# Lawrence Livermore National Lab: HRA

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

**Coverage Period: 01/01/2017 – 12/31/2017**

**Coverage for:** Retiree | **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.ybr.com/benefits/llns or by calling 1-866-994-5567.

| Important Questions | Answers | Why this Matters: |
|---|---|---|
| What is the overall deductible? | $ | |
| Are there other deductibles for specific services? | $ | |
| Is there an out–of–pocket limit on my expenses? | $ | |
| What is not included in the out–of–pocket limit? | | |
| Is there an overall annual limit on what the plan pays? | | |
| Does this plan use a network of providers? | | |
| Do I need a referral to see a specialist? | | |
| Are there services this plan doesn't cover? | | |

The LLNS Health and Welfare Benefit Plan for Retirees (the Plan) provides a Health Reimbursement Arrangement (HRA) for Medicare eligible retirees who elect medical coverage through the Plan. The HRA amount is $2,450 for 2017, subject to graduated eligibility (refer to the Plan's Summary Plan Description for more information) and can be used to pay plan premiums, copays, and other eligible qualified medical expenses as allowed under the Plan rules and or acceptable under IRS rules (refer to IRS Publication 502).

OMB Control Numbers 1545-2229, 1210-0147, and 0938-1146

Corrected on May 11, 2012

**Questions:** Call 1-844-750-5567 or visit us at www.llnsretireebenefits.com.

- **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 be $200. This may change if 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 | | | |
| | Specialist visit | | | |
| | Other practitioner office visit | | | |
| | Preventive care/screening/immunization | | | |
| **If you have a test** | Diagnostic test (x-ray, blood work) | | | |
| | Imaging (CT/PET scans, MRIs) | | | |
| **If you need drugs to treat your illness or condition**<br><br>More information about **prescription drug coverage** is available at www.[insert]. | Generic drugs | | | |
| | Preferred brand drugs | | | |
| | Non-preferred brand drugs | | | |
| | Specialty drugs | | | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | | | |
| | Physician/surgeon fees | | | |
| **If you need** | Emergency room services | | | |

| 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 |
|---|---|---|---|---|
| **immediate medical attention** | Emergency medical transportation | | | |
| | Urgent care | | | |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | | | |
| | Physician/surgeon fee | | | |
| **If you have mental health, behavioral health, or substance abuse needs** | Mental/Behavioral health outpatient services | | | |
| | Mental/Behavioral health inpatient services | | | |
| | Substance use disorder outpatient services | | | |
| | Substance use disorder inpatient services | | | |
| **If you are pregnant** | Prenatal and postnatal care | | | |
| | Delivery and all inpatient services | | | |
| **If you need help recovering or have other special health needs** | Home health care | | | |
| | Rehabilitation services | | | |
| | Habilitation services | | | |
| | Skilled nursing care | | | |
| | Durable medical equipment | | | |
| | Hospice service | | | |
| **If your child needs dental or eye care** | Eye exam | | | |
| | Glasses | | | |
| | Dental check-up | | | |

## 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.)

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| **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.)** |
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## Your Rights to Continue Coverage:

[insert applicable information from instructions]

## 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].

[Insert heading and applicable tagline(s):

## Language Access Services:

[Spanish (Español): Para obtener asistencia en Español, llame al [insert telephone number]. ]

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa [insert telephone number]. ]

[Chinese (中文): 如果需要中文的帮助，请拨打这个号码 [insert telephone number]. ]

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' [insert telephone number].]

*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** $
- **Patient pays** $

**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 | $ |
| Copays | $ |
| Coinsurance | $ |
| Limits or exclusions | $ |
| **Total** | **$** |

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

- **Amount owed to providers:** $5,400
- **Plan pays** $
- **Patient pays** $

**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 | $ |
| Copays | $ |
| Coinsurance | $ |
| Limits or exclusions | $ |
| **Total** | **$** |

# 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.