Sand Creek Employee Assistance Program: Waconia School District #110

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

Coverage Period: 07/01/2018
Coverage for: Employee and Family
Plan Type: Employee Assistance Counseling

This is only a summary. ***This plan only provides limited counseling sessions.*** If you want more detail about your coverage and costs, you can get the complete terms of the program at www.sandcreekeap.com or by calling 651-430-3383.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$0**	See the chart starting on page 2 for your costs for services this plan covers.
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?	N/A	Not applicable.
What is not included in the out–of–pocket limit?	**N/A.**	Not applicable.
Is there an overall annual limit on what the plan pays?	**No.**	This plan does not pay benefits based upon the dollar value of the services.
Does this plan use a network of providers?	Yes.	This plan only provides benefits through specific, in-network providers.
Do I need a referral to see a specialist?	**No.**	You can see the specialist you choose without permission from this plan. However, this plan does not provide (or pay for) those expenses.
Are there services this plan doesn't cover?	**Yes.**	Some of the services this plan does not cover are listed on page 4. See your plan document for additional information about excluded services.

- **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**.)
- Coverage under this plan requires use of specific, in-network **provider**.

Common Medical Event	Services You May Need	Your Cost	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	No charge to the extent services included as part of the limited counseling services. Testing, drug treatment and outpatient surgery are not covered by the EAP.	Coverage is limited to expenses included as part of the limited counseling services.
	Specialist visit		
	Other practitioner office visit		
	Preventive care/screening/immunization		
If you have a test	Diagnostic test (x-ray, blood work)		
	Imaging (CT/PET scans, MRIs)		
If you need drugs to treat your illness or condition	Generic drugs		
	Preferred brand drugs		
	Non-preferred brand drugs		
	Specialty drugs		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)		
	Physician/surgeon fees		

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Common Medical Event	Services You May Need	Your Cost	Limitations & Exceptions
If you need immediate medical attention	Emergency room services	No charge to the extent services included as part of the limited counseling services. The EAP does not cover emergency room visits, hospital stays, health care pregnancy related services other than brief counseling or other health, dental or eye care needs.	Coverage is limited to expenses included as part of the limited counseling services.
	Emergency medical transportation		
	Urgent care		
If you have a hospital stay	Facility fee (e.g., hospital room)		
	Physician/surgeon fee		
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services		
	Mental/Behavioral health inpatient services		
	Substance use disorder outpatient services		
	Substance use disorder inpatient services		
If you are pregnant	Prenatal and postnatal care		
	Delivery and all inpatient services		
If you need help recovering or have other special health needs	Home health care		
	Rehabilitation services		
	Habilitation services		
	Skilled nursing care		
	Durable medical equipment		
	Hospice service		
If your child needs dental or eye care	Eye exam		
	Glasses		
	Dental check-up		

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.)

- Amounts for other expenses other than expenses included as part of the limited counseling services.

Other Covered Services (Check your individual coverage policy or plan document for covered services under that plan and your costs for these services.)

- This plan ***only*** covers limited counseling sessions. Visit www.sandcreekeap.com for a complete list of services available through this EAP provider.

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 [6]. You may also government agencies including 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 [6].

Language Access Services:

[7] [Spanish (Español): Para obtener asistencia en Español, llame al Reyna 651-430-3383 ext 102.

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 (after coverage under individual policy):** $7,540
- **Plan pays expenses incurred for limited counseling sessions**
- **Patient pays remainder**

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 under this plan:

Deductibles	$0
Copays	$0
Coinsurance	$0
Limits or exclusions	$0
Total	**$7,540***

* Assuming no expenses part of limited counseling services

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

- **Amount owed to providers (after coverage under individual policy):** $5,400
- **Plan pays expenses incurred for limited counseling sessions**
- **Patient pays remainder**

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 under this plan:

Deductibles	$0
Copays	$0
Coinsurance	$0
Limits or exclusions	$0
Total	**$5,400***

* Assuming no expenses part of limited counseling services

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- None of the expenses were incurred as part of covered limited counseling sessions.
- Costs doe not 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 not have been covered.

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 (1) major medical coverage, and (2) contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay expenses not paid under this plan.