

Health Benefit Plan – HSA 5000 Referenced Based Pricing Plan

Coverage Period:

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

Coverage for: All levels Plan Type: RBP



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.groupresources.com. 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 1-800-749-9963 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	In-network - \$5,000 person \$10,000 family Out-of-network - \$7,000 person \$14,000 family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of the deductible expenses paid by all family members meets the overall family deductible .
Are there services covered before you meet your deductible ?	Yes. There is no deductible for preventive care or to any office services which have co-payments .	This plan covers some items and services even if you haven't yet met the deductible amount. But a co-payment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible . See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan ?	In-network - \$7,000 person \$14,000 family Out-of-network - \$9,000 person \$18,000 family	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.
What is not included in the out-of-pocket limit ?	Premiums , balance-billed charges, penalties and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit .
Will you pay less if you use a network provider ?	Yes. Call PHCS at (877) 952-7427, or visit www.multiplan.com/phcspracanc for a list of participating providers.	You will pay less if you use a provider in the plan's network. Be aware, your network provider may use a non-participating provider for some services. All facility services are subject to Referenced Based Pricing.
Do you need a referral to see a specialist ?	No	You can see the specialist you choose without a referral.

[* For more information about limitations and exceptions, see the plan or policy document at www.groupresources.com.]



All [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies. All services are subject to Referenced Based Pricing.

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 (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$25 co-payment per visit.	40% coinsurance	You will pay a \$10 co-payment (deductible does not apply) if you receive telephone consultation services through the telemedicine program.
	Specialist visit	\$50 co-payment per visit.	40% coinsurance	
	Preventive care/screening/immunizations	No charge Deductible does not apply	Not covered	You may have to pay for services that aren't preventive . Ask your provider if the services you need are preventive . Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	Must be pre-certified or benefits will be reduced by \$250.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.scriptcare.com or www.presmartinc.com	Generic drugs	\$10 co-payment retail or \$20 co-payment mail order	Not covered	Deductible does not apply Covers up to a 90 day supply (retail through Scriptcare), or a 90-day supply (mail order through Prescription Mart).
	Preferred brand drugs	\$35 co-payment retail or \$70 co-payment mail order	Not covered	
	Non-preferred brand drugs	50% co-payment to a maximum of \$100 per prescription retail or \$200 per prescription mail order	Not covered	
	Specialty drugs	35% co-payment to a maximum of \$300 per prescription	Not covered	Covers up to a 30 day supply (retail through Scriptcare)
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery ctr)	20% coinsurance	40% coinsurance	Must be pre-certified or benefits will be reduced by \$250. All services are subject to Referenced Based Pricing.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	None
If you need immediate medical attention	Emergency room care – Medical emergency	20% coinsurance (In-network deductible/out-of-pocket maximum apply to all providers)		All services are subject to Referenced Based Pricing
	Emergency room care – Non-emergency	20% coinsurance	40% coinsurance	All services are subject to Referenced Based Pricing.
	Emergency medical transportation	20% coinsurance (In-network deductible/out-of-pocket maximum apply to all providers)		None

[* For more information about limitations and exceptions, see the plan or policy document at [www.groupresources.com](#).]

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 (You will pay the most)	
	Urgent care	\$150 <u>co-payment</u> per visit	<u>40% coinsurance</u>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	<u>40% coinsurance</u>	Must be pre-certified or benefits will be reduced by \$250. All services are subject to Referenced Based Pricing.
	Physician/surgeon fees	20% coinsurance	<u>40% coinsurance</u>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Mental/behavioral health and substance abuse services are covered like any other illness. To determine benefits, please check this grid for the provider or facility that is performing the service		None
	Inpatient services			Inpatient services must be pre-certified or benefits will be reduced by \$250. All services are subject to Referenced Based Pricing.
If you are pregnant	Office visits	\$25 <u>co-payment</u> per visit	<u>40% coinsurance</u>	None
	Childbirth/delivery professional services	20% <u>coinsurance</u>	<u>40% coinsurance</u>	Inpatient services must be pre-certified or benefits will be reduced by \$250. All services are subject to Referenced Based Pricing.
	Childbirth/delivery facility services	20% <u>coinsurance</u>	<u>40% coinsurance</u>	
If you need help recovering or have other special health needs	Home health care	20% <u>coinsurance</u>	<u>40% coinsurance</u>	Coverage limited to 100 days per calendar year. Must be pre-certified or benefits will be reduced by \$250.
	Rehabilitation services	20% <u>coinsurance</u>	<u>40% coinsurance</u>	Includes physical, speech & occupational therapy
	Habilitation services	Not Covered	Not Covered	This exclusion will not apply to Autism, ADD, or ADHD
	Skilled nursing care	20% <u>coinsurance</u>	<u>40% coinsurance</u>	Coverage limited to 100 days per calendar year. Must be pre-certified or benefits will be reduced by \$250. All services are subject to Referenced Based Pricing.
	Durable medical equipment	20% <u>coinsurance</u>	<u>40% coinsurance</u>	Must be pre-certified or benefits will be reduced by \$250.
	Hospice services	20% <u>coinsurance</u>	<u>40% coinsurance</u>	None
If your child needs dental or eye care	Children's eye exam	No charge <u>Deductible</u> does not apply	Not Covered	Limited to one exam per 12-month period.

[* For more information about limitations and exceptions, see the plan or policy document at www.groupresources.com.]

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 (You will pay the most)	
	Children's glasses	Not covered		None
	Children's dental check-up	Not covered		None

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 .)			
<ul style="list-style-type: none"> Bariatric surgery Habilitation services 	<ul style="list-style-type: none"> Weight loss programs Infertility treatment 	<ul style="list-style-type: none"> Glasses (Adult & Child) Hearing aids Long-term care 	<ul style="list-style-type: none"> Non-emergency care if traveling outside the U.S. Routine foot care Dental care (Adult & Child)
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)			
<ul style="list-style-type: none"> Acupuncture Chiropractic care Cosmetic surgery (Limited to treatment of congenital birth defects, and treatment resulting from an illness or injury if performed within 24 months of the date of such illness or injury) Dental care (Adult – limited to treatment of an accidental injury to mouth, teeth, gums and alveolar processes but only if treatment is received within 6 months of such accident - includes the replacement of teeth, and setting of a dislocated or fractured jaw) 			

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: US Dept of Labor, Employee Benefits Security Administration (866) 444-3272 or www.dol.gov/ebsa/healthreform. You may also call Group Resources at (800) 749-9963. 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: Group Resources 770-623-8383 or the Department of Labor's Employee Benefit Security Administration (866) 444-3272 or www.dol.gov/ebsa/healthreform.

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: (202) 727-4559

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](#) \$5,000
- [Specialist](#) \$50 co-payment/visit
- Hospital (facility) [coinsurance](#) 20%
- Other [coinsurance](#) 20%

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
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$5,000
Copayments	\$90
Coinsurance	\$1,500
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$6,650

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

- The [plan's](#) overall [deductible](#) \$5,000
- [Specialist](#) \$50 co-payment/visit
- Hospital (facility) [coinsurance](#) 20%
- Other [coinsurance](#) 20%

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
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,900
Copayments	\$970
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Joe would pay is	\$2,930

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

- The [plan's](#) overall [deductible](#) \$5,000
- [Specialist](#) \$50 co-payment/visit
- Hospital (facility) [coinsurance](#) 20%
- Other [coinsurance](#) 20%

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	\$1,700
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,600
Copayments	\$50
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,650