**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, 1-800-251-4107. 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 https://www.healthcare.gov/sbc-glossary or call 1-800-251-4107 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | $0 | See the Common Medical Events chart below for your costs for services this plan covers. |
| **Are there services covered before you meet your deductible?** | Not applicable. | No covered services are subject to a deductible. |
| **Are there other deductibles for specific services?** | No. | You don't have to meet deductibles for specific services. |
| **What is the out-of-pocket limit for this plan?** | Not applicable. | This plan does not have an out-of-pocket limit on your expenses. |
| **What is not included in the out-of-pocket limit?** | Not applicable. | This plan does not have an out-of-pocket limit on your expenses. |
| **Will you pay less if you use a network provider?** | Not applicable. | This plan does not use a provider network. You can receive covered services from any provider. |
| **Do you need a referral to see a specialist?** | No. | You can see the specialist you choose without a referral. |

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 |
|---|---|---|---|
| **If you visit a health care provider's office or clinic** | Primary care visit to treat an injury or illness | 100% - However, qualified Medical Expenses may be reimbursed by your HRA if they are not paid by any other health care coverage. | Only qualified Medical Expenses that are not paid by any other health care coverage may be reimbursed. They may be reimbursed only up to the amount available in your HRA at the time of reimbursement.<br><br>A qualified Medical Expense means a medical expense to prevent, diagnose, treat, or cure a disease as described in Internal Revenue Code Section 213(d). The "Services You May Need" column in this chart generally describes qualified Medical Expenses that may be reimbursed by your HRA. |
| | Specialist visit | Same as above. | Same as above. |
| | Preventive care/screening/ immunization | Same as above. | Same as above. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | Same as above. | Same as above. |
| | Imaging (CT/PET scans, MRIs) | Same as above. | Same as above. |
| **If you need drugs to treat your illness or condition**<br>More information about **prescription drug coverage** is available at 1-800-251-4107. | Generic drugs | Same as above. | Same as above. |
| | Preferred brand drugs | Same as above. | Same as above. |
| | Non-preferred brand drugs | Same as above. | Same as above. |
| | Specialty drugs | Same as above. | Same as above. |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | Same as above. | Same as above. |
| | Physician/surgeon fees | Same as above. | Same as above. |
| **If you need immediate medical attention** | Emergency room care | Same as above. | Same as above. |
| | Emergency medical transportation | Same as above. | Same as above. |

| Common Medical Event | Services You May Need | What You Will Pay | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|
| | Urgent care | Same as above. | Same as above. |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | Same as above. | Same as above. |
| | Physician/surgeon fees | Same as above. | Same as above. |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | Same as above. | Same as above. |
| | Inpatient services | Same as above. | Same as above. |
| **If you are pregnant** | Office visits | Same as above. | Same as above. |
| | Childbirth/delivery professional services | Same as above. | Same as above. |
| | Childbirth/delivery facility services | Same as above. | Same as above. |
| **If you need help recovering or have other special health needs** | Home health care | Same as above. | Same as above. |
| | Rehabilitation services | Same as above. | Same as above. |
| | Habilitation services | Same as above. | Same as above. |
| | Skilled nursing care | Same as above. | Same as above. |
| | Durable medical equipment | Same as above. | Same as above. |
| | Hospice services | Same as above. | Same as above. |
| **If your child needs dental or eye care** | Children's eye exam | Same as above. | Same as above. |
| | Children's glasses | Same as above. | Same as above. |
| | Children's dental check-up | Same as above. | Same as above. |

## Excluded Services & Other Covered Services:

**Services Your Plan Generally Does NOT Cover (Check your plan document for more information and a list of any other excluded services.)**

- Acupuncture that is not medically necessary
- Cosmetic surgery , unless necessary to improve a deformity arising from, or directly related to, a congenital abnormality, personal injury, or disfiguring disease
- Hot tubs, home spas, swimming pools and any expenses incurred for the maintenance of such items
- Weight loss programs, unless prescribed to treat a medical illness

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

- Bariatric surgery
- Chiropractic care
- Dental care (Adult)
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care

**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: U.S. Department of Labor, 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 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: 1-800-251-4107.

**Does this plan provide Minimum Essential Coverage? Yes**

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.
***However, since the USW HRA Fund is intended to be integrated with your primary health coverage under an employer-sponsored medical plan, please refer to the Summary of Benefits and Coverage for that plan.**

**Language Access Services:**

Para obtener asistencia en Español, llame al 1-855-450-1874.

* For more information about limitations and exceptions, see the plan document at www.uswbenefitfunds.com.

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

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## 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 | $0 |
| Specialist coinsurance | 100%* |
| Hospital (facility) coinsurance | 100%* |
| Other coinsurance | 100%* |

**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 | $0 |
| Copayments | $0 |
| Coinsurance | $12,700 |
| *What isn't covered* | |
| Limits or exclusions | † |
| **The total Peg would pay is** | **$12,700** |

### Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

| | |
|---|---|
| The plan's overall deductible | $0 |
| Specialist coinsurance | 100%* |
| Hospital (facility) coinsurance | 100%* |
| Other coinsurance | 100%* |

**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 | $0 |
| Copayments | $0 |
| Coinsurance | $5,600 |
| *What isn't covered* | |
| Limits or exclusions | † |
| **The total Joe would pay is** | **$5,600** |

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

| | |
|---|---|
| The plan's overall deductible | $0 |
| Specialist coinsurance | 100%* |
| Hospital (facility) coinsurance | 100%* |
| Other coinsurance | 100%* |

**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 | $0 |
| Copayments | $0 |
| Coinsurance | $2,800 |
| *What isn't covered* | |
| Limits or exclusions | † |
| **The total Mia would pay is** | **$2,800** |

***Qualified Medical Expenses may be reimbursed by your HRA if they are not paid by any other health care coverage.**
**† Qualified Medical Expenses may be reimbursed only up to the amount available in your HRA at the time of reimbursement.**
The plan would be responsible for the other costs of these EXAMPLE covered services.