Health Flexible Spending Account; XYZ Plumbing

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

Coverage Period: 01/01/2012–12/31/2012
Coverage for: Individual | **Plan Type:** Health FSA

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at by emailing _____ or by calling _____.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$** 0	"See the chart starting on page 3 for your costs for services this plan covers." The FSA reimburses first dollar of any medically necessary service, that is substantiated, and is not reimbursed by any other source, up to the Health FSA election chosen by the Employee. This FSA may be used to offset all or a portion of your deductible under a major medical plan.
Are there other deductibles for specific services?	**$** 0	"You don't have to meet deductibles for specific services, but see the chart starting on page 3 for costs for services this plan covers." This FSA may be used to offset all or a portion of your deductible under a major medical plan.
Is there an out–of–pocket limit on my expenses?	**$**	"No". The Health FSA can only reimburse you up to the amount of your annual Health FSA election. "There's no limit on how much you could pay during a coverage period for your share of the cost of covered services."
What is not included in the out–of–pocket limit?		"This plan has no out-of-pocket limit." "Not applicable because there's no out-of-pocket limit on your expenses."
Is there an overall annual limit on what the plan pays?	Yes	You determine the overall annual limit when you complete your Health FSA Election form, but, Health care Reform does not allow an election greater than $2,500.00 for Plan Years beginning after 12/31/2012. "This plan will pay for covered services only up to this limit during each covereage period, even if your own need is greater. You're responsible for all expenses above this limit. The chart starting on page 3 describes specific coverage limits, such as limits on the number of office visits."
Does this plan use a network of providers?	No	"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 permission from this plan."
Are there services this plan doesn't cover?	Yes	Schedule B, as referenced in the Summary Plan Description, specifies certain expenses that are excluded under this Plan with respect to reimbursement from the Health FSA—that is, expenses that *are not reimbursable*, even if they meet the definition of "medical care" under Code § 213(d) and may otherwise be reimbursable under the regulations governing Health

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		FSAs.

OMB Control Numbers 1545-2229, 1210-0147, and 0938-1146

Corrected on May 11, 2012

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use _____ **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Reimbursement Non-Networked Health FSA Plan	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 Health FSA balance	Cannot reimburse any part of payment that is payable from another source, such as health insurance.
	Specialist visit	Same as above	Same as above
	Other practitioner office visit	Same as above	Same as above
	Preventive care/screening/immunization	Same as above	Same as above
If you have a test	Diagnostic test (x-ray, blood work)	Same as above	Same as above
	Imaging (CT/PET scans, MRIs)	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 www.[insert].	Generic drugs	Same as above	Same as above
	Preferred brand drugs	Same as above	Same as above
	Non-preferred brand drugs	Same as above	Same as above
	Specialty drugs	Same as above	Same as above
If you have	Facility fee (e.g., ambulatory surgery center)	Same as above	Same as above

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Common Medical Event	Services You May Need	Your Reimbursement Non-Networked Health FSA Plan	Limitations & Exceptions
outpatient surgery	Physician/surgeon fees	100% up to available Health FSA balance	Cannot reimburse any part of payment that is payable from another source, such as health insurance.
If you need immediate medical attention	Emergency room services	Same as above	Same as above
	Emergency medical transportation	Same as above	Same as above
	Urgent care	Same as above	Same as above
If you have a hospital stay	Facility fee (e.g., hospital room)	Same as above	Same as above
	Physician/surgeon fee	Same as above	Same as above
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	Same as above	Same as above
	Mental/Behavioral health inpatient services	Same as above	Same as above
	Substance use disorder outpatient services	Same as above	Same as above
	Substance use disorder inpatient services	Same as above	Same as above
If you are pregnant	Prenatal and postnatal care	Same as above	Same as above
	Delivery and all inpatient services	Same as above	Same as above
If you need help recovering or have other special health needs	Home health care	Same as above	Same as above
	Rehabilitation services	Same as above	Same as above
	Habilitation services	Same as above	Same as above
	Skilled nursing care	Same as above	Same as above
	Durable medical equipment	Same as above	Same as above
	Hospice service	Same as above	Same as above
If your child needs dental or eye care	Eye exam	Same as above	Same as above
	Glasses	Same as above	Same as above
	Dental check-up	Same as above	Same as above

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- **Any expense payable through another source** (such as a health insurance plan)
- **Cosmetic surgery** or other similar procedures, unless the surgery or procedure is necessary to ameliorate a deformity arising from, or directly related to, a congenital abnormality, a personal injury resulting from an accident or trauma, or a disfiguring disease. "Cosmetic surgery" means any procedure that is directed at improving the patient's appearance and does not meaningfully promote the proper function of the body or prevent or treat illness or disease.
- **Long-term care**
- **Private-duty nursing** (such as the salary expense of a nurse to care for a healthy newborn at home)

The following **Dual Purpose products**, items for general well-being, or items not typically medically necessary are excluded from reimbursement unless accompanied by a letter of medical necessity. The letter of medical necessity must be from a Physician and must include a diagnosis, duration of treatment, and description of treatment plan.

- Acupuncture
- Dermatology Products
- Massage Therapy
- Supplements
- Vitamins
- Weight Loss Programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Chiropractic care
- Dental care (Adult)
- Hearing Aids
- Infertility treatment
- Routine eye care (Adult)
- Routine foot care

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 888.755.3373. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877267-2323 x61565 or www.cciio.cms.gov.

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Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: HR Dept. by email at _____ or by phone at _____.

If the Health FSA is not an excepted benefit, it is subject to external review requirements. If the denial of your claim is not related to your (or your beneficiary's) failure to meet the requirements for eligibility under the terms of your employer's Health FSA, you may be eligible to request an external review. View current procedures and timeline relevant to the external review request at http://www.dol.gov/ebsa or call the Employee Benefits Security Administration, 866-444 EBSA (3272).

Language Access Services:

This Summary of Benefits and Coverage is available in English only.

PHS Act section 2719 requires non-grandfathered group health plans and health insurance issuers offering non-grandfathered health insurance coverage to provide relevant notices in a culturally and linguistically appropriate manner. The regulations implementing section 2719 require these plans and issuers to make certain accommodations for notices sent to an address in a county meeting a threshold percentage of people who are literate only in the same non-English language. This threshold percentage is set at 10 percent or more of the population residing in the claimant's county, as determined based on American Community Survey (ACS) data published by the United States Census Bureau. 26 CFR. §54.9815-2719T, 29 CFR. §2590.715-2719, and 45 CFR. §147.136.

The participants of this Health FSA do not reside in a county that requires a non-English language translation.

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

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $2,500 max (up to available FSA balance)
- **Patient pays** $5,040 or more (determined by available FSA balance)

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$
Copays	$
Coinsurance	$
Limits or exclusions	$
Total	**$7,540**

Please Note: The payment is made from your pre-taxed Health FSA election, up to the available amount of your annual election.

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $2,500 max (up to available FSA balance)
- **Patient pays** $ 2,900 or more (determined by available FSA balance)

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$
Copays	$
Coinsurance	$
Limits or exclusions	$
Total	**$5,400**

Please Note: The payment is made from your pre-taxed Health FSA election, up to the available amount of your annual election. With your Health FSA you have paid up to $2,500.00 of this expense tax-free.

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✗ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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