**East Allen County Schools Bus Drivers: HSA Option 1**  
Coverage Period: 09/01/2014 – 08/31/2015

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

**Coverage for:** Individual & Family  
**Plan Type:** HDHP

---

**Important Questions** | **Answers** | **Why this Matters:**
--- | --- | ---
What is the overall **deductible**? | In-Network & Out-of-Network Combined  
Single $3,000 / Family $6,000 | 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 –  
In-Network & Out-of-Network Combined  
Single $3,000 / Family $6,000 | 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 the covered services. This limit helps you plan for health care expenses.

What is not included in the **out-of-pocket limit**? | Premiums, Healthcare this plan doesn’t cover, charges not authorized thru a Utilization Review program | Even though you pay these expenses, they don’t count toward the **out-of-pocket limit** on your expenses.

Is there an overall annual limit on what the plan pays? | No | 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, for a list of participating providers go to:  
[www.parkviewtotalhealth.com](http://www.parkviewtotalhealth.com) | If you use an in-network **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 the network. See the chart starting on page 2 for how this plan pays different kinds of **providers**.

---

**Questions:** Call 1-800-800-964-7444  
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.eacs.k12.in.us/departments/human_resources/employee_benefits](http://www.eacs.k12.in.us/departments/human_resources/employee_benefits) or call 1-800-964-7444 to request a copy.
**Summary of Benefits and Coverage:** What this Plan Covers & What it Costs

**Coverage Period:** 09/01/2014 – 08/31/2015

**Coverage for:** Individual & Family | **Plan Type:** HDHP

### Common Medical Event

<table>
<thead>
<tr>
<th>Services You May Need</th>
<th>Your Cost If You Use an In-network Provider</th>
<th>Your Cost If You Use an Out-of-network Provider</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary care visit to treat an injury or illness</td>
<td>0% after deductible</td>
<td>50% after deductible</td>
<td>None</td>
</tr>
<tr>
<td>Specialist visit</td>
<td>0% after deductible</td>
<td>50% after deductible</td>
<td>None</td>
</tr>
<tr>
<td>Other practitioner office visit</td>
<td>0% after deductible</td>
<td>50% after deductible</td>
<td>None</td>
</tr>
<tr>
<td>Preventive care/screening/immunization</td>
<td>0%</td>
<td>50% after deductible</td>
<td>Evidence-based items or services with an A or B rating recommended by the United States Preventive Services Task Force, Immunizations recommended by the Centers for Disease Control and Prevention, preventative care and screenings recommended by the Health Resources and Services Administration.</td>
</tr>
</tbody>
</table>

**Questions:** Call 1-800- 800-964-7444

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.eacs.k12.in.us/departments/human_resources/employee_benefits or call 1-800-964-7444 to request a copy.
## East Allen County Schools Bus Drivers: HSA Option 1

**Coverage Period:** 09/01/2014 – 08/31/2015

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

**Coverage for:** Individual & Family  |  **Plan Type:** HDHP

### Common Medical Event

<table>
<thead>
<tr>
<th>Services You May Need</th>
<th>Your Cost If You Use an In-network Provider</th>
<th>Your Cost If You Use an Out-of-network Provider</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>If you have a test</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diagnostic test (x-ray, blood work)</td>
<td>0% after deductible</td>
<td>50% after deductible</td>
<td>None</td>
</tr>
<tr>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>0% after deductible</td>
<td>50% after deductible</td>
<td>None</td>
</tr>
<tr>
<td><strong>If you need drugs to treat your illness or condition</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Generic drugs</td>
<td>Retail &amp; Mail Order</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td><strong>Preferred</strong> brand drugs</td>
<td></td>
<td></td>
<td>Retail 34 day limit per fill</td>
</tr>
<tr>
<td>Non-<strong>preferred</strong> brand drugs</td>
<td></td>
<td></td>
<td>Mail order 90 day limit per fill</td>
</tr>
<tr>
<td>Specialty drugs</td>
<td>0% after deductible</td>
<td>100%</td>
<td>34 day limit per fill</td>
</tr>
<tr>
<td><strong>If you have outpatient surgery</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>0% after deductible</td>
<td>50% after deductible</td>
<td>None</td>
</tr>
<tr>
<td>Physician/surgeon fees</td>
<td>0% after deductible</td>
<td>50% after deductible</td>
<td>None</td>
</tr>
<tr>
<td><strong>If you need immediate medical attention</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency room services</td>
<td>0% after deductible</td>
<td>0% after deductible</td>
<td>None</td>
</tr>
<tr>
<td>Emergency medical transportation</td>
<td>0% after deductible</td>
<td>50% after deductible</td>
<td>Must be medically necessary</td>
</tr>
<tr>
<td>Urgent care</td>
<td>0% after deductible</td>
<td>50% after deductible</td>
<td>None</td>
</tr>
<tr>
<td><strong>If you have a hospital stay</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Facility fee (e.g., hospital room)</td>
<td>0% after deductible</td>
<td>50% after deductible</td>
<td>Non-Precertification Penalty $500</td>
</tr>
<tr>
<td>Physician/surgeon fee</td>
<td>0% after deductible</td>
<td>50% after deductible</td>
<td>None</td>
</tr>
</tbody>
</table>

### Questions

Call 1-800-800-964-7444

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.eacs.k12.in.us/departments/human_resources/employee_benefits](http://www.eacs.k12.in.us/departments/human_resources/employee_benefits) or call 1-800-964-7444 to request a copy.
## East Allen County Schools Bus Drivers: HSA Option 1

