# Kenosha County: PPO SFKENC34 (General Emp Med Plan)

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

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 copay/visit; deductible does not apply | 30% after deductible | Includes telehealth ($10 copay) or telemedicine services. |
| | Specialist visit | $45 copay/visit; deductible does not apply | 30% after deductible | Includes telementalhealth or telemedicine services. |
| | Preventive care/screening/ Immunization | No charge | 30% after deductible | - You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.<br>- For Breast Feeding Counseling Non-PAR is No charge<br>- Male Contraceptives , Routine Hearing and Routine Screening Not covered for PAR and Non-PAR. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | 10% after deductible | 30% after deductible | Cost share may vary based on where service is performed. |
| | Imaging (CT/PET scans, MRIs) | 10% after deductible | 30% after deductible | - Cost share may vary based on where service is performed.<br>- Preauthorization may be required - if not obtained, penalty will be $75 Inpatient only |
| **If you need drugs to treat your illness or condition**<br>More information about **prescription drug coverage** is available at www.serveyourx.com | Generic drugs (Tier 1) | $12.00 / 30 day supply<br>$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<br>$70.00 / 90 day supply | | |
| | Non-preferred brand drugs (Tier 3) | $60.00 / 30 day supply<br>$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 deductible | 30% after deductible | Preauthorization may be required - if not obtained, penalty will be $75 Inpatient only |
| | Physician/surgeon fees | 10% after deductible | 30% after deductible | None |
| **If you need immediate medical attention** | Emergency room care<br>True Emergency<br><br>Non-Emergency | $200 copay/visit; deductible does not apply<br><br>10% after deductible | $200 copay/visit; deductible does not apply<br><br>30% after deductible | Copay waived if admitted. |
| | Emergency medical transportation | 10% after deductible | 30% after deductible | None |
| | Urgent care | $35 copay/visit; deductible does not apply | 30% after deductible | None |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 10% after deductible | 30% after deductible | - Preauthorization may be required - if not obtained, penalty will be $75 Inpatient only |
| | Physician/surgeon fees | 10% after deductible | 30% after deductible | None |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | 10% after deductible | 30% after deductible | None |
| | Inpatient services | 10% after deductible | 30% after deductible | - Preauthorization may be required - if not obtained, penalty will be $75 Inpatient only |
| **If you are pregnant** | Office visits | $35 PCP/ $45 Specialist copay/visit; deductible does not apply | 30% after deductible | Cost sharing does not apply for preventive services. |
| | Childbirth/delivery professional services | 10% after deductible | 30% after deductible | Depending on the type of services, a coinsurance or deductible may apply. |
| | Childbirth/delivery facility services | 10% after deductible | 30% after deductible | - 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** | Home health cares | 10% after deductible | 30% after deductible | Preauthorization may be required - if not obtained, penalty will be $75 Inpatient only |
| | Rehabilitation services | $45 copay/visit; deductible does not apply | 30% after deductible | - 15 then pend for medical necessity<br>- Preauthorization may be required - if not obtained, penalty will be $75 Inpatient only |
| | Habilitation services | $45 copay/visit; deductible does not apply | 30% after deductible | - 15 then pend for medical necessity<br>- Preauthorization may be required - if not obtained, penalty will be $75 Inpatient only |
| | Skilled nursing care | 10% after deductible | 30% after deductible | - 60 day per admission<br>- $350 per day to a maximum of 3 copays per admission<br>- Preauthorization may be required - if not obtained, penalty will be $75 Inpatient only |
| | Durable medical equipment | 10% after deductible | 30% after deductible | - Excludes vehicle modifications, home modifications, exercise, and bathroom equipment.<br>- Preauthorization may be required - if not obtained, penalty will be $75 Inpatient only |
| | Hospice services | 10% after deductible | 30% after deductible | 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, kwiijigo 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** |

**In this example, Peg would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $500 |
| Copayments | $45 |
| Coinsurance | $1,200 |
| *What isn't covered* | |
| 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** |

**In this example, Joe would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $500 |
| Copayments | $1,220 |
| Coinsurance | $10 |
| *What isn't covered* | |
| 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** |

**In this example, Mia would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $500 |
| Copayments | $425 |
| Coinsurance | $100 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$1,050** |

The **plan** would be responsible for the other costs of these EXAMPLE covered services.