This Summary of **Benefits and Coverage (SBC)** document describes the coverage provided by the Health Reimbursement Arrangement (HRA), which is intended to supplement your other major medical coverage. **This is only a summary**. For more detailed information regarding your HRA coverage and costs or to obtain the complete terms in the policy or plan document, contact **Marathon County** at **(715) 261-1180.**

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$0.00**	The HRA may be used to offset all or a portion of your major medical plan deductible offered in connection with the HRA. See the Summary of Benefits Coverage (SBC) for your major medical plan.
Are there services covered before you meet your deductible?	**No**	The HRA may be used to offset all or a portion of your major medical plan deductible offered in connection with the HRA. See the Summary of Benefits Coverage (SBC) for your major medical plan to determine if any services are covered before you meet your deductible.
Are there other deductibles for specific services?	**No**	There are no other deductibles for specific services for this plan.
What is the out-of-pocket limit for this plan?	**Not applicable.**	There is no out-of-pocket limit for this plan.
What is not included in the out-of-pocket limit?	**Not applicable.**	There is no out-of-pocket limit for this plan.
Will you pay less if you use a network provider?	**Unknown**	See the Summary of Benefits and Coverage (SBC) for your major medical plan to determine if there is a network of providers and if costs are less by using in-network providers.
Do you need a referral to see a specialist?	**Unknown**	See the Summary of Benefits and Coverage (SBC) for your major medical plan to determine if you need a referral to see a specialist.

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	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	The HRA is intended to supplement the coverage under your major medical plan. For more information on co-pays, coinsurance and deductible amounts please reference the SBC for your major medical plan.
	Specialist visit	
	Preventive care/screening/ immunization	
If you have a test	Diagnostic test (x-ray, blood work)	The HRA is intended to supplement the coverage under your major medical plan. For more information on co-pays, coinsurance and deductible amounts please reference the SBC for your major medical plan.
	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.[insert].com	Generic drugs	The HRA is intended to supplement the coverage under your major medical plan. For more information on co-pays, coinsurance and deductible amounts please reference the SBC for your major medical plan.
	Preferred brand drugs	
	Non-preferred brand drugs	
	Specialty drugs	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	The HRA is intended to supplement the coverage under your major medical plan. For more information on co-pays, coinsurance and deductible amounts please reference the SBC for your major medical plan.
	Physician/surgeon fees	
If you need immediate medical attention	Emergency room care	The HRA is intended to supplement the coverage under your major medical plan. For more information on co-pays, coinsurance and deductible amounts please reference the SBC for your major medical plan.
	Emergency medical transportation	
	Urgent care	
If you have a hospital stay	Facility fee (e.g., hospital room)	The HRA is intended to supplement the coverage under your major medical plan. For more information on co-pays, coinsurance and deductible amounts please reference the SBC for your major medical plan.
	Physician/surgeon fees	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	The HRA is intended to supplement the coverage under your major medical plan. For more information on co-pays, coinsurance and deductible amounts please reference the SBC for your major medical plan.
	Inpatient services	
If you are pregnant	Office visits	The HRA is intended to supplement the coverage under your major medical plan. For more information on co-pays, coinsurance and deductible amounts please reference the SBC for your major medical plan.
	Childbirth/delivery professional services	

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

Common Medical Event	Services You May Need	Limitations, Exceptions, & Other Important Information
	Childbirth/delivery facility services	(Continued from page 2)
If you need help recovering or have other special health needs	Home health care	The HRA is intended to supplement the coverage under your major medical plan. For more information on co-pays, coinsurance and deductible amounts please reference the SBC for your major medical plan.
	Rehabilitation services	
	Habilitation services	
	Skilled nursing care	
	Durable medical equipment	
	Hospice services	
If your child needs dental or eye care	Children's eye exam	The HRA is intended to supplement the coverage under your major medical plan. For more information on co-pays, coinsurance and deductible amounts please reference the SBC for your major medical plan.
	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.)

- Services not covered by the major medical plan.

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

- Please see SBC for major 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: [insert State, HHS, DOL, and/or other applicable agency contact information]. 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: [insert applicable contact information from instructions].

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.

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

Language Access Services: **None**

[Spanish (Español): Para obtener asistencia en Español, llame al [insert telephone number].]

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa [insert telephone number].]

[Chinese (中文): 如果需要中文的帮助， **请拨打这个号码** [insert telephone number].]

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' [insert telephone number].]

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** $
- **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	**$**

In this example, Peg would pay:

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

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

- **The plan's overall deductible** $
- **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	**$**

In this example, Joe would pay:

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

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

- **The plan's overall deductible** $
- **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	**$**

In this example, Mia would pay:

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

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