

 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 at [Employer phone and/or website contact information here] 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 or request a copy the Uniform Glossary at www.dol.gov/ebsa/healthreform or www.cciio.cms.gov.

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	\$0	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 deductible expenses paid by all family members meets the overall family deductible . If \$0: See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible ?	Yes	If Yes: This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment 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/ . If "No": You will have to meet the deductible before the plan pays for any services.
Are there other deductibles for specific services?	No	If Yes: 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. If "No": You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan ?	Not Applicable	This plan does not have an out-of-pocket limit on your expenses.
What is not included in the out-of-pocket limit ?	Not Applicable	This plan does not have an out-of-pocket limit on your expenses.
Will you pay less if you use a network provider ?	Not Applicable	This plan does not use a provider network . You can receive covered services from any provider .
Do you need a referral to see a specialist ?	No.	You can see a specialist you choose without a referral .

 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	Limitations, Exceptions, & Other Important Information
		Network Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Not Applicable	Only qualified medical expenses up to the available account balance in the HRA
	Specialist visit	Not Applicable	
	Preventive care/screening/immunization	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	Only qualified medical expenses up to the available account balance in the HRA
	Preferred brand drugs (Tier 2)	Not Applicable	
	Non-preferred brand drugs (Tier 3)	Not Applicable	
	Specialty drugs (Tier 4)	Not Applicable	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Not Applicable	Only qualified medical expenses up to the available account balance in the HRA
	Physician/surgeon fees	Not Applicable	
If you have a hospital stay	Facility fee (e.g., hospital room)	Not Applicable	Only qualified medical expenses up to the available account balance in the HRA
	Physician/surgeon fees	Not Applicable	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Not Applicable	Only qualified medical expenses up to the available account balance in the HRA
	Inpatient services	Not Applicable	
If you are pregnant	Office visits	Not Applicable	Only qualified medical expenses up to the available account balance in the HRA
	Childbirth/delivery professional services	Not Applicable	
	Childbirth/delivery facility services	Not Applicable	
If you need help recovering or have other special health needs	Home health care	Not Applicable	Only qualified medical expenses up to the available account balance in the HRA
	Rehabilitation services	Not Applicable	
	Habilitation services	Not Applicable	
	Skilled nursing care	Not Applicable	
	Durable medical equipment	Not Applicable	
Hospice services	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
- Funeral Expenses
- Long Term Care
- Non-emergency care when traveling outside the U.S.
- Private Duty Nursing
- Hair transplants
- Teeth whitening

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

- Acupuncture (if prescribed for rehabilitation purposes)
- Bariatric Surgery
- Chiropractic Care
- Hearing Aids
- Weight Loss Programs

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. For group health coverage subject to ERISA, for the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. For non-federal governmental group health plans, for the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. Church plans are not covered by the Federal COBRA continuation coverage rules. If the coverage is insured, individuals should contact their State insurance regulator regarding their possible rights to continuation coverage under State law. 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: Contact your Plan Administrator Director of Compensation and Benefits, Human Resources, 570-320-2400, ext. 7413, State Department of Insurance, Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. For non-federal governmental group health plans and church plans that are group health plans, contact your State Department of Insurance. Additionally, a state consumer assistance program can help you file your appeal. A list of states with Consumer Assistance Programs is available at: www.dol.gov/ebsa/healthreform and <http://www.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants>

Does this plan provide Minimum Essential Coverage? **No.**

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? **No.**

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:

In order to satisfy the requirement to provide the SBC in a culturally and linguistically appropriate manner, a plan or issuer follows the rules in the claims and appeals regulations under PHS Act section 2719. Plans and issuers can find written translations of the SBC template and uniform glossary in non-English languages at <http://cciio.cms.gov/programs/consumer/summaryandglossary/index.html>.

[Spanish (Español): Para obtener asistencia en Español, llame al 570-320-2400

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 570-320-2400

[Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 570-320-2400

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 570-320-2400

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](#) \$0
- [Specialist copayment](#) N/A
- Hospital (facility) [coinsurance](#) N/A
- Other [coinsurance](#) N/A

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
---------------------------	-----------------

In this example, Peg would pay:

Cost Sharing	
Deductibles	\$500
Copayments	\$0
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
The total Peg would pay is	\$12,800

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

- The [plan's](#) overall [deductible](#) \$0
- [Specialist copayment](#) N/A
- Hospital (facility) [coinsurance](#) N/A
- Other [coinsurance](#) N/A

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
---------------------------	----------------

In this example, Joe would pay:

Cost Sharing	
Deductibles*	\$500
Copayments	\$0
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
The total Joe would pay is	\$7,400

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

- The [plan's](#) overall [deductible](#) \$0
- [Specialist copayment](#) N/A
- Hospital (facility) [coinsurance](#) N/A
- Other [coinsurance](#) N/A

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	\$1,900
---------------------------	----------------

In this example, Mia would pay:

Cost Sharing	
Deductibles*	\$500
Copayments	\$0
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$1,900

Note: These numbers assume the patient does not participate in the [plan's](#) wellness program. If you participate in the [plan's](#) wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: Pennsylvania College of Technology.

*Note: This plan has other [deductibles](#) for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above.