This is only a summary. ***This plan only pays certain cost sharing amounts under a specific Employer group medical plan***. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document for this plan and the specific group medical plan at the Employer's own website or by calling Employer at: (815) 426-2162.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$500 per Employee/ Max. 2 Ded Emp + 1 Dependent/ Max. 3 Ded Emp + Family**	See the Common Medical Events chart below for your costs for services this plan covers. This HRA plan is integrated with your Employer's Group Health Plan, which may have a different overall annual Deductible (see SBC for your Employer's 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, but see the chart starting on page 2 for other costs for services this plan covers.
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, but your Employer's Group Health Plan may provide an out-of-pocket limit.
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?	**Yes.**	This plan only covers in and out-of-network providers under your Employer's Group Health Plan.
Do you need a referral to see a specialist?	**No.**	You can see the specialist you choose without permission from this plan, however your Employer's Group Health Plan may impose referral requirements.

- 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	Your Cost	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	This Plan will reimburse in-network and out-of-network deductible expenses Incurred during the Period of Coverage that exceed $500 per Employee or maximum of 2 individual deductibles for Employee plus 1 Dependent or maximum of 3 individual deductibles per Family under the Employer's PPO Group Health Plan. After the Employee, Employee plus 1 Dependent or Family limit has been met, this Plan will pay 100% of in-network and out-of-network deductible expenses incurred under the Employer's PPO Group Health Plan up to a Plan Year maximum of $2,000 Employee Only* $4,000** Employee plus 1 Dependent* $6,000** Employee plus Family*. ** No one family member may receive more than the amount allowed for single coverage, with the family total not exceeding the HRA Plan Year Maximum Benefit.	Coverage (a) limited to amounts subject to certain cost sharing under specific group medical plan, and (b) limited to individual's account balance **Note:** For deductible expenses Incurred during the last three months of the previous Plan Year "Deductible Carryover" will apply toward the deductible required to be met for the current Plan Year. No cash benefit will be paid from the current year on Deductible Carryover amounts. Deductible incurred under the Employer's PPO Group Health Plan can never be paid more than one time by this Plan. * To enroll in the HRA at this level of coverage a participant and his eligible dependents must be concurrently enrolled in the Employer's PPO Group Health Plan at the same level of coverage.
	Specialist visit		
	Preventive care/screening/immunization		
If you have a test	Diagnostic test (x-ray, blood work)		
	Imaging (CT/PET scans, MRIs)		
If you need drugs to treat your illness or condition	Generic drugs		
	Preferred brand drugs		
	Non-preferred brand drugs		
	Specialty drugs		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)		
	Physician/surgeon fees		

Common Medical Event	Services You May Need	Your Cost	Limitations, Exceptions & Other Important Information
If you need immediate medical attention	Emergency room services	This Plan will reimburse in-network and out-of-network deductible expenses Incurred during the Period of Coverage that exceed $500 per Employee or maximum of 2 individual deductibles for Employee plus 1 Dependent or maximum of 3 individual deductibles per Family under the Employer's PPO Group Health Plan. After the Employee, Employee plus 1 Dependent or Family limit has been met, this Plan will pay 100% of in-network and out-of-network deductible expenses incurred under the Employer's PPO Group Health Plan up to a Plan Year maximum of $2,000 Employee Only* $4,000** Employee plus 1 Dependent* $6,000** Employee plus Family*. ** No one family member may receive more than the amount allowed for single coverage, with the family total not exceeding the HRA Plan Year Maximum Benefit.	Coverage (a) limited to amounts subject to certain cost sharing under specific group medical plan, and (b) limited to individual's account balance **Note:** For deductible expenses Incurred during the last three months of the previous Plan Year "Deductible Carryover" will apply toward the deductible required to be met for the current Plan Year. No cash benefit will be paid from the current year on Deductible Carryover amounts. Deductible incurred under the Employer's PPO Group Health Plan can never be paid more than one time by this Plan. * To enroll in the HRA at this level of coverage a participant and his eligible dependents must be concurrently enrolled in the Employer's PPO Group Health Plan at the same level of coverage.
	Emergency medical transportation		
	Urgent care		
If you have a hospital stay	Facility fee (e.g., hospital room)		
	Physician/surgeon fee		
If you have mental health, behavioral health, or substance abuse needs	Outpatient Services		
	Inpatient Services		
If you are pregnant	Office visits		
	Childbirth/delivery professional services		
	Childbirth/delivery facility services		
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		
If your child needs dental or eye care	Children's eye exam		
	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.)

