**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, call (269) 342-1700 ext. 213. 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 or call (269) 342-1700 ext. 213 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | **$0.00** | See the Common Medical Events chart below for your costs for services this plan covers. |
| **Are there services covered before you meet your deductible?** | No. This plan is an HRA that reimburses covered expenses up to the limits described below. | This plan covers some items and services even if you haven't yet met the deductible amount. |
| **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?** | Not applicable. | 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 | You pay 100% of eligible unreimbursed expenses under your employer's group health plan after any deductible in this plan and you may then seek reimbursement under this plan for In and Out of Network Deductibles and Coinsurance, Prescriptions, Copays, Dental, and Vision expenses. | Coverage limited to the HRA account balance. |
| | Specialist visit | You pay 100% of eligible unreimbursed expenses under your employer's group health plan after any deductible in this plan and you may then seek reimbursement under this plan for In and Out of Network Deductibles and Coinsurance, Prescriptions, Copays, Dental, and Vision expenses. | Coverage limited to the HRA account balance. |
| | Preventive care/screening/ Immunization | You pay 100% of eligible unreimbursed expenses under your employer's group health plan after any deductible in this plan and you may then seek reimbursement under this plan for In and Out of Network Deductibles and Coinsurance, Prescriptions, Copays, Dental, and Vision expenses. | Coverage limited to the HRA account balance. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | You pay 100% of eligible unreimbursed expenses under your employer's group health plan after any deductible in this plan and you may then seek reimbursement under this plan for In and Out of Network Deductibles and Coinsurance, Prescriptions, Copays, Dental, and Vision expenses. | Coverage limited to the HRA account balance. |
| | Imaging (CT/PET scans, MRIs) | You pay 100% of eligible unreimbursed expenses under your employer's group health plan after any deductible in this plan and you may then seek reimbursement under this plan for In and Out of Network Deductibles and Coinsurance, Prescriptions, | Coverage limited to the HRA account balance. |

| Common Medical Event | Services You May Need | What You Will Pay | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|
| | | Copays, Dental, and Vision expenses. | |
| **If you need drugs to treat your illness or condition** More information about **prescription drug coverage** is available at www.**[insert]**.com | Generic drugs | You pay 100% of eligible unreimbursed expenses under your employer's group health plan after any deductible in this plan and you may then seek reimbursement under this plan for In and Out of Network Deductibles and Coinsurance, Prescriptions, Copays, Dental, and Vision expenses. | Coverage limited to the HRA account balance. |
| | Preferred brand drugs | You pay 100% of eligible unreimbursed expenses under your employer's group health plan after any deductible in this plan and you may then seek reimbursement under this plan for In and Out of Network Deductibles and Coinsurance, Prescriptions, Copays, Dental, and Vision expenses. | Coverage limited to the HRA account balance. |
| | Non-preferred brand drugs | You pay 100% of eligible unreimbursed expenses under your employer's group health plan after any deductible in this plan and you may then seek reimbursement under this plan for In and Out of Network Deductibles and Coinsurance, Prescriptions, Copays, Dental, and Vision expenses. | Coverage limited to the HRA account balance. |
| | Specialty drugs | You pay 100% of eligible unreimbursed expenses under your employer's group health plan after any deductible in this plan and you may then seek reimbursement under this plan for In and Out of Network Deductibles and Coinsurance, Prescriptions, Copays, Dental, and Vision expenses. | Coverage limited to the HRA account balance. |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | You pay 100% of eligible unreimbursed expenses under your employer's group health plan after any deductible in this plan and you may then seek reimbursement under this plan for In and Out of Network Deductibles and Coinsurance, Prescriptions, | Coverage limited to the HRA account balance. |

