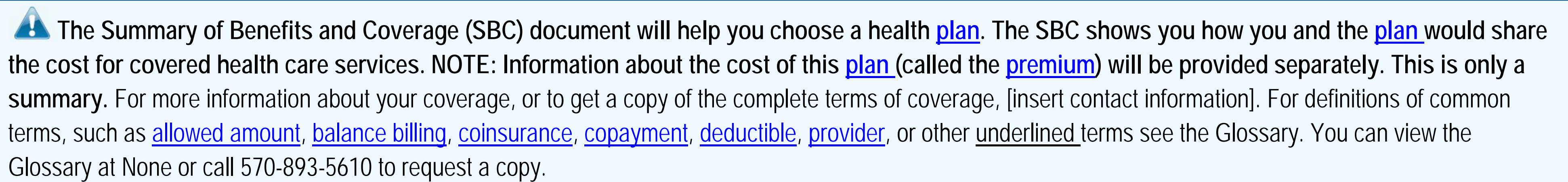
Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services
City of Lock Haven

Coverage Period: 1/1/2021-12/31/2021
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, [insert contact information]. For 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 None or call 570-893-5610 to request a copy.

Important Questions	Answers	Why This Matters
What is the overall deductible?	$ n/a	n/a
Are there services covered before you meet your deductible?	n/a	n/a
Are there other deductibles for specific services?	$ n/a	n/a
What is the out-of-pocket limit for this plan?	$ n/a	n/a
What is not included in the out-of-pocket limit?	n/a	n/a
Will you pay less if you use a network provider?	n/a	n/a
Do you need a referral to see a specialist?	n/a	n/a

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(HHS - OMB control number: 0938-1146/Expiration date: 10/31/2022)

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 Network Provider (You will pay the least)	What You Will Pay Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	n/a	n/a	n/a
	Specialist visit	n/a	n/a	n/a
	Preventive care/screening/ immunization	n/a	n/a	n/a
If you have a test	Diagnostic test (x-ray, blood work)	n/a	n/a	n/a
	Imaging (CT/PET scans, MRIs)	n/a	n/a	n/a
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.[insert].com	Generic drugs	n/a	n/a	n/a
	Preferred brand drugs	n/a	n/a	n/a
	Non-preferred brand drugs	n/a	n/a	n/a
	Specialty drugs	n/a	n/a	n/a
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	n/a	n/a	n/a
	Physician/surgeon fees	n/a	n/a	n/a
If you need immediate medical attention	Emergency room care	n/a	n/a	n/a
	Emergency medical transportation	n/a	n/a	n/a
	Urgent care	n/a	n/a	n/a
If you have a hospital stay	Facility fee (e.g., hospital room)	n/a	n/a	n/a
	Physician/surgeon fees	n/a	n/a	n/a
If you need mental health, behavioral health, or substance abuse services	Outpatient services	n/a	n/a	n/a
	Inpatient services	n/a	n/a	n/a
If you are pregnant	Office visits	n/a	n/a	n/a

[* For more information about limitations and exceptions, see the plan or policy document at None.]

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 are pregnant	Childbirth/delivery professional services	n/a	n/a	n/a
	Childbirth/delivery facility services	n/a	n/a	n/a
If you need help recovering or have other special needs	Home health care	n/a	n/a	n/a
	Rehabilitation services	n/a	n/a	n/a
	Habilitation services	n/a	n/a	n/a
	Skilled nursing center	n/a	n/a	n/a
	Durable medical equipment	n/a	n/a	n/a
	Hospice services	n/a	n/a	n/a
If your child needs dental or eye care	Children's eye exam	n/a	n/a	n/a
	Children's glasses	n/a	n/a	n/a
	Children's dental checkups	n/a	n/a	n/a

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.)		
• n/a	•	•

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

HRA FUND AMOUNT:
Employee Only $1,500
Employee and Family $3,000

ELIGIBLE EXPENSES: Qualifying Medical Expenses include expenses that are considered "qualifying expenses" under the Health Plan, as described in the certificate of coverage, and which are applied to the "deductible" of that Plan.

CARRY FORWARD AMOUNT: The following funds are eligible to be carried forward into the succeeding plan years: None

PLEASE REFER TO THE MEDICAL SBC FOR VERIFICATION OF THE MEDICAL PLAN'S MINIMUM ESSENTIAL COVERAGE AND MINIMUM VALUE STANDARD REQUIREMENTS

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: [insert State, HHS, DOL, and/or other applicable agency contact information]. 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-

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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 on how 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: [insert applicable contact information from instructions].

Does this plan provide Minimum Essential Coverage? [Yes/No]
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? [Yes/No/Not Applicable]
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.

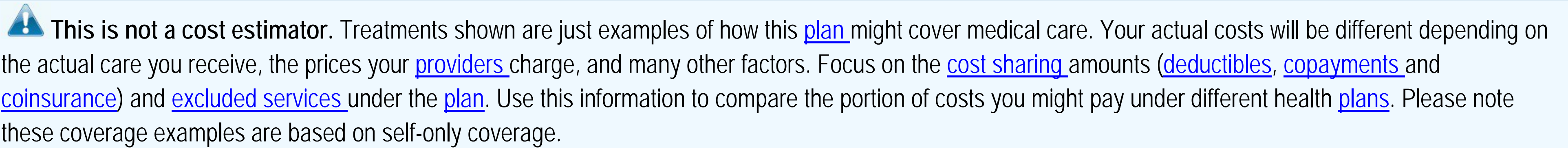
Language Access Services:

[Spanish (Español): Para obtener asistencia en Español, llame al [insert telephone number].]
[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa [insert telephone number].]
[Chinese (中文): 如果需要中文的帮助，请拨打这个号码[insert telephone number].]
[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' [insert telephone number].]

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

[* For more information about limitations and exceptions, see the plan or policy document at None.]

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	$
▪ Specialist [cost sharing]	$
▪ Hospital (facility) [cost sharing]	%
▪ Other [cost sharing]	%

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	$12,700

In this example, Peg would pay:

Cost Sharing	
Deductibles	$
Copayments	$
Coinsurance	$
What isn't covered	
Limits or exclusions	$
The total Peg would pay is	**$**

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

▪ The plan's overall deductible	$
▪ Specialist [cost sharing]	$
▪ Hospital (facility) [cost sharing]	%
▪ Other [cost sharing]	%

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	$5,600

In this example, Joe would pay:

Cost Sharing	
Deductibles	$
Copayments	$
Coinsurance	$
What isn't covered	
Limits or exclusions	$
The total Joe would pay is	**$**

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

▪ The plan's overall deductible	$
▪ Specialist [cost sharing]	$
▪ Hospital (facility) [cost sharing]	%
▪ Other [cost sharing]	%

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	$2,800

In this example, Mia would pay:

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

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