Name of Plan: VIT (HRA)

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

Coverage Period: 1/1/2017-12/31/2017

Coverage for: Individual/Family Plan Type: HRA

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 www.consociate.com or by calling 1-800-798-2422.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$2,000** person **/ $2,000 x 2** Family It **_X_** does or __does not apply to preventive care. (check one)	You must pay all medical expenses up to the **deductible** amount before this plan begins to reimburse for covered medical expenses you use. Check the Summary Plan Description to see when the deductible starts over (usually, but not always the beginning of the Plan Year).
Are there other deductibles for specific services?	There are no other specific **deductibles**	You must pay all of the medical expenses for these services up to the specific **deductible** amount before this plan begins to pay for these medical expenses.
Is there an out–of–pocket limit on my expenses?	Yes for participating providers **$3,500** person **$7,000** family	The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered medical expenses. If the HRA does not contain any out-of-pocket limitations, please refer to the SBC of the insured group health plan.
What is not included in the out–of–pocket limit?	Premiums, deductible, balance-billed charges, and medical expenses that this plan does not cover.	Even though you pay these medical expenses, they do not count towards the out-of-pocket limit.
Is there an overall annual limit on what the plan pays?	This year, the plan will reimburse medical expenses up to **$4,500** person/**$9,000** family.	This amount may vary each year. Any amounts not paid by the plan will either be paid by you or the insured group medical plan.
Does this plan use a network of providers?	See the SBC of the insured group health plan.	If the plan reimburses any eligible medical expense, please indicate that it reimburses services from any providers. If the plan only pays those medical expense not paid by the insured group health plans, refer to the SBC of the insured group health plan.
Do I need a referral to	See the SBC of the insured	You can see the specialist you choose without permission from this plan. If not, refer the

see a specialist?	group health plan.	answer of the SBC of the insured group health plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan does not cover are listed on page 4. See the Summary Plan Description for additional information about **excluded services.**

- **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 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 Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	See the SBC of the insured group health plan.	See the SBC of the insured group health plan.	See the SBC of the insured group health plan.
	Specialist visit	See the SBC of the insured group health plan.	See the SBC of the insured group health plan.	See the SBC of the insured group health plan.
	Other practitioner office visit	See the SBC of the insured group health plan.	See the SBC of the insured group health plan.	See the SBC of the insured group health plan.
	Preventive care/screening/immunization	See the SBC of the insured group health plan.	See the SBC of the insured group health plan.	See the SBC of the insured group health plan.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you have a test	Diagnostic test (x-ray, blood work)	See the SBC of the insured group health plan.	See the SBC of the insured group health plan.	See the SBC of the insured group health plan.
	Imaging (CT/PET scans, MRIs)	See the SBC of the insured group health plan.	See the SBC of the insured group health plan.	See the SBC of the insured group health plan.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.[insert].	Generic drugs	See the SBC of the insured group health plan.	See the SBC of the insured group health plan.	See the SBC of the insured group health plan.
	Preferred brand drugs	See the SBC of the insured group health plan.	See the SBC of the insured group health plan.	See the SBC of the insured group health plan.
	Non-preferred brand drugs	See the SBC of the insured group health plan.	See the SBC of the insured group health plan.	See the SBC of the insured group health plan.
	Specialty drugs	See the SBC of the insured group health plan.	See the SBC of the insured group health plan.	See the SBC of the insured group health plan.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	See the SBC of the insured group health plan.	See the SBC of the insured group health plan.	See the SBC of the insured group health plan.
	Physician/surgeon fees	See the SBC of the insured group health plan.	See the SBC of the insured group health plan.	See the SBC of the insured group health plan.
If you need immediate medical attention	Emergency room services	See the SBC of the insured group health plan.	See the SBC of the insured group health plan.	See the SBC of the insured group health plan.
	Emergency medical transportation	See the SBC of the insured group health plan.	See the SBC of the insured group health plan.	See the SBC of the insured group health plan.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
	Urgent care	See the SBC of the insured group health plan.	See the SBC of the insured group health plan.	See the SBC of the insured group health plan.
If you have a hospital stay	Facility fee (e.g., hospital room)	See the SBC of the insured group health plan.	See the SBC of the insured group health plan.	See the SBC of the insured group health plan.
	Physician/surgeon fee	See the SBC of the insured group health plan.	See the SBC of the insured group health plan.	See the SBC of the insured group health plan.
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	See the SBC of the insured group health plan.	See the SBC of the insured group health plan.	See the SBC of the insured group health plan.
	Mental/Behavioral health inpatient services	See the SBC of the insured group health plan.	See the SBC of the insured group health plan.	See the SBC of the insured group health plan.
	Substance use disorder outpatient services	See the SBC of the insured group health plan.	See the SBC of the insured group health plan.	See the SBC of the insured group health plan.
	Substance use disorder inpatient services	See the SBC of the insured group health plan.	See the SBC of the insured group health plan.	See the SBC of the insured group health plan.
If you are pregnant	Prenatal and postnatal care	See the SBC of the insured group health plan.	See the SBC of the insured group health plan.	See the SBC of the insured group health plan.
	Delivery and all inpatient services	See the SBC of the insured group health plan.	See the SBC of the insured group health plan.	See the SBC of the insured group health plan.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	See the SBC of the insured group health plan.	See the SBC of the insured group health plan.	See the SBC of the insured group health plan.
	Rehabilitation services	See the SBC of the insured group health plan.	See the SBC of the insured group health plan.	See the SBC of the insured group health plan.
	Habilitation services	See the SBC of the insured group health plan.	See the SBC of the insured group health plan.	See the SBC of the insured group health plan.
	Skilled nursing care	See the SBC of the insured group health plan.	See the SBC of the insured group health plan.	See the SBC of the insured group health plan.
	Durable medical equipment	See the SBC of the insured group health plan.	See the SBC of the insured group health plan.	See the SBC of the insured group health plan.
	Hospice service	See the SBC of the insured group health plan.	See the SBC of the insured group health plan.	See the SBC of the insured group health plan.
If your child needs dental or eye care	Eye exam	See the SBC of the insured group health plan.	See the SBC of the insured group health plan.	See the SBC of the insured group health plan.
	Glasses	See the SBC of the insured group health plan.	See the SBC of the insured group health plan.	See the SBC of the insured group health plan.
	Dental check-up	See the SBC of the insured group health plan.	See the SBC of the insured group health plan.	See the SBC of the insured group health plan.

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.)

- Check the terms of the Summary Plan Description.

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.)

- Check the terms of the Summary Plan Description.

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 1-800-798-2422. 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 1-877-267-2323 x61565 or www.cciio.cms.gov."

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: [insert applicable contact information from instructions].

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." This plan or policy does provide minimum essential coverage.

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). This health coverage does meet the minimum value standard for the benefits it provides.

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** $2,032
- **Patient pays** $5,508
- **HRA Plan Reimbursement** -$2,400
- **Net Patient Responsibility** $3,108

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	$5,000
Less HRA Reimbursement	-$2,400
Copays	N/A
Coinsurance	$508
Less HRA Reimbursement	N/A
Limits or exclusions	N/A
Total	**$3,108**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $320
- **Patient pays** $5,080
- **HRA Plan Reimbursement** -$2,400
- **Net Patient Responsibility** $2,680

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	$5,000
Less HRA Reimbursement	-$2,400
Copays	N/A
Coinsurance	$80
Less HRA Reimbursement	N/A
Limits or exclusions	N/A
Total	**$2,680**

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.