Reading School District – PPO II Option

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

Coverage Period: 01/01/2016 – 12/31/2016
Coverage for: Employee / 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 **www.loomisco.com** or by calling **1-866-203-3929**.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**In-network** **$500** single / **$1,000** family **Out-of-network** **$1,000** single / **$2,000** family *Does not apply to in-network preventive care.*	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?	Yes $50 per person for class IV dental services.	You must pay all of the costs for theses 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. For participating providers **$1,500** single / **$3,000** family For out-of-network providers **$3,000** single / **$6,000** 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, co-pays, balance-billed charges, penalties & 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?	Yes $1,000,000 out-of-network benefits.	This plan will pay for covered services only up to this limit during each coverage period, even if your own need is greater. You're responsible for all expenses above this limit. The chart starting on page 2 describes specific coverage limits, such as limits on the number of office visits.
Does this plan use a network of providers?	Yes. See **www.loomisco.com** or call **1-866-203-3929** 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 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 5. See your policy or plan document for additional information about **excluded services**.

Questions: Call **1-866-203-3929** or visit us at **www.loomisco.com.**
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.loomisco.com** or call 1-866-203-3929 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 participating providers by charging you lower deductibles, copayments and coinsurance amounts.

Thereafter

Common Medical Event	Services You May Need	*Your Cost If You Use a In-Network Provider	*Your Cost If You Use a Out-of-Network Provider	Limitations & Exceptions
	* Refer to page 1 under "What is the overall deductible" for what is required to be satisfied prior to benefits being paid.			
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% coinsurance	40% coinsurance	none
	Specialist visit	20% coinsurance	40% coinsurance	
	Other practitioner office visit *(chiropractor)*	20% coinsurance	40% coinsurance	30 visits per calendar year.
	Preventive care/screening/immunization	20% coinsurance	Not covered	Refer to the SPD for specific limitations
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	none
	Imaging (CT/PET scans, MRIs)			
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	none
	Physician/surgeon fees	20% coinsurance	40% coinsurance	none

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	* Refer to page 1 under "What is the overall deductible" for what is required to be satisfied prior to benefits being paid.			
If you need immediate medical attention	Emergency room services	20% coinsurance	40% coinsurance	——————none——————
	Emergency medical transportation	20% coinsurance	40% coinsurance	——————none——————
	Urgent care	20% coinsurance	40% coinsurance	——————none——————
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Benefit reduced by $300 for failure to obtain pre-notification.
	Physician/surgeon fee	20% coinsurance	40% coinsurance	——————none——————
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	20% coinsurance	40% coinsurance	——————none——————
	Mental/Behavioral health inpatient services	20% coinsurance	40% coinsurance	Benefit reduced by $300 for failure to obtain pre-notification.
	Substance use disorder outpatient services	20% coinsurance	40% coinsurance	——————none——————
	Substance use disorder inpatient services	20% coinsurance	40% coinsurance	Benefit reduced by $300 for failure to obtain pre-notification.
If you are pregnant	Prenatal and postnatal care	20% coinsurance	40% coinsurance	No coverage for dependents age 19 and older.
	Delivery and all inpatient services	20% coinsurance	40% coinsurance	Benefit reduced by $300 for failure to obtain pre-notification.
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	Benefit reduced by $300 for failure to obtain pre-notification.
	Rehabilitation services	20% coinsurance	40% coinsurance	——————none——————
	Habilitation services	20% coinsurance	40% coinsurance	Physical therapy is limited to 30 visits per calendar year.
	Skilled nursing care	20% coinsurance	40% coinsurance	Benefit reduced by $300 for failure to obtain pre-notification. Limited to 180 days per consecutive 12 month period.
	Durable medical equipment	20% coinsurance	40% coinsurance	——————none——————
	Hospice service	20% coinsurance	40% coinsurance	Limited to $2,500 outpatient / office benefits per lifetime.

Common Medical Event	Services You May Need	*Your Cost If You Use a In-Network Provider	*Your Cost If You Use a Out-of-Network Provider	Limitations & Exceptions
	* Refer to page 1 under "What is the overall deductible" for what is required to be satisfied prior to benefits being paid.			
If your child needs dental or eye care	Eye exam	No charge *payable up to the reasonable and customary amount*		Limited to one exam every 24 months.
	Glasses	No charge		Limited to $200 every 24 months for glasses, frames and contact lenses.
	Dental check-up	No charge		Limited to two visits per calendar year. Non-UCCI providers services are payable based on UCCI contracted amount and member may be billed the balance.

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.)

- Cosmetic surgery
- Hearing aids
- Infertility treatment
- Non-emergency care when traveling outside the U.S. (elective)
- Private-duty nursing
- Routine foot 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.)

- Acupuncture
- Bariatric surgery (morbid obesity diagnosis)
- Chiropractic care
- Dental care
- Long-term care (hospital)
- Routine eye care
- Weight loss programs (morbid obesity diagnosis)

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 1-866-203-3929. 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 Loomis Company at 1-866-203-3929 or the Department of Labor's Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform.

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** $5,890
- **Patient pays** $1,650

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	$500
Copays	$0
Coinsurance	$1,000
Limits or exclusions	$150
Total	**$1,650**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $3,970
- **Patient pays** $1,430

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	$500
Copays	$380
Coinsurance	$470
Limits or exclusions	$80
Total	**$1,430**

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.
- 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.