- Amounts other than those subject to cost sharing under specific group medical plan
- Amounts that exceed the individual's account balance
- Amounts other than those subject to the in-network and out-of-network deductible under specific group medical plan

Other Covered Services **(Check your policy or plan document of for the specific group medical plan for covered services under that plan and your costs for these services.)**
• This plan only covers in-network and out-of-network deductible cost sharing expenses under the specific group medical 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 Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform, or the U.S. Department of Health and Human Services, Center for Consumer Information and Insurance Oversight at 1-877-267-2323 x61565 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 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 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]
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 (815) 426-2162.

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

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	$500
Specialist cost sharing/copay	N/A
Hospital (facility) cost sharing	N/A
Other cost sharing	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	**$7,500**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$500
Copayments	Entire Amount
Coinsurance	Entire Amount
What isn't covered	
Limits or exclusions	-
The total Peg would pay is	*

*Amount in excess of individual's account balance

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

The plan's overall deductible	$500
Specialist cost sharing/copay	N/A
Hospital (facility) cost sharing	N/A
Other cost sharing	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	**$5,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$500
Copayments	Entire Amount
Coinsurance	Entire Amount
What isn't covered	
Limits or exclusions	-
The total Joe would pay is	*

*Amount in excess of individual's account balance

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

The plan's overall deductible	$500
Specialist cost sharing/copay	N/A
Hospital (facility) cost sharing	N/A
Other cost sharing	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	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$500
Copayments	Entire Amount
Coinsurance	Entire Amount
What isn't covered	
Limits or exclusions	-
The total Mia would pay is	*

*Amount in excess of individual's account balance

**Note: This example considers the coverage provided by the HRA alone. A covered individual should consider this example in conjunction with the SBC for the Employer's Group Health Plan, which may impose other amounts for Deductible, Copayments and Coinsurance. The amount paid by the HRA plan will depend on how the Employer's Group Health Plan classifies expenses and may depend on which items are submitted for reimbursement by the covered individual.*

This is only a summary. ***This plan only pays certain cost sharing amounts under a specific Employer group medical plan***. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document for this plan and the specific group medical plan at the Employer's own website or by calling Employer at: (815) 426-2162.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$750 per Employee/ Max. 2 Ded Emp + 1 Dependent/ Max. 3 Ded Emp + Family**	See the Common Medical Events chart below for your costs for services this plan covers. This HRA plan is integrated with your Employer's Group Health Plan, which may have a different overall annual Deductible (see SBC for your Employer's 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, but see the chart starting on page 2 for other costs for services this plan covers.
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, but your Employer's Group Health Plan may provide an out-of-pocket limit.
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?	**Yes.**	This plan covers in and out-of-network providers under your Employer's Group Health Plan.
Do you need a referral to see a specialist?	**No.**	You can see the specialist you choose without permission from this plan, however your Employer's Group Health Plan may impose referral requirements.

- 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	Your Cost	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	This Plan will reimburse in-network and out-of-network deductible expenses Incurred during the Period of Coverage that exceed $750 per Employee or maximum of 2 individual deductibles for Employee plus 1 Dependent or maximum of 3 individual deductibles per Family under the Employer's PPO Group Health Plan. After the Employee, Employee plus 1 Dependent or family limit has been met, this Plan will pay 100% of in-network and out-of-network deductible expenses incurred under the Employer's PPO Group Health Plan up to a Plan Year maximum of $1,750 Employee Only* $3,500** Employee plus 1 Dependent* $5,250** Employee plus Family*. ** No one family member may receive more than the amount allowed for single coverage, with the family total not exceeding the HRA Plan Year Maximum Benefit.	Coverage (a) limited to amounts subject to certain cost sharing under specific group medical plan, and (b) limited to individual's account balance. **Note:** For deductible expenses Incurred during the last three months of the previous Plan Year "Deductible Carryover" will apply toward the deductible required to be met for the current Plan Year. No cash benefit will be paid from the current year on Deductible Carryover amounts. Deductible incurred under the Employer's PPO Group Health Plan can never be paid more than one time by this Plan. * To enroll in the HRA at this level of coverage a participant and his eligible dependents must be concurrently enrolled in the Employer's PPO Group Health Plan at the same level of coverage.
	Specialist visit		
	Preventive care/screening/immunization		
If you have a test	Diagnostic test (x-ray, blood work)		
	Imaging (CT/PET scans, MRIs)		
If you need drugs to treat your illness or condition	Generic drugs		
	Preferred brand drugs		
	Non-preferred brand drugs		
	Specialty drugs		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)		
	Physician/surgeon fees		

