LSU FIRST: The LSU System Health Plan Option 1

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

Coverage Period: 01/01/2017 – 12/31/2017

Coverage for: Plan Participants | 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.lsufirst.org or by calling 1-855-346-5781.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$1500** Employee/**$2,250** Employee + Spouse/**$2,250** Employee + Child(ren)/**$3,000** Employee + Family **HRA: $1,000** Employee/**$1,500** Employee + Spouse/**$1,500** Employee + Child(ren)/**$2,000** Family The remaining deductible does not apply to First Choice Providers and Generic Drugs. Preventive Care is covered at 100%.	Your deductible includes your Health Reimbursement Account (HRA). After your HRA fund has been exhausted, you must pay all the costs up to the **remaining deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **remaining 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 **remaining deductible**. For more details see your SPD at www.lsufirst.org
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?	In-Network: Employee only **$4,500** Employee + Spouse, Employee + Child(ren)**$6,750** Employee + Family **$9,000** Each Individual: no more than **$6,850** Out-of-Network: Employee only **$7,500** Employee + Spouse, Employee + Child(ren)**$11,250** Employee + Family **$15,000**	Your **out-of-pocket limit** includes your HRA. **For First Choice Providers: Not applicable (no cost to you)** 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?	Premiums, RX Ancillary Charges, and Other 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**.
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.

Questions: Call 1-855-346-5781 or visit us at www.lsufirst.org

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.cciio.cms.gov or call 1-855-346-5781 to request a copy.

Does this plan use a network of providers?	Yes. This plan uses three networks: First Choice, Verity HealthNet, and Aetna ASA. To help limit your costs, select a First Choice provider where available. For a complete list of participating providers see www.lsufirst.org. For Out-of-Network providers, you may be responsible for charges in excess of Maximum Reimbursable Charge (MRC).	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 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 In Network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	First Choice Provider	In–Network Provider	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	No charge	10% co-insurance	40% co-insurance	None
	Specialist visit	No charge	10% co-insurance	40% co-insurance	None

Common Medical Event	Services You May Need	First Choice Provider	In–Network Provider	Out-of-Network Provider	Limitations & Exceptions
	Other practitioner office visit	No charge	10% co-insurance	40% co-insurance	None
	Preventive care/screening/immunization	No charge	No Charge	100% of MRC	Please refer to your SPD for specific listing of covered preventive services.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	10% co-insurance	40% co-insurance	None
	Imaging (CT/PET scans, MRIs)	No charge	10% co-insurance	40% co-insurance	Must obtain prior authorization
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.citizensrx.com	Generic drugs	$0 - copay			Coverage is limited up to a 30-day supply (retail) and up to a 90-day supply (home delivery) Specialty Drugs must be obtained through PraxisRx Specialty Pharmacy. Ancillary fees may apply to certain Brand name drugs.
	Preferred brand drugs	$40 co-pay After Deductible for each 30-day supply			
	Non-preferred brand drugs	$40 co-pay After Deductible for each 30-day supply			
	Specialty drugs	$150 co-pay After Deductible for each 30-day supply			
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	10% co-insurance	40% co-insurance	None
	Physician/surgeon fees	No charge	10% co-insurance	40% co-insurance	None
If you need immediate medical attention	Emergency room services	No charge	10% co-insurance	10% of MRC	None
	Emergency medical transportation	No charge	10% co-insurance	10% of MRC	None

Common Medical Event	Services You May Need	First Choice Provider	In–Network Provider	Out-of-Network Provider	Limitations & Exceptions
	Urgent care	No charge	10% co-insurance	40% co-insurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	10% co-insurance	40% co-insurance	Must obtain prior authorization
	Physician/surgeon fee	No charge	10% co-insurance	40% co-insurance	Must obtain prior authorization
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	No charge	10% co-insurance	40% co-insurance	Must obtain prior authorization and engage in care coordination
	Mental/Behavioral health inpatient services	No charge	10% co-insurance	40% co-insurance	Must obtain prior authorization and engage in care coordination
	Substance use disorder outpatient services	No charge	10% co-insurance	40% co-insurance	Must obtain prior authorization and engage in care coordination
	Substance use disorder inpatient services	No charge	10% co-insurance	40% co-insurance	Must obtain prior authorization and engage in care coordination
If you are pregnant	Prenatal and postnatal care	No charge	10% co-insurance	40% co-insurance	Maternity care is not covered for dependent children
	Delivery and all inpatient services	No charge	10% co-insurance	40% co-insurance	Must obtain prior authorization when over 48/96 hours
If you need help recovering or have other special health needs	Home health care	No charge	10% co-insurance	40% co-insurance	Must obtain prior authorization. Refer to your SPD for limitations
	Rehabilitation services	No charge	10% co-insurance	40% co-insurance	Must obtain prior authorization. Refer to your SPD for limitations
	Habilitation services	Not Covered	Not Covered	Not Covered	Not Covered
	Skilled nursing care	No charge	10% co-insurance	40% co-insurance	Must obtain prior authorization. Refer to your SPD for limitations
	Durable medical equipment	No charge	10% co-insurance	40% co-insurance	Must obtain prior authorization when over $1,000
	Hospice service	No charge	10% co-insurance	40% co-insurance	Must obtain prior authorization
If your child	Eye exam	No charge	No charge	100% of MRC	Refer to your SPD for limitations

Common Medical Event	Services You May Need	First Choice Provider	In–Network Provider	Out-of-Network Provider	Limitations & Exceptions
needs dental or eye care	Glasses	Not Covered	Not Covered	Not Covered	Not Covered
	Dental check-up	Not Covered	Not Covered	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.)**

Bariatric Surgery, Cosmetic Surgery	Long-Term Care, Private Duty Nursing	Non-Emergency care when traveling outside the U.S.
Dental Care(Adult & Children)	Massage Therapy, Acupuncture	Routine Foot Care
Habilitation Services	Methadone Maintenance	

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.)**

Chiropractic Care	Hearing Aids	Infertility Treatment

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 (903) 531-4472. 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.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: WEB-TPA at 1-855-346-5781, 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.

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 provides 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%. **This health coverage meets the minimum value standard for the benefits it provides.**

Additionally, a consumer assistance program can help you file your appeal. Contact

Louisiana Department of Insurance

Mailing Address:

P.O. Box 94214

Baton Rouge, LA 70804

(225) 219-4770

(800) 259-5301

http://www.ldi.louisiana.gov/

Language Access Services:

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Spanish (Español): Para obtener asistencia en Español, llame al 1-866-889-8977.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-889-8977.

Chinese (中文): 如果需要中文的帮助，**请拨打这个号码**1-866-889-8977.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-866-889-8977.

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** $6,210
- **Patient pays** $1,330

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	$500
Copays	$0
Coinsurance	$680
Limits or exclusions	$150
Total	**$1,330**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $4,630
- **Patient pays** $770

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	$500
Copays	$0
Coinsurance	$190
Limits or exclusions	$80
Total	**$770**

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?

✗ **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 **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.