

MENOMINEE COUNTY HRA Plan

Coverage Period: 1/1/2020-12/31/2020

Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services

Coverage for: Single / Employee + Spouse/ Employee + Child(ren) Family Plan Type: HRA Plan



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 1-800-422-4661 or online at www.tasconline.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 <https://www.healthcare.gov/sbc-glossary/> or call 1-800-422-4661 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall HRA deductible?	Single HRA DED \$400.00 Family HRA DED \$800.00	<p>If you do not have an HRA Deductible listed in previous column, see the chart starting on page 3 for your costs for services this HRA Plan covers.</p> <p>If you have an HRA Deductible listed in previous column, you must pay all of the costs up to that HRA Deductible amount before reimbursement from this HRA Plan can be made for covered services.</p> <p>The HRA may be used to offset all or a portion of your Deductible under another major medical plan offered in connection with the HRA. See your major medical coverage summary for more details regarding your major medical coverage.</p>
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	<p>If you do not have a Deductible listed in previous column, see the chart starting on page 3 for your costs for services this HRA Plan covers.</p> <p>If you have a Deductible listed in previous column, you must pay all of the costs up to that Deductible amount before reimbursement from this HRA Plan can be made for covered services.</p> <p>The HRA may be used to offset all or a portion of your Deductible under another major medical plan offered in connection with the HRA. See your major medical coverage summary for more details regarding your major medical coverage.</p>
Is there an overall annual limit on what the plan pays?	Single HRA LIMIT \$4700.00 Family HRA LIMIT \$9400.00	<p>This HRA plan will pay for covered services only up to this limit during each coverage period, even if your need is greater. You are responsible for all expenses above this limit.</p> <p>The HRA plan is intended to supplement the coverage under your major medical plan. See the Summary for your major medical coverage for more details regarding your major medical coverage.</p>

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<p>Does this plan use a <u>network of providers</u>?</p>	<p>No</p>	<p>This HRA plan treats providers the same in determining payment for the same services. However, the HRA plan 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 plan. See you HRA Summary Plan Description for more details. Also, see the Summary for your major medical coverage for more details regarding your major medical coverage.</p>
<p>Do I need a referral to see a <u>specialist</u>?</p>	<p>No</p>	<p>You can see the specialist you choose without permission from this HRA. However, the HRA plan 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 plan. See you HRA Summary Plan Description for more details. Also, see the Summary for your major medical coverage for more details regarding your major medical coverage.</p>

<p>Covered Services Under This HRA</p>	<p>Your Cost for Covered Services Under the HRA</p>	<p>Your Cost If You Use an In-Network or Out-of-Network Provider</p>
<p>This HRA generally covers expenses that (i) qualify as “medical care” by the Internal Revenue Code and (ii) satisfy any additional requirements imposed by the HRA Summary Plan Description (SPD). See the SPD for additional details regarding Covered Services under this HRA.</p>	<p>The HRA is intended to supplement the coverage under your major medical plan for which you may require cost sharing. See your HRA Summary Plan Description for more details. Also see the Summary for your major medical coverage for more details regarding your major medical coverage.</p>	<p>The HRA is intended to supplement the coverage under your major medical plan for which you may require cost sharing. See your HRA Summary Plan Description for more details. Also see the Summary for your major medical coverage for more details regarding your major medical coverage.</p>

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Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your Summary Plan Description for other excluded services.)

- Cosmetic Procedures
- Non-213(d) eligible expenses

Other Covered Services (This isn't a complete list. Check your Summary Plan Description for other covered services and your costs for these services.)

- Check the terms of the Summary Plan Description

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-800-422-4661. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 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 questions about your rights, this notice, or assistance, contact: TASC Customer Care at 800-422-4661 or online at www.tasconline.com.

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.

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Does this plan meet the Minimum Value Standards?

Employer will provide to each covered person an annual report showing whether the plan meets Minimum Value Standards. 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 1-800-422-4661.

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

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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 copayment: \$50
- Hospital (facility) coinsurance: 20%
- Other coinsurance: 20%

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 \$12,800

In this example, Peg would pay:

<u>Cost Sharing</u>	
Deductibles	\$500
Copayments	\$300
Coinsurance	\$2,300
<u>What isn't covered</u>	
Limits or exclusions	\$60

The total Peg would pay is \$3,160

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 copayment: \$50
- Hospital (facility) coinsurance: 20%
- Other coinsurance: 20%

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 \$7,400

In this example, Joe would pay:

<u>Cost Sharing</u>	
Deductibles*	\$800
Copayments	\$1,200
Coinsurance	\$300
<u>What isn't covered</u>	
Limits or exclusions	\$60

The total Peg would pay is \$2,360

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

- The plan's overall deductible: \$500
- Specialist copayment: \$50
- Hospital (facility) coinsurance: 20%
- Other coinsurance: 20%

This EXAMPLE event includes services like:

Emergency room care (including medical supplies)
 Diagnostic tests (x-ray)
 Durable medical equipment (crutches)
 Rehabilitation services (physical therapy)

Total Example Cost \$1,900

In this example, Mia would pay:

<u>Cost Sharing</u>	
Deductibles*	\$700
Copayments	\$50
Coinsurance	\$300
<u>What isn't covered</u>	
Limits or exclusions	\$0

The total Peg would pay is \$1,050

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs.

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*Note: This plan has other [deductibles](#) for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above.