



My Company Plan

Appendix to the EBC HRA Summary Plan Description

This document outlines all of the options included in your company's EBC HRA. For further information about your plan, refer to your EBC HRA Summary Plan Description.

My Plan

Organization Name	County of Jackson (770233)
HRA Name	County of Jackson Health Reimbursement Arrangement
Plan Year	January 1 - December 31

My Plan Eligibility

To be eligible to participate in this HRA you must enroll in a qualifying group health plan according to your employer's requirements.

My Eligible Expenses

A health reimbursement arrangement (HRA) allows your employer to provide additional funds for your health care expenses. These may be expenses eligible for coverage under your medical insurance policy, for which you have a responsibility to pay, or they may be expenses you pay for outside of your medical insurance. Refer to the My HRA Benefits by Coverage Level section for details about how much your HRA pays and when.

Your HRA pays for the following eligible expense types: Deductible expenses submitted with an Explanation of Benefits (EOB) provided by your health plan

My HRA Benefit Availability

Your employer contributes to your HRA at the start of the Plan Year. At this time your entire HRA balance is available to reimburse eligible expenses.

My HRA Benefits by Coverage Level

Find the Coverage Level below that applies to you to understand how much and when your HRA pays for each eligible expense types. If you don't use all of your HRA funds for eligible expenses incurred within the plan year, the remaining balance does not carry forward to the following plan year.



Single (Employee Only) Coverage

Deductible expenses

(submitted with an Explanation of Benefits (EOB) provided by your health plan)

<u>Payment Tier</u>	<u>You Pay</u>	<u>Your HRA Pays</u>
The first \$1,000 of eligible expenses	\$1,000	\$0
The next \$4,000 of eligible expenses	\$0	\$4,000
Maximum for this eligible expense type	\$1,000 out of pocket	\$4,000 maximum benefit



Family Coverage

Deductible expenses

(submitted with an Explanation of Benefits (EOB) provided by your health plan)

<u>Payment Tier</u>	<u>You Pay</u>	<u>Your HRA Pays</u>
The first \$1,000 per individual, or the first \$2,000 per family, whichever is reached first	\$1,000 per individual, max of \$2,000 per family	\$0
The next \$4,000 per individual, or the first \$8,000 per family, whichever is reached first	\$0	\$4,000 per individual, max of \$8,000 per family
Maximum for this eligible expense type	\$2,000 out of pocket per family	\$8,000 maximum benefit per family

Accessing Your HRA Funds

The Accessing Your Funds section in your EBC HRA Summary Plan Description includes more information about the following.

Submitting HRA Claims Online, through the Mobile App, or As Paper Claims

If you are required to file any claims directly with Employee Benefits Corporation, you may submit claims for reimbursement online at www.ebcflex.com, through the mobile app, or by filling out and submitting a claim form. Reimbursement is made in the order claims are received. The first claim received and processed is the first one paid from the HRA.

Runout Period

Your runout period is 3 months long and you may submit claims for eligible expenses incurred during the plan year until March 31, 2020. If you end your employment or lose eligibility mid-plan year, claims may be submitted for up to 3 months from the date your employment ended or you lost eligibility.

My HRA ERISA Information

ERISA Status	The Plan is governed by ERISA
Contact	Human Resources Representative
Plan Administrator	County of Jackson
Address	307 Main St Black River Falls, WI 54615
Telephone	(715)284-0268
Federal ID Number	39-6005703
Legal Plan Name	County of Jackson Health Reimbursement Plan
Plan Number	505
Original Effective Date	1/1/2009
Agent for Service of Process	Kyle Deno
Collectively Bargained	No

Your company, County of Jackson, has adopted the EBC HRA (the Plan) and has engaged Employee Benefits Corporation, P.O. Box 44347, Madison, WI, 53744 (telephone: 608 831 8445; toll free: 800 346 2126), to provide services related to the Plan. For purposes of federal law, the Employer is the Plan Sponsor and the Plan Administrator.

Contact Employee Benefits Corporation

Web Address	www.ebcflex.com
E-mail Address	participantservices@ebcflex.com
Fax Number	(608) 831-4790
Mailing Address	Employee Benefits Corporation PO Box 44347 Madison, WI 53744-4347
Phone Number	Monday-Friday 7:00 am-5:00 pm Central Time (800) 346-2126 (608) 831-8445