Checklist for
Summary of Benefits and Coverage for HRA Plans

Full Name of Employer: _____

Full Name of Plan: _____

Coverage Period: _____

Who is Coverage for (ex. Employee Only, Family, etc.): _____

Website where Plan info can be accessed: _____

Phone Number where Plan info can be obtained: _____

Website where Defined Terms can be accessed: _____

Phone Number where Defined Terms info can be obtained: _____

IMPORTANT QUESTIONS

What is the overall deductible?
(if there is no deductible, please skip to the next section)

Deductible • Individual • Family Unit	

Deductible does not apply to preventive care…:

	Out-of-network coinsurance
	Out-of-network copayments
	Other:
	Other:
	Other:
	Other:

Are there any other deductibles for specific services?
(if NO, please skip to the next section)

Please list the 3 most significant deductibles…
• • •

Is there an out-of-pocket limit on my expenses?
(if NO, please skip to the next section)

Out-of-pocket maximum • Individual • Family Unit	

What is not included in the out-of-pocket limit?
(if the Plan has not OOP limit, please skip to the next section)

	Copayments
	Out-of-network coinsurance
	Deductibles
	Penalties for failure to obtain pre-authorization for services
	Other:
	Other:
	Other:

Is there an overall annual limit on what the plan pays?

The plan will reimburse medical expenses up to:	$_____

Does this plan use a network of providers?

☐ YES ☐ NO

Do I need a referral to see a specialist?

☐ YES ☐ NO

Are there services this plan doesn't cover?

☐ YES ☐ NO

Important Information:
(please choose one)

	This plan may encourage you to use in-network providers by charging you lower deductibles, copayments, and coinsurance amounts.
	Your cost sharing does not depend on whether a provider is in a network.

EXCLUDED SERVICES & OTHER COVERED SERVICES

Services your plan does NOT cover:

	Acupuncture		Bariatric surgery
	Chiropractic care		Cosmetic surgery
	Dental care (adult)		Hearing aids
	Infertility treatment		Long-term care
	Non-emergency care when traveling outside the US		Private duty nursing
	Routine eye care (adult)		Routine foot care
	Weight loss programs		Other:
	Other:		Other:
	Other:		Other:
	Other:		Other:

YOUR GRIEVANCE AND APPEAL RIGHTS

Type of Plan:
(please choose one of the following groups, and complete all information in that table that applies)

	Self-funded ERISA Plan
	Plan's Phone:

	Fully insured ERISA Plan
	Plan's Phone:
	State:
	State Department of Insurance Phone:

	Self-funded non-federal governmental group health plan
	Plan's Phone:
	TPA's Phone:

	Fully-insured non-federal governmental group health plan
	Plan's Phone:
	TPA's Phone:
	State:
	State Department of Insurance Phone:

Does the applicable State offer a consumer assistance program?
(if NO, please skip to the next section)

☐ NO ☐ YES. Contact Name & Phone: _____

LANGUAGE ACCESS SERVICES

Your document may require a foreign language notification. Please check the following website for a list of state and county requirements: http://www.cciio.cms.gov/resources/factsheets/clas-data.html

Which language, if any, must be included in your plan:

	Spanish		Tagalog
	Chinese		Navajo

Phone for customer assistance where non-English language help can be obtained: _____

COVERAGE EXAMPLES

Having a Baby (normal delivery)		**Managing type 2 diabetes (routine maintenance of a well-controlled condition)**	
Amount owed to providers:	$7,540	Amount owed to providers:	$5,400
Plan pays:	[_____]	Plan pays:	[_____]
Patient pays:	[_____]	Patient pays:	[_____]
Sample Care Costs:		**Sample Care Costs:**	
Hospital charges (mother)	$2,700	Prescriptions	$2,900
Routine obstetric care	$2,100	Medical equipment & supplies	$1,300
Hospital charges (baby)	$900	Office visits & procedures	$700
Anesthesia	$900	Education	$300
Laboratory tests	$500	Laboratory tests	$100
Prescriptions	$200	Vaccines, other preventive	$100
Radiology	$200	**TOTAL**	**$5,400**
Vaccines, other preventive	$40		
TOTAL	**$7,540**		
Patient pays:		**Patient pays:**	
Deductibles	[_____]	Deductibles	[_____]
Copays	[_____]	Copays	[_____]
Coinsurance	[_____]	Coinsurance	[_____]
Limits or exclusions	[_____]	Limits or exclusions	[_____]
TOTAL:	[_____]	**TOTAL:**	[_____]