Laurens County Cares Employee Health Plan
Quick Reference Summary
$500 80%/60% OV: $25/$30 Rx: $5/$45/$80/25%
Preferred Provider Organization (PPO)

Schedule of Benefits

Deductibles, Coinsurance and Maximums	In-Network Benefit	Out-of-Network Benefit
Calendar Year Deductible – Individual – Family	 $500 $1,500	 $500 $1,500
Coinsurance	**Plan pays 80% after deductible**	Plan pays 60% after deductible
Lifetime Maximum	Unlimited	Unlimited
Out-of-Pocket Calendar Year Maximum – Individual – Family	 $3,000 $9,000	 $3,000 $9,000

All benefits are subject to the calendar year deductible, except those with in-network copayments, unless otherwise noted.
All calendar year benefit visit maximums are combined between in-network and out-of-network. In addition to copayments, members are responsible for deductibles and any applicable coinsurance. Members are also responsible for all costs over the plan maximums. Some services may require pre-certification before services are covered by the Plan.
When using out-of-network providers, members are responsible for any difference between the Maximum Allowed Amount and the amount the provider actually charges, as well as any copayments, deductibles and/or applicable coinsurance.
*Deductibles and out-of-pocket maximums are added separately for in-network and out-of-network services. One family member may reach his or her Individual deductible and be eligible for coverage on health care expenses before other family members. Each family member's deductible amount also applies to the Family deductible and out-of-pocket maximum. Not everyone has to meet his or her deductible and out-of-pocket maximum for the family to meet theirs. When the Family deductible is met, all family members can access coverage for health care expenses. The medical and pharmacy copayments, deductible(s), and coinsurance on this plan will apply toward the out-of-pocket maximums. The following do not apply to out-of-pocket maximums: non- covered items, plan premiums, any balance billing due to Out-of-Network services, or any fourth quarter deductible amounts carried over from previous benefit period.

Covered Services	In-Network Benefit **** Member Pays ****	Out-of-Network Benefit **** Member Pays ****
Preventive Care and Services Preventive Care Services are those that meet the requirements of federal and state law, including certain screenings, immunizations, and physician visits.		
• Well-child care, immunizations, vaccines • Annual adult health examinations and physicals • Annual gynecology examination and mammograms • Annual prostate screening	Member pays 0% (not subject to deductible)	Member pays 30% after deductible (deductible waived through age 5)
Primary Care Physician (PCP) Services Services performed AND billed in a physician's office		
• Teladoc Visit Teladoc.com or call 1-800-TELADOC (835-2362)	$20 Copay	
• **Office Visit** (including laboratory analysis performed inside or outside of the office. X-rays performed in the office.)	$25 Copay	Member pays deductible then 40%
• **Specialist Office Visit** (including laboratory analysis performed inside or outside of the office. X-rays performed in the office.)	$30 Copay	Member pays deductible then 40%
• Surgery in a physician's office (surgery & administration of general anesthesia)	Member pays deductible then 20%	Member pays deductible then 40%
• Allergy Services (Office visits, testing and the administration of allergy injections) • Allergy injection Serum	$25 PCP or $30 Specialist copay Member pays 0% (Not subject to deductible)	Member pays deductible then 40% Member pays deductible then 40%
• Nutritional Counseling (4 visits per Benefit period) • Nutritional Counseling for Diabetes (UNLIMITED) Nutritional Counseling for Eating Disorders (UNLIMITED)	$25 Copay	Member pays deductible then 40%

• Maternity physician services (prenatal, delivery, postpartum)	Member pays deductible then 20%	Member pays deductible then 40%
Retail Health Clinic- (located in some pharmacies) • Immunizations • Periodic health examinations	$25 Copay	Member pays deductible then 40%
Emergency Room Services		
• True Emergency use of the ER	$100 Copay **(waived if admitted)**	$100 Copay **(waived if admitted)**
• Non-Emergency use of the ER	$500 Copay • ER Doctor charge- 20% after deductible and copay • Other Facility charges (inc. diagnostic x-ray and labs, medical supplies, MRI's, CAT scans)	$500 Copay • ER Doctor charge- 20% after deductible and copay • Other Facility charges (inc. diagnostic x-ray and labs, medical supplies, MRI's, CAT scans)
Inpatient Hospital Services		
• Daily room, board and general nursing care at semi-private room rate; ICU/CCU; other medically necessary hospital charges such as diagnostic x-ray and lab services; newborn nursery care	Member pays deductible then 20%	Member pays deductible then 40%
• Physician services (anesthesiologist, radiologist, pathologist)		
Outpatient Services		
• Surgery facility / hospital charges	Member pays deductible then 20%	Member pays deductible then 40%
• Diagnostic X-ray and lab services	Member pays deductible then 20%	Member pays deductible then 40%
• Physician services (anesthesiologist, radiologist, pathologist)	Member pays deductible then 20%	Member pays deductible then 40%
• Outpatient Dialysis Treatment: (In-Network and Out of Network)-100% of the lesser of (i) the Usual, Customary, and Reasonable Outpatient Dialysis Charge as defined in "Outpatient Dialysis Treatment" Section in the Plan Document, (ii) the maximum allowable charge after all applicable deductibles and cost-sharing; and (iii) such charge as is negotiated between the Plan Administrator and the provider of Outpatient Dialysis Treatment.	Member pays deductible then 20% of Usual, Customary and Reasonable Charge	Member pays deductible then 40% of Usual and Customary Charge