| Common Medical Event | Services You May Need | What You Will Pay | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|
| | | Copays, Dental, and Vision expenses. | |
| | Physician/surgeon fees | You pay 100% of eligible unreimbursed expenses under your employer's group health plan after any deductible in this plan and you may then seek reimbursement under this plan for In and Out of Network Deductibles and Coinsurance, Prescriptions, Copays, Dental, and Vision expenses. | Coverage limited to the HRA account balance. |
| **If you need immediate medical attention** | Emergency room care | You pay 100% of eligible unreimbursed expenses under your employer's group health plan after any deductible in this plan and you may then seek reimbursement under this plan for In and Out of Network Deductibles and Coinsurance, Prescriptions, Copays, Dental, and Vision expenses. | Coverage limited to the HRA account balance. |
| | Emergency medical transportation | You pay 100% of eligible unreimbursed expenses under your employer's group health plan after any deductible in this plan and you may then seek reimbursement under this plan for In and Out of Network Deductibles and Coinsurance, Prescriptions, Copays, Dental, and Vision expenses. | Coverage limited to the HRA account balance. |
| | Urgent care | You pay 100% of eligible unreimbursed expenses under your employer's group health plan after any deductible in this plan and you may then seek reimbursement under this plan for In and Out of Network Deductibles and Coinsurance, Prescriptions, Copays, Dental, and Vision expenses. | Coverage limited to the HRA account balance. |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | You pay 100% of eligible unreimbursed expenses under your employer's group health plan after any deductible in this plan and you may then seek reimbursement under this plan for In and Out of Network Deductibles and Coinsurance, Prescriptions, | Coverage limited to the HRA account balance. |

| Common Medical Event | Services You May Need | What You Will Pay | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|
| | | Copays, Dental, and Vision expenses. | |
| | Physician/surgeon fees | You pay 100% of eligible unreimbursed expenses under your employer's group health plan after any deductible in this plan and you may then seek reimbursement under this plan for In and Out of Network Deductibles and Coinsurance, Prescriptions, Copays, Dental, and Vision expenses. | Coverage limited to the HRA account balance. |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | You pay 100% of eligible unreimbursed expenses under your employer's group health plan after any deductible in this plan and you may then seek reimbursement under this plan for In and Out of Network Deductibles and Coinsurance, Prescriptions, Copays, Dental, and Vision expenses. | Coverage limited to the HRA account balance. |
| | Inpatient services | You pay 100% of eligible unreimbursed expenses under your employer's group health plan after any deductible in this plan and you may then seek reimbursement under this plan for In and Out of Network Deductibles and Coinsurance, Prescriptions, Copays, Dental, and Vision expenses. | Coverage limited to the HRA account balance. |
| **If you are pregnant** | Office visits | You pay 100% of eligible unreimbursed expenses under your employer's group health plan after any deductible in this plan and you may then seek reimbursement under this plan for In and Out of Network Deductibles and Coinsurance, Prescriptions, Copays, Dental, and Vision expenses. | Coverage limited to the HRA account balance. |
| | Childbirth/delivery professional services | You pay 100% of eligible unreimbursed expenses under your employer's group health plan after any deductible in this plan and you may then seek reimbursement under this plan for In and Out of Network Deductibles and Coinsurance, Prescriptions, | Coverage limited to the HRA account balance. |

| Common Medical Event | Services You May Need | What You Will Pay | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|
| | | Copays, Dental, and Vision expenses. | |
| | Childbirth/delivery facility services | You pay 100% of eligible unreimbursed expenses under your employer's group health plan after any deductible in this plan and you may then seek reimbursement under this plan for In and Out of Network Deductibles and Coinsurance, Prescriptions, Copays, Dental, and Vision expenses. | Coverage limited to the HRA account balance. |
| **If you need help recovering or have other special health needs** | Home health care | You pay 100% of eligible unreimbursed expenses under your employer's group health plan after any deductible in this plan and you may then seek reimbursement under this plan for In and Out of Network Deductibles and Coinsurance, Prescriptions, Copays, Dental, and Vision expenses. | Coverage limited to the HRA account balance. |
| | Rehabilitation services | You pay 100% of eligible unreimbursed expenses under your employer's group health plan after any deductible in this plan and you may then seek reimbursement under this plan for In and Out of Network Deductibles and Coinsurance, Prescriptions, Copays, Dental, and Vision expenses. | Coverage limited to the HRA account balance. |
| | Habilitation services | You pay 100% of eligible unreimbursed expenses under your employer's group health plan after any deductible in this plan and you may then seek reimbursement under this plan for In and Out of Network Deductibles and Coinsurance, Prescriptions, Copays, Dental, and Vision expenses. | Coverage limited to the HRA account balance. |
| | Skilled nursing care | You pay 100% of eligible unreimbursed expenses under your employer's group health plan after any deductible in this plan and you may then seek reimbursement under this plan for In and Out of Network Deductibles and Coinsurance, Prescriptions, | Coverage limited to the HRA account balance. |

