



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, contact J & K Consultants, Inc. at 877-872-4232. 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 [www.dol.gov/ebsa/healthreform.com](http://www.dol.gov/ebsa/healthreform.com) or call 1-877-872-4232 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	\$ 0	See the Common Medical Events chart below for your costs for services this <a href="#">plan</a> covers.
Are there services covered before you meet your <a href="#">deductible</a> ?	Not Applicable	
Are there other <a href="#">deductibles</a> for specific services?	No	You don't have to meet <a href="#">deductibles</a> for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	Not Applicable	This plan does not have an <a href="#">out-of-pocket</a> limit on your expenses.
What is not included in the <a href="#">out-of-pocket limit</a> ?	Not Applicable	This plan does not have an <a href="#">out-of-pocket</a> limit on your expenses.
Will you pay less if you use a <a href="#">network provider</a> ?	Yes	Any procedure not covered by the alternate coverage will not be reimbursed under this plan.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	Indirectly only	This plan will not reimburse for expenses not covered by the alternate coverage, And the alternate coverage may require a referral to see the specialist.



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 (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	\$0	\$0	You may have coverage for this service under the alternative coverage, but not under this plan. This plan reimburses for co-pays, co-insurance and deductibles incurred under the alternate coverage up to the annual limit, if any. Any procedure not covered by the alternate coverage will not be reimbursed under this plan.
	<a href="#">Specialist</a> visit	\$0	\$0	
	<a href="#">Preventive care/screening/immunization</a>	\$0	\$0	
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	\$0	\$0	You may have coverage for this service under the alternative coverage, but not under this plan. This plan reimburses for co-pays, co-insurance and deductibles incurred under the alternate coverage up to the annual limit, if any. Any procedure not covered by the alternate coverage will not be reimbursed under this plan.
	Imaging (CT/PET scans, MRIs)	\$0	\$0	
If you need drugs to treat your illness or condition	Generic drugs	\$0	\$0	You may have coverage for this service under the alternative coverage, but not under this plan. This plan reimburses for co-pays, co-insurance and deductibles incurred under the alternate coverage up to the annual limit, if any. Any drug not covered by the alternate coverage will not be reimbursed under this plan.
	Preferred brand drugs	\$0	\$0	
	Non-preferred brand drugs	\$0	\$0	
	<a href="#">Specialty drugs</a>	\$0	\$0	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$0	\$0	You may have coverage for this service under the alternative coverage, but not under this plan. This plan reimburses for co-pays, co-insurance and deductibles incurred under the alternate coverage up to the annual limit, if any. Any procedure
	Physician/surgeon fees	\$0	\$0	

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)	
				not covered by the alternate coverage will not be reimbursed under this plan.
If you need immediate medical attention	<a href="#">Emergency room care</a>	\$0	\$0	You may have coverage for this service under the alternative coverage, but not under this plan. This plan reimburses for co-pays, co-insurance and deductibles incurred under the alternate coverage up to the annual limit, if any. Any procedure not covered by the alternate coverage will not be reimbursed under this plan.
	<a href="#">Emergency medical transportation</a>	\$0	\$0	
	<a href="#">Urgent care</a>	\$0	\$0	
If you have a hospital stay	Facility fee (e.g., hospital room)	\$0	\$0	You may have coverage for this service under the alternative coverage, but not under this plan. This plan reimburses for co-pays, co-insurance and deductibles incurred under the alternate coverage up to the annual limit, if any. Any procedure not covered by the alternate coverage will not be reimbursed under this plan.
	Physician/surgeon fees	\$0	\$0	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$0	\$0	You may have coverage for this service under the alternative coverage, but not under this plan. This plan reimburses for co-pays, co-insurance and deductibles incurred under the alternate coverage up to the annual limit, if any. Any procedure not covered by the alternate coverage will not be reimbursed under this plan.
	Inpatient services	\$0	\$0	
If you are pregnant	Office visits	\$0	\$0	You may have coverage for this service under the alternative coverage, but not under this plan. This plan reimburses for co-pays, co-insurance and deductibles incurred under the alternate coverage up to the annual limit, if any. Any procedure
	Childbirth/delivery professional services	\$0	\$0	
	Childbirth/delivery facility services	\$0	\$0	

