PLAN H HEALTH PLAN: KENOSHA COUNTY

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 01/01/2016-12/31/2016

Coverage for: Single/Family **Plan Type:** PPO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at donnaesposito@kenoshacounty.org or by calling -262-653-2422.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	Non PAR **$600** single **$1,200** family (2 family members) **$1,800** (3 or more family members).	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	Yes RX Level 2&3 PAR **$150** single **$450** family Non Par **$150** single **$450** family	You must pay all of the costs for these services up to the specific **deductible** amount before this plan begins to pay for these services.
Is there an out–of–pocket limit on my expenses?	Yes Medial Non PAR **$1,750** single **$3,250** family RX PAR **$6,350 $12,700** family Plan Max PAR **$6,350 $12,700** family	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Penalties, **premiums**, balance-billed charges, health care this plan does not cover & amounts over the **allowed amount**	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. See **www.humana.com**	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

Questions: Call 262-653-2422 or donnaesposito@kenoshacounty.org.

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.dol.gov/ebsa/healthreform and www.cciio.cms.gov or call 262-653-2422 to request a copy.

OMB Control Numbers 1545-2229,

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use PAR **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a PAR Provider	Your Cost If You Use a NONPAR Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$35 copay/visit	25% after **deductible**	PAR services not subject to **deductible.**
	Specialist visit	$35 copay/visit	25% after **deductible**	PAR services not subject to **deductible.**
	Other practitioner office visit (chiro)	$35 copay /day	25% after **deductible**	PAR services not subject to **deductible.** PAR lab and x-ray no charge One copay per day
	Preventive care/screening/immunization	No Charge	25% after **deductible**	PAR services not subject to **deductible.** HPV vaccine covered for ages 9-26. Meningitis vaccine covered through age 25. Immunizations for foreign travel are covered. Hepatitis covered for series of three, no age limit
If you have a test	Diagnostic test (x-ray, blood work)	$35 copay/visit	25% after **deductible**	PAR services not subject to **deductible** No charge for PAR services billed with office exam
	Imaging (CT/PET scans, MRIs)	$50 copay/visit	25% after **deductible**	PAR services not subject to **deductible** One copay per day when same day as office visit

Common Medical Event	Services You May Need	Your Cost If You Use a PAR Provider	Your Cost If You Use a NONPAR Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.humana.com.	Level 1 - Low-cost generic drugs	$12 copay	PAR copay+ the difference between the default rate and the Non-PAR pharmacy's charge.	Prior authorization and quantity limitations may be required for some medications. No Charge for flu & pneumonia immunizations, HCR Preventive Medications and Drugs on Women's Healthcare Drug list. Mail and 90 days at retail 2 times copayment for 90 day supply –Level 2&3 subject to RX listed on page 1 All services subject to RX **out-of-pocket** limit listed on page 1 --Your cost for Oral Chemo medications is applicable copay w/$100 maximum for 30 day supply, and applicable copay w/$200 maximum for 90 day supply and applicable copay w/$200 max for mail order.
	Level 2 - Brand name drugs	$35 copay after **deductible**		
	Level 3 - Highest cost drugs	$60 copay after **deductible**		
	Specialty drugs -Obtained at pharmacy -Obtained through SpecialtyRX and office administered by provider -Paid under medical benefits	Same as above No Charge Medical benefit apply	Same as above Not applicable Medical benefit apply	Self-administered specialty drugs may be limited to a 30 day supply
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$150 copay/visit	25% after **deductible**	PAR services not subject to **deductible** No charge PAR ancillary services
	Physician/surgeon fees	$35 copay/visit	25% after **deductible**	PAR services not subject to **deductible**

Common Medical Event	Services You May Need	Your Cost If You Use a PAR Provider	Your Cost If You Use a NONPAR Provider	Limitations & Exceptions
If you need immediate medical attention	Emergency room services Physician Services Facility Charges	No Charge $200/copay/visit	25% after **deductible** 25% after **deductible**	PAR services not subject to **deductible.** Copay waived if admitted. True emergency services NONPAR paid the same as PAR
	Emergency medical transportation	$100 copay/trip	$100 copay/trip	Services not subject to **deductible.**
	Urgent care	$35 copay/visit	25% after **deductible**	PAR services not subject to **deductible.** One copay per day when tied to office visit, higher copay will apply
If you have a hospital stay	Facility fee (e.g., hospital room)	$350 copay/admission	25% after **deductible**	PAR services not subject to **deductible.**
	Physician/surgeon fee	No Charge	25% after **deductible**	PAR services not subject to **deductible**
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services Therapy Services	$35 copay/visit	25% after **deductible**	PAR services not subject to **deductible** Lab and x-ray, no charge for PAR services
	Mental/Behavioral health inpatient services	No Charge	25% after **deductible**	PAR services not subject to **deductible** Residential services are not covered. Half-way houses must be a licensed facility. Partial hospitalization $35/copay/visit, room and board $350 copay/visit.
	Substance use disorder outpatient services	Same as Mental/Behavior health outpatient services	Same as Mental/Behavior health outpatient services	Same as Mental/Behavior health outpatient services
	Substance use disorder inpatient services	Same as Mental/Behavior health inpatient services	Same as Mental/Behavior health inpatient services	Same as Mental/Behavior health inpatient services
If you are pregnant	Prenatal and postnatal care	$35 copay/ initial visit	25% after **deductible**	PAR services not subject to **deductible**

Common Medical Event	Services You May Need	Your Cost If You Use a PAR Provider	Your Cost If You Use a NONPAR Provider	Limitations & Exceptions
	Delivery and all inpatient services	$350 copay/ admission	25% after **deductible**	PAR services not subject to **deductible**
If you need help recovering or have other special health needs	Home health care	$35 copay/ visit	25% after **deductible**	PAR services not subject to **deductible.** No charge for PAR ancillary services
	Rehabilitation services	$35 copay/ visit	25% after **deductible**	PAR services not subject to **deductible** All therapies limited to 15 combined visits then pend for medical necessity. Speech therapy covered if required due to illness or injury.
	Habilitation services	$35 copay/ visit	25% after **deductible**	
	Skilled nursing care	$350 copay/ visit	25% after **deductible**	PAR services not subject to **deductible** Limited to 60 days per admission. PAR Physician visits no charge
	Durable medical equipment	10% **coinsurance**	25% after **deductible**	PAR services not subject to **deductible.** Wigs for cancer patients limited to 1 per lifetime
	Hospice service	No Charge	25% after **deductible**	PAR services not subject to **deductible.** Outpatients including home health visits $35 copay/visit
If your child needs dental or eye care	Eye exam	Not covered	Not covered	No coverage for eye exams
	Glasses	Not covered	Not covered	No coverage for glasses
	Dental check-up	Not covered	Not covered	No coverage for dental check-ups

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Bariatric surgery
- Dental care (Adult and child)
- Infertility treatment
- Long-term care
- Private-duty nursing
- Routine eye care
- Routine foot care
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Chiropractic care
- Cosmetic surgery (Requires prior auth. Services will only be considered if due to a bodily injury or illness and functional impairment is present.)
- Hearing aids (including cost of treatment and cochlear implants/devices 1 hearing aid per ear, per child every 3 years, for children ages 0 through 17)
- Non-emergency care when traveling outside the U.S (as determined by the group)

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 1-262-653-2422. 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, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: Donna Esposito at 262-653-2422 or email donna.esposito@kenoshacounty.org

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

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

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✗ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.