STOP! Read this first.

Much of the information contained in the enclosed **Summary of Benefits and Coverage** (SBC) does not directly apply to your health reimbursement arrangement (HRA). SBCs are mandated by federal health care reform to help consumers understand and compare health insurance plans. While your HRA is a group health plan, it is not insurance. Some of the information and defined terms in the enclosed SBC are not applicable to your HRA. Nevertheless, they are required to be included.

When reading through the enclosed SBC, keep in mind:

- Your HRA is not an insurance plan. It is an account you can use to reimburse your qualified out-of-pocket medical care expenses.
- Your HRA is funded with employer contributions, which may include mandatory salary reductions.
- With your HRA, you do not have co-pays or deductibles, and you do not pay a premium for HRA coverage unless you have elected COBRA continuation of coverage. However, you can use funds in your HRA to reimburse these types of qualified expenses if your HRA is claims-eligible.
- Qualified expenses, as defined by the IRS, include services received from any licensed healthcare provider.
- Your maximum benefit (reimbursement) amount is equal to your available HRA account balance at the time your claim is processed.

If you have a question about the enclosed SBC, send it via email to **customercare@hraveba.org.** Most emails receive a response within 24-48 hours. You may also contact the HRA VEBA Plan's customer care center by calling the telephone number contained in the enclosed SBC.

To learn more about your HRA VEBA Plan benefits, your best resource is the **HRA VEBA Plan Summary**. To get a copy, log in at **hraveba.org** and click **Resources**, or contact the HRA VEBA Plan's customer care center at **customercare@hraveba.org** or **1-888-659-8828**.

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, please log into www.hraveba.org or call 1-888-659-8828. 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.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$0**	See the chart starting on page 2 for your costs for services this plan covers.
Are there services covered before you meet your deductible?	**Yes.**	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Are there other deductibles for specific services?	**No.**	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
What is the out-of-pocket limit for this plan?	This plan has no **out-of-pocket limit.**	There is no limit on how much you could pay during a coverage period for your share of the cost of covered services.
What is not included in the out-of-pocket limit?	This plan has no **out-of-pocket limit.**	There is no limit on how much you could pay during a coverage period for your share of the cost of covered services.
Will you pay less if you use a network provider?	**No.**	This 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 plan.

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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	May be reimbursed up to 100%	May be reimbursed up to 100%	Once claims-eligible, reimbursement is limited by your current account balance and coverage elections*
	Specialist visit	May be reimbursed up to 100%	May be reimbursed up to 100%	Once claims-eligible, reimbursement is limited by your current account balance and coverage elections*
	Preventive care/screening/ immunization	May be reimbursed up to 100%	May be reimbursed up to 100%	Once claims-eligible, reimbursement is limited by your current account balance and coverage elections*
If you have a test	Diagnostic test (x-ray, blood work)	May be reimbursed up to 100%	May be reimbursed up to 100%	Once claims-eligible, reimbursement is limited by your current account balance and coverage elections*
	Imaging (CT/PET scans, MRIs)	May be reimbursed up to 100%	May be reimbursed up to 100%	Once claims-eligible, reimbursement is limited by your current account balance and coverage elections*
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.hraveba.org	Generic drugs	May be reimbursed up to 100%	May be reimbursed up to 100%	Once claims-eligible, reimbursement is limited by your current account balance and coverage elections*
	Preferred brand drugs	May be reimbursed up to 100%	May be reimbursed up to 100%	Once claims-eligible, reimbursement is limited by your current account balance and coverage elections*
	Non-preferred brand drugs	May be reimbursed up to 100%	May be reimbursed up to 100%	Once claims-eligible, reimbursement is limited by your current account balance and coverage elections*
	Specialty drugs	May be reimbursed up to 100%	May be reimbursed up to 100%	Once claims-eligible, reimbursement is limited by your current account balance and coverage elections*

