Eden II Schools PPO Group Health Plan: Low 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 deductible?	**In-Network $0 individual/$0 family. Out-of-network: $3000 Individual/$9000 family.**	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 deductibles for specific services?	**No**	
Is there an out–of–pocket limit on my expenses?	**Yes. $3000 Individual. $9000 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?	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 annual limit on what the plan pays?	No	See your plan document for any limits on specific services.
Does this plan use a network of providers?	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 specialist?	No	
Are there services this plan doesn't cover?	Yes	See plan document for additional information about excluded services.

Questions: Call 1-800-252-4624 or visit us at www.sieba.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.sieba.com or call 1-800-252-4624 to request a copy.

OMB Control Numbers 1545-2229, 1210-0147, and 0938-1146

- **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 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	
	Specialist visit	$25 copay/visit	30% coinsurance	
	Other practitioner office visit	$25 copay/visit	30% 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	30% coinsurance	See plan document for specific limits and exceptions.
If you have a test	Diagnostic test (x-ray, blood work)	With office visit or outpatient hospital: No charge. No office visit: $25 copay/visit.	30% coinsurance	
	Imaging (CT/PET scans, MRIs)	Outpatient hospital: no charge. Other provider: $25 copay/visit	30% coinsurance	
If you need drugs to treat your illness or condition	Generic drugs	$10	No coverage	
	Preferred brand drugs	$25	No coverage	
	Non-preferred brand drugs	$40	No coverage	

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
More information about **prescription drug coverage** is available www.sieba.com.	Specialty drugs			
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	30% coinsurance	
	Physician/surgeon fees	No charge	30% coinsurance	
If you need immediate medical attention	Emergency room services	$300 copay	30% coinsurance	Copay waived for in-network emergency services
	Emergency medical transportation	No charge	30% coinsurance	
	Urgent care	No charge	30% coinsurance	
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	30% coinsurance	
	Physician/surgeon fee	$25 copay	30% coinsurance	
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$25 copay	30% coinsurance	
	Mental/Behavioral health inpatient services	No charge	30% coinsurance	
	Substance use disorder outpatient services	$25 copay	30% coinsurance	
	Substance use disorder inpatient services	No charge	30% coinsurance	
If you are pregnant	Prenatal and postnatal care	$25 copay	30% coinsurance	
	Delivery and all inpatient services	No charge	30% coinsurance	
If you need help recovering or have other special health needs	Home health care	No charge	30% coinsurance	120 day limit per year
	Rehabilitation services	$25 copay	30% coinsurance	
	Habilitation services	No charge	30% coinsurance	
	Skilled nursing care	No charge	30% coinsurance	
	Durable medical equipment	No charge	30% coinsurance	
	Hospice service	N ocharge	30% coinsurance	
If your child needs dental or eye care	Eye exam	$10 copay	Not covered	
	Glasses	Not covered	Not covered	

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
	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.)**

- Acupuncunture
- 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, 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: 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.

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** $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
Total	**$7,540**

Patient pays:

Deductibles	$0
Co-pays	$100
Co-insurance	$0
Limits or exclusions	$0
Total	**$100**

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
Total	**$4,100**

Patient pays:

Deductibles	$0
Co-pays	$600
Co-insurance	$0
Limits or exclusions	$0
Total	**$600**

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.