|  |
| --- |
| The Summary of Benefits and Coverage (SBC) document will help you choose a health [plan](https://www.healthcare.gov/sbc-glossary/#plan). The SBC shows you how you and the [plan](https://www.healthcare.gov/sbc-glossary/#plan) would share the cost for covered health care services. NOTE: Information about the cost of this [plan](https://www.healthcare.gov/sbc-glossary/#plan) (called the [premium](https://www.healthcare.gov/sbc-glossary/#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 at [Employer phone and/or website contact information here] For general definitions of common terms, such as [allowed amount](https://www.healthcare.gov/sbc-glossary/#allowed-amount), [balance billing](https://www.healthcare.gov/sbc-glossary/#balance-billing), [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance), [copayment](https://www.healthcare.gov/sbc-glossary/#copayment), [deductible](https://www.healthcare.gov/sbc-glossary/#deductible), [provider](https://www.healthcare.gov/sbc-glossary/#provider), or other underlined terms see the Glossary. You can view or request a copy the Uniform Glossary at [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform) or [www.cciio.cms.gov](http://www.cciio.cms.gov) . |

|  |  |  |
| --- | --- | --- |
| **Important Questions** | **Answers** | **Why This Matters:** |
| **What is the overall** [**deductible**](https://www.healthcare.gov/sbc-glossary/#deductible)**?** | Network: $1,500 Individual / $3,000 Family  No out of network benefit | Generally, you must pay all of the costs from providers up to the [deductible](https://www.healthcare.gov/sbc-glossary/#deductible) amount before this [plan](https://www.healthcare.gov/sbc-glossary/#plan) begins to pay. If you have other family members on the [plan](https://www.healthcare.gov/sbc-glossary/#plan), each family member must meet their own individual [deductible](https://www.healthcare.gov/sbc-glossary/#deductible) until the total amount of [deductible](https://www.healthcare.gov/sbc-glossary/#deductible) expenses paid by all family members meets the overall family [deductible](https://www.healthcare.gov/sbc-glossary/#deductible). If $0: See the Common Medical Events chart below for your costs for services this [plan](https://www.healthcare.gov/sbc-glossary/#plan) covers. |
| **Are there services covered before you meet your** [**deductible**](https://www.healthcare.gov/sbc-glossary/#deductible)**?** | Yes, Preventive Care Services and categories with a copay are covered before you meet your deductible. | If Yes: This [plan](https://www.healthcare.gov/sbc-glossary/#plan) covers some items and services even if you haven’t yet met the [deductible](https://www.healthcare.gov/sbc-glossary/#deductible) amount. But a [copayment](https://www.healthcare.gov/sbc-glossary/#copayment) or [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) may apply. For example, this [plan](https://www.healthcare.gov/sbc-glossary/#plan) covers certain [preventive services](https://www.healthcare.gov/sbc-glossary/#preventive-care) without [cost-sharing](https://www.healthcare.gov/sbc-glossary/#cost-sharing) and before you meet your [deductible](https://www.healthcare.gov/sbc-glossary/#deductible). See a list of covered [preventive services](https://www.healthcare.gov/sbc-glossary/#preventive-care) at <https://www.healthcare.gov/coverage/preventive-care-benefits/>. If “No”: You will have to meet the [deductible](https://www.healthcare.gov/sbc-glossary/#deductible) before the plan pays for any services. |
| **Are there other**  [**deductibles**](https://www.healthcare.gov/sbc-glossary/#deductible) **for specific services?** | No | If Yes: You must pay all of the costs for these services up to the specific [deductible](https://www.healthcare.gov/sbc-glossary/#deductible)amount before this [plan](https://www.healthcare.gov/sbc-glossary/#plan)begins to pay for these services. If “No”: You don’t have to meet deductibles for specific services. |
| **What is the** [**out-of-pocket limit**](https://www.healthcare.gov/sbc-glossary/#out-of-pocket-limit) **for this** [**plan**](https://www.healthcare.gov/sbc-glossary/#plan)**?** | Not Applicable | This [plan](https://www.healthcare.gov/sbc-glossary/#plan) does not have an [out-of-pocket limit](https://www.healthcare.gov/sbc-glossary/#out-of-pocket-limit) on your expenses. |
| **What is not included in**  **the** [**out-of-pocket limit**](https://www.healthcare.gov/sbc-glossary/#out-of-pocket-limit)**?** | Not Applicable | This [plan](https://www.healthcare.gov/sbc-glossary/#plan) does not have an [out-of-pocket limit](https://www.healthcare.gov/sbc-glossary/#out-of-pocket-limit) on your expenses. |
| **Will you pay less if you use a** [**network provider**](https://www.healthcare.gov/sbc-glossary/#network-provider)**?** | Not Applicable | This [plan](https://www.healthcare.gov/sbc-glossary/#plan) does not use a provider [network](https://www.healthcare.gov/sbc-glossary/#network). You can receive covered services from any [provider](https://www.healthcare.gov/sbc-glossary/#provider). |
| **Do you need a** [**referral**](https://www.healthcare.gov/sbc-glossary/#referral) **to see a** [**specialist**](https://www.healthcare.gov/sbc-glossary/#specialist)**?** | No. | You can see a [specialist](https://www.healthcare.gov/sbc-glossary/#specialist)you choose without a [referral](https://www.healthcare.gov/sbc-glossary/#referral). |

