




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 <a href="#">deductible</a> ?	\$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 <a href="#">deductible</a> ?	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 <a href="#">deductibles</a> for specific services?	No	There are no other deductibles for specific services for this plan.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	Not applicable.	There is no out-of-pocket limit for this plan.
What is not included in the <a href="#">out-of-pocket limit</a> ?	Not applicable.	There is no out-of-pocket limit for this plan.
Will you pay less if you use a <a href="#">network provider</a> ?	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 <a href="#">referral</a> to see a <a href="#">specialist</a> ?	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
<b>If you visit a health care <a href="#">provider's office</a> or clinic</b>	Primary care visit to treat an injury or illness <a href="#">Specialist</a> visit <a href="#">Preventive care/screening/immunization</a>	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.
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work) Imaging (CT/PET scans, MRIs)	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.
<b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is available at <a href="#">www.[insert].com</a>	Generic drugs Preferred brand drugs Non-preferred brand drugs <a href="#">Specialty drugs</a>	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.
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center) Physician/surgeon fees	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.
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a> <a href="#">Emergency medical transportation</a> <a href="#">Urgent care</a>	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.
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room) Physician/surgeon fees	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.
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services Inpatient 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.
<b>If you are pregnant</b>	Office visits Childbirth/delivery professional 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.

[\*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	<a href="#">Home health care</a>	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.
	<a href="#">Rehabilitation services</a>	
	<a href="#">Habilitation services</a>	
	<a href="#">Skilled nursing care</a>	
	<a href="#">Durable medical equipment</a>	
	<a href="#">Hospice services</a>	
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](http://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](#).

**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, kwijigo 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*)

<b>Total Example Cost</b>	<b>\$</b>
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**In this example, Peg would pay:**

<i>Cost Sharing</i>	
Deductibles	\$
Copayments	\$
Coinsurance	\$
<i>What isn't covered</i>	
Limits or exclusions	\$
<b>The total Peg would pay is</b>	<b>\$</b>

**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*)

<b>Total Example Cost</b>	<b>\$</b>
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**In this example, Joe would pay:**

<i>Cost Sharing</i>	
Deductibles	\$
Copayments	\$
Coinsurance	\$
<i>What isn't covered</i>	
Limits or exclusions	\$
<b>The total Joe would pay is</b>	<b>\$</b>

**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*)

<b>Total Example Cost</b>	<b>\$</b>
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**In this example, Mia would pay:**

<i>Cost Sharing</i>	
Deductibles	\$
Copayments	\$
Coinsurance	\$
<i>What isn't covered</i>	
Limits or exclusions	\$
<b>The total Mia would pay is</b>	<b>\$</b>