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, [insert contact information]. 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 and www.cciio.coms.gov or call 1-800-877-1122 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$0	See the Common Medical Events chart below for your costs for services this plan covers. This HRA is integrated with the company health plan, which has an overall annual deductible (see SBC for company group health plan).
Are there services covered before you meet your deductible?	No	You will have to meet the deductible before the plan pays for any services.
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.
Do you need a referral to see a specialist?	No	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
		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	No charge up to available balance	No charge up to available balance	Reimbursement limited to eligible expenses up to the HRA maximum
	Specialist visit	No charge up to available balance	No charge up to available balance	Reimbursement limited to eligible expenses up to the HRA maximum
	Preventive care/screening/ immunization	No charge up to available balance	No charge up to available balance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. Reimbursement limited to eligible expenses up to the HRA maximum.
If you have a test	Diagnostic test (x-ray, blood work)	No charge up to available balance	No charge up to available balance	Reimbursement limited to eligible expenses up to the HRA maximum
	Imaging (CT/PET scans, MRIs)	No charge up to available balance	No charge up to available balance	Reimbursement limited to eligible expenses up to the HRA maximum
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.[insert].com	Generic drugs	No charge up to available balance	No charge up to available balance	Reimbursement limited to eligible expenses up to the HRA maximum
	Preferred brand drugs	No charge up to available balance	No charge up to available balance	Reimbursement limited to eligible expenses up to the HRA maximum
	Non-preferred brand drugs	No charge up to available balance	No charge up to available balance	Reimbursement limited to eligible expenses up to the HRA maximum
	Specialty drugs	No charge up to available balance	No charge up to available balance	Reimbursement limited to eligible expenses up to the HRA maximum
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge up to available balance	No charge up to available balance	Reimbursement limited to eligible expenses up to the HRA maximum
	Physician/surgeon fees	No charge up to available balance	No charge up to available balance	Reimbursement limited to eligible expenses up to the HRA maximum
If you need immediate medical attention	Emergency room care	No charge up to available balance	No charge up to available balance	Reimbursement limited to eligible expenses up to the HRA maximum
	Emergency medical transportation	No charge up to available balance	No charge up to available balance	Reimbursement limited to eligible expenses up to the HRA maximum
	Urgent care	No charge up to available balance	No charge up to available balance	Reimbursement limited to eligible expenses up to the HRA maximum

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 a hospital stay	Facility fee (e.g., hospital room)	No charge up to available balance	No charge up to available balance	Reimbursement limited to eligible expenses up to the HRA maximum
	Physician/surgeon fees	No charge up to available balance	No charge up to available balance	Reimbursement limited to eligible expenses up to the HRA maximum
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge up to available balance	No charge up to available balance	Reimbursement limited to eligible expenses up to the HRA maximum
	Inpatient services	No charge up to available balance	No charge up to available balance	Reimbursement limited to eligible expenses up to the HRA maximum
If you are pregnant	Office visits	No charge up to available balance	No charge up to available balance	Reimbursement limited to eligible expenses up to the HRA maximum
	Childbirth/delivery professional services	No charge up to available balance	No charge up to available balance	Reimbursement limited to eligible expenses up to the HRA maximum
	Childbirth/delivery facility services	No charge up to available balance	No charge up to available balance	Reimbursement limited to eligible expenses up to the HRA maximum
If you need help recovering or have other special health needs	Home health care	No charge up to available balance	No charge up to available balance	Reimbursement limited to eligible expenses up to the HRA maximum
	Rehabilitation services	No charge up to available balance	No charge up to available balance	Reimbursement limited to eligible expenses up to the HRA maximum
	Habilitation services	No charge up to available balance	No charge up to available balance	Reimbursement limited to eligible expenses up to the HRA maximum
	Skilled nursing care	No charge up to available balance	No charge up to available balance	Reimbursement limited to eligible expenses up to the HRA maximum
	Durable medical equipment	No charge up to available balance	No charge up to available balance	Reimbursement limited to eligible expenses up to the HRA maximum
	Hospice services	No charge up to available balance	No charge up to available balance	Reimbursement limited to eligible expenses up to the HRA maximum
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	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.)		
• Acupuncture • Bariatric surgery • Cosmetic surgery • Chiropractic care • Dental care (Adult)	• Hearing aids • Infertility treatment • Long-term care • Non-emergency care when traveling outside of the U.S.	• Private-duty nursing • Routine eye care (Adult) • Routine foot care • Weight loss programs

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

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 (DOL) - 1-866-487-2365. 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 on how 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: Allegiance Benefit Plan Management, Inc – 800-877-1122.

Does this plan provide Minimum Essential Coverage? **No**

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

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 800-877-1122.]

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 800-877-1122.]

[Chinese (中文): 如果需要中文的帮助，请拨打这个号码 800-877-1122.]

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 800-877-1122.]

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	**N/A**
Specialist Coinsurance	**N/A**
Hospital (facility) Coinsurance	**N/A**
Other Coinsurance	**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	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	N/A
Copayments	N/A
Coinsurance	N/A
What isn't covered	
Limits or exclusions	$12,100
The total Peg would pay is	**$12,100**

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

The plan's overall deductible	**N/A**
Specialist Coinsurance	**N/A**
Hospital (facility) Coinsurance	**N/A**
Other Coinsurance	**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	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	N/A
Copayments	N/A
Coinsurance	N/A
What isn't covered	
Limits or exclusions	$5,000
The total Joe would pay is	**$5,000**

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

The plan's overall deductible	**N/A**
Specialist Coinsurance	**N/A**
Hospital (facility) Coinsurance	**N/A**
Other Coinsurance	**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	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	N/A
Copayments	N/A
Coinsurance	N/A
What isn't covered	
Limits or exclusions	$2,200
The total Mia would pay is	**$2,200**

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 in excess of the available account balance. Refer to the Company Health Plan for additional information.