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, go to www.uwuabenefits.org or call 1-800-920-8116. 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 or call 1-855-756-4448 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	There is no deductible. But a deductible may apply under the employer group health plan that is integrated with this HRA plan.	Not applicable to this HRA plan but check the SBC of the employer group health plan with which this HRA plan is integrated. See the chart starting on page 2 for your costs for services this HRA plan covers.
Are there services covered before you meet your deductible?	No. But a deductible may apply under the employer group health plan that is integrated with this HRA plan.	This is not applicable to the HRA plan. You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this HRA plan covers. And, check the SBC of the employer group health plan that is integrated with this HRA plan.
Are there other deductibles for specific services?	No.	Not applicable to this HRA plan but check the SBC of the employer group health plan with which this HRA plan is integrated. See the chart starting on page 2 for your costs for services this HRA plan covers.
What is the out-of-pocket limit for this plan?	No. But, an out-of-pocket limit may apply under the employer group health plan that is integrated with this HRA plan.	This is not applicable to the HRA plan but, check the SBC of the employer group health plan that is integrated with this HRA plan.
What is not included in the out-of-pocket limit?	This HRA plan has no out-of-pocket limit.	Not applicable to this HRA plan because there is no out-of-pocket limit on your expenses. But, check the SBC of the employer group health plan that is integrated with this HRA plan.
Will you pay less if you use a network provider?	No.	This HRA plan treats providers the same in determining payment for the same services.
Do you need a referral to see a specialist?	No.	HRA plan You can see the specialist you choose without permission from this HRA plan. But, check the SBC of the employer group health plan that is integrated with this HRA plan.

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	Not applicable	Not applicable	None
	Specialist visit	Not applicable	Not applicable	None
	Preventive care/screening/ immunization	Not applicable	Not applicable	None
If you have a test	Diagnostic test (x-ray, blood work)	Not applicable	Not applicable	None
	Imaging (CT/PET scans, MRIs)	Not applicable	Not applicable	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available by contacting your employer group health plan.	Generic drugs	Not applicable	Not applicable	None
	Preferred brand drugs	Not applicable	Not applicable	None
	Non-preferred brand drugs	Not applicable	Not applicable	None
	Specialty drugs	Not applicable	Not applicable	None
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Not applicable	Not applicable	None
	Physician/surgeon fees	Not applicable	Not applicable	None
If you need immediate medical attention	Emergency room care	Not applicable	Not applicable	None
	Emergency medical transportation	Not applicable	Not applicable	None
	Urgent care	Not applicable	Not applicable	None
If you have a hospital stay	Facility fee (e.g., hospital room)	Not applicable	Not applicable	None
	Physician/surgeon fees	Not applicable	Not applicable	None

For more information about limitations and exceptions call 1-800-920-8116.

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	Not applicable	Not applicable	None
	Inpatient services	Not applicable	Not applicable	None
If you are pregnant	Office visits	Not applicable	Not applicable	None
	Childbirth/delivery professional services	Not applicable	Not applicable	None
	Childbirth/delivery facility services	Not applicable	Not applicable	None
If you need help recovering or have other special health needs	Home health care	Not applicable	Not applicable	None
	Rehabilitation services	Not applicable	Not applicable	None
	Habilitation services	Not applicable	Not applicable	None
	Skilled nursing care	Not applicable	Not applicable	None
	Durable medical equipment	Not applicable	Not applicable	None
	Hospice services	Not applicable	Not applicable	None
If your child needs dental or eye care	Children's eye exam	Not applicable	Not applicable	None
	Children's glasses	Not applicable	Not applicable	None
	Children's dental check-up	Not applicable	Not applicable	None

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.)

- Any item not qualifying as Internal Revenue Code Section 213 medical care expenses. See IRS Publication 502.
- Cosmetic surgery
- Long-term care
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. Please see your plan document.)

- All items qualifying as Internal Revenue Code Section 213 medical care expenses. See IRS Publication 502.

For more information about limitations and exceptions call 1-800-920-8116.

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, Employee Benefits Security Administration, 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: www.uwuabenefits.org or call 1-800-920-8116. You may also contact the Department of Laborer Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

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 1-800-920-8116.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-920-8116.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码1-800-920-8116.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-920-8116.

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

About these Coverage Examples: Please see your Employer's group health plan SBC for information about these 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 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	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	n/a
Copayments	n/a
Coinsurance	n/a
What isn't covered	
Limits or exclusions	n/a
The total Peg would pay is	**$*** **

****Amounts paid depend on account balance or unused annual limits.**

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 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	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles*	n/a
Copayments	n/a
Coinsurance	n/a
What isn't covered	
Limits or exclusions	n/a
The total Joe would pay is	**$*** **

****Amounts paid depend on account balance or unused annual limits.**

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

- **The plan's overall deductible** n/a
- **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	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles*	n/a
Copayments	n/a
Coinsurance	n/a
What isn't covered	
Limits or exclusions	n/a
The total Mia would pay is	**$*** **

****Amounts paid depend on account balance or unused annual limits.**

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

For more information about limitations and exceptions call 1-800-920-8116.