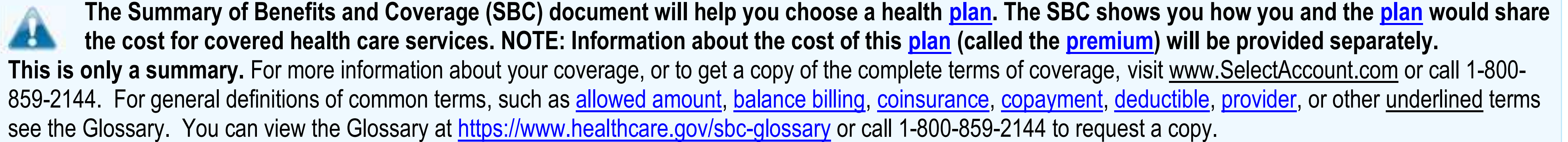
New Prague Area Schools ISD 721 VEBA

Coverage Period: 1/01/2018- 12/31/2018

Summary of Benefits and Coverage: Coverage for: What this Plan Covers & What You Pay For Covered Services

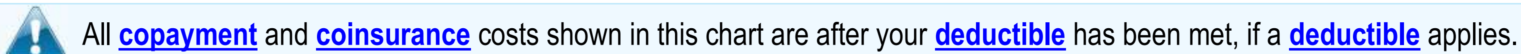
Single and family | **Plan Type: VEBA**



The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.SelectAccount.com or call 1-800-859-2144. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary or call 1-800-859-2144 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$0	You should also consider the employer contributions made to your VEBA that can help pay your overall out-of-pocket expenses.
Are there services covered before you meet your deductible?	No	You don't have to meet the deductible before the health plan pays for any services. You should also consider the employer contributions made to your VEBA that can help pay your overall out-of-pocket expenses.
Are there "other" deductibles for specific services?	No.	You don't have to meet "other" deductibles for specific services.
What is the out-of-pocket limit for this plan?	No.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met. You should also consider the employer contributions made to your VEBA that can help pay your overall out-of-pocket expenses.
What is not included in the out-of-pocket limit?	Not Applicable	This plan does not have an out-of-pocket limit on your expenses.
Will you pay less if you use a network provider?	Not Applicable	This plan does not use a provider network. You can receive covered services from any provider.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.


All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Not Applicable	Not Applicable	Not Applicable
	Specialist visit	Not Applicable	Not Applicable	Not Applicable
	Preventive care/screening/ immunization	Not Applicable	Not Applicable	Not Applicable
If you have a test	Diagnostic test (x-ray, blood work)	Not Applicable	Not Applicable	Not Applicable
	Imaging (CT/PET scans, MRIs)	Not Applicable	Not Applicable	Not Applicable
If you need drugs to treat your illness or condition. A Retail Pharmacy is any licensed pharmacy that you can physically enter to obtain a prescription drug. A Mail Service Pharmacy dispenses prescription drugs through the U.S. Mail. More information about prescription drug coverage is available at www.bluecrossmnonline.com	Preferred generic drugs	Not Applicable	Not Applicable	Not Applicable
	Preferred brand drugs	Not Applicable	Not Applicable	Not Applicable
	Non-preferred drugs	Not Applicable	Not Applicable	Not Applicable
	Specialty drugs	Not Applicable	Not Applicable	Not Applicable
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Not Applicable	Not Applicable	Not Applicable
	Physician/surgeon fees	Not Applicable	Not Applicable	Not Applicable
If you need immediate medical attention	Emergency room care	Not Applicable	Not Applicable	Not Applicable
	Emergency medical transportation	Not Applicable	Not Applicable	Not Applicable
	Urgent care	Not Applicable	Not Applicable	Not Applicable

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider	
If you have a hospital stay	Facility fee (e.g., hospital room)	Not Applicable	Not Applicable	Not Applicable
	Physician/surgeon fees	Not Applicable	Not Applicable	Not Applicable
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Not Applicable	Not Applicable	Not Applicable
	Inpatient services	Not Applicable	Not Applicable	Not Applicable
If you are pregnant	Office visits	Not Applicable	Not Applicable	Not Applicable
	Childbirth/delivery professional services	Not Applicable	Not Applicable	Not Applicable
	Childbirth/delivery facility services	Not Applicable	Not Applicable	Not Applicable
If you need help recovering or have other special health needs	Home health care	Not Applicable	Not Applicable	Not Applicable
	Rehabilitation services	Not Applicable	Not Applicable	Not Applicable
	Habilitation services	Not Applicable	Not Applicable	Not Applicable
	Skilled nursing care	Not Applicable	Not Applicable	Not Applicable
	Durable medical equipment	Not Applicable	Not Applicable	Not Applicable
	Hospice services	Not Applicable	Not Applicable	Not Applicable
If your child needs dental or eye care	Children's eye exam	Not Applicable	Not Applicable	Not Applicable
	Children's glasses	Not Applicable	Not Applicable	Not Applicable
	Children's dental check-up	Not Applicable	Not Applicable	Not Applicable

