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, visit www.fundoffice.org or call 1-800-862-3386. 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 or call 1-855-756-4448 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. HRA reimburses first dollar of any medically necessary service that is an eligible HRA expense. This HRA may be used to offset all or a portion of your deductible under a major medical plan.
Are there services covered before you meet your deductible?	Not applicable.	You don't have to meet **deductibles** for specific services but see the chart starting on page 2 for costs for services this plan covers. This HRA may be used to offset all or a portion of your **deductible** under a major medical **plan.**
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services but see the chart starting on page 2 for costs for services this plan covers. This HRA may be used to offset all or a portion of your **deductible** under a major medical **plan.**
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. You can receive covered services from any **provider**.
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
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	100% reimbursable up to the available HRA balance for Qualified Medical Expense as determined by Internal Revenue Code Section 213(d).	Cannot reimburse any part of expense that is payable from another source, such as health insurance or Medicare.
	Specialist visit		
	Preventive care, screening, immunization		
If you have a test	Diagnostic test (x-ray, blood work)	100% reimbursable up to the available HRA balance for Qualified Medical Expense as determined by Internal Revenue Code Section 213(d).	Cannot reimburse any part of expense that is payable from another source, such as health insurance or Medicare.
	Imaging (CT/PET scans, MRIs)		
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.caremark.com or 1-800-566-5693	Generic drugs	100% reimbursable up to the available HRA balance for Qualified Medical Expense as determined by Internal Revenue Code Section 213(d).	Cannot reimburse any part of expense that is payable from another source, such as health insurance or Medicare.
	Preferred brand drugs		
	Non-preferred brand drugs		
	Specialty drugs		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	100% reimbursable up to the available HRA balance for Qualified Medical Expense as determined by Internal Revenue Code Section 213(d).	Cannot reimburse any part of expense that is payable from another source, such as health insurance or Medicare.
	Physician/surgeon fees		
If you need immediate medical attention	Emergency room care	100% reimbursable up to the available HRA balance for Qualified Medical Expense as determined by Internal Revenue Code Section 213(d).	Cannot reimburse any part of expense that is payable from another source, such as health insurance or Medicare.
	Emergency medical transportation		
	Urgent care		
If you have a hospital stay	Facility fee (e.g., hospital room)	100% reimbursable up to the available HRA balance for Qualified Medical Expense as determined by Internal Revenue Code Section 213(d).	Cannot reimburse any part of expense that is payable from another source, such as health insurance or Medicare.
	Physician/surgeon fees		
If you need mental health, behavioral health, or substance abuse services	Outpatient services	100% reimbursable up to the available HRA balance for Qualified Medical Expense as determined by Internal Revenue Code Section 213(d).	Cannot reimburse any part of expense that is payable from another source, such as health insurance or Medicare.
	Inpatient services		

* For more information about limitations and exceptions, see the plan or policy document at www.fundoffice.org.

Common Medical Event	Services You May Need	What You Will Pay	Limitations, Exceptions*, & Other Important Information
If you are pregnant	Office visits Childbirth/delivery professional services Childbirth/delivery facility services	100% reimbursable up to the available HRA balance for Qualified Medical Expense as determined by Internal Revenue Code Section 213(d).	Cannot reimburse any part of expense that is payable from another source, such as health insurance or Medicare.
If you need help recovering or have other special health needs	Home health care Rehabilitation services Habilitation services Skilled nursing care Durable medical equipment Hospice services	100% reimbursable up to the available HRA balance for Qualified Medical Expense as determined by Internal Revenue Code Section 213(d).	Cannot reimburse any part of expense that is payable from another source, such as health insurance or Medicare.
If your child needs dental or eye care	Children's eye exam Children's glasses Children's dental check-up	100% reimbursable up to the available HRA balance for Qualified Medical Expense as determined by Internal Revenue Code Section 213(d).	Cannot reimburse any part of expense that is payable from another source, such as health insurance or Medicare.

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.)

- Expenses not defined by Internal Revenue Code Section 213(d)

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

- Acupuncture
- Bariatric surgery
- Cosmetic surgery (if meets Internal Revenue Code Section 213(d) requirements)
- Chiropractic care
- Dental Care
- Hearing aids
- Infertility treatment
- Long Term Care
- Non-emergency care when traveling outside the United States
- Private-duty nursing
- Routine eye care (Adult and Children)
- Routine foot care
- Weight loss programs

* For more information about limitations and exceptions, see the plan or policy document at www.fundoffice.org.

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 Department of Labor's Employee Benefits Security Administration is 1-866-444-EBSA (3272). 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: [insert applicable contact information from instructions].

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**.

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:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-862-3386.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-862-3386.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-862-3386.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-862-3386.

*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	$0
Hospital (facility)	0
Other	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	$0
The total Peg would pay is	**$12,700***

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	$0
Hospital (facility)	0
Other	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	$5,600*
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$5,600***

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

The plan's overall deductible	$0
Specialist	$0
Hospital (facility	0
Other	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	$2,800*
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$0
Coinsurance	$0
400What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,800***

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**Examples assume no group health insurance or individual policy. Amounts paid by the individual for Qualified Expenses as determined under Internal Revenue Code Section 213(d) may be reimbursed from the individual's HRA by the Plan up to the available HRA balance.*

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