Le Mars Community School District
940 Lincoln St. SE
Le Mars, IA 51031

Le Mars Community School District $1500.00 PPO HRA PlanSBC
Effective January 1, 2022

Le Mars CSD – $1,500.00 PPO HRA Plan SBC

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

Coverage Period: 01/01/22 – 12/31/2022

Coverage for: All Covered Tiers | **Plan Type:** HRA

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, call 712-546-4155. 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 by calling 712-546-4155 to request a copy.

Important Questions	Answers	Why this Matters
What is the overall **deductible**?	$1,500.00 Single/$3,000.00 Family	This HRA may be used to offset all or a portion of your **deductible** of a major medical **plan**.
Are there services covered before you meet your **deductible?**	Not applicable.	No separate deductible required for HRA benefit.
Are there other **deductibles** for specific services?	No.	This HRA may be used to offset all or a portion of your **deductible** of a major medical **plan**.
What is the **out-of-pocket** limit for this **plan**?	$3,000.00 Single/$6,000.00 Family	The **out-of-pocket limit** is the most you could pay during a could pay during a coverage period (usually one year) for your share of the cost of covered services.
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** treats **providers** the same in determining payment for the same services.
Do I need a **referral** to see a **specialist**?	No.	You can see the **specialist** you choose **without** a referral, for the HRA benefits.

All costs shown in this chart are after your **out of pocket maximum** has been met, if **deductible, coinsurance, and/or copay** applies.

Common Medical Event	Services You May Need	Your Reimbursement if You Use a Participating Provider	Your Reimbursement if You Use a Non-Participating Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	100% up to available HRA balance	100% up to available HRA balance	See page 3 for applicable details.
	specialist visit	Same as above	Same as above	Same as above
	Preventive care / **screening** / immunization	Same as above	Not covered	Same as above
If you have a test	**Diagnostic test** (x-ray, blood work)	Same as above	100% up to available HRA balance	Same as above
	Imaging (CT / PET scans, MRIs)	Same as above	Same as above	Same as above
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at: n/a.	Generic drugs	Same as above	Same as above	Same as above
	Preferred brand drugs	Same as above	Same as above	Same as above
	Non-preferred brand drugs	Same as above	Same as above	Same as above
	Specialty drugs	Same as above	Same as above	Same as above
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Same as above	Same as above	Same as above
	Physician / surgeon fees	Same as above	Same as above	Same as above
If you need immediate medical attention	**Emergency room services**	Same as above	Same as above	See page 3 for applicable details.
	Emergency Medical Transportation	Same as above	Same as above	Same as above
	Urgent Care	Same as above	Same as above	Same as above
If you have a hospital stay	Facility fee (e.g., hospital room)	Same as above	Same as above	Same as above
	Physician / surgeon fee	Same as above	Same as above	Same as above
If you have mental health, behavioral health, or substance abuse needs	Inpatient services	Same as above	Same as above	Same as above
	Outpatient Services	Same as above	Same as above	Same as above
If you are pregnant	Office visits	Same as above	Same as above	Same as above
	Childbirth/delivery professional services	Same as above	Same as above	Same as above

Common Medical Event	Services You May Need	Your Reimbursement if You Use a Participating Provider	Your Reimbursement if You Use a Non-Participating Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	**Home health care**	Same as above	Same as above	Same as above
	Rehabilitation services	Same as above	Same as above	Same as above
	Habilitation services	Same as above	Same as above	Same as above
	Skilled nursing care	Same as above	Same as above	Same as above
	Durable medical equipment	Same as above	Same as above	Same as above
	Hospice service	Same as above	Same as above	Same as above
If your child needs dental or eye care	Children's Eye exam	Not covered	Not covered	Same as above
	Children's Glasses	Same as above	Same as above	Same as above
	Children's Dentalcheck-up	Same as above	Same as above	Same as above

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.)

Acupuncture	Cosmetic Surgery	Custodial care – in home or facility	Dental Care (Adult)
Dental check-up	Extended home skilled nursing	Eye Exam	Glasses
Hearing Aids	Long-term care	Routine eye car – Adult	Routine foot care
Weight loss programs			

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

Applied Behavior Analysis therapy – covered through age 18 subject to annual limits	Bariatric Surgery	Chiropractic Care	Infertility treatment ($25,000 LTM)	Most coverage provided outside the US
Private-duty nursing - short term intermittent home skilled nursing				

[For more information about limitations and exceptions, contact 712-546-4155 to see the plan or policy document.]

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: Department of Labor's Employee Benefits Security Administration at: 1-866-444-EBSA(3272) or www.dol.gov/ebsa/healthreform. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit 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: 712-546-4155.

Does this plan provide Minimum Essential Coverage? - Yes

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 the Minimum Value Standards? - Yes

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 the **Marketplace**.

Language Access Services:

SPANISH (Español): Para obtener asistencia en Español, llame al 555-555-5555.
TAGALOG (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 555-555-5555.
CHINESE (中文): 如果需要中文的帮助, 请拨打这个号码 555-555-5555.
NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 555-555-5555.

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

Bridge Design

Individual	The Employee will pay the first $1,500.00 of deductible expenses. The Employee will then pay 10% and the HRA will pay 90% of the remaining $3,500.00 of deductible expenses. The Employee will be responsible for coinsurance and copay expenses up to $3,000.00. The HRA will pay the remaining coinsurance and copay expenses. Unused benefits at the end of the coverage period shall be forfeited.
Family	The Employee will pay the first $3,000.00 of deductible expenses. The Employee will then pay 10% and the HRA will pay 90% of the remaining $7,000.00 of deductible expenses. The Employee will be responsible for coinsurance and copay expenses up to $6,000.00. The HRA will pay the remaining coinsurance and copay expenses. Unused benefits at the end of the coverage period shall be forfeited.

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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 existing coverage examples are based on only self-coverage.

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

- **Amount owed to providers:** $5,340
- **HRA pays:** $2,700
- **Member pays:** $2,640

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	$5,340
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$1,500
Copayments	$80
Coinsurance	$1000
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$2,640

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

- **Amount owed to providers:** $870
- **HRA pays:** $0
- **Member pays:** $870

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	$870
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$50
Copayments	$800
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	$870

Mia's simple fracture
(in-network emergency room visit and follow up care)

- **Amount owed to providers:** $2,100
- **HRA pays:** $360
- **Member pays:** $1,740

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	$2,100
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$1,500
Copayments	$200
Coinsurance	$40
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$1,740