Blackwater Community Schools Employee Benefit Plan (PPO Plan): Blackwater Community Schools

Coverage Period: 07/1/16- 06/30/17

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 policy or **plan** document by calling the plan at 520-215-7910. (Note: the Uniform Glossary can be accessed at: www.dol.gov/ebsa/healthreform).

Important Questions	Answers	Why this Matters:
What is the overall deductible?	Per calendar year - **PPO** - $2,000 Per Person/$4,000 Per Family - **Non-PPO** - $4,000 Per Person/$8,000 Per Family; **Deductible** doesn't apply to **PPO** preventive care; prescription drugs	You must pay all 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 (usually, but not always, January 1st). See 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 don't have to meet **deductibles** for specific services, but 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 and RX** - $6,000 Per Person/ $12,000 Per Family; **Non-PPO** - $8,000 Per Person/$16,000 Per Family	The **out-of-pocket limit** is the most you could pay for covered services 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?	**Premiums, balanced billed charges** and health care this **plan** doesn't cover.	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	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 participating providers?	Yes. The **PPO** is BCBSAZ. See www.azblue.com/CHSnetwork or call Summit at 1-888-690-2020 for a list of **PPO providers**	If you use a **PPO provider** doctor or other health care provider, this **plan** will pay some or all of the costs of covered services. Be aware, your **PPO provider** doctor or hospital may use a **Non-PPO 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 providers.
Do I need a referral to see a specialist?	No	You can see the specialist you choose without permission from the **plan.**
Are there services this plan doesn't cover?	Yes	Some of the services this plan doesn't cover are listed on page 6. See your policy or **plan** document for additional information about **excluded services**.

Questions: Call 1- 520-215-5859 x- 7910
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can call 1-520-215-5859 x- 7910 to request a copy.

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- **Copayments** are fixed dollar amounts (for example, $15) 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 **preferred providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a PPO Provider	Your Cost If You Use a Non-PPO 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**	50% **coinsurance**	Limited to 20 visits per calendar year for chiropractic and outpatient therapy
	Specialist visit	20% **coinsurance**	50% **coinsurance**	
	Other practitioner office visit	20% **coinsurance**	50% **coinsurance**	
	Preventive care/screening/immunization	0% **coinsurance**	Not Covered	**PPO deductible** waived.
If you have a test	Diagnostic test (x-ray, blood work)	20% **coinsurance**	50% **coinsurance**	
	Imaging (CT/PET scans, MRIs)	20% **coinsurance**	50% **coinsurance**	

Common Medical Event	Services You May Need	Your Cost If You Use a PPO Provider	Your Cost If You Use a Non-PPO Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.magellanrx.com	Contraceptives and Mandated OTC Drugs	Retail - $0 **copay**	Not Covered	Limited to a 30 day supply
	Generic drugs	Retail - $5 **copay** Mail - $5 **copay**	Not Covered	Limited to 30 day supply – Retail 90 day supply - Mail
	Formulary Brand Name drugs	Retail - $25 **copay** Mail - $25 **copay**	Not Covered	Limited to 30 day supply – Retail 90 day supply - Mail
	Non-Formulary Brand Name drugs	Retail - $75 **copay** Mail - $75 **copay**	Not Covered	Limited to 30 day supply – Retail 90 day supply - Mail
	Specialty Drugs	Retail - $200 **copay** Mail - $200 **copay**	Not Covered	Requires precertification
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% **coinsurance**	50% **coinsurance**	Specified outpatient procedures require precertification. $300 penalty for noncompliance.
	Physician/surgeon fees	20% **coinsurance**	50% **coinsurance**	
If you need immediate medical attention	**Emergency room services**	20% **coinsurance**	20% **coinsurance**	**PPO deductible** applies to **Non-PPO** treatment
	Emergency medical transportation	20% **coinsurance**	20% **coinsurance**	
	Urgent care	20% **coinsurance**	50% **coinsurance**	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% **coinsurance**	50% **coinsurance**	Precertification required. $300 penalty for noncompliance.
	Physician/surgeon fee	20% **coinsurance**	50% **coinsurance**	

Common Medical Event	Services You May Need	Your Cost If You Use a PPO Provider	Your Cost If You Use a Non-PPO Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	20% **coinsurance**	50% **coinsurance**	Precertification required. $300 penalty for noncompliance.
	Mental/Behavioral health inpatient services	20% **coinsurance**	50% **coinsurance**	
	Substance abuse disorder outpatient services	20% **coinsurance**	50% **coinsurance**	
	Substance abuse disorder inpatient services	20% **coinsurance**	50% **coinsurance**	
If you are pregnant	Prenatal and postnatal care **Physician**	20% **coinsurance**	50% **coinsurance**	Routine prenatal care is payable as preventive care.
	Delivery and all inpatient services	20% **coinsurance**	50% **coinsurance**	
If you need help recovering or have other special health needs	**Home health care**	20% **coinsurance**	50% **coinsurance**	
	Rehabilitation services	20% **coinsurance**	50% **coinsurance**	Limited to 20 visits per calendar year for physical and occupational therapy and 20 visits per calendar year for speech therapy
	Habilitation services	20% **coinsurance**	50% **coinsurance**	
	Skilled nursing care	20% **coinsurance**	50% **coinsurance**	
	Durable medical equipment	20% **coinsurance**	50% **coinsurance**	
	Hospice service	20% **coinsurance**	50% **coinsurance**	
If your child needs dental or eye care	Eye exam	0% **coinsurance**	Not Covered	Covered under preventive care with **deductible waived.**
	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.)**

- Acupuncture
- Cosmetic Surgery or complications as a result of such services
- Dental Care
- Infertility Treatment
- Long Term Care
- Non-emergency care when traveling outside the United States.
- Private Duty Nursing
- Refractive Eye Surgery
- Routine Foot Care
- Weight Loss Programs

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.)**

- Bariatric Surgery
- Chiropractic Care
- Hearing Aids

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 502-215-7910. 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 X 61565 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: Blackwater Community Schools: (502) 215-79810 or the Department of Labor, Employee Benefit Security Administration at 1-866-444-EBSA or www.dol.ebsa/healthreform.

Does This Plan Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health coverage that qualifies as "minimum essential coverage." **This plan does provide minimum essential coverage.**

Does This Coverage Meet The Minimum Value Standard?

The Affordable Care Act established a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum standard for the benefits it provides.**

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** $4,455
- **Patient pays** $3,085

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	$2,000
Copays	$25
Coinsurance	$1,060
Limits or exclusions	$0
Total	**$3,085**

Note: Assumes **PPO Providers**
Assumes all charges are for the mother except routine nursery, vaccines and other preventive
Assumes 5 generic prescriptions

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

- **Amount owed to providers:** $5,400
- **Plan pays** $3,260
- **Patient pays** $2,140

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	$2,000
Copays	$60
Coinsurance	$80
Limits or exclusions	$0
Total	**$2,140**

Note: Assumes **PPO Providers**
Assumes 12 generic prescriptions
Assumes 4 physician office visits

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**, **copayments**, 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 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.