The Artcraft Group, Inc.

Coverage Period: 01/01/2026 – 12/31/2026

Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage for:** All Participants | **Plan Type:** HRA

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 Human Resources Department. 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 https://www.healthcare.gov/sbc-glossary/ or call 1-866-487-2365 to request a copy.

Questions: Call (856) 727-5200 or visit us at www.abc.com for more information, including a copy of your plan's summary plan description.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$** 0	See the Common Medical Events chart starting on page 2 for your costs for services this plan covers.
Are there services covered before you meet your deductible?	N/A	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.
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 of your Medical carrier's SBC for other costs for services that your Medical plan covers.
What is the out-of-pocket limit for this plan?	This HRA has no **out-of-pocket limit**.	There's no limit on how much you could pay during a coverage period for your share of the cost of covered services. However, the HRA is intended to supplement the coverage under your major medical plan, which may have a limit on out-of-pocket expenses that you pay. See the Summary for your major medical coverage for more details regarding your major medical coverage.
What is not included in the out-of-pocket limit?	This HRA has no **out-of-pocket limit**.	Not applicable because there's no **out-of-pocket limit** on your expenses.
Will you pay less if you use a network provider?	No. See explanation in "Why This Matters."	This HRA treats **providers** the same in determining payment for the same services. However the HRA is intended to supplement the coverage under your major medical plan, which may limit use of providers. If eligible expenses under this HRA are limited to expenses covered by the major medical plan, your choice of providers may impact the reimbursement under this HRA. See your HRA summary plan description for more details.
Do you need a referral to see a specialist?	No.	You can see the **specialist** you choose without permission from this HRA. However, the HRA is intended to supplement the coverage under your major medical plan, which may impose requirements on the use of providers. If eligible expenses under this HRA are limited to expenses

		covered by the major medical plan, your choice of providers may impact the reimbursement under this HRA. See your HRA summary plan description for more details.

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	Not Applicable	Not Applicable	Not Applicable
	Specialist visit	Not Applicable	Not Applicable	Not Applicable
	Preventive care/screening/ immunization	Not Applicable	Not Applicable	Not Applicable
If you have a test	Diagnostic test (x-ray, blood work)	Not Applicable	Not Applicable	Not Applicable
	Imaging (CT/PET scans, MRIs)	Not Applicable	Not Applicable	Not Applicable
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.[insert].com	Generic drugs	Not Applicable	Not Applicable	Not Applicable
	Preferred brand drugs	Not Applicable	Not Applicable	Not Applicable
	Non-preferred brand drugs	Not Applicable	Not Applicable	Not Applicable
	Specialty drugs	Not Applicable	Not Applicable	Not Applicable
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Not Applicable	Not Applicable	Not Applicable
	Physician/surgeon fees	Not Applicable	Not Applicable	Not Applicable
If you need immediate medical attention	Emergency room care	Not Applicable	Not Applicable	Not Applicable
	Emergency medical transportation	Not Applicable	Not Applicable	Not Applicable
	Urgent care	Not Applicable	Not Applicable	Not Applicable
If you have a hospital stay	Facility fee (e.g., hospital room)	Not Applicable	Not Applicable	Not Applicable
	Physician/surgeon fees	Not Applicable	Not Applicable	Not Applicable

[* For more information about limitations and exceptions, see the plan or policy document at [www.insert.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)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Not Applicable	Not Applicable	Not Applicable
	Inpatient services	Not Applicable	Not Applicable	Not Applicable
If you are pregnant	Office visits	Not Applicable	Not Applicable	Not Applicable
	Childbirth/delivery professional services	Not Applicable	Not Applicable	Not Applicable
	Childbirth/delivery facility services			
If you need help recovering or have other special health needs	Home health care	Not Applicable	Not Applicable	Not Applicable
	Rehabilitation services	Not Applicable	Not Applicable	Not Applicable
	Habilitation services	Not Applicable	Not Applicable	Not Applicable
	Skilled nursing care	Not Applicable	Not Applicable	Not Applicable
	Durable medical equipment	Not Applicable	Not Applicable	Not Applicable
	Hospice services	Not Applicable	Not Applicable	Not Applicable
If your child needs dental or eye care	Children's eye exam	Not Applicable	Not Applicable	Not Applicable
	Children's glasses	Not Applicable	Not Applicable	Not Applicable
	Children's dental check-up	Not Applicable	Not Applicable	Not Applicable

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.)

* Long term care expenses
* Cosmetic surgery
* Vision
* Dental
* Over The Counter (OTC)

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

* Prescription expenses
* In-Network deductible expenses
* Copays

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

* Coinsurance

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

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: U.S. Department of Labor, Employee Benefits Security Administration: 1-866-444-3272 or www.dol.gov/ebsa/healthreform ; or the U.S. Department of Health and Human Services 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 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 Human Resources Department.

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.*———————————

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

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	N/A
Specialist	N/A
Hospital (facility)	N/A
Other	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	**N/A**

In this example, Peg would pay:

Cost Sharing	
Deductibles	N/A
Copayments	N/A
Coinsurance	N/A
What isn't covered	
Limits or exclusions	N/A
The total Peg would pay is	N/A

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

The plan's overall deductible	N/A
Specialist	N/A
Hospital (facility)	N/A
Other	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	**N/A**

In this example, Joe would pay:

Cost Sharing	
Deductibles	N/A
Copayments	N/A
Coinsurance	N/A
What isn't covered	
Limits or exclusions	N/A
The total Joe would pay is	N/A

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

The plan's overall deductible	N/A
Specialist	N/A
Hospital (facility)	N/A
Other	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	**N/A**

In this example, Mia would pay:

Cost Sharing	
Deductibles	N/A
Copayments	N/A
Coinsurance	N/A
What isn't covered	
Limits or exclusions	N/A
The total Mia would pay is	N/A

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