**Coverage Period:** 09/01/2014 – 08/31/2015  
**Summary of Benefits and Coverage:** What this Plan Covers & What it Costs  
**Coverage for:** Individual & Family  
**Plan Type:** HDHP

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>Your Cost If You Use an In-network Provider</th>
<th>Your Cost If You Use an Out-of-network Provider</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you have mental health, behavioral health, or substance abuse needs</td>
<td>Mental/Behavioral health outpatient services</td>
<td>0% after deductible</td>
<td>50% after deductible</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Mental/Behavioral health inpatient services</td>
<td>0% after deductible</td>
<td>50% after deductible</td>
<td>Non-Precertification Penalty $500</td>
</tr>
<tr>
<td></td>
<td>Substance use disorder outpatient services</td>
<td>0% after deductible</td>
<td>50% after deductible</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Substance use disorder inpatient services</td>
<td>0% after deductible</td>
<td>50% after deductible</td>
<td>Non-Precertification Penalty $500</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Prenatal and postnatal care</td>
<td>0% after deductible</td>
<td>50% after deductible</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Delivery and all inpatient services</td>
<td>0% after deductible</td>
<td>50% after deductible</td>
<td>None</td>
</tr>
</tbody>
</table>

**Questions:** Call 1-800-800-964-7444

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.eacs.k12.in.us/departments/human_resources/employee_benefits](http://www.eacs.k12.in.us/departments/human_resources/employee_benefits) or call 1-800-964-7444 to request a copy.
## Summary of Benefits and Coverage: What this Plan Covers & What it Costs

### Coverage Period:
09/01/2014 – 08/31/2015

### Plan Type:
HDHP

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>Your Cost If You Use an In-network Provider</th>
<th>Your Cost If You Use an Out-of-network Provider</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Home health care</td>
<td>0% after deductible</td>
<td>50% after deductible</td>
<td>Limited to 40 visit per calendar year; Each 4 hours of service equals 1 visit. Services and supplies not in the Home Health Care plan, services of a relative or person normally residing in your home, Social workers, transportation, meals and custodial care are not covered.</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>0% after deductible</td>
<td>50% after deductible</td>
<td>Medical Necessity</td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>0% after deductible</td>
<td>50% after deductible</td>
<td>Only covered if an illness or injury and medically necessary.</td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care</td>
<td>0% after deductible</td>
<td>50% after deductible</td>
<td>Non-Precertification Penalty $500</td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment</td>
<td>0% after deductible</td>
<td>50% after deductible</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Hospice service</td>
<td>0% after deductible</td>
<td>50% after deductible</td>
<td>Review after 6 months</td>
</tr>
<tr>
<td>If your child needs dental or eye care</td>
<td>Eye exam</td>
<td>0%</td>
<td>50% after deductible</td>
<td>Subject to the Patient Protection and Affordable Care Act guidelines.</td>
</tr>
<tr>
<td></td>
<td>Glasses</td>
<td>100%</td>
<td>100%</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Dental check-up</td>
<td>100%</td>
<td>100%</td>
<td>Not Covered</td>
</tr>
</tbody>
</table>

### Questions:
Call 1-800- 800-964-7444
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.eacs.k12.in.us/departments/human_resources/employee_benefits](http://www.eacs.k12.in.us/departments/human_resources/employee_benefits) or call 1-800-964-7444 to request a copy.
**Services Your Plan Does NOT Cover (This isn’t a complete list. Check your policy or plan document for other excluded services.):**

- Acupuncture
- Dental Care (Adult)
- Non-Emergency Care when Traveling Outside the U.S.
- Weight Loss Programs
- Bariatric Surgery
- Infertility Treatment
- Routine Eye Care (Adult)
- Cosmetic Surgery
- Long-Term Care
- 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.):**

- Chiropractic Care
- Private-Duty Nursing
- Hearing Aids
- 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.)

**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 1-800-964-7444. 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](http://www.dol.gov/ebsa), or the U.S. Department of Health and Human Services at 1-877-267-2323 x 61565 or [www.cciio.cms.gov](http://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: Employee Plans, LLC, 1111 Chestnut Hills Parkway, Fort Wayne, Indiana 46814, Phone: (260) 625-7470. Additionally, a consumer assistance program can help you file your appeal, contact Indiana Department of Insurance, Consumer Service Department, 311 West Washington Street, Suite 300, Indianapolis IN 46204-2787, or go to [http://www.in.gov/idoi/2547.htm#2](http://www.in.gov/idoi/2547.htm#2) for more information.

**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.

---

**Questions:** Call 1-800- 800-964-7444
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.eacs.k12.in.us/departments/human_resources/employee_benefits](http://www.eacs.k12.in.us/departments/human_resources/employee_benefits) or call 1-800-964-7444 to request a copy.
East Allen County Schools Bus Drivers: HSA Option 1

Coverage Examples

Coverage Period: 09/01/2014 – 08/31/2015
Coverage for: Individual & Family | Plan Type: HDHP

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.

Having a baby
(normal delivery)

| Amount owed to providers: $7,540 |
| Plan pays $3,450 |
| Patient pays $4,100 |

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** $3,900
- **Copays** $0
- **Coinsurance** $0
- Limits or exclusions $200
- **Total** $4,100

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

| Amount owed to providers: $5,400 |
| Plan pays $2,300 |
| Patient pays $3,100 |

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** $3,000
- **Copays** $0
- **Coinsurance** $0
- Limits or exclusions $100
- **Total** $3,100

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.

Questions: Call 1-800-800-964-7444
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.eacs.k12.in.us/departments/human_resources/employee_benefits](http://www.eacs.k12.in.us/departments/human_resources/employee_benefits) or call 1-800-964-7444 to request a copy.
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.