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)	
				not covered by the alternate coverage will not be reimbursed under this plan.
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	\$0	\$0	You may have coverage for this service under the alternative coverage, but not under this plan. This plan reimburses for co-pays, co-insurance and deductibles incurred under the alternate coverage up to the annual limit, if any. Any procedure not covered by the alternate coverage will not be reimbursed under this plan.
	<a href="#">Rehabilitation services</a>	\$0	\$0	
	<a href="#">Habilitation services</a>	\$0	\$0	
	<a href="#">Skilled nursing care</a>	\$0	\$0	
	<a href="#">Durable medical equipment</a>	\$0	\$0	
	<a href="#">Hospice services</a>	\$0	\$0	
If your child needs dental or eye care	Children's eye exam	Not Covered		Not Covered
	Children's glasses			
	Children's dental check-up			

**Excluded Services & Other Covered Services:**

<b>Services Your <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other <a href="#">excluded services</a>.)</b>		
<ul style="list-style-type: none"> <li>• Acupuncture</li> <li>• Any expense payable through another source (such as the alternate coverage)</li> <li>• Bariatric surgery</li> <li>• Chiropractic care</li> <li>• Cosmetic Surgery</li> </ul>	<ul style="list-style-type: none"> <li>• Dental care (Adult)</li> <li>• Hearing aids</li> <li>• Infertility treatment</li> <li>• Long-term care</li> <li>• Non-emergency care when traveling outside the U.S.</li> </ul>	<ul style="list-style-type: none"> <li>• Private-duty nursing</li> <li>• Routine eye care (adult)</li> <li>• Routine foot care</li> <li>• Weight loss programs</li> </ul>
<b>Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> document.)</b>		
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**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: 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). 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](http://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 the plan at 1-877-872-4232. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform).

**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 the Minimum Value Standards? [N/A] – integrated with standard plan**

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](#).

-----*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](#) \$N/A
- [Specialist \[co-pay/co-insurance\]](#) \$N/A
- Hospital (facility) [\[co-pay/co-insurance\]](#) %N/A
- Other [\[co-pay/co-insurance\]](#) %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*)

<b>Total Example Cost</b>	<b>\$12,800</b>
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**In this example, Peg would pay:**

<i>Cost Sharing</i>	
Deductibles	\$ N/A
Copayments	\$ N/A
Coinsurance	\$ N/A
<i>What isn't covered</i>	
Limits or exclusions	\$ N/A
<b>The total Peg would pay is</b>	<b>\$ N/A</b>

This plan does not cover specific services, it only pays for co-pays, co-insurance and deductibles up to the amount available in the Integrated HRA

**Managing Joe's type 2 Diabetes**

(a year of routine in-network care of a well-controlled condition)

- The [plan's](#) overall [deductible](#) \$N/A
- [Specialist \[co-pay/co-insurance\]](#) \$N/A
- Hospital (facility) [\[co-pay/co-insurance\]](#) %N/A
- Other [\[co-pay/co-insurance\]](#) %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*)

<b>Total Example Cost</b>	<b>\$ 7,400</b>
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**In this example, Joe would pay:**

<i>Cost Sharing</i>	
Deductibles	\$ N/A
Copayments	\$ N/A
Coinsurance	\$ N/A
<i>What isn't covered</i>	
Limits or exclusions	\$ N/A
<b>The total Joe would pay is</b>	<b>\$ N/A</b>

This plan does not cover specific services, it only pays for co-pays, co-insurance and deductibles up to the amount available in the Integrated HRA.

**Mia's Simple Fracture**

(in-network emergency room visit and follow up care)

- The [plan's](#) overall [deductible](#) \$N/A
- [Specialist \[co-pay/co-insurance\]](#) \$N/A
- Hospital (facility) [\[co-pay/co-insurance\]](#) %N/A
- Other [\[co-pay/co-insurance\]](#) %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*)

<b>Total Example Cost</b>	<b>\$ 1,900</b>
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**In this example, Mia would pay:**

<i>Cost Sharing</i>	
Deductibles	\$ N/A
Copayments	\$ N/A
Coinsurance	\$ N/A
<i>What isn't covered</i>	
Limits or exclusions	\$ N/A
<b>The total Mia would pay is</b>	<b>\$ N/A</b>

This plan does not cover specific services, it only pays for co-pays, co-insurance and deductibles up to the amount available in the Integrated HRA.

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