| Common Medical Event | Services You May Need | What You Will Pay | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|
| | | Copays, Dental, and Vision expenses. | |
| | Durable medical equipment | You pay 100% of eligible unreimbursed expenses under your employer's group health plan after any deductible in this plan and you may then seek reimbursement under this plan for In and Out of Network Deductibles and Coinsurance, Prescriptions, Copays, Dental, and Vision expenses. | Coverage limited to the HRA account balance. |
| | Hospice services | You pay 100% of eligible unreimbursed expenses under your employer's group health plan after any deductible in this plan and you may then seek reimbursement under this plan for In and Out of Network Deductibles and Coinsurance, Prescriptions, Copays, Dental, and Vision expenses. | Coverage limited to the HRA account balance. |
| **If your child needs dental or eye care** | Children's eye exam | You pay 100% of eligible unreimbursed expenses under your employer's group health plan after any deductible in this plan and you may then seek reimbursement under this plan for In and Out of Network Deductibles and Coinsurance, Prescriptions, Copays, Dental, and Vision expenses. | Coverage limited to the HRA account balance. |
| | Children's glasses | You pay 100% of eligible unreimbursed expenses under your employer's group health plan after any deductible in this plan and you may then seek reimbursement under this plan for In and Out of Network Deductibles and Coinsurance, Prescriptions, Copays, Dental, and Vision expenses. | Coverage limited to the HRA account balance. |
| | Children's dental check-up | You pay 100% of eligible unreimbursed expenses under your employer's group health plan after any deductible in this plan and you may then seek reimbursement under this plan for In and Out of Network Deductibles and Coinsurance, Prescriptions, | Coverage limited to the HRA account balance. |

| Common Medical Event | Services You May Need | What You Will Pay | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|
| | | Copays, Dental, and Vision expenses. | |

**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.)** | | |
|---|---|---|
| • Cosmetic surgery | • Weight loss programs | • All other exclusions as listed under your employer's group health plan |

| **Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)** | | |
|---|---|---|
| • Acupuncture | • 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 | • In-network deductible expenses |
| • Out-of-network deductible expenses | • In-network coinsurance expenses | • Out-of-network coinsurance expenses |
| • Prescriptions | • Copays | • Dental |
| • Vision | | |

**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 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: [insert applicable plan phone number] or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

**Does this plan provide Minimum Essential Coverage?** **Yes**
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

**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 https://www.uhclatino.com/content/lat-muhclati/uhc-latino/es.html

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa http://www.uhcasian.com/
[Chinese (中文): 如果需要中文的帮助，请拨打这个号码 http://www.uhcasian.com/
[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' (505) 272-5399]

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

## 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 copayment | $0 |
| Hospital (facility) coinsurance | %0 |
| Other coinsurance | %0 |

**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** | **$12,800** |

**In this example, Peg would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $0 |
| Copayments | $0 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $varies* |
| **The total Peg would pay is** | **$varies*** |

### 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 copayment | $0 |
| Hospital (facility) coinsurance | %0 |
| Other coinsurance | %0 |

**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** | **$7,400** |

**In this example, Joe would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $0 |
| Copayments | $0 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $varies* |
| **The total Joe would pay is** | **$varies*** |

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

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

**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** | **$1,900** |

**In this example, Mia would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $0 |
| Copayments | $0 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $varies* |
| **The total Mia would pay is** | **$varies*** |

*Note: The plan is a health reimbursement arrangement (HRA). Limits and the amount paid by the HRA vary depending on the amount in the individual's HRA and the amount submitted by the individual as a claim for reimbursement from the available HRA funds. See your health plan's SBC for more information on coverage.

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