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, Call 1-888-301-0747 or visit us at www.groupplansolutions.com. 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.cciio.cms.gov or call 1-888-301-0747 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**In-Network $3,000 per individual and $6,000 for a family** per calendar year. No one person will be responsible for more than the individual amount. Out-of-Network is not covered under this HRA plan.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. The **deductible** starts over January 1st. Refer to the Welch Systems, Inc. Health Plan Summary of Benefits and Coverage ("Health Plan SBC") for covered services for your health plan.
Are there services covered before you meet your deductible?	No	This HRA plan may be used to offset a portion of your in-network **deductible** under the Welch Systems, Inc. Health Plan. Refer to the Welch Systems, Inc. Health Plan SBC for covered services for your health plan for services covered under that plan.
Are there other deductibles for specific services?	No	You don't have to meet deductibles for specific services. This HRA may be used to offset a portion of your **deductible** under the Welch Systems, Inc. health plan.
What is the out-of-pocket limit for this plan?	This HRA plan has no out-of-pocket limit.	After the deductible under this HRA plan is met, the employer self-funds a maximum of **$3,000 per individual and $6,000 for a family** per calendar year for payment of some of the In-Network **deductible** incurred under the Welch Systems, Inc. Health Plan This plan will pay for In-Network deductible only up to the amount accrued in your HRA account, even if your own need is greater. You're responsible for all expenses above this limit. Refer to the Welch Systems, Inc. Health Plan SBC for covered services for your health plan.
What is not included in the out-of-pocket limit?	N/A	This plan has no out-of-pocket limit. Refer to the Welch Systems, Inc. Health Plan SBC for covered services for your health plan.
Will you pay less if you use a network provider?	Yes	This plan uses a provider network. You will pay less if you use a provider in the plan's network (In-Network/preferred provider). This HRA Plan only covers In-Network **deductible**. It does not cover Out-of-Network/non-preferred providers.

Do you need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the **specialist** you choose without permission from this plan. Refer to the Welch Systems, Inc. Health Plan SBC for covered services for your 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	100% up to available HRA balance.	Not covered	Cannot reimburse any part of expense that is payable from another source, such as health insurance.
	Specialist visit	Same as above	Not covered	Same as above
	Preventive care/screening/ Immunization	Same as above	Not covered	Same as above
If you have a test	Diagnostic test (x-ray, blood work)	Same as above	Not covered	Same as above
	Imaging (CT/PET scans, MRA,MRIs)	Same as above	Not covered	Same as above
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at: www.magellanrx.com	Generic drugs	Same as above	Not covered	Same as above
	Preferred brand drugs			Same as above
	Non-preferred brand drugs			Same as above

	Specialty drugs	Same as above	Not covered	Same as above
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	100% up to available HRA balance.	Not covered	Same as above
	Physician/surgeon fees	Same as above	Not covered	Same as above
Access If you need immediate medical attention	Emergency room care	100% up to available HRA balance.		Same as above
	Emergency medical transportation	100% up to available HRA balance.		Same as above
	Urgent care	100% up to available HRA balance.	Not covered	Same as above
If you have a hospital stay	Facility fee (e.g., hospital room)	Same as above	Not covered	Same as above
	Physician/surgeon fees	Same as above	Not covered	Same as above
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Same as above	Not covered	Same as above
	Inpatient services	Same as above	Not covered	Same as above

* For more information about HRA Plan limitations and exceptions call 1-888-301-0747 or visit us at www.groupplansolutions.com.

If you are pregnant	Office visits	Same as above	Not covered	Same as above
	Childbirth/delivery professional services	Same as above	Not covered	Same as above
	Childbirth/delivery facility services	Same as above	Not covered	Same as above
If you need help recovering or have other special health needs	Home health care	Same as above	Not covered	Same as above
	Rehabilitation services	Same as above	Not covered	Same as above
	Habilitation services	Same as above	Not covered	
	Skilled nursing care	Same as above	Not covered	Same as above
	Durable medical equipment	Same as above	Not covered	Same as above
	Hospice services	Same as above	Not covered	Same as above
If your child needs dental or eye care	Eye exam	Same as above	Not covered	Same as above
	Glasses	Same as above	Not covered	Same as above
	Dental Check-up	Same as above	Not covered	Same as above

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.)

- Out-of-Network deductible
- Refer to the Welch Systems, Inc. Health Plan SBC for services not covered under your health plan.
- Any expense payable through another source (such as health insurance plan).

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- In-Network deductible
- Refer to the Welch Systems, Inc. Health Plan SBC for covered services for your health plan.

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. You can contact the plan at 1-888-301-0747 or the contact information for those agencies is: Department of Labor's Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. 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: GPS Claim Committee at Group Plan Solutions, 2505 Court Street and Pekin, IL 61558 or call us at 888-301-0747 or you may also contact the Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? The Welch Systems, Inc. Health Plan and this HRA plan self- funded by your employer does provide minimum essential coverage.

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? The Welch Systems, Inc. Health Plan and this HRA plan self- funded by your employer does meet the minimum value standard for the benefits it provides.

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: *** These benefits are for this HRA Plan Only - Welch System's Inc. Health Plan may pay part of the balance**

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 HRA plan's overall deductible** **$3000**
- **Specialist copayment** **N/A**
- **Hospital (facility) coinsurance** **N/A**
- **Other coinsurance** **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	**$7,540**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$3,000
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is*	**$1,540***

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

- **The plan's overall deductible** **$3000**
- **Specialist *copayment*** **N/A**
- **Hospital (facility) & Other coinsurance** **N/A**
- **Prescription coinsurance for Preferred Brand drug** **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	$3,000
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions RX Copays	$0
The total Joe would pay is*	**$0**

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

- **The plan's overall deductible** **$3000**
- **Specialist copayment** **N/A**
- **Hospital (facility) & Other coinsurance** **N/A**
- **Other - Emergency Room Copay** **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	**$2,400**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$2,400
Copayments/Access Fee	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is*	**$0**

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