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 Shasta Administrative Services at 1-800-441-4518, or by email at question@shastatpa.com. 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.shastatpa.com or call 1-800-441-4518 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$2,000** individual / **$4,000** family for participating providers. **$2,000** individual / **Unlimited** family for non-participating providers.	After the Plan Participant has met $300 of their deductible, the Suquamish Tribe Employee HRA reimburses any eligible deductible expense that is substantiated by the group plan's Explanation of Benefits (EOB) up to the maximum listed below in the overall annual limit on what the plan pays.
Are there services covered before you meet your deductible?	No.	You don't have to meet a deductible for specific services; see the chart on page 3 of the group plan SBC for other costs for services this plan covers. This HRA is to be used to offset a portion of your deductible under the Suquamish Tribe Employee Health Plan.
Are there other deductibles for specific services?	No.	The Suquamish Tribe Employee HRA reimburses 100% of your deductible expense, substantiated by the EOB, **after** you meet the first $300 of eligible deductible expenses. The **out-of-pocket limit** is the most you could pay in a year for covered services. See the Suquamish Tribe Employee Health Plan for out of pocket limits.
What is the out-of-pocket limit for this plan?	Premiums, balance-billed charges, pre-authorization penalties, out of network charges, and health care this **plan** doesn't cover.	Not applicable to the HRA. Even though you pay these expenses, they don't count toward the **out-of-pocket limit of your group health plan**.
What is not included in the out-of-pocket limit?	$1,700 per individual/ $3,400 for a family of two / $5,100 for a family of three or more.	The annual deductibles are: **$2,000** individual / **$4,000** family for participating providers. **$2,000** individual / **Unlimited** family for non-participating providers. The Suquamish Tribe Employee HRA will only pay up to the maximums listed towards all deductibles. This plan will pay for covered services only up to these limits noted, even if your own need is greater. You are responsible for all deductible expenses above these limits.
Will you pay less if you use a network provider?	No.	You can see the **specialist** you choose without a **referral**.
Do you need a referral to see a specialist?	**$2,000** individual / **$4,000** family for participating providers. **$2,000** individual / **Unlimited** family for non-participating providers.	After the Plan Participant has met $300 of their deductible, the Suquamish Tribe Employee HRA reimburses any eligible deductible expense that is substantiated by the group plan's Explanation of Benefits (EOB) up to the maximum listed below in the overall annual limit on what the plan pays.

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 provider's office or clinic	Primary care visit to treat an injury or illness	N/A	N/A	N/A
	Specialist visit	N/A	N/A	N/A
	Preventive care/screening/ immunization	N/A	N/A	N/A
If you have a test	Diagnostic test (x-ray, blood work)	N/A	N/A	N/A
	Imaging (CT/PET scans, MRIs)	N/A	N/A	N/A
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.[insert].com	Generic drugs	N/A	N/A	N/A
	Preferred brand drugs	N/A	N/A	N/A
	Non-preferred brand drugs	N/A	N/A	N/A
	Specialty drugs	N/A	N/A	N/A
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	N/A	N/A	N/A
	Physician/surgeon fees	N/A	N/A	N/A
If you need immediate medical attention	Emergency room care	N/A	N/A	N/A
	Emergency medical transportation	N/A	N/A	N/A
	Urgent care	N/A	N/A	N/A
If you have a hospital stay	Facility fee (e.g., hospital room)	N/A	N/A	N/A
	Physician/surgeon fees	N/A	N/A	N/A

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	N/A	N/A	N/A
	Inpatient services	N/A	N/A	N/A
If you are pregnant	Office visits	N/A	N/A	N/A
	Childbirth/delivery professional services	N/A	N/A	N/A
	Childbirth/delivery facility services	N/A	N/A	N/A
If you need help recovering or have other special health needs	Home health care	N/A	N/A	N/A
	Rehabilitation services	N/A	N/A	N/A
	Habilitation services	N/A	N/A	N/A
	Skilled nursing care	N/A	N/A	N/A
	Durable medical equipment	N/A	N/A	N/A
	Hospice services	N/A	N/A	N/A
If your child needs dental or eye care	Children's eye exam	N/A	N/A	N/A
	Children's glasses	N/A	N/A	N/A
	Children's dental check-up	N/A	N/A	N/A

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.)
• N/A

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)
• N/A

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: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or 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 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 on how 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: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

[* For more information about limitations and exceptions, see the plan or policy document at www.shastatpa.com.]

Does this plan provide Minimum Essential Coverage? [No]

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the 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:

[Spanish (Español): Para obtener asistencia en Español, llame al [(800) 441 - 4518.]

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa [(800) 441 - 4518.]

[Chinese (中文): 如果需要中文的帮助，请拨打这个号码 [(800) 441 - 4518.]

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' [(800) 441 - 4518.]

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

[* For more information about limitations and exceptions, see the plan or policy document at www.shastatpa.com.]

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 *[cost sharing]*	**N/A**
Hospital (facility) *[cost sharing]*	**N/A**
Other *[cost sharing]*	**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	**N/A**

In this example, Peg would pay:

Cost Sharing	*N/A*
Deductibles	
Copayments	
Coinsurance	
What isn't covered	
Limits or exclusions	N/A
The total Peg would pay is	**N/A**

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 *[cost sharing]*	**N/A**
Hospital (facility) *[cost sharing]*	**N/A**
Other *[cost sharing]*	**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	**N/A**

In this example, Joe would pay:

Cost Sharing	*N/A*
Deductibles	
Copayments	
Coinsurance	
What isn't covered	
Limits or exclusions	N/A
The total Joe would pay is	**N/A**

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

The plan's overall deductible	**N/A**
Specialist *[cost sharing]*	**N/A**
Hospital (facility) *[cost sharing]*	**N/A**
Other *[cost sharing]*	**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	**N/A**

In this example, Mia would pay:

Cost Sharing	*N/A*
Deductibles	
Copayments	
Coinsurance	
What isn't covered	
Limits or exclusions	N/A
The total Mia would pay is	**N/A**

The plan would be responsible for the other costs of these EXAMPLE covered services.