Teton School District 401

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

Coverage Period: Beginning 9/1/2017

Coverage for: Enrollee +Eligible Dependents | **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 by calling 1-877-878-3541.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	$ 1000 person/$2,000 Family. Does not apply to pharmacy, copays, in-network hospice care and listed preventive care.	You must pay all costs up to the deductible amount before this plan begins to pay for covered services you use. Plan deductible starts over 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. There are no other specific deductibles	You don't have to meet deductibles for specific services, but see the chart on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. $2900 person/$5800 family In-Network. This does include deductible. Out of Network is different.	The out-of-pocket limit is the most you could pay during a coverage period (1/1/2017-12/31/2017). This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Co-pays, premiums, balance-billed charges, dental, vision, pharmacy and health care not covered by this plan.	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 providers?	Yes. For a list of in-network providers, see www.bcidaho.com or call 1-800-627-1188.	If you use an in-network doctor or other health care provider, this plan will pay some of 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 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 3. See your policy or plan document for additional information about excluded services.

Questions: Call 1-877-878-3541.

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.cciio.cms.gov.

- **Copayments** are fixed dollar amounts (for example, $30) 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 percentage 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 30% would be $300. This may change if you haven't met your **deductible**. *Keep in mind that the co-insurance on the buydown/pool is 20% until you have hit $3,000 in deductible related expenses.*
- 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 in-network **providers** by charging you lower **deductibles**, **copayments** and **co-insurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a 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	$30 co-pay/ visit	40% co-insurance	Does not apply to additional services
	Specialist visit	$30 copay/visit	40% co-insurance	
	Other practitioner office visit	$30 co-pay/ visit	40% co-insurance	Does not apply to additional services
	Preventive care/screening/immunization	No charge for listed preventive, screening and immunization services.	No charge for listed immunizations, 50% co-insurance preventive and screening	----------None----------
If you have a test	Diagnostic test (x-ray, blood work)	No charge up to $100 then 20% co-insurance	40% co-insurance	----------None----------
	Imaging (CT/PET scans, MRIs)	No charge up to $100 then 20% co-insurance	40% co-insurance	Preauthorization required

Common Medical Event	Services You May Need	Your Cost If You Use a In-Network Provider	Your Cost If You Use an Out-Of-Network Provider	Limitations & Exceptions
More information about **prescription drug coverage** is available at www.bcidaho.com	Generic drugs	**20% co-insurance (retail (mail order)**		**Covers up to 90 day supply with multiple Co-pays**
	Preferred brand drugs	**$10 copay/ prescription, 20% co-insurance (retail and mail order)**		**Covers up to 90 day supply with multiple copays**
	Non-preferred brand drugs	**$10 copay/ prescription, 20% co-insurance (retail and mail order)**		**Covers up to 90 day supply with multiple copays**
	Specialty drugs	**$10 copay/ prescription, 20% co-insurance (retail and mail order)**		**Covers up to 90 day supply with multiple copays**
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% co-insurance	40% co-insurance	Preauthorization required
	Physician/surgeon fees	20% co-insurance	40% co-insurance	Preauthorization required
If you need immediate medical attention	Emergency room services	20% co-insurance after $100 co-pay	40% co-insurance after $100 co-pay	Co-Pay waived if admitted
	Emergency medical transportation	20% co-insurance	40% co-insurance	----------none----------
	Urgent care	$30 copay/visit	40% co-insurance	Does not apply to additional services
If you have a hospital stay	Facility fee (e.g., hospital room)	20% co-insurance	40% co-insurance	Preauthorization required
	Physician/surgeon fee	20% co-insurance	40% co-insurance	Preauthorization required

Common Medical Event	Services You May Need	Your Cost If You Use a In-Network Provider	Your Cost If You Use an Out-Of-Network Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$30 co–pay / visit, 20% co-insurance for facility and other services	40% co-insurance	Preauthorization required
	Mental/Behavioral health inpatient services	20% co-insurance	40% co-insurance	Preauthorization required
	Substance use disorder outpatient services	$30 co–pay / visit, 20% co-insurance for facility and other services	40% co-insurance	Preauthorization required
	Substance use disorder inpatient services	20% co-insurance	40% co-insurance	Preauthorization required
If you are pregnant	Prenatal and postnatal care	20% co-insurance	40% co-insurance	Maternity services for children are not covered.
	Delivery and all inpatient services	20% co-insurance	40% co-insurance	
If you need help recovering or have other special health needs	Home Health Care	20% co-insurance	40% co-insurance	Preauthorization required
	Rehabilitation services	20% co-insurance	40% co-insurance	Coverage is limited to 20 visit annual max for rehabilitation services
	Habilitation services	20% co-insurance	40% co-insurance	Coverage is limited to 20 visit annual max for habilitation services
	Skilled nursing care	20% co-insurance	40% co-insurance	Coverage is limited to 30 day annual max.
	Durable medical equipment	20% co-insurance	40% co-insurance	Preauthorization required
	Hospice service	20% co-insurance	40% co-insurance	Preauthorization required. Coverage is limited to $10,000 lifetime
If your child needs dental or eye care	Eye Exam	Not Covered	Not Covered	----------NONE----------
	Dental check-up	Not Covered	Not Covered	----------NONE----------
	Glasses	Not Covered	Not Covered	----------NONE----------

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, except congenital anomalies
Dental care (Adult)
Hearing aids
Infertility treatment
Long-term care
Private-duty nursing
Routine eye care (Adult)
Routine foot care except for diabetic patients
Weight loss programs except for nutritional counseling
Vision hardware

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.)

- Non-emergency care when traveling outside the U.S.
- Chiropractic care
- Bariatric surgery

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 1-800-627-1188. 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 plan at 1-800-627-1188 or visit www.bcidaho.com You may also contact your state insurance department at 1 (800) 721-3272 or www.doi.idaho.gov or the U.S. Department of Labor, Employee Benefits Security Administration at 1 (866) 444-3272 or www.dol.gov/ebsa/healthreform.
SPANISH (Español): Para obtener asistencia en Español, llame al 1 (888) 367-2117.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

Language Access Services:

[Spanish (Español): Para obtener asistencia en Español, llame al 1 (888) 367-2117.

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1 (888) 367-2117.

[Chinese (中文): 如果需要中文的帮助，**请拨打这个号码** 1 (888) 367-2117.

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1 (888) 367-2117.

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** $5110.00
- **Patient pays** $2430.00

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	$1000.00
Copays	$70
Co-insurance	$1,830
Limits or exclusions	
Total	**$2,900**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $3300
- **Patient pays** $ 2100

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	$1000
Copays	$700
Co-insurance	$760
Limits or exclusions	
Total	**$2460**

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 **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 **copayments**, **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.