


# Eden II Schools PPO Group Health Plan: High Plan

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

Coverage Period: 07/01/2016-06/30/2017

Coverage for: Individual Plan Type: PPO

 **This is only a summary.** If you want more detail about your coverage and costs, you can review your plan document or call SIEBA, LTD. at 800-252-4624

Important Questions	Answers	Why this Matters:
What is the overall <b>deductible</b> ?	<b>In-Network \$0 individual/\$0 family. Out-of-network: \$250 Individual/\$500 family.</b>	For out-of-network benefits only, you must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use.
Are there other <b>deductibles</b> for specific services?	<b>No</b>	
Is there an <b>out-of-pocket limit</b> on my expenses?	<b>Yes. \$1000 Individual. \$2000 Family.</b>	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 <b>out-of-pocket limit</b> ?	Network & benefit copayments, precertification penalties, certain specific benefits (durable medical equipment), prescriptions paid through the Rx plan, other services as described in your plan document, premiums, balance-billed charges, and health care this plan does not cover.	Even though you pay these expenses, they do not count toward the out-of-pocket limit.
Is there an overall <b>annual limit</b> on what the plan pays?	No	See your plan document for any limits on specific services.
Does this plan use a <b>network of providers</b> ?	Yes. The Plan utilizes the Magnacare network for In-network benefits. www.magnacare.com	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.
Do I need a referral to see a <b>specialist</b> ?	No	
Are there services this plan doesn't cover?	Yes	See plan document for additional information about excluded services.

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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 Magnacare **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	Out-of-network Provider	
<b>If you visit a health care provider's office or clinic</b>	Primary care visit to treat an injury or illness	\$25 copay/visit	20% coinsurance	See plan document for specific limits and exceptions.
	Specialist visit	\$30 copay/visit	20% coinsurance	
	Other practitioner office visit	\$30 copay/visit	20% coinsurance	
	Preventive care/screening/immunization	Well child: generally no charge. Well adult: no charge for one annual physical per year. Additional screenings may incur additional copays	20% coinsurance	
<b>If you have a test</b>	Diagnostic test (x-ray, blood work)	With office visit or outpatient hospital: No charge. No office visit: \$30 copay/visit.	20% coinsurance	
	Imaging (CT/PET scans, MRIs)	Outpatient hospital: no charge. Other provider: \$30 copay/visit	20% coinsurance	
<b>If you need drugs to treat your illness or condition</b>	Generic drugs	\$10	No coverage	
	Preferred brand drugs	\$25	No coverage	
	Non-preferred brand drugs	\$40	No coverage	

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		In-network Provider	Out-of-network Provider	
More information about <b>prescription drug coverage</b> is available <a href="http://www.sieba.com">www.sieba.com</a> .	Specialty drugs			
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	No charge	20% coinsurance	
	Physician/surgeon fees	No charge	20% coinsurance	
<b>If you need immediate medical attention</b>	Emergency room services	\$300 copay	20% coinsurance	Copay waived for in-network emergency services
	Emergency medical transportation	No charge	20% coinsurance	
	Urgent care	No charge	20% coinsurance	
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	No charge	20% coinsurance	
	Physician/surgeon fee	\$30 copay	20% coinsurance	
<b>If you have mental health, behavioral health, or substance abuse needs</b>	Mental/Behavioral health outpatient services	\$30 copay	20% coinsurance	
	Mental/Behavioral health inpatient services	No charge	20% coinsurance	
	Substance use disorder outpatient services	\$30 copay	20% coinsurance	
	Substance use disorder inpatient services	No charge	20% coinsurance	
<b>If you are pregnant</b>	Prenatal and postnatal care	\$30 copay	20% coinsurance	
	Delivery and all inpatient services	No charge	20% coinsurance	
<b>If you need help recovering or have other special health needs</b>	Home health care	No charge	20% coinsurance	120 day limit per year
	Rehabilitation services	\$30 copay	20% coinsurance	
	Habilitation services	No charge	20% coinsurance	
	Skilled nursing care	No charge	20% coinsurance	
	Durable medical equipment	No charge	20% coinsurance	
	Hospice service	No charge	20% coinsurance	
<b>If your child needs dental or eye care</b>	Eye exam	\$10 copay	Not covered	
	Glasses	Not covered	Not covered	

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		In-network Provider	Out-of-network Provider	
	Dental check-up	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**.)

- Acupuncture
- Dental services
- Vision services

**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.)

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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. 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](http://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](http://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: SIEBA, LTD. 111 Grant Ave. Suite 202, Endicott, NY 13760, Tel. 1-800-252-4624. 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](http://www.dol.gov/ebsa/healthreform). ———

—————*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 \$7,440
- Patient pays \$ 100

##### 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
<b>Total</b>	<b>\$7,540</b>

##### Patient pays:

Deductibles	\$0
Co-pays	\$120
Co-insurance	\$0
Limits or exclusions	\$0
<b>Total</b>	<b>\$100</b>

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

- Amount owed to providers: \$4,100
- Plan pays \$3,500
- Patient pays \$ 600

##### Sample care costs:

Prescriptions	\$1,500
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$730
Education	\$290
Laboratory tests	\$140
Vaccines, other preventive	\$140
<b>Total</b>	<b>\$4,100</b>

##### Patient pays:

Deductibles	\$0
Co-pays	\$600
Co-insurance	\$0
Limits or exclusions	\$0
<b>Total</b>	<b>\$600</b>

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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.

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