



Kenosha County: PPO SFKENC34 Plan (Plan H)

Coverage for: Individual +Family | Plan Type: PPO

 **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, please contact Human Resources by calling 262-653-2800. 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 262-653-2800 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	<u>Network Providers</u> : \$500 Individual / \$1,000 Family; for <u>Non-Network Providers</u> : \$1,000 Individual / \$2,000 Family. <u>Coinsurance</u> and <u>copayments</u> don't count toward the deductible.	Generally, you must pay all of the costs from providers up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family deductible..
Are there services covered before you meet your deductible?	Yes. <u>Preventive care</u> Office Visits, <u>Emergency Room Care</u> , <u>Urgent Care</u> and Therapy services are covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits .
Are there other deductibles for specific services?	No	You don't have to meet <u>deductibles</u> for specific services
What is the out-of-pocket limit for this plan?	<u>Network Providers</u> : \$6,000 Individual / \$12,000 Family; for <u>Out-of-Network Providers</u> : \$7,900 Individual / \$15,800 Family.	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the out-of-pocket limit?	<u>Premiums</u> , <u>Balance-billing</u> charges, Health care this <u>plan</u> doesn't cover, <u>Penalties</u> , <u>Non-network Transplant</u> .	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a network provider?	Yes. See www.humana.com/directories or call 1-866-4ASSIST (427-7478) for a list of <u>network providers</u> .	This <u>plan</u> uses a provider <u>network</u> . You will pay less if you use a <u>provider</u> in the plan's <u>network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the provider's charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a referral to see a specialist?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .

 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	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit	\$35 <u>copay</u> /visit; <u>deductible</u> does not apply	30% after <u>deductible</u>	Includes telehealth (\$10 copay) or telemedicine services.
	<u>Specialist</u> visit	\$45 <u>copay</u> /visit; <u>deductible</u> does not apply	30% after <u>deductible</u>	Includes telementalhealth or telemedicine services.
	<u>Preventive care/screening/Immunization</u>	No charge	30% after <u>deductible</u>	- You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services you need are <u>preventive</u> . Then check what your <u>plan</u> will pay for. - For Breast Feeding Counseling Non-PAR is No charge - Male Contraceptives , Routine Hearing and Routine Screening Not covered for PAR and Non-PAR.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	10% after <u>deductible</u>	30% after <u>deductible</u>	Cost share may vary based on where service is performed.
	Imaging (CT/PET scans, MRIs)	10% after <u>deductible</u>	30% after <u>deductible</u>	- Cost share may vary based on where service is performed. - <u>Preauthorization</u> may be required - if not obtained, penalty will be \$75 Inpatient only
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.serveyourx.com	Generic drugs (Tier 1)	\$12.00 / 30 day supply \$24.00 / 90 day supply	NA	Prescriptions are processed through Serve You RX. Telephone: 800-759-3203
	Preferred brand drugs (Tier 2)	\$35.00 / 30 day supply \$70.00 / 90 day supply		
	Non-preferred brand drugs (Tier 3)	\$60.00 / 30 day supply \$120.00 / 90 day supply		