|  | All [**copayment**](https://www.healthcare.gov/sbc-glossary/#copayment) and [**coinsurance**](https://www.healthcare.gov/sbc-glossary/#coinsurance) costs shown in this chart are after your [**deductible**](https://www.healthcare.gov/sbc-glossary/#deductible) has been met, if a [**deductible**](https://www.healthcare.gov/sbc-glossary/#deductible) applies. |
| --- | --- |

| **Common  Medical Event** | **Services You May Need** | **What You Will Pay** | **Limitations, Exceptions, & Other Important Information** |
| --- | --- | --- | --- |
| **Network Provider** |
| **If you visit a health care** [**provider’s**](https://www.healthcare.gov/sbc-glossary/#provider) **office or clinic** | Primary care visit to treat an injury or illness | Not Applicable | Only qualified medical expenses up to the available account balance in the HRA |
| [Specialist](https://www.healthcare.gov/sbc-glossary/#specialist) visit | Not Applicable |
| [Preventive care](https://www.healthcare.gov/sbc-glossary/#preventive-care)/[screening](https://www.healthcare.gov/sbc-glossary/#screening)/  immunization | Not Applicable |
| **If you need drugs to treat your illness or condition**  More information about [**prescription drug coverage**](https://www.healthcare.gov/sbc-glossary/#prescription-drug-coverage)is available at www.[insert].com | Generic drugs (Tier 1) | Not Applicable | Only qualified medical expenses up to the available account balance in the HRA |
| Preferred brand drugs (Tier 2) | Not Applicable |
| Non-preferred brand drugs (Tier 3) | Not Applicable |
| [Specialty drugs](https://www.healthcare.gov/sbc-glossary/#specialty-drug) (Tier 4) | Not Applicable |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | Not Applicable | Only qualified medical expenses up to the available account balance in the HRA |
| Physician/surgeon fees | Not Applicable |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | Not Applicable | Only qualified medical expenses up to the available account balance in the HRA |
| Physician/surgeon fees | Not Applicable |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | Not Applicable | Only qualified medical expenses up to the available account balance in the HRA |
| Inpatient services | Not Applicable |
| **If you are pregnant** | Office visits | Not Applicable | Only qualified medical expenses up to the available account balance in the HRA |
| Childbirth/delivery professional services | Not Applicable |
| Childbirth/delivery facility services | Not Applicable |
| **If you need help recovering or have other special health needs** | [Home health care](https://www.healthcare.gov/sbc-glossary/#home-health-care) | Not Applicable | Only qualified medical expenses up to the available account balance in the HRA |
| [Rehabilitation services](https://www.healthcare.gov/sbc-glossary/#rehabilitation-services) | Not Applicable |
| [Habilitation services](https://www.healthcare.gov/sbc-glossary/#habilitation-services) | Not Applicable |
| [Skilled nursing care](https://www.healthcare.gov/sbc-glossary/#skilled-nursing-care) | Not Applicable |
| [Durable medical equipment](https://www.healthcare.gov/sbc-glossary/#durable-medical-equipment) | Not Applicable |
| [Hospice services](https://www.healthcare.gov/sbc-glossary/#hospice-services) | Not Applicable |