Common Medical Event	Services You May Need	Your Cost	Limitations, Exceptions & Other Important Information
If you need immediate medical attention	Emergency room services	This Plan will reimburse in-network and out-of-network deductible expenses Incurred during the Period of Coverage that exceed $750 per Employee or maximum of 2 individual deductibles for Employee plus 1 Dependent or maximum of 3 individual deductibles per Family under the Employer's PPO Group Health Plan. After the Employee, Employee plus 1 Dependent or family limit has been met, this Plan will pay 100% of in-network and out-of-network deductible expenses incurred under the Employer's PPO Group Health Plan up to a Plan Year maximum of $1,750 Employee Only* $3,500** Employee plus 1 Dependent* $5,250** Employee plus Family*. ** No one family member may receive more than the amount allowed for single coverage, with the family total not exceeding the HRA Plan Year Maximum Benefit.	Coverage (a) limited to amounts subject to certain cost sharing under specific group medical plan, and (b) limited to individual's account balance. **Note:** For deductible expenses Incurred during the last three months of the previous Plan Year "Deductible Carryover" will apply toward the deductible required to be met for the current Plan Year. No cash benefit will be paid from the current year on Deductible Carryover amounts. Deductible incurred under the Employer's PPO Group Health Plan can never be paid more than one time by this Plan. * To enroll in the HRA at this level of coverage a participant and his eligible dependents must be concurrently enrolled in the Employer's PPO Group Health Plan at the same level of coverage.
	Emergency medical transportation		
	Urgent care		
If you have a hospital stay	Facility fee (e.g., hospital room)		
	Physician/surgeon fee		
If you have mental health, behavioral health, or substance abuse needs	Outpatient Services		
	Inpatient Services		
If you are pregnant	Office visits		
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- Amounts other than those subject to cost sharing under specific group medical plan
- Amounts that exceed the individual's account balance
- Amounts other than those subject to the in-network and out-of-network deductible under specific group medical plan

Other Covered Services (Check your policy or plan document of for the specific group medical plan for covered services under that plan and your costs for these services.)

- This plan covers in-network and out-of-network deductible cost sharing expenses under the specific group medical 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 Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform, or the U.S. Department of Health and Human Services, Center for Consumer Information and Insurance Oversight at 1-877-267-2323 x61565 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.

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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 (815) 426-2162.

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

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

- **The plan's overall deductible** **$750**
- **Specialist cost sharing/copay** **N/A**
- **Hospital (facility) cost sharing** **N/A**
- **Other cost sharing** **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	**$7,500**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$750
Copayments	Entire Amount
Coinsurance	Entire Amount
What isn't covered	
Limits or exclusions	-
The total Peg would pay is	*

*Amount in excess of individual's account balance

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

- **The plan's overall deductible** **$750**
- **Specialist cost sharing/copay** **N/A**
- **Hospital (facility) cost sharing** **N/A**
- **Other cost sharing** **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	**$5,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$750
Copayments	Entire Amount
Coinsurance	Entire Amount
What isn't covered	
Limits or exclusions	-
The total Joe would pay is	*

*Amount in excess of individual's account balance

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

- **The plan's overall deductible** **$750**
- **Specialist cost sharing/copay** **N/A**
- **Hospital (facility) cost sharing** **N/A**
- **Other cost sharing** **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	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$750
Copayments	Entire Amount
Coinsurance	Entire Amount
What isn't covered	
Limits or exclusions	-
The total Mia would pay is	*

*Amount in excess of individual's account balance

**Note: This example considers the coverage provided by the HRA alone. A covered individual should consider this example in conjunction with the SBC for the Employer's Group Health Plan, which may impose other amounts for Deductible, Copayments and Coinsurance. The amount paid by the HRA plan will depend on how the Employer's Group Health Plan classifies expenses and may depend on which items are submitted for reimbursement by the covered individual.*