**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, contact your employer or Mid-American Benefits, LLC at 402-571-6224 or 800-364-9505. 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 402-571-6224 or 800-364-9505 to request a copy.

**This document contains only a partial description of the benefits, limitations, exclusions, and other provisions of this health care plan. It is not a Plan document. It is a general overview only. It does not provide all the details of this coverage, including benefits, exclusions, and Plan limitations. In the event there are discrepancies between this document and the Plan document, the terms and conditions of the Plan document will govern.**

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | In-Network<br>$3,000.00 individual<br>$3,200.00 individual within a family<br>$6,000.00 family | Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay.<br>If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible. |
| **Are there services covered before you meet your deductible?** | Refer to the SBC of the Integrated Group Health Plan | Refer to the SBC of the Integrated Group Health Plan |
| **Are there other deductibles for specific services?** | Refer to the SBC of the Integrated Group Health Plan | Refer to the SBC of the Integrated Group Health Plan |
| **What is the out-of-pocket limit for this plan?** | In-Network<br>$3,000.00 individual<br>$3,200.00 individual within a family<br>$6,000.00 family | The out-of-pocket limit is the most you could pay in a year for covered services.<br>If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.<br>After the HRA Out-of-Pocket limit is met, the employee is responsible for charges subject to the terms of the Integrated Group Health Plan. Refer to the SBC of the Group Health Plan. |
| **What is not included in the out-of-pocket limit?** | Premiums, balance-billing charges, health care this plan doesn't cover, penalties | Even though you pay these expenses, they don't count toward the out-of-pocket limit. |
| **Will you pay less if you use a network provider?** | Refer to the SBC of the Integrated Group Health Plan | Refer to the SBC of the Integrated Group Health Plan |
| **Do you need a referral to see a specialist?** | Refer to the SBC of the Integrated Group Health Plan | Refer to the SBC of the Integrated Group Health Plan |

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 |
|---|---|---|---|---|
| | | In-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 | Refer to the SBC of the Integrated Group Health Plan | | Refer to the SBC of the Integrated Group Health Plan |
| | Specialist visit | Refer to the SBC of the Integrated Group Health Plan | | |
| | Preventive care/screening/ immunization | Refer to the SBC of the Integrated Group Health Plan | | |
| **If you have a test** | Diagnostic test (x-ray, blood work) | Refer to the SBC of the Integrated Group Health Plan | | Refer to the SBC of the Integrated Group Health Plan |
| | Imaging (CT/PET scans, MRIs) | Refer to the SBC of the Integrated Group Health Plan | | |
| **If you need drugs to treat your illness or condition** | Generic drugs | Refer to the SBC of the Integrated Group Health Plan | | Refer to the SBC of the Integrated Group Health Plan |
| | Preferred brand drugs | Refer to the SBC of the Integrated Group Health Plan | | |
| | Non-preferred brand drugs | Refer to the SBC of the Integrated Group Health Plan | | |
| | Specialty drugs | Refer to the SBC of the Integrated Group Health Plan | | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | Refer to the SBC of the Integrated Group Health Plan | | Refer to the SBC of the Integrated Group Health Plan |
| | Physician/surgeon fees | Refer to the SBC of the Integrated Group Health Plan | | |
| **If you need immediate medical attention** | Emergency room care | Refer to the SBC of the Integrated Group Health Plan | | Refer to the SBC of the Integrated Group Health Plan |
| | Emergency medical transportation | Refer to the SBC of the Integrated Group Health Plan | | |
| | Urgent care | Refer to the SBC of the Integrated Group Health Plan | | |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | Refer to the SBC of the Integrated Group Health Plan | | Refer to the SBC of the Integrated Group Health Plan |
| | Physician/surgeon fees | Refer to the SBC of the Integrated Group Health Plan | | |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | Refer to the SBC of the Integrated Group Health Plan | | Refer to the SBC of the Integrated Group Health Plan |
| | Inpatient services | Refer to the SBC of the Integrated Group Health Plan | | |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | In-Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| **If you are pregnant** | Office visits | Refer to the SBC of the Integrated Group Health Plan | | Refer to the SBC of the Integrated Group Health Plan |
| | Childbirth/delivery professional services | Refer to the SBC of the Integrated Group Health Plan | | |
| | Childbirth/delivery facility services | Refer to the SBC of the Integrated Group Health Plan | | |
| **If you need help recovering or have other special health needs** | Home health care | Refer to the SBC of the Integrated Group Health Plan | | Refer to the SBC of the Integrated Group Health Plan |
| | Rehabilitation services | Refer to the SBC of the Integrated Group Health Plan | | |
| | Habilitation services | Refer to the SBC of the Integrated Group Health Plan | | |
| | Skilled nursing care | Refer to the SBC of the Integrated Group Health Plan | | |
| | Durable medical equipment | Refer to the SBC of the Integrated Group Health Plan | | |
| | Hospice services | Refer to the SBC of the Integrated Group Health Plan | | |
| **If your child needs dental or eye care** | Children's eye exam | Refer to the SBC of the Integrated Group Health Plan | | Refer to the SBC of the Integrated Group Health Plan |
| | Children's glasses | Refer to the SBC of the Integrated Group Health Plan | | |
| | Children's dental check-up | Refer to the SBC of the Integrated Group Health Plan | | |

**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.)** |
|---|
| • Please check the terms of the Summary Plan Description of the Integrated Group Health Plan |

| **Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)** |
|---|
| • Please check the terms of the Summary Plan Description of the Integrated Group Health Plan |

**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 Health and Human Services, Center for Consumer Information and Insurance Oversight at 1-877-267-2323 x-61565 or www.cciio.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 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 your employer or Mid-American Benefits, LLC at 402-571-6224 or 1-800-364-9505 or visit us at www.mid-americanbenefits.com.

**Does this plan provide Minimum Essential Coverage? No**
**This HRA plan, by itself, does not provide minimum essential coverage. These requirements may be satisfied in coordination with the major medical plan of which this HRA is a component piece. Please refer to the SBC of the Integrated Group Health Plan.**
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**
**This HRA plan, by itself, does not provide minimum essential coverage. These requirements may be satisfied in coordination with the major medical plan of which this HRA is a component piece. Please refer to the SBC of the Integrated Group Health Plan.**
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.

*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)

**Refer to the Integrated Group Health Plan for Specialist, Hospital (facility) and Other information.**

- **The plan's overall deductible** **$3,000**
- **Specialist *[cost sharing]*** **$**
- **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** | **$12,700** |
|---|---|

**In this example, Peg would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $3,000 |
| Copayments | $0 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$3,060** |

## Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

**Refer to the Integrated Group Health Plan for Specialist, Hospital (facility) and Other information.**

- **The plan's overall deductible** **$3,000**
- **Specialist *[cost sharing]*** **$**
- **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** | **$5,600** |
|---|---|

**In this example, Joe would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $3,000 |
| Copayments | $0 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $70 |
| **The total Joe would pay is** | **$3,070** |

## Mia's Simple Fracture

(in-network emergency room visit and follow up care)

**Refer to the Integrated Group Health Plan for Specialist, Hospital (facility) and Other information.**

- **The plan's overall deductible** **$3,000**
- **Specialist *[cost sharing]*** **$**
- **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** | **$2,800** |
|---|---|

**In this example, Mia would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $2,800 |
| Copayments | $0 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$2,800** |

The plan and/or the Integrated Group Health plan would be responsible for the other costs of these EXAMPLE covered services.