**Excluded Services & Other Covered Services:**

|  |  |  |
| --- | --- | --- |
| **Services Your** [**Plan**](https://www.healthcare.gov/sbc-glossary/#plan) **Generally Does NOT Cover (Check your policy or** [**plan**](https://www.healthcare.gov/sbc-glossary/#plan) **document for more information and a list of any other** [**excluded services**](https://www.healthcare.gov/sbc-glossary/#excluded-services)**.)** | | |
| * Cosmetic Surgery * Funeral Expenses | * Long Term Care * Non-emergency care when traveling outside the U.S. * Private Duty Nursing | * Hair transplants * Teeth whitening |

|  |  |  |
| --- | --- | --- |
| **Other Covered Services (Limitations may apply to these services. This isn’t a complete list. Please see your** [**plan**](https://www.healthcare.gov/sbc-glossary/#plan) **document.)** | | |
| * Acupuncture (if prescribed for rehabilitation purposes) * Bariatric Surgery | * Chiropractic Care * Hearing Aids | * Weight Loss Programs |

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. For group health coverage subject to ERISA, for the Department of Labor’s Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. For non-federal governmental group health plans, for the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. Church plans are not covered by the Federal COBRA continuation coverage rules. If the coverage is insured, individuals should contact their State insurance regulator regarding their possible rights to continuation coverage under State law. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance [Marketplace](https://www.healthcare.gov/sbc-glossary/#marketplace). For more information about the [Marketplace](https://www.healthcare.gov/sbc-glossary/#marketplace), visit [www.HealthCare.gov](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](https://www.healthcare.gov/sbc-glossary/#plan) for a denial of a [claim](https://www.healthcare.gov/sbc-glossary/#claim). This complaint is called a [grievance](https://www.healthcare.gov/sbc-glossary/#grievance) or [appeal](https://www.healthcare.gov/sbc-glossary/#appeal). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](https://www.healthcare.gov/sbc-glossary/#claim). Your [plan](https://www.healthcare.gov/sbc-glossary/#plan) documents also provide complete information to submit a [claim](https://www.healthcare.gov/sbc-glossary/#claim), [appeal](https://www.healthcare.gov/sbc-glossary/#appeal), or a [grievance](https://www.healthcare.gov/sbc-glossary/#grievance) for any reason to your [plan](https://www.healthcare.gov/sbc-glossary/#plan). For more information about your rights, this notice, or assistance, contact: Contact your Plan Administrator in Human Resources, State Department of Insurance, Department of Labor’s Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). For non-federal governmental group health plans and church plans that are group health plans, contact your State Department of Insurance. Additionally, a state consumer assistance program can help you file your appeal. A list of states with Consumer Assistance Programs is available at: www.dol.gov/ebsa/healthreform and http://www.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants

**Does this plan provide Minimum Essential Coverage? No**.

If you don’t have [Minimum Essential Coverage](https://www.healthcare.gov/sbc-glossary/#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? No**.

