City of Kettering: Health Reimbursement Arrangement

Effective Date: * January 1, 2020

Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services **Coverage Period: *January 1st through December 31st**

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. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage contact your plan administrator, (937) 296- 2446. 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.dol.gov/ebsa/pdf/SBC-Uniform-Glossary-final.pdf or call 1-877-264-2323 x 61565 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$0	*If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Is there an overall annual limit on what this plan pays?	Yes, this year the plan will reimburse medical expenses up to *$1,300/Person or Single; $2,600/Family. This plan will reimburse you for in-network deductible expenses. *If you complete the wellness incentive as outlined by the City of Kettering, your HRA will reimburse you an additional $350/Single; $700/Family. This incentive will be deposited into your tax-free plan the following plan year.	This amount may vary each year. This plan will pay for covered services only up to this limit during each coverage period, even if your own need is greater. You will be responsible for all expenses outside of the limits. This plan will reimburse you expenses as described in the “answers” column to the left.
Are there services covered before you meet your deductible?	N/A	Refer to the group health plan SBC, certificate of coverage, or policy booklet.
Are there other deductibles for specific services?	N/A	Refer to the group health plan SBC, certificate of coverage, or policy booklet.
What is the out-of-pocket limit for this plan?	N/A	Refer to the group health plan SBC, certificate of coverage, or policy booklet.
What is not included in the out-of-pocket limit?	N/A	Refer to the group health plan SBC, certificate of coverage, or policy booklet.
Will you pay less if you use a network provider?	N/A	Refer to the group health plan SBC, certificate of coverage, or policy booklet.
Do you need a referral to see a specialist?	N/A	Refer to the group health plan SBC, certificate of coverage, or policy booklet.

All **copayment** and **coinsurance** costs shown in this chart may be after your **deductible** has been met, if a **deductible** applies.

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	Not Applicable.	Not Applicable.	Only expenses reimbursable under the conditions of the Health Reimbursement Arrangement (HRA) will be covered up to the available HRA benefit balance.
	Specialist visit	Not Applicable.	Not Applicable.	
	Preventive care/screening/ immunization	Not Applicable.	Not Applicable.	
If you have a test	Diagnostic test (x-ray, blood work)	Not Applicable.	Not Applicable.	
	Imaging (CT/PET scans, MRIs)	Not Applicable.	Not Applicable.	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.[insert].com	Generic drugs (Tier 1)	Not Applicable.	Not Applicable.	
	Preferred brand drugs (Tier 2)	Not Applicable.	Not Applicable.	
	Non-preferred brand drugs (Tier 3)	Not Applicable.	Not Applicable.	
	Specialty drugs (Tier 4)	Not Applicable.	Not Applicable.	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Not Applicable.	Not Applicable.	
	Physician/surgeon fees	Not Applicable.	Not Applicable.	
If you need immediate medical attention	Emergency room care	Not Applicable.	Not Applicable.	
	Emergency medical transportation	Not Applicable.	Not Applicable.	
	Urgent care	Not Applicable.	Not Applicable.	
If you have a hospital stay	Facility fee (e.g., hospital room) Physician/surgeon fees	Not Applicable.	Not Applicable.	

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 need mental health, behavioral health, or substance abuse services	Outpatient services	Not Applicable.	Not Applicable.	
	Inpatient services	Not Applicable.	Not Applicable.	
If you are pregnant	Office visits	Not Applicable.	Not Applicable.	
	Childbirth/delivery professional services	Not Applicable.	Not Applicable.	
	Childbirth/delivery facility services	Not Applicable.	Not Applicable.	
If you need help recovering or have other special health needs	Home health care	Not Applicable.	Not Applicable.	
	Rehabilitation services	Not Applicable.	Not Applicable.	Only expenses reimbursable under the conditions of the Health Reimbursement Arrangement (HRA) will be covered up to the available HRA benefit balance.
	Habilitation services	Not Applicable.	Not Applicable.	
	Skilled nursing care	Not Applicable.	Not Applicable.	
	Durable medical equipment	Not Applicable.	Not Applicable.	
	Hospice services	Not Applicable.	Not Applicable.	
If your child needs dental or eye care	Children's eye exam	Not Applicable.	Not Applicable.	
	Children's glasses	Not Applicable.	Not Applicable.	
	Children's dental check-up	Not Applicable.	Not Applicable.	

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.)
• Cosmetic Surgery

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)
Refer to your Heath Reimbursement Arrangement (HRA) summary plan description (SPD).

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 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 1-877 267-2323 x61565 or www.cciio.cms.gov. 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: *ER Phone #.

Does this plan provide Minimum Essential Coverage? ***The HRA alone does not provide Minimum Essential Coverage**.
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 Minimum Value Standards? ***The HRA alone does not meet Minimum Value Standards**.
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 *ER Phone.
[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa *ER Phone.
[Chinese (中文): 如果需要中文的帮助， **请拨打这个号码** *ER Phone.
[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' *ER Phone.