Bartholomew Consolidated School Corp: Option 2

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

Coverage Period: 1/1/2014-12/31/2014

Coverage for: Single/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 policy or plan document at your employer or by calling SIHO 1-800-443-2980

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$750** single/**$1,500** 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 policy or plan document to see when the **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 **deductible**.
Are there other deductibles for specific services?	No.	You must pay all of the costs for these services up to the specific **deductible** amount before this plan begins to pay for these services.
Is there an out–of–pocket limit on my expenses?	Yes. **$2,750** single/**$5,500** 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?	precertification penalties	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. Unlimited	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.siho.org **or call 1-800-443-2980** for a list of participating providers.	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 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**.

- **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

Questions: Call 1-800-443-2980 or visit us at www.siho.org.
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.dol.gov/ebsa/pdf/sbc or call 1-800-443-2980 to request a copy.

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

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 **preferred 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	20% co-insurance	40% co-insurance	
	Specialist visit	20% co-insurance	40% co-insurance	
	Other practitioner office visit	20% co-insurance	40% co-insurance	Chiropractic calendar year maximum: 20 visits
	Preventive care/screening/immunization	No charge	No charge	Based on SIHO's Comprehensive Preventive Guidelines
If you have a test	Diagnostic test (x-ray, blood work)	20% co-insurance	40% co-insurance	
	Imaging (CT/PET scans, MRIs)	20% co-insurance	40% co-insurance	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.siho.org.	Generic drugs	Retail: $12 co-pay Mail order: $24 co-pay	Member is responsible for cost of medication	
	Preferred brand drugs	Retail: $24 co-pay Mail order: $48 co-pay	Member is responsible for cost of medication	
	Non-preferred brand drugs	Retail: $48 co-pay Mail order: $80 co-pay	Member is responsible for cost of medication	
	Specialty drugs	Covered under pharmacy benefit	Covered under pharmacy benefit	Prior authorization required
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% co-insurance	40% co-insurance	
	Physician/surgeon fees	10% co-insurance	40% co-insurance	

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 need immediate medical attention	Emergency room services	Facility-$100 co-pay, then 20% co-insurance, Physician services-20% co-insurance	Facility-$100 co-pay, then 20% co-insurance, Physician services-20% co-insurance	Co-pay waived if directly admitted to hospital from ER.
	Emergency medical transportation	20% co-insurance	40% co-insurance	
	Urgent care	20% co-insurance	40% co-insurance	
If you have a hospital stay	Facility fee (e.g., hospital room)	10% co-insurance	40% co-insurance	Prior authorization required
	Physician/surgeon fee	10% co-insurance	40% co-insurance	Prior authorization required
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	20% co-insurance	40% co-insurance	Prior authorization required
	Mental/Behavioral health inpatient services	20% co-insurance	40% co-insurance	Prior authorization required
	Substance use disorder outpatient services	20% co-insurance	40% co-insurance	Prior authorization required
	Substance use disorder inpatient services	20% co-insurance	40% co-insurance	Prior authorization required
If you are pregnant	Prenatal and postnatal care	10% co-insurance	40% co-insurance	Dependent daughters are covered. Newborn charges are not covered under the mother.
	Delivery and all inpatient services	10% co-insurance	40% co-insurance	Dependent daughters are covered. Newborn charges are not covered under the mother.

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 need help recovering or have other special health needs	Home health care	10% co-insurance	40% co-insurance	Prior authorization required. Calendar year maximum: 60 visits
	Rehabilitation services	20% co-insurance	40% co-insurance	Prior authorization required
	Habilitation services	20% co-insurance	40% co-insurance	Prior authorization required for Speech Therapy.
	Skilled nursing care	10% co-insurance	40% co-insurance	Prior authorization required. Calendar year maximum: 180 days
	Durable medical equipment	20% co-insurance	40% co-insurance	Prior authorization required on all purchases over $200 and on all rentals
	Hospice service	10% co-insurance	40% co-insurance	Prior authorization required. Calendar year maximum: 3 months outpatient and 6 months inpatient. Covers bereavement counseling 100% up to maximum of $25/visit within 9 months of death
If your child needs dental or eye care	Eye exam	Not covered	Not covered	
	Glasses	Not covered	Not covered	
	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.)

- Hearing Aids
- Acupuncture (unless performed as an alternative to anesthesia)
- Bariatric surgery
- Private duty nursing
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult)
- Cosmetic surgery
- Dental care (Adult)
- Weight loss programs
- Long-term care

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.)

- Routine foot care
- Chiropractic care
- Infertility treatments

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 [contact number]. 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: the Appeals Coordinator in writing P.O. Box 1787 Columbus, IN 47202 or verbally by calling 1-800-443-2980.

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** $5,760
- **Patient pays** $ 1,780

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	$750
Co-pays	$20
Co-insurance	$860
Limits or exclusions	$150
Total	**$1,780**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $3,730
- **Patient pays** $ 1,670

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	$750
Co-pays	$430
Co-insurance	$410
Limits or exclusions	$80
Total	**$1,670**

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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