If your [plan](https://www.healthcare.gov/sbc-glossary/#plan) doesn’t meet the [Minimum Value Standards](https://www.healthcare.gov/sbc-glossary/#minimum-value-standard), you may be eligible for a [premium tax credit](https://www.healthcare.gov/sbc-glossary/#premium-tax-credits) to help you pay for a [plan](https://www.healthcare.gov/sbc-glossary/#plan) through the [Marketplace](https://www.healthcare.gov/sbc-glossary/#marketplace).

**Language Access Services:**

In order to satisfy the requirement to provide the SBC in a culturally and linguistically appropriate manner, a plan or issuer follows the rules in the claims and appeals regulations under PHS Act section 2719. Plans and issuers can find written translations of the SBC template and uniform glossary in non-English languages at <http://cciio.cms.gov/programs/consumer/summaryandglossary/index.html>.

[Spanish (Español): Para obtener asistencia en Español, llame al 1-866-633-2246.

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-633-2446.

[Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-866-633-2446.

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-266-633-2446.

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

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



**About these Coverage Examples:**

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

◼ **The** [**plan’s**](https://www.healthcare.gov/sbc-glossary/#plan) **overall** [**deductible**](https://www.healthcare.gov/sbc-glossary/#deductible) **$500**

◼ [**Specialist**](https://www.healthcare.gov/sbc-glossary/#specialist)[**copayment**](https://www.healthcare.gov/sbc-glossary/#copayment) **N/A**

◼ **Hospital (facility)** [**coinsurance**](https://www.healthcare.gov/sbc-glossary/#coinsurance) **N/A**

◼ **Other** [**coinsurance**](https://www.healthcare.gov/sbc-glossary/#coinsurance) **N/A**

**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 | $500 |
| Copayments | $0 |
| Coinsurance | $0 |
| *What isn’t covered* | |
| Limits or exclusions | $0 |
| **The total Peg would pay is** | **$500** |

Note: These numbers assume the patient does not participate in the [plan’s](https://www.healthcare.gov/sbc-glossary/#plan) wellness program. If you participate in the [plan’s](https://www.healthcare.gov/sbc-glossary/#plan) wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: Enter employer contact information].

\*Note: This plan has other [deductibles](https://www.healthcare.gov/sbc-glossary/#deductible) for specific services included in this coverage example. See "Are there other deductibles for specific services?” row above.

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

◼ **The** [**plan’s**](https://www.healthcare.gov/sbc-glossary/#plan) **overall** [**deductible**](https://www.healthcare.gov/sbc-glossary/#deductible) **$500**

◼ [**Specialist**](https://www.healthcare.gov/sbc-glossary/#specialist)[**copayment**](https://www.healthcare.gov/sbc-glossary/#copayment) **N/A**

◼ **Hospital (facility)** [**coinsurance**](https://www.healthcare.gov/sbc-glossary/#coinsurance) **N/A**

◼ **Other** [**coinsurance**](https://www.healthcare.gov/sbc-glossary/#coinsurance) **N/A**

**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\* | $500 |
| Copayments | $0 |
| Coinsurance | $0 |
| *What isn’t covered* | |
| Limits or exclusions | $0 |
| **The total Joe would pay is** | **$500** |

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

◼ **The** [**plan’s**](https://www.healthcare.gov/sbc-glossary/#plan) **overall** [**deductible**](https://www.healthcare.gov/sbc-glossary/#deductible) **$500**

◼ [**Specialist**](https://www.healthcare.gov/sbc-glossary/#specialist)[**copayment**](https://www.healthcare.gov/sbc-glossary/#copayment) **N/A**

◼ **Hospital (facility)** [**coinsurance**](https://www.healthcare.gov/sbc-glossary/#coinsurance) **N/A**

◼ **Other** [**coinsurance**](https://www.healthcare.gov/sbc-glossary/#coinsurance) **N/A**

**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\* | $500 |
| Copayments | $0 |
| Coinsurance | $0 |
| *What isn’t covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$500** |