Health Benefits Plan for the Employees of Columbia Falls School District #6 **Coverage Period: 07/01/2015 – 06/30/2016**
Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage for:** Individual + Family **Type:** Physician-only 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 www.ebms.com or by calling **1-866-894-1499**.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$2,000** person, **$4,000** family Does not apply to outpatient mental disorder treatment, routine well newborn nursery care (while mother is hospitalized), preventive care, preadmission testing, and generic prescription drugs.	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 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. **$3,500** person, **$6,500** 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?	Premiums, amounts over the allowable charge, balance-billed charges (unless balanced billing is prohibited), 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. 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. For a list of **preferred providers**, see www.ebms.com or call 1-866-894-1499.	See the chart starting on page 2 for how this plan pays network and non-network 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 6. See your policy or plan document for additional information about **excluded services.**

Questions: Call **1-800-777-3575** or visit us at **www.ebms.com.** *This SBC is not the Plan Document and does not provide, nor is it intended to provide complete details of the benefits. If this SBC and the Plan Documents do not agree, the Plan Documents will prevail.* 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 **1-866-487-2365** to request a copy.

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
	Preventive care/screening/immunization	0% coinsurance, deductible waived	0% coinsurance for child to age 8. 0% coinsurance for the first $350; age 8 and older; then, 30% coinsurance after deductible for remainder of benefit year.	A "benefit year" shall mean the period beginning July 1st and ending June 30th.
If you have a test	Diagnostic test (x-ray, blood work)	30% coinsurance after deductible		———none———
	Imaging (CT/PET scans, MRIs)	30% coinsurance after deductible		———none———
If you need drugs to treat your illness or condition More information about **<u>prescription drug coverage</u>** is available at <u>www.ebms.com</u> (and refer to your personalized miBenefits log-in page)	Generic drugs	20% coinsurance, medical deductible waived (retail pharmacy and miRx mail order pharmacy)		Limited to a 90-day supply (retail pharmacy or miRx mail order pharmacy). For more information, contact EBMS toll-free at 1-866-894-1499.
	Brand drugs	30% coinsurance after medical deductible (retail pharmacy and miRx mail order pharmacy)		
	Specialty drugs	30% coinsurance after medical deductible (specialty pharmacy program applies)		Limited to 30 day supply. ICORE is the administrator of the specialty pharmacy program. For more information contact ICORE toll-free at 1-866-554-2673.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% coinsurance after deductible		
	Physician/surgeon fees	30% coinsurance after deductible		———none———
If you need immediate medical	Emergency room services	30% coinsurance after deductible		———none———
	Emergency medical transportation	30% coinsurance after deductible		———none———

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
	Substance use disorder inpatient services	30% coinsurance after deductible		Limited to 30 days per benefit year combined with Mental/Behavioral health inpatient services.
If you are pregnant	Prenatal and postnatal care	30% coinsurance after deductible		———————-none———————
	Delivery and all inpatient services	30% coinsurance after deductible		Limited to the facility's semi-private room rate.
If you need help recovering or have other special health needs	Home health care	10% coinsurance after deductible		Limited to 100 visits maximum per benefit year. Limited to 4 hours per visit.
	Rehabilitation services	30% coinsurance after deductible		Limited to 30 visits per benefit year for speech therapy, 30 visits per benefit year for physical therapy and 20 visits per benefit year for occupational therapy.
	Habilitation services	30% coinsurance after deductible		Maximum of $50,000 per benefit year for members 0-8 and $20,000 per benefit year for members 9-18 years of age for Applied Behavioral Analysis (ABA) for Autism Spectrum Disorder. No ABA benefits available for members 19 years of age or older.
	Skilled nursing care	30% coinsurance after deductible		Limited to 90 days maximum per benefit year. Limited to the facility's semi-private room rate.
	Durable medical equipment	30% coinsurance after deductible		Pre-notification is recommended for equipment in excess of $2,000.
	Hospice service	30% coinsurance after deductible		Inpatient services are limited to 30 days maximum per benefit year. Bereavement counseling is limited to 7 visits maximum per benefit year.

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: Employee Benefits Management Services, Inc. (EBMS) at 1-800-777-3575 or www.ebms.com. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Additionally, a consumer assistance program can help you file your appeal. A list of states with Consumer Assistance Programs is available at www.dol.gov/ebsa/healthreform and http://cciio.cms.gov/prgrams/consumer/capgrants/index.html.

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 or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard? The Affordable Care Act establishes 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 value standard for the benefits it provides.**

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al **1-866-894-1499**.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa **1-866-894-1499**.

Chinese (中文): 如果需要中文的帮助，**请拨打这个号码 1-866-894-1499**.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' **1-866-894-1499**.

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

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 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.