**Hillsdale Local School District Medical Benefits Plan** Coverage Period Beginning 06/01/2014
**Summary of Benefits and Coverage:** What this Plan Covers & What it Costs **Coverage for:** Individual + Family **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 plan document at www. HillsdaleLocalSchools.org by calling (419) 368-8231.

| Important Questions | Answers | Why this Matters |
|---|---|---|
| **What is the overall deductible?** | PPO: **$150**/person and **$325**/family. Non-PPO: **$500**/person and **$1,000**/family. | You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your plan document to see when the deductible starts over. See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**. The PPO and non-PPO **deductibles** will not be applied toward each other. |
| **Are there other deductibles for specific services?** | No. | 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. PPO is $950/person and $1,500/family. Non-PPO is $2,000/person and $4,000/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. The PPO and non-PPO out-of-pocket limits will not apply toward each other. |
| **What is not included in the out-of-pocket limit?** | Deductibles, prescription drug charges, penalties, balance-billed and excluded charges. | Even though you pay these expenses, they don't count toward the **out-of-pocket limit**. |
| **Is there an overall limit on what the plan pays?** | No. This plan has no overall annual limit on the amount it will pay each year. | 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. See www.aetna.com or call 888-632-3862. | 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 **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 plan document for additional information about **excluded** , **services.** |

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- **Copayments** are the fixed dollar amounts (for example, $200) 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 participating **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

| Common Medical Event | Services You May Need | Your Cost if You use a Participating Provider | Your Cost if You use a Non-Participating Provider | Limitations & Exceptions |
|---|---|---|---|---|
| **If you visit a health care provider's office or clinic** | Primary care visit to treat an injury or illness | 20% coinsurance | 40% coinsurance | None |
| | Specialist Visit | 20% coinsurance | 40% coinsurance | None |
| | Other practitioner office visit | 20% coinsurance | 40% coinsurance | Chiro limited to 15 visits (PPO) and 8 visits (non-PPO) |
| | Preventive care/screening/immunization | 20% coinsurance | Not covered | PPO is 10% coinsurance for paps and mammograms. Limits described in SPD. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | 20% coinsurance | 40% coinsurance | None |
| | Imaging (CT/PET scans, MRIs) | 20% coinsurance | 40% coinsurance | None |

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| Common Medical Event | Services You May Need | Your Cost if You use a Participating Provider | Your Cost if You use a Non-Participating Provider | Limitations & Exceptions |
|---|---|---|---|---|
| **If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.CVSCaremark.com** | Generic Drugs | 20% coinsurance Deductible waived | | For all drugs, when $1,800 has been paid by person in a cal yr, plan pays balance at 100% |
| | Preferred Brand Drugs | 20% coinsurance Deductible waived | | |
| | Non-preferred Brand Drugs | 20% coinsurance Deductible waived | | See above |
| | Specialty Drugs | 20% coinsurance Deductible waived | | See above |
| **If you have outpatient surgery** | Facility Fee (e.g. ambulatory surg ctr) | 20% coinsurance | 40% coinsurance | None |
| | Physician/Surgeon Fee | 20% coinsurance | 40% coinsurance | None |
| **If you need immediate medical attention** | Emergency room svcs | 20% coinsurance | 20% coinsurance | None |
| | Emergency medical transportation | 20% coinsurance | 40% coinsurance | None |
| | Urgent Care | 20% coinsurance | 40% coinsurance | None |
| **If you have a hospital stay** | Facility (hosp room) | 20% coinsurance | 40% coinsurance | None |
| | Physician/surgeon fee | 20% coinsurance | 40% coinsurance | None |

