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, log into www.ebcflex.com or call 1-800-346-2126. 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.healthcare.gov/SBC-GLOSSARY or call 1-800-346-2126 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$0	This Health Reimbursement Arrangement (HRA) plan may help you pay for some of the deductible expenses associated with your major medical plan. Check your major medical plan's Summary of Benefits and Coverage (SBC) for overall **deductible**.
Are there services covered before you meet your deductible?	No.	This Health Reimbursement Arrangement (HRA) plan may help you pay for some of the deductible expenses associated with your major medical plan. Check your major medical plan's Summary of Benefits and Coverage (SBC) to see if any services are covered before you meet your **deductible**.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services for this plan. Check your major medical plan's SBC for other **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. Check your major medical plan's SBC for **out-of-pocket limits**.
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. Check your major medical plan's SBC for **out-of-pocket limits**.
Will you pay less if you use a network provider?	Unknown.	Check your major medical plan's SBC to see whether there is a **network** of **providers.**
Do you need a referral to see a specialist?	No.	Check your major medical plan's SBC to see whether you need a referral to see a **specialist**.

(DT - OMB control number: 1545-0047/Expiration Date: 12/31/2019)(DOL - OMB control number: 1210-0147/Expiration date: 5/31/2022)
(HHS - OMB control number: 0938-1146/Expiration date: 10/31/2022)

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Limitations, Exceptions, & Other Important Information
If you visit a health care provider's office or clinic	This EBC HRA is intended to operate in conjunction with your employer's major medical plan to assist with out-of-pocket costs associated with Health Plan Deductible. Please see your major medical plan's SBC.
If you have a test	This EBC HRA is intended to operate in conjunction with your employer's major medical plan to assist with out-of-pocket costs associated with Health Plan Deductible. Please see your major medical plan's SBC.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.ebcflex.com	This EBC HRA is intended to operate in conjunction with your employer's major medical plan to assist with out-of-pocket costs associated with Health Plan Deductible. Please see your major medical plan's SBC.
If you have outpatient surgery	This EBC HRA is intended to operate in conjunction with your employer's major medical plan to assist with out-of-pocket costs associated with Health Plan Deductible. Please see your major medical plan's SBC.
If you need immediate medical attention	This EBC HRA is intended to operate in conjunction with your employer's major medical plan to assist with out-of-pocket costs associated with Health Plan Deductible. Please see your major medical plan's SBC.
If you have a hospital stay	This EBC HRA is intended to operate in conjunction with your employer's major medical plan to assist with out-of-pocket costs associated with Health Plan Deductible. Please see your major medical plan's SBC.
If you need mental health, behavioral health, or substance abuse services	This EBC HRA is intended to operate in conjunction with your employer's major medical plan to assist with out-of-pocket costs associated with Health Plan Deductible. Please see your major medical plan's SBC.
If you are pregnant	This EBC HRA is intended to operate in conjunction with your employer's major medical plan to assist with out-of-pocket costs associated with Health Plan Deductible. Please see your major medical plan's SBC.

[* For more information about limitations and exceptions, see the plan or policy document at www.ebcflex.com.]

Common Medical Event	Limitations, Exceptions, & Other Important Information
If you need help recovering or have other special health needs	This EBC HRA is intended to operate in conjunction with your employer's major medical plan to assist with out-of-pocket costs associated with Health Plan Deductible. Please see your major medical plan's SBC.
If your child needs dental or eye care	This EBC HRA is intended to operate in conjunction with your employer's major medical plan to assist with out-of-pocket costs associated with Health Plan Deductible. Please see your major medical plan's SBC.

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 services not covered by the major medical plan.
- Services not first submitted to the major medical plan.

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

- See your major medical plan's SBC

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: your state insurance department, 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 x61565 or www.ccio.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: Sadie Wrobel, Gorman & Company, LLC, 200 N Main Street, WI 53575, 608-835-5788, 82-3739186, Gorman & Company, LLC Health Reimbursement Plan, 504,Sadie Wrobel. 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**

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.

[* For more information about limitations and exceptions, see the plan or policy document at www.ebcflex.com.]

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:

None

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

[* For more information about limitations and exceptions, see the plan or policy document at www.ebcflex.com.]

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. NOTE: The HRA operates in connection with your major medical plan and benefits may be coordinated between the two plans.

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

- **The plan's overall deductible** **$**
- **Specialist** **$**
- **Hospital (facility)** **%**
- **Other** **%**

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	$
Copayments	$
Coinsurance	$
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** **$**
- **Specialist** **$**
- **Hospital (facility)** **%**
- **Other** **%**

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	$
Copayments	$
Coinsurance	$
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** **$**
- **Specialist** **$**
- **Hospital (facility)** **%**
- **Other** **%**

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	$
Copayments	$
Coinsurance	$
What isn't covered	
Limits or exclusions	$
The total Mia would pay is	**$**

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