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?	PAR: **$2,400** single/**$4,800** family; NONPAR: **$4,800** single/**$9,600** family.	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?	No	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. PAR **$3,400** single/**$6,800** family NONPAR **$6,950**single/**$13,650** 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 6. 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, 1210-0147 and 0938-1146

- **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	100% after **deductible**	30% after **deductible**	——————none——————
	Specialist visit	100% after **deductible**	30% after **deductible**	——————none——————
	Other practitioner office visit (chiro)	100% after **deductible**	30% after **deductible**	——————none——————
	Preventive care/screening/immunization	No Charge	30% 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.
If you have a test	Diagnostic test (x-ray, blood work)	100% after **deductible**	30% after **deductible**	——————none——————
	Imaging (CT/PET scans, MRIs)	100% after **deductible**	30% after **deductible**	——————none——————

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 after **deductible**	30% after **deductible**+ the difference between the default rate and the Non-PAR pharmacy charge	Prescription drugs are subject to the PAR provider medical **deductible** and **out-of-pocket limit** Prior authorization and quantity limitations may be required for some medications. No Charge for flu & pneumonia immunizations, HCR Preventive Drugs and women's preventative medications Mail and 90 days at retail 2 times copayment for 90 day supply -Your cost for Oral chemo medications: Retail: Applicable copay w/100 max, Retail (90 day supply): Applicable copay w/200 max, Mail order (90day supply) Applicable copay w/200 max after **deductible** is met.
	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 100% after **deductible** 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)	100% after **deductible**	30% after **deductible**	————————none————
	Physician/surgeon fees	100% after **deductible**	30% after **deductible**	————————none————

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	100% after **deductible**	30% after **deductible**	True Emergency NONPAR payable the Same as PAR–
	Emergency medical transportation	100% after **deductible**	100% after **deductible**	NONPAR services subject to PAR **deductible.** Must be medically necessary
	Urgent care	100% after **deductible**	30% after **deductible**	————————none————
If you have a hospital stay	Facility fee (e.g., hospital room)	100% after **deductible**	30% after **deductible**	————————none————
	Physician/surgeon fee	100% after **deductible**	30% after **deductible**	————————none————
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services Therapy Services	100% after **deductible**	30% after **deductible**	————————none————
	Mental/Behavioral health inpatient services	100% after **deductible**	30% after **deductible**	Residential services are not covered. Half-way houses must be a licensed facility.
	Substance use disorder outpatient services	100% after **deductible**	30% after **deductible**	————————none————
	Substance use disorder inpatient services	100% after **deductible**	30% after **deductible**	Residential services are not covered. Half-way houses must be a licensed facility.
If you are pregnant	Prenatal and postnatal care	100% after **deductible**	30% after **deductible**	————————none————
	Delivery and all inpatient services	100% after **deductible**	30% after **deductible**	————————none————
If you need help recovering or have other special health needs	Home health care	100% after **deductible**	30% after **deductible**	————————none————
	Rehabilitation services	100% after **deductible**	30% after **deductible**	All therapies limited to 15 combined visits then pend for medical necessity.
	Habilitation services	100% after **deductible**	30% after **deductible**	
	Skilled nursing care	100% after **deductible**	30% after **deductible**	Limited to 180 days per admission.
	Durable medical equipment	100% after **deductible**	30% after **deductible**	Wigs for cancer patients limited to 1 per lifetime
	Hospice service	100% after **deductible**	30% after **deductible**	————————none————
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

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
	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
- Dental care (Adult and child)
- Infertility treatment
- Long-term care
- 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.)

- Bariatric surgery(limited to one surgery per lifetime including lap band adjustment when medically necessary)
- 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)
- Private-duty nursing (Inpatient only medical or hospital)

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.