This is only a summary. Your health insurance benefit comes from two plans working together, your Employer-sponsored Group Health Plan and the Health Reimbursement Account (HRA). If you want more details about the HRA coverage and costs, you can get the complete terms of the HRA by calling **1-800-388-0964** or emailing **hra@averillanderson.com.**

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$1,000 / Single** **$2,000 / Family**	You must pay all the costs up to the deductible amount before the HRA begins to pay for covered services you use. Check your policy or plan document to see when the deductible starts over (usually, but not always, January 1).
Are there services covered before you meet your deductible?	Yes. Please refer to your health plan SBC	Please refer to your Health Plan SBC.
Are there other deductibles for specific services?	**No**	You may have to meet deductibles (or copays) for other specific services. See your Health Plan policy or your HRA Brochure for additional information about these deductibles/copays.
What is the out-of-pocket limit for this plan?	**$3,000 / Single** **$6,000 / Family**	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expense.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges and health care this plan does not cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit. Your HRA deductible and HRA coinsurance do apply to your HRA out-of-pocket limit.
Will you pay less if you use a network provider?	Yes	When you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network clinic or hospital may use an out-of-network **provider** for some services. See the chart starting on page 2 for how this plan pays different kinds of **providers**. The HRA does not reimburse for Out-of-Network medical expenses.
Do you need a referral to see a specialist?	Please refer to your health plan SBC	Please refer to your Health Plan SBC.

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	$40 Copay	See Health Plan SBC	Same as Health Plan
	Specialist visit	$60 Copay	See Health Plan SBC	Same as Health Plan
	Preventive care/screening/ immunization	See Health Plan SBC	See Health Plan SBC	Same as Health Plan
If you have a test	Diagnostic test (x-ray, blood work)	See Health Plan SBC	See Health Plan SBC	Same as Health Plan
	Imaging (CT/PET scans, MRIs)	See Health Plan SBC	See Health Plan SBC	Same as Health Plan
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.[insert].com	Generic drugs	See Health Plan SBC	See Health Plan SBC	Same as Health Plan
	Preferred brand drugs	See Health Plan SBC	See Health Plan SBC	Same as Health Plan
	Non-preferred brand drugs	See Health Plan SBC	See Health Plan SBC	Same as Health Plan
	Specialty drugs	See Health Plan SBC	See Health Plan SBC	Same as Health Plan
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	See Health Plan SBC	See Health Plan SBC	Same as Health Plan
	Physician/surgeon fees	See Health Plan SBC	See Health Plan SBC	Same as Health Plan
If you need immediate medical attention	Emergency room care	See Health Plan SBC	See Health Plan SBC	Same as Health Plan
	Emergency medical transportation	See Health Plan SBC	See Health Plan SBC	Same as Health Plan
	Urgent care	$60 Copay	See Health Plan SBC	Same as Health Plan
If you have a hospital stay	Facility fee (e.g., hospital room)	See Health Plan SBC	See Health Plan SBC	Same as Health Plan
	Physician/surgeon fees	See Health Plan SBC	See Health Plan SBC	Same as Health Plan
If you need mental health, behavioral health, or substance abuse services	Outpatient services	See Health Plan SBC	See Health Plan SBC	Same as Health Plan
	Inpatient services	See Health Plan SBC	See Health Plan SBC	Same as Health Plan
If you are pregnant	Office visits	See Health Plan SBC	See Health Plan SBC	Same as Health Plan

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)	
	Childbirth/delivery professional services	See Health Plan SBC	See Health Plan SBC	Same as Health Plan
	Childbirth/delivery facility services	See Health Plan SBC	See Health Plan SBC	Same as Health Plan
If you need help recovering or have other special health needs	Home health care	See Health Plan SBC	See Health Plan SBC	Same as Health Plan
	Rehabilitation services	See Health Plan SBC	See Health Plan SBC	Same as Health Plan
	Habilitation services	See Health Plan SBC	See Health Plan SBC	Same as Health Plan
	Skilled nursing care	See Health Plan SBC	See Health Plan SBC	Same as Health Plan
	Durable medical equipment	See Health Plan SBC	See Health Plan SBC	Same as Health Plan
	Hospice services	See Health Plan SBC	See Health Plan SBC	Same as Health Plan
If your child needs dental or eye care	Children's eye exam	See Health Plan SBC	See Health Plan SBC	Same as Health Plan
	Children's glasses	See Health Plan SBC	See Health Plan SBC	Same as Health Plan
	Children's dental check-up	See Health Plan SBC	See Health Plan SBC	Same as Health Plan

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.)

Consult the SBC provided by your employer's group health plan to determine the coverage of these benefits.

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

Consult the SBC provided by your employer's group health plan to determine the coverage of these benefits.

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 Office of the Commissioner of Insurance , a state agency which enforces Wisconsin's insurance laws, at 1-800-236-8517, or the U.S. Department of Labor, Employee Benefits Security Administration at 866-444-3272, or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x612565 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, you can contact HRA Customer Service at 1-800-388-0964 or hra@averillanderson.com. You may also contact the Office of the Commissioner of Insurance , a state agency which enforces Wisconsin's insurance laws, at 1-800-236-8517, or the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or visit www. dol.gov/ebsa.

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? YES
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:
This Summary of Benefits and Coverage is available in English only.

PHS Act section 2719 requires non-grandfathered group health plans and health insurance issuers offering non-grandfathered health insurance coverage to provide relevant notices in a culturally and linguistically appropriate manner. The regulations implementing section 2719 require these plans and issuers to make certain accommodations for notices sent to an address in a county meeting a threshold percentage of people who are literate only in the same non-English language. This threshold percentage is set at 10 percent or more of the population residing in the claimant's county, as determined based on American Community Survey (ACS) data published by the United States Census Bureau. 26 CFR. §54.9815-2719T, 29 CFR. §2590.715-2719, and 45 CFR. §147.136.

The participants of this Health HRA do not reside in a county that requires a non-English language translation.

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	$1,000
Specialist *[cost sharing]*	$60
Hospital (facility) *[cost sharing]*	40%
Other *[cost sharing]*	40%

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	$1,000
Copayments	$1,140
Coinsurance	$3,584
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$5,784**

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

The plan's overall deductible	$1,000
Specialist *[cost sharing]*	$60
Hospital (facility) *[cost sharing]*	40%
Other *[cost sharing]*	40%

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	$1,000
Copayments	$1,205
Coinsurance	$0
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$2,260**

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

The plan's overall deductible	$1,000
Specialist *[cost sharing]*	$60
Hospital (facility) *[cost sharing]*	40%
Other *[cost sharing]*	40%

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	$736
Copayments	$826
Coinsurance	$338
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,900**

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