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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 have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	May be reimbursed up to 100%	May be reimbursed up to 100%	Once claims-eligible, reimbursement is limited by your current account balance and coverage elections*
	Physician/surgeon fees	May be reimbursed up to 100%	May be reimbursed up to 100%	Once claims-eligible, reimbursement is limited by your current account balance and coverage elections*
If you need immediate medical attention	Emergency room care	May be reimbursed up to 100%	May be reimbursed up to 100%	Once claims-eligible, reimbursement is limited by your current account balance and coverage elections*
	Emergency medical transportation	May be reimbursed up to 100%	May be reimbursed up to 100%	Once claims-eligible, reimbursement is limited by your current account balance and coverage elections*
	Urgent care	May be reimbursed up to 100%	May be reimbursed up to 100%	Once claims-eligible, reimbursement is limited by your current account balance and coverage elections*
If you have a hospital stay	Facility fee (e.g., hospital room)	May be reimbursed up to 100%	May be reimbursed up to 100%	Once claims-eligible, reimbursement is limited by your current account balance and coverage elections*
	Physician/surgeon fees	May be reimbursed up to 100%	May be reimbursed up to 100%	Once claims-eligible, reimbursement is limited by your current account balance and coverage elections*
If you need mental health, behavioral health, or substance abuse services	Outpatient services	May be reimbursed up to 100%	May be reimbursed up to 100%	Once claims-eligible, reimbursement is limited by your current account balance and coverage elections*
	Inpatient services	May be reimbursed up to 100%	May be reimbursed up to 100%	Once claims-eligible, reimbursement is limited by your current account balance and coverage elections*
If you are pregnant	Office visits	May be reimbursed up to 100%	May be reimbursed up to 100%	Once claims-eligible, reimbursement is limited by your current account balance and coverage elections*

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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 are pregnant *(cont'd)*	Childbirth/delivery professional services	May be reimbursed up to 100%	May be reimbursed up to 100%	Once claims-eligible, reimbursement is limited by your current account balance and coverage elections*
	Childbirth/delivery facility services	May be reimbursed up to 100%	May be reimbursed up to 100%	Once claims-eligible, reimbursement is limited by your current account balance and coverage elections*
If you need help recovering or have other special health needs	Home health care	May be reimbursed up to 100%	May be reimbursed up to 100%	Once claims-eligible, reimbursement is limited by your current account balance and coverage elections*
	Rehabilitation services	May be reimbursed up to 100%	May be reimbursed up to 100%	Once claims-eligible, reimbursement is limited by your current account balance and coverage elections*
	Habilitation services	May be reimbursed up to 100%	May be reimbursed up to 100%	Once claims-eligible, reimbursement is limited by your current account balance and coverage elections*
	Skilled nursing care	May be reimbursed up to 100%	May be reimbursed up to 100%	Once claims-eligible, reimbursement is limited by your current account balance and coverage elections*
	Durable medical equipment	May be reimbursed up to 100%	May be reimbursed up to 100%	Once claims-eligible, reimbursement is limited by your current account balance and coverage elections*
	Hospice services	May be reimbursed up to 100%	May be reimbursed up to 100%	Once claims-eligible, reimbursement is limited by your current account balance and coverage elections*

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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 your child needs dental or eye care	Children's eye exam	May be reimbursed up to 100%	May be reimbursed up to 100%	Once claims-eligible, reimbursement is limited by your current account balance and coverage elections*
	Children's glasses	May be reimbursed up to 100%	May be reimbursed up to 100%	Once claims-eligible, reimbursement is limited by your current account balance and coverage elections*
	Children's dental check-up	May be reimbursed up to 100%	May be reimbursed up to 100%	Once claims-eligible, reimbursement is limited by your current account balance and coverage elections*

*** If you use up your account balance, any remaining unpaid expenses may be re-submitted if you receive additional contributions into your account.**

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 and procedures

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

- Acupuncture
- Bariatric surgery (if prescribed to treat a specific medical condition)
- Chiropractic care
- Dental care (Adult)
- Hearing aids
- Infertility treatment
- Long-term care (if qualifies as medical care)
- Non-emergency care when traveling outside of the U.S. (if primarily for medical care and is legal in the U.S. and the other country)
- Private-duty nursing (if providing nursing services; not household or personal services)
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs (if prescribed to treat a specific medical condition)

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: [insert State, HHS, DOL, and/or other applicable agency contact information]. 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.