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Specialty drugs (Tier 4)	10% - maximum \$200 / 30 day supply	Not Covered	Specialty Drugs are limited to Serve You DirectRX Specialty Pharmacy
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% after <u>deductible</u>	30% after <u>deductible</u>	<u>Preauthorization</u> may be required - if not obtained, penalty will be \$75 Inpatient only
	Physician/surgeon fees	10% after <u>deductible</u>	30% after <u>deductible</u>	None
If you need immediate medical attention	<u>Emergency room care</u> True Emergency	\$200 <u>copay</u> /visit; <u>deductible</u> does not apply	\$200 <u>copay</u> /visit; <u>deductible</u> does not apply	<u>Copay</u> waived if admitted.
	Non-Emergency	10% after <u>deductible</u>	30% after <u>deductible</u>	
	<u>Emergency medical transportation</u>	10% after <u>deductible</u>	30% after <u>deductible</u>	None
	<u>Urgent care</u>	\$35 <u>copay</u> /visit; <u>deductible</u> does not apply	30% after <u>deductible</u>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	10% after <u>deductible</u>	30% after <u>deductible</u>	- <u>Preauthorization</u> may be required - if not obtained, penalty will be \$75 Inpatient only
	Physician/surgeon fees	10% after <u>deductible</u>	30% after <u>deductible</u>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	10% after <u>deductible</u>	30% after <u>deductible</u>	None
	Inpatient services	10% after <u>deductible</u>	30% after <u>deductible</u>	- <u>Preauthorization</u> may be required - if not obtained, penalty will be \$75 Inpatient only
If you are pregnant	Office visits	\$35 PCP/ \$45 Specialist <u>copay</u> /visit; <u>deductible</u> does not apply	30% after <u>deductible</u>	<u>Cost sharing</u> does not apply for <u>preventive services</u> .
	Childbirth/delivery professional services	10% after <u>deductible</u>	30% after <u>deductible</u>	Depending on the type of services, a <u>coinsurance</u> or <u>deductible</u> may apply.
	Childbirth/delivery facility services	10% after <u>deductible</u>	30% after <u>deductible</u>	- Maternity care may include tests and services described elsewhere in the SBC (i.e.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
				ultrasound).
If you need help recovering or have other special health needs	<u>Home health cares</u>	10% after <u>deductible</u>	30% after <u>deductible</u>	<u>Preauthorization</u> may be required - if not obtained, penalty will be \$75 Inpatient only
	<u>Rehabilitation services</u>	\$45 <u>copay</u> /visit; <u>deductible</u> does not apply	30% after <u>deductible</u>	- 15 then pend for medical necessity - <u>Preauthorization</u> may be required - if not obtained, penalty will be \$75 Inpatient only
	<u>Habilitation services</u>	\$45 <u>copay</u> /visit; <u>deductible</u> does not apply	30% after <u>deductible</u>	- 15 then pend for medical necessity - <u>Preauthorization</u> may be required - if not obtained, penalty will be \$75 Inpatient only
	<u>Skilled nursing care</u>	10% after <u>deductible</u>	30% after <u>deductible</u>	- 60 day per admission - \$350 per day to a maximum of 3 copays per admission - <u>Preauthorization</u> may be required - if not obtained, penalty will be \$75 Inpatient only
	<u>Durable medical equipment</u>	10% after <u>deductible</u>	30% after <u>deductible</u>	- Excludes vehicle modifications, home modifications, exercise, and bathroom equipment. - <u>Preauthorization</u> may be required - if not obtained, penalty will be \$75 Inpatient only
	<u>Hospice services</u>	10% after <u>deductible</u>	30% after <u>deductible</u>	None
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

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.)

- Acupuncture, unless it is prescribed by a physician for rehabilitation purposes
- Bariatric Surgery
- Cosmetic Surgery, if to correct a functional impairment
- Dental Care
- Hearing Aids
- Infertility Counseling and Treatment
- Long Term Care
- Non-emergency care when traveling outside the U.S.
- Private Duty Nursing
- Routine eye care (Adult), unless for an eye exam
- Routine Foot Care
- Weight Loss Programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Chiropractic Care – spinal manipulations are covered

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:

- For group health coverage subject to ERISA, you may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform
- For non-federal governmental group health plans, you may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov.
- If your coverage is a church plan, church plans are not covered by the Federal COBRA continuation coverage rules.

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:

- Your plan at calling 262-653-2422
- Department of Labor Employee Benefits Security Administration: 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform

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? Yes

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 1-866-4ASSIST (427-7478).

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-4ASSIST (427-7478).

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码1-866-4ASSIST (427-7478).

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-866-4ASSIST (427-7478).

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** \$500
- **Specialist copayment** \$45
- **Hospital (facility) coinsurance** 10%
- **Other** 10%

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
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$500
Copayments	\$45
Coinsurance	\$1,200
<i>What isn't covered</i>	
Limits or exclusions	\$30
The total Peg would pay is	\$1,775

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** \$45
- **Hospital (facility) coinsurance** 10%
- **Other** 10%

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
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$500
Copayments	\$1,220
Coinsurance	\$10
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$1,750

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- **The plan's overall deductible** \$500
- **Specialist copayment** \$45
- **Hospital (facility) coinsurance** 10%
- **Other** 10%

This EXAMPLE event includes services like:

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

Total Example Cost	\$1,900
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$500
Copayments	\$425
Coinsurance	\$100
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,050