatient services	10% coinsurance	30% coinsurance	Dependent daughters not covered.

If you need help recovering or have other special health needs	Home health care	10% coinsurance	30% coinsurance	---none---
	Rehabilitation services	10% coinsurance	30% coinsurance	---none---
	Habilitation services	Not covered	Not covered	---none---
	Skilled nursing care	10% coinsurance	30% coinsurance	---none---
	Durable medical equipment	10% coinsurance	30% coinsurance	---none---
	Hospice service	10% coinsurance	30% coinsurance	Limited to 180 days inpatient and outpatient lifetime max.
If your child needs dental or eye care	Eye exam	$40 copay/visit	$40 copay/visit	Limited to 1 exam per plan year.
	Glasses	No charge	No charge	Limited to $125 max every 12 month period. Dependent children under the age of 19 will be allowed one pair of glasses (lenses and frames) or one contact lense purchase per 12 month period.
	Dental check-up	Not covered	Not covered	Dental benefits may be available if a member chooses to participate in the dental plan, see Plan Document and Summary Plan Description.

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
- Cosmetic surgery
- Dental care
- Infertility treatment
- Non-emergency care when traveling outside the U.S.
- Hearing aids
- Routine foot care
- Weight loss programs
- Long-term care

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.)

- Bariatric surgery (covered under the Specialized Services Plan)
- Routine eye care
- Chiropractic care (limited to 30 visits/plan year)
- 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 (contact number). 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.ccio.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:

- Interactive Medical Systems: www.myhealthplanonline.com, 800-426-8739
- Department of Labor's Employee Benefits Security Administration: www.dol.gov/ebsa/healthreform, 1-866-444-EBSA (3272)
- Additionally, a consumer assistance program can help you file your appeal. Contact 877-885-0231 (NC), 804-371-9741 (VA).

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 does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

In order for certain types of health coverage (for example, individually purchased insurance or job-based coverage) to qualify as minimum essential coverage, the plan must pay, on average, at least 60 percent of allowed charges for covered services. This is called the "minimum value standard." **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** $ 6,030
- **Patient pays** $ 1,510

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	$650
Copays	$50
Coinsurance	$660
Limits or exclusions	$150
Total	**$1,510**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $ 3,880
- **Patient pays** $ 1,520

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	$650
Copays	$680
Coinsurance	$110
Limits or exclusions	$80
Total	**$1,520**

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?

û **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?

û **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?

ü **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?

ü **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.

Questions: Call 800-426-8739 or visit us at www.myhealthplanonline.com. If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.dol.gov/ebsa/healthreform or call your employer to request a copy. OMB Control Numbers 1545-2229, 1210-0147, and 0938-1146 Released on April 23, 2013