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)		
• Cosmetic Surgery (except as specified in Plan benefits)	• Amounts that exceed the individual's VEBA account balance	

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Acupuncture (if prescribed for rehabilitation purposes) • Bariatric surgery • Chiropractic care • Dental care (Adult)	• Hearing aids • Infertility treatment • Long-term care • Non-emergency care when traveling outside of the U.S.	• Private-duty nursing • Routine eye care (Adult) • Routine foot care • Weight loss programs

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: For group health coverage subject to ERISA, contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Other options to continue coverage are available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit http://www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: your Claims Administrator by calling toll-free 1-866-873-5943 or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? Yes- the VEBA is integrated with your medical health plan.
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet Minimum Value Standards? Yes- the VEBA is integrated with your medical health plan.
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through MNsure.

Notice of Nondiscrimination Practices

Effective July 18, 2016

MII Life, Incorporated (d/b/a SelectAccount) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or gender. Blue Cross does not exclude people or treat them differently because of race, color, national origin, age, disability, or gender.

SelectAccount provides resources to access information in alternative formats and languages:

- Auxiliary aids and services, such as qualified interpreters and written information available in other formats, are available free of charge to people with disabilities to assist in communicating with us.
- Language services, such as qualified interpreters and information written in other languages, are available free of charge to people whose primary language is not English.

If you need these services, contact SelectAccount Customer Service at 1-800-859-2144, M-F, 7 am to 8 pm Central Time. TTY users call 711.

If you believe that SelectAccount has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or gender, you can file a grievance with the SelectAccount Compliance Officer

- by email at: SelectAccount.Compliance.Officer@selectaccount.com
- by mail at: SelectAccount Compliance Officer
MII Life, Incorporated (d/b/a SelectAccount)
S140
1750 Yankee Doodle Road
Eagan, MN 55121
- or by telephone at: 1-800-859-2144 or by tax at 1-866-231-0214

Grievance forms are available by contacting us at the contacts listed above, by calling 1-800-859-2144. TTY users call 711. If you need help filing a grievance, assistance is available by contacting us at the numbers listed above.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights

- electronically through the Office for Civil Rights Complaint Portal, available at: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
- by telephone at: 1-800-368-1019 or 1-800-537-7697 (TDD)
- or by mail at: U.S. Department of Health and Human Services
200 Independence Avenue SW
Room 509F, HHH Building
Washington, DC 20201

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Language Access Services:

This information is available in other languages. Free language assistance services are available by calling the toll free number below. For TTY, call 711.

Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-859-2144 (TTY: 711).

如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-859-2144 (TTY: 711)。

Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-859-2144 (TTY: 711).

한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-859-2144 (TTY: 711)번으로 전화해 주십시오.

Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-859-2144 (TTY: 711)

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1- 1-800-859-2144 (رقم هاتف الصم والبكم: 1-711).

Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-859-2144 (TTY: 711).

Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-859-2144 (ATS : 711).

Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-859-2144 (TTY: 711).

Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-800-859-2144 (TTY: 711).

In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-859-2144 (TTY: 711).

Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-859-2144 (TTY: 711).

日本語を話される場合、無料の言語支援をご利用いただけます。1-800-859-2144 (TTY:711）まで、お電話にてご連絡ください。

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با (TTY: 711) 1-800-859-2144 تماس بگیرید.

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

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- **The plan's overall deductible** **$4500**
- **Specialist copayment** **$0**
- **Hospital (facility) coinsurance** **0%**
- **Other coinsurance** **0%**

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$4,500
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$4,560**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible** **$4500**
- **Specialist copayment** **$0**
- **Hospital (facility) coinsurance** **0%**
- **Other coinsurance** **0%**

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$4,500
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$4, 555**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- **The plan's overall deductible** **$4500**
- **Specialist copayment** **$0**
- **Hospital (facility) coinsurance** **0%**
- **Other coinsurance** **0%**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,900
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,900**

The total patient would pay amount assumes the patient is not using funds from a Flexible Spending Account (FSA), Health Savings Account (HSA), or an integrated Health Reimbursement Account (HRA), including an integrated HRA funded through a Voluntary Employee Beneficiary Association (HRA-VEBA). Account balances may provide you funds to help cover out-of-pocket expenses.

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs.

The **plan** would be responsible for the other costs of these EXAMPLE covered services.