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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:

HRA VEBA Plan
PO Box 80587
Seattle, WA 98108

Phone: 1-888-659-8828
Email: customercare@hraveba.org

Additionally, a consumer assistance program can help you file your appeal. Contact your local Consumer Assistance Program if you are a resident of Washington using the information below.

Washington Consumer Assistance Program
5000 Capitol Blvd
Tumwater, WA 98501

Phone: 1-800-562-6900
Email: cap@oic.wa.gov

Does this plan provide Minimum Essential Coverage? Yes

This plan or policy does provide minimum essential coverage, except in the case where a participant has elected limited HRA coverage to qualify for the premium tax credit or for Medicare coordination purposes. 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

This plan is an account-based health reimbursement arrangement that is not designed to meet, and does not meet, the minimum value standard for the benefits it provides. 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 1-888-659-8828.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-659-8828.
Chinese (中文): 如果需要中文的帮助，**请拨打这个号码** 1-888-659-8828.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-888-659-8828.

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.

The below examples assume these individuals have no health plan other than the HRA.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- **Peg's current HRA account balance $5,000**
- **The plan's overall deductible** — **N/A**
- **Specialist *[cost sharing]*** — **N/A**
- **Hospital (facility) *[cost sharing]*** — **N/A**
- **Other *[cost sharing]*** — **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	**$7,540**

In this example, Peg would pay:

Cost Sharing	
Deductibles	N/A
Copayments	N/A
Coinsurance	N/A
What isn't covered	
Limits or exclusions	$0**
The total Peg would pay out-of-pocket	**$7,540**
Total out-of-pocket amount reimbursable by this Plan	**$5,000[1]**

**NOTE: This plan is a health reimbursement arrangement (HRA). The plan reimburses participants for out-of-pocket medical care expenses. Reimbursements in this example are not limited, except up to the account balance of the HRA.

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

- **Joe's current HRA account balance $5,000**
- **The plan's overall deductible** — **N/A**
- **Specialist *[cost sharing]*** — **N/A**
- **Hospital (facility) *[cost sharing]*** — **N/A**
- **Other *[cost sharing]*** — **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	**$4,100**

In this example, Joe would pay:

Cost Sharing	
Deductibles	N/A
Copayments	N/A
Coinsurance	N/A
What isn't covered	
Limits or exclusions	$0**
The total Joe would pay out-of-pocket	**$4,100**
Total out-of-pocket amount reimbursable by this Plan*	**$4,100[1]**

**NOTE: This plan is a health reimbursement arrangement (HRA). The plan reimburses participants for out-of-pocket medical care expenses. Reimbursements in this example are not limited, except up to the account balance of the HRA.

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

- **Mia's current HRA account balance $5,000**
- **The plan's overall deductible** — **N/A**
- **Specialist *[cost sharing]*** — **N/A**
- **Hospital (facility) *[cost sharing]*** — **N/A**
- **Other *[cost sharing]*** — **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	**$2,300**

In this example, Mia would pay:

Cost Sharing	
Deductibles	N/A
Copayments	N/A
Coinsurance	N/A
What isn't covered	
Limits or exclusions	$0**
The total Mia would pay out-of-pocket	**$2,300**
Total out-of-pocket amount reimbursable by this Plan*	**$2,300[1]**

**NOTE: This plan is a health reimbursement arrangement (HRA). The plan reimburses participants for out-of-pocket medical care expenses. Reimbursements in this example are not limited, except up to the account balance of the HRA.

[1]The Plan would NOT be responsible for any other costs of these EXAMPLE covered services.

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