Covered Services	In-Network Benefit	Out-of-Network Benefit
Therapy Services **Calendar year maximums are combined between in-network and out-of-network** **Notes:** The limits for physical, occupational, and speech therapy will not apply if you get that care as part of the Hospice Care or the Inpatient Facility Services benefit. When physical, occupational, or speech therapy is rendered in the home, the Home Care Visit limit will apply instead of the Therapy Services limits listed above. Therapy visit limits do not apply to autism services. ****See SPD for details on Early Intervention Services**		
• Speech therapy (20 visit benefit period max)	$25 Copay	Member pays deductible then 40%
• Physical therapy and Occupational therapy (20 visit benefits period maximum combined)		
• Chiropractic Care/ Manipulation Therapy (20 visit benefit period max)		
• Other Therapy Services: Radiation therapy, chemotherapy, cardiac rehabilitation (there is no Cardiac Rehabilitation visit max on this plan; authorization required) and respiratory/ pulmonary therapy	Member pays deductible then 20%	Member pays deductible then 40%
Mental Health / Substance Abuse ***Services must be authorized by calling 1-888-741-2673**		

• Inpatient mental health AND substance abuse services* (facility and physician fee)	Member pays deductible then 20%	Member pays deductible then 40%
• Partial Hospitalization Program (PHP) & Intensive Outpatient Program (IOP)* (facility and physician fee)	Member pays 0%, No Copayment, No Deductible or Coinsurance	Member pays deductible then 30%
• Office mental health and substance abuse services (physician fee)	$25 Copay	Member pays deductible then 40%
• Professional Outpatient mental health and substance abuse services (physician fee)	Member pays deductible then 20%	Member pays deductible then 40%
Other Services **Calendar year maximums are combined between in-network and out-of-network**		
• Urgent Care Center	$25 Copay	Member pays deductible then 40%
• Skilled Nursing Facility (60-day benefit period max)	Member pays deductible then 20%	Member pays deductible then 40%
• Home Health Care (120-day benefit period max)	$25 Copay	Member pays deductible then 40%
• Hospice Care (Inpatient and Outpatient services covered under the hospice treatment program)	Member pays 0%, No Copayment, No Deductible or Coinsurance	Member pays 0%, No Copayment, No Deductible or Coinsurance
• Ambulance- Air & Ground (covered when medically necessary)	Member pays 0%, No Copayment, No Deductible or Coinsurance	Member pays 0%, No Copayment, No Deductible or Coinsurance *Out-of-Network Providers may also bill you for any charges that exceed the Plan's Maximum Allowed Amount.
• Durable Medical Equipment (DME) *Wigs needed after Cancer Treatment Benefit Max- One (1) per benefits period. *Hearing Aids covered for Members 18 years and under. Max benefits is limited to $3,000 per hearing aid per hearing impaired ear every 48 months, in and out of network combined.	Member pays deductible then 20%	Member pays deductible then 40%
PRESCRIPTION CO-PAYS Deductible- $75 (Individual) $150 (Family)	**RETAIL PHARMACY** (30-day supply only)	**MAIL ORDER** (90-day supply)
Generic	$5	$5
Preferred	$45	$90
Non-Preferred	$80	$240
Specialty Drug Co-pay	25% ($400 max)	N/A

This Schedule of Benefits is part of your Certificate of Insurance but does not replace it. Many words are defined elsewhere in the Certificate, and other limitations or exclusions may be listed in other sections of your Certificate. Reading this Schedule by itself could give you an inaccurate impression of the terms of your coverage. This Schedule must be read with the rest of your Certificate.

- **Prior authorization may be required for specific services.**
- **Payment to Out-of-Network providers is based on the Out-of-Network Rate (ONR).**
- **Preventative Services must qualify as such as specified in your contract and the PPACA in order to be exempt from applicable deductibles.**
- **Physician services are limited to one Copay per Member, per provider, per date of service and per place of service.**