
 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](#) will be provided separately.**
This is only a summary. For more information about your HRA coverage, or to get a copy of the complete terms of coverage, please read your summary plan description. 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 provided on the EBC webportal at www.ebcsolutions.com or call 1-888-507-6053 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	\$ 0	The health reimbursement arrangement (HRA) has no deductible requirement, but your insurance plan may.
Are there services covered before you meet your deductible ?	Yes	You may submit eligible deductible expenses to your HRA for reimbursement. The HRA itself has no deductible requirement, but your insurance plan may.
Are there other deductibles for specific services?	No	The HRA plan has no deductible requirement, but your insurance plan may.
What is the out-of-pocket limit for this plan ?	Not applicable to HRA	The HRA has no limit but your insurance plan may.
What is not included in the out-of-pocket limit ?	Not applicable to HRA	The HRA has no limit but your insurance plan may.
Will you pay less if you use a network provider ?	Not applicable to HRA	Check the SBC provided by your insurance provider
Do you need a referral to see a specialist ?	Not applicable to HRA	Check the SBC provided by your insurance provider

 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	Determined by group policy whose premium may or may not be paid for through funds in this HRA plan	Determined by group policy whose premium may or may not be paid for through funds in this HRA plan	Medical expenses paid with fund in the HRA plan may not be deducted on your annual income tax or submitted to our 125 Cafeteria Plan for reimbursement
	Specialist visit			
	Preventive care/screening/immunization			
If you have a test	Diagnostic test (x-ray, blood work)	Determined by group policy whose premium may or may not be paid for through funds in this HRA plan	Determined by group policy whose premium may or may not be paid for through funds in this HRA plan	Medical expenses paid with fund in the HRA plan may not be deducted on your annual income tax or submitted to our 125 Cafeteria Plan for reimbursement
	Imaging (CT/PET scans, MRIs)			
If you need drugs to treat your illness or condition More information about prescription drug coverage is available via your health insurance provider	Generic drugs	Determined by group policy whose premium may or may not be paid for through funds in this HRA plan	Determined by group policy whose premium may or may not be paid for through funds in this HRA plan	Medical expenses paid with fund in the HRA plan may not be deducted on your annual income tax or submitted to our 125 Cafeteria Plan for reimbursement
	Preferred brand drugs			
	Non-preferred brand drugs			
	Specialty drugs			
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Determined by group policy whose premium may or may not be paid for through funds in this HRA plan	Determined by group policy whose premium may or may not be paid for through funds in this HRA plan	Medical expenses paid with fund in the HRA plan may not be deducted on your annual income tax or submitted to our 125 Cafeteria Plan for reimbursement
	Physician/surgeon fees			
If you need immediate medical attention	Emergency room care	Determined by group policy whose premium may or may not be paid for through funds in this HRA plan	Determined by group policy whose premium may or may not be paid for through funds in this HRA plan	Medical expenses paid with fund in the HRA plan may not be deducted on your annual income tax or submitted to our 125 Cafeteria Plan for reimbursement
	Emergency medical transportation			
	Urgent care			
If you have a hospital stay	Facility fee (e.g., hospital room)	Determined by group policy whose premium may or may not be paid	Determined by group policy whose premium may or may not be paid for through	Medical expenses paid with fund in the HRA plan may not be deducted on your annual income tax or submitted to our 125 Cafeteria

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

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)	
	Physician/surgeon fees	for through funds in this HRA plan	funds in this HRA plan	Plan for reimbursement
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Determined by group policy whose premium may or may not be paid for through funds in this HRA plan	Determined by group policy whose premium may or may not be paid for through funds in this HRA plan	Medical expenses paid with fund in the HRA plan may not be deducted on your annual income tax or submitted to our 125 Cafeteria Plan for reimbursement
	Inpatient services			
If you are pregnant	Office visits	Determined by group policy whose premium may or may not be paid for through funds in this HRA plan	Determined by group policy whose premium may or may not be paid for through funds in this HRA plan	Medical expenses paid with fund in the HRA plan may not be deducted on your annual income tax or submitted to our 125 Cafeteria Plan for reimbursement
	Childbirth/delivery professional services			
	Childbirth/delivery facility services			
If you need help recovering or have other special health needs	Home health care	Determined by group policy whose premium may or may not be paid for through funds in this HRA plan	Determined by group policy whose premium may or may not be paid for through funds in this HRA plan	Medical expenses paid with fund in the HRA plan may not be deducted on your annual income tax or submitted to our 125 Cafeteria Plan for reimbursement.
	Rehabilitation services			
	Habilitation services			
	Skilled nursing care			
	Durable medical equipment			
Hospice services				
If your child needs dental or eye care	Children's eye exam	Determined by group policy whose premium may or may not be paid for through funds in this HRA plan	Determined by group policy whose premium may or may not be paid for through funds in this HRA plan	Medical expenses paid with fund in the HRA plan may not be deducted on your annual income tax or submitted to our 125 Cafeteria Plan for reimbursement
	Children's glasses			
	Children's dental check-up			

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](#).)

- Premium or out-of-pocket health care expenses that exceed the dollar value in your HRA account
- Pre-tax payroll deducted premiums
- Health care expenses incurred for non-dependent beneficiaries
- Elective cosmetic services and other expenses not allowed under IRC 213(d)
- Medical expenses incurred before participant's entry date into the HRA Plan
- If this is an "integrated" HRA and you are enrolled in single coverage you may not seek reimbursements for other family members unless they are enrolled in another family member's employer sponsored group health insurance plan that meets MEC and MV standards. You must complete an eligibility attestation form provided by EBC or your employer.

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

This HRA plan covers eligible health, vision and dental premiums that are paid for on an after-tax basis and qualified out-of-pocket health care expenses incurred by you, your legal spouse and legal dependent(s).

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: [State of MN, 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.

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: your employer.

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](#).

Language Access Services:

[Spanish (Español): Para obtener asistencia en Español, llame al 1-888-507-6053].

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-507-6053].

[Chinese (中文): 如果需要中文的帮助, 请拨打这个号码1-888-507-6053].

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-888-507-6053].

—————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](#) \$
- [Specialist](#) [*cost sharing*] \$
- Hospital (facility) [*cost sharing*] %
- Other [*cost sharing*] %

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	\$
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$
Copayments	\$
Coinsurance	\$
<i>What isn't covered</i>	
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](#) [*cost sharing*] \$
- Hospital (facility) [*cost sharing*] %
- Other [*cost sharing*] %

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	\$
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$
Copayments	\$
Coinsurance	\$
<i>What isn't covered</i>	
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](#) [*cost sharing*] \$
- Hospital (facility) [*cost sharing*] %
- Other [*cost sharing*] %

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	\$
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$
Copayments	\$
Coinsurance	\$
<i>What isn't covered</i>	
Limits or exclusions	\$
The total Mia would pay is	\$*

*The HRA reimburses out-of-pocket expenses not covered by your insurance. The reimbursement amounts vary based on each individual's account balance.

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.