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 contact your company's HR department. 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.

Important Questions	Answers	Why This Matters:
What is the overall deductible for the HRA?	Single - $500.00 Family - $500.00	You must pay all the costs up to the deductible before this HRA pays for covered services you use. Review your company's HRA SPD or Plan Document to confirm when the deductible starts over (usually, but not always, on January 1st). If applicable, review the SBC specific to the company's major medical plan(s) for more details.
Are there services covered by the HRA before you meet the HRA deductible?	No.	This HRA plan does not cover services prior to having met the HRA deductible amount required by the company.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services. Review the information in this SBC for services the HRA plan covers. This HRA is used to supplement other major medical coverage, which may have a deductible for specific services. If applicable, review the SBC specific to the company's major medical plan(s) for more details.
What is the out-of-pocket limit for this plan?	Not applicable.	There's no limit on how much you could pay during a coverage period for your share of the cost of covered services. However, the HRA plan may be used to supplement other major medical coverage, which may have a deductible for specific services. If applicable, review the SBC specific to the company's major medical plan(s) for more details.
Is there an overall annual limit on what the HRA plan pays?	Yes, for the HRA, but the integrated major medical plan may not. Single - $1000.00 Family - $1000.00	The HRA plan will pay for covered services only up to the specified limit during each coverage period, even if your own need is greater. You're responsible for all expenses above this limit, subject to your major medical plan coverage. If applicable, review the SBC specific to the company's major medical plan(s) for more details.
Will you pay less if you use a network provider?	Not applicable.	This HRA 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.	Under this HRA plan 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	No charge up to available account balance.	Only expenses for unreimbursed medical care up to the available account balance are covered.
	Specialist visit	No charge up to available account balance.	
	Preventive care/screening/ immunization	No charge up to available account balance.	
If you have a test	Diagnostic test (x-ray, blood work)	No charge up to available account balance.	Only expenses for unreimbursed medical care up to the available account balance are covered.
	Imaging (CT/PET scans, MRIs)	No charge up to available account balance.	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.[*insert*].com [*or insert a contact phone number, if there is no website*]	Generic drugs	No charge up to available account balance.	Only expenses for unreimbursed medical care up to the available account balance are covered.
	Preferred brand drugs	No charge up to available account balance.	
	Non-preferred brand drugs	No charge up to available account balance.	
	Specialty drugs	No charge up to available account balance.	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge up to available account balance.	Only expenses for unreimbursed medical care up to the available account balance are covered.
	Physician/surgeon fees	No charge up to available account balance.	
If you need immediate medical attention	Emergency room care	No charge up to available account balance.	Only expenses for unreimbursed medical care up to the available account balance are covered.
	Emergency medical transportation	No charge up to available account balance.	
	Urgent care	No charge up to available account balance.	
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge up to available account balance.	Only expenses for unreimbursed medical care up to the available account balance are covered.
	Physician/surgeon fees	No charge up to available account balance.	

Common Medical Event	Services You May Need	What You Will Pay	Limitations, Exceptions, & Other Important Information
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge up to available account balance.	Only expenses for unreimbursed medical care up to the available account balance are covered.
	Inpatient services	No charge up to available account balance.	
If you are pregnant	Office visits	No charge up to available account balance.	Only expenses for unreimbursed medical care up to the available account balance are covered.
	Childbirth/delivery professional services	No charge up to available account balance.	
	Childbirth/delivery facility services	No charge up to available account balance.	
If you need help recovering or have other special health needs	Home health care	No charge up to available account balance.	Only expenses for unreimbursed medical care up to the available account balance are covered.
	Rehabilitation services	No charge up to available account balance.	
	Habilitation services	No charge up to available account balance.	
	Skilled nursing care	No charge up to available account balance.	
	Durable medical equipment	No charge up to available account balance.	
	Hospice services	No charge up to available account balance.	
If your child needs dental or eye care	Children's eye exam	No charge up to available account balance.	Only expenses for unreimbursed medical care up to the available account balance are covered.
	Children's glasses	No charge up to available account balance.	
	Children's dental check-up	No charge up to available account balance.	

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
- Long-term care
- Weight-loss programs (if merely to improve general health)

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

- Acupuncture (if rendered in connection with the diagnosis, cure, mitigation, treatment, or prevention of disease, or for the purpose of affecting any structure or function of the body)
- Bariatric surgery
- Chiropractic care
- Dental care (Adult)
- Hearing aids
- Infertility treatment
- Non-emergency care when traveling outside the U.S. (if for qualifying medical care)
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care
- Weight-loss programs (if recommended by a physician 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: Department of Labor Employee Benefits Security Administration, 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 contact information*]. You may also contact 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. However, please also refer to the SBC for the ABC Company Health Plan.

Language Access Services: [*include one or more of the following if necessary to satisfy the culturally and linguistically appropriate requirement*]

Spanish (Español): Para obtener asistencia en Español, llame al [*insert telephone number*].

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa [*insert telephone number*].

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 [*insert telephone number*].

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' [*insert telephone number*].

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 deductible	**$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	**$12,700**

In this example, Peg would pay:

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

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 deductible	**$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	$*
The total Joe would pay is	**$***

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

The plan's overall deductible	**$0**
Specialist deductible	**$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	$*
The total Mia would pay is	**$***

* Note: The amount paid by the HRA plan will depend on the items submitted for reimbursement by the covered individual. No amounts are paid automatically. The amount paid by the HRA plan is limited to the available account balance. The covered individual may be responsible for amounts more than the available account balance. However, please refer to the SBC for the ABC Company Health Plan for additional information.