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| Common Medical Event | Services You May Need | Your Cost if You use a Participating Provider | Your Cost if You use a Non-Participating Provider | Limitations & Exceptions |
|---|---|---|---|---|
| **If you have mental health, behavioral health, or substance abuse needs** | Mental health outpat | 20% coinsurance | 40% coinsurance | None |
| | Mental health inpat | 20% coinsurance | 40% coinsurance | None |
| | Subst abuse outpat | 20% coinsurance | 40% coinsurance | None |
| | Subst abuse inpat | 20% coinsurance | 40% coinsurance | None |
| **If you are pregnant** | Pre- and Post-natal care | 20% coinsurance | 40% coinsurance | None |
| | Delivery and all inpatient services | 20% coinsurance | 40% coinsurance | None |
| **If you need help recovering or have other special health needs** | Home health care | 20% coinsurance | 40% coinsurance | Max 100 visits (PPO) and 60 visits (non-PPO) |
| | Rehab Services | 20% coinsurance | 40% coinsurance | Max 60 days SNF (PPO) and 30 days (non-PPO) |
| | Habilitation services | 20% coinsurance | 40% coinsurance | PT max is 30 visits (PPO) and 15 visits (non-PPO) |
| | Skilled nursing care | 20% coinsurance | 40% coinsurance | None |
| | Durable medical equip | 20% coinsurance | 40% coinsurance | Must be covered by Medicare guidelines |
| | Hospice service | 20% coinsurance | 40% coinsurance | Max 100 days |
| **If your child needs dental or eye care** | Eye exam | Not Covered | Not Covered | Not Covered |
| | Glasses | Not Covered | Not Covered | Not Covered |
| | Dental check-up | Not Covered | Not Covered | Not Covered |

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**Excluded Services & Other Covered Services:**

| **Services Your Plan Does NOT Cover (This is not a complete list. Check your plan document for other excluded services.)** | | |
|---|---|---|
| ▪Cosmetic surgery | ▪Infertility treatment (some) | ▪Routine foot care |
| ▪Dental care (Adult) | ▪Long-Term Care | ▪Weight loss programs |
| ▪Hearing Aids | ▪Routine eye care (Adult) | |

| **Other Covered Services (This is not a complete list. Check your plan document for other covered services.)** | |
|---|---|
| ▪Acupuncture (if prescribed for rehab) | ▪Infertility treatment (some) |
| ▪Bariatric surgery | ▪Non-emergency care when traveling outside the US |
| ▪Chiropractic care | ▪Private duty nursing |

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**Your Rights to Continue Coverage:**

If you lose coverage under the plan, then, depending upon the circumstances, federal 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, call the plan supervisor at extension 7005 at either (800) 722-7374 or (216) 566-1455. You may also contact the U.S. Department of Labor, Employee Benefits Security Administration at (866) 444-3272 (website is www.dol.gov/ebsa) or the U.S. Department of Health and Human Services at (877) 267-2323 ext 61565 (website www.cciio.com.gov).

**Your Grievance and Appeal 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 Self-Funded Plans, Inc. at 800-722-7374. Also, the Department of Labor's Employee Benefits Security Administration can be contacted at 866-444-3272 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 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% 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.**

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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. 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.

**! This is not a cost estimator**

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See the next page for important information about these examples.

| **Having a baby (normal delivery)**<br>**Amount owed to providers:** $7,540<br>**Plan pays** $6,132<br>**Patient pays** $1,408 | | **Managing type 2 diabetes**<br>**Amount owed to providers:** $5,400<br>**Plan pays** $3,880<br>**Patient pays** $1,520 | |
|---|---|---|---|
| **Sample care costs:** | | **Sample care costs:** | |
| Hospital charges (mother) | $2,700 | Prescriptions | $2,900 |
| Routine obstetric care | $2,100 | Med equipment and supplies | $1,300 |
| Hospital charges (baby) | $900 | Office visits and procedures | $700 |
| Anesthesia | $900 | Education | $300 |
| Laboratory tests | $500 | Laboratory tests | $100 |
| Prescriptions | $200 | Vaccines, other preventive | $100 |
| Radiology | $200 | **Total** | **$5,400** |
| Vaccines, other preventive mom | $40 | **Patient pays:** | |
| **Total** | **$7,540** | Deductibles | $150 |
| **Patient pays:** | | Co-Pays | $0 |
| Deductibles (mother and baby) | $300 | Coinsurance | $970 |
| Co-Pays | 0 | Limits or Exclusions | $400 |
| Coinsurance (mother and baby | $1,108 | **Total** | **$1,520** |
| Limits or exclusions | 0 | | |
| **Total** | **$1,408** | | |

**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 average 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 pre-existing 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 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 must 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.

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