105 Window of Self Insurance: Ballard Community School District

Coverage Period: 07/01/2022 - 6/30/2023 **Coverage for: Employee & Family | Plan Type: Section 105**

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

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 1-800-301-6692.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$** 500 per person **$** 1,000 per 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?	Determined by primary health insurance coverage	The primary health insurance plan determines deductibles.
Is there an out–of–pocket limit on my expenses?	$1,000 per person $2,000 per 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 expense.
What is not included in the out–of–pocket limit?	Premiums, pre-service review penalties, balance-billed charges and health care this plan does not 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 partial self insured plan pays?	Yes, the overall annual limit is $3,000 per person and $6,000 per family	This partial self insured plan will pay for covered services only up to this limit during each coverage period.
Does this plan use a network of providers?	Determined by primary health insurance coverage	The primary health insurance plan determines network eligibility.
Do I need a referral to see a specialist?	Determined by primary health insurance coverage	The primary health insurance plan determines referrals to specialists.
Are there services this plan doesn't cover?	Determined by primary health insurance coverage	The primary health insurance plan determines what services are covered and not covered.

Questions: Call 1-800-301-6692

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.dol.gov/ebsa/healthreform or call 1-800-301-6692 to request a copy.

- **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 primary health network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** 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	Determined by primary insurance	Determined by primary insurance	Determined by primary insurance
	Specialist visit	Determined by primary insurance	Determined by primary insurance	Determined by primary insurance
	Other practitioner office visit	Determined by primary insurance	Determined by primary insurance	Determined by primary insurance
	Preventive care/screening/immunization	Determined by primary insurance	Determined by primary insurance	Determined by primary insurance
If you have a test	Diagnostic test (x-ray, blood work)	Determined by primary insurance	Determined by primary insurance	Determined by primary insurance
	Imaging (CT/PET scans, MRIs)	Determined by primary insurance	Determined by primary insurance	Determined by primary 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 drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.[insert].	Generic drugs	Determined by primary insurance	Determined by primary insurance	Determined by primary insurance
	Preferred brand drugs	Determined by primary insurance	Determined by primary insurance	Determined by primary insurance
	Non-preferred brand drugs	Determined by primary insurance	Determined by primary insurance	Determined by primary insurance
	Specialty drugs	Determined by primary insurance	Determined by primary insurance	Determined by primary insurance
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Determined by primary insurance	Determined by primary insurance	Determined by primary insurance
	Physician/surgeon fees	Determined by primary insurance	Determined by primary insurance	Determined by primary insurance
If you need immediate medical attention	Emergency room services	Determined by primary insurance	Determined by primary insurance	Determined by primary insurance
	Emergency medical transportation	Determined by primary insurance	Determined by primary insurance	Determined by primary insurance
	Urgent care	Determined by primary insurance	Determined by primary insurance	Determined by primary insurance
If you have a hospital stay	Facility fee (e.g., hospital room)	Determined by primary insurance	Determined by primary insurance	Determined by primary insurance
	Physician/surgeon fee	Determined by primary insurance	Determined by primary insurance	Determined by primary 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 have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	Determined by primary insurance	Determined by primary insurance	Determined by primary insurance
	Mental/Behavioral health inpatient services	Determined by primary insurance	Determined by primary insurance	Determined by primary insurance
	Substance use disorder outpatient services	Determined by primary insurance	Determined by primary insurance	Determined by primary insurance
	Substance use disorder inpatient services	Determined by primary insurance	Determined by primary insurance	Determined by primary insurance
If you are pregnant	Prenatal and postnatal care	Determined by primary insurance	Determined by primary insurance	Determined by primary insurance
	Delivery and all inpatient services	Determined by primary insurance	Determined by primary insurance	Determined by primary 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 help recovering or have other special health needs	Home health care	Determined by primary insurance	Determined by primary insurance	Determined by primary insurance
	Rehabilitation services	Determined by primary insurance	Determined by primary insurance	Determined by primary insurance
	Habilitation services	Determined by primary insurance	Determined by primary insurance	Determined by primary insurance
	Skilled nursing care	Determined by primary insurance	Determined by primary insurance	Determined by primary insurance
	Durable medical equipment	Determined by primary insurance	Determined by primary insurance	Determined by primary insurance
	Hospice service	Determined by primary insurance	Determined by primary insurance	Determined by primary insurance
If your child needs dental or eye care	Eye exam	Determined by primary insurance	Determined by primary insurance	Determined by primary insurance
	Glasses	Determined by primary insurance	Determined by primary insurance	Determined by primary insurance
	Dental check-up	Determined by primary insurance	Determined by primary insurance	Determined by primary insurance

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.)		
Determined by primary insurance	•	•

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.)**
Determined by primary insurance

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 your employer or group sponsor. 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 x612565 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: Eagle Ridge Corporate Services at 1-800-301-6692 or Department of Labor Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. Additionally, a consumer assistance program can help you file your appeal. Contact Iowa Consumer Advocate Bureau, 330 Maple Street, Des Moines, IA 50319, 1-877-55-1212 or www.isuraqnceca.iowa.gov.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 800-301-6692
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 800-301-6692
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 800-301-6692
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 800-301-6692

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: see primary health plan**
- **Patient pays** $ *

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: see primary health plan

Deductibles	$
Copays	$
Coinsurance	$
Limits or exclusions	$
Total	**$**

*** Maximum 105 reimbursement is $3,000 single and $6,000 family**

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

- **Amount owed to providers:** $5,400
- **Plan pays: see primary health plan**
- **Patient pays** $ *

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: see primary health plan

Deductibles	$
Copays	$
Coinsurance	$
Limits or exclusions	$
Total	**$**

***Maximum 105 reimbursement is $3,000 single and $6,000 family**

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.