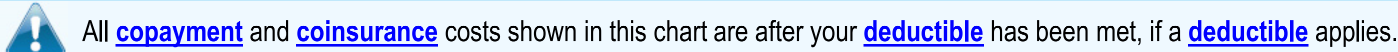
Utility Workers Union of America: Integrated HRA Plan

Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services **Coverage Period: 01/01/2021 – 12/31/2021**

Coverage for: Participant, Spouse, Family | **Plan Type:** HRA

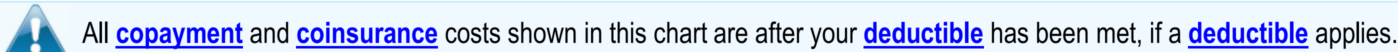
The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. 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 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.	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.	There's no limit under this HRA plan on how much you could pay during a coverage period for your share of covered services. 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.	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---
	Formulary 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---


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 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	Eye exam and Glasses	Not applicable	Not applicable	---none---
	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."
- Cosmetic surgery
- Long term care services
- Over the counter medicine not doctor prescribe
- Weight loss programs
- Routine foot care

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
- Hearing aids
- Infertility treatment
- Non-emergency care when traveling outside U.S.
- Private-duty nursing
- Routine eye care (Adult)
- Dental Care (Adult)

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: the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x 61565 or www.cciio.cms.gov. 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 the Fund Office at 1-800-920-8116.

Does this plan provide Minimum Essential Coverage? No.
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 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:

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 *[cost sharing]*** **$0**
- **Hospital (facility) *[cost sharing]*** **0%**
- **Other *[cost sharing]*** **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	**$20,000**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$*****
*****Amounts paid depend on account balance or unused annual limit**	

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 *[cost sharing]*** **$0**
- **Hospital (facility) *[cost sharing]*** **0%**
- **Other *[cost sharing]*** **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	**$3,000**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$*****
*****Amounts paid depend on account balance or unused annual limit**	

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

- **The plan's overall deductible** **$0**
- **Specialist *[cost sharing]*** **$0**
- **Hospital (facility) *[cost sharing]*** **0%**
- **Other *[cost sharing]*** **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	**$4,000**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$*****
*****Amounts paid depend on account balance or unused annual limit**	