Kenosha County: PPO SFKENC35 Plan (General Employee Medical 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 Donna Esposito, donnaesposito@kenoshacounty.org or by calling 262-653-2422. 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 262-653-2422 to request a copy.

Important Questions	Answers	Why This Matters
What is the overall deductible?	Network: $500 Individual / $1,000 Family. Non-network: $1,000 Individual / $2,000 Family.	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?	Network Providers: Yes. Preventive Care, Certain Office Visits, Emergency Room Care, Urgent Care, Prescription Drugs and Certain therapies. Non-Network Providers: Yes. Emergency Room Care and Prescription Drugs.	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 care services without cost-sharing and before you meet your deductible. See a list of covered preventive care 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?	For Network Providers: $3,000 Individual / $6,000 Family. For Non-network providers: $6,000 Individual / $12,000 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, non-network prescription drugs, non-network specialty drugs.	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.humana.com/directories or call 866-4ASSIST (427-7478) for a list of network providers.	This plan uses a network provider. 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-pocket limit 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)	Non-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Primary care visit: $35 copay/visit; deductible does not apply Virtual visit: $10 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 tele-mental health or telemedicine services.
	Preventive care/screening/ immunization	No charge; deductible does not apply	30% after deductible	You may have to pay for services that aren't preventive care. Ask your provider if the services needed are preventive care. Then check what your plan will pay for. For Breast Feeding Counseling PAR & Non PAR is No charge. For Male Contraceptives PAR & Non PAR is Not covered.
If you have a test	Diagnostic test (x-ray, blood work)	10% after deductible	30% after deductible	Cost sharing may vary based on where service is performed.
	Imaging (CT/PET scans, MRIs)	10% after deductible	30% after deductible	Cost sharing may vary based on where service is performed. Preauthorization may be required - if not obtained, penalty will be $75 Inpatient only.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** 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. Specialty Drugs are limited to Serve You DirectRX Specialty Pharmacy
	Preferred brand drugs (Tier 2)	$35.00 / 30 day supply $70.00 / 90 day supply	NA	
	Non-preferred brand drugs (Tier 3)	$60.00 / 30 day supply $120.00 / 90 day supply	NA	
	Specialty drugs (Tier 4)	10% - maximum $200 / 30 day supply	Not Covered	
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 True Emergency Non True Emergency	$200 copay/visit; deductible does not apply 10% after deductible	$200 copay/visit; deductible does not apply 30% after network deductible	Copayment waived if admitted.
	Emergency medical transportation	10% after deductible	30% after network 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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Therapy: $35 copay/visit; deductible does not apply Other outpatient non-surgical 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	Primary care visit: $35 copay / Specialist visit $45 copay/visit; deductible does not apply	30% after deductible	Cost-sharing does not apply for preventive care services.
	Childbirth/delivery professional services	10% after deductible	30% after deductible	Depending on the type of services, a copayment, 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. ultrasound).
If you need help recovering or have other special health needs	Home health care	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	Therapies: Physical, occupational, speech, cognitive and audiology therapy 15 visits per year. 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	Therapies: Physical, occupational, speech, cognitive and audiology therapy 15 visits per year. Preauthorization may be required - if not obtained, penalty will be $75 Inpatient only.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
	Skilled nursing care	10% after deductible	30% after deductible	60 days per admission. Preauthorization may be required - if not obtained, penalty will be $75 Inpatient only.
	Durable medical equipment	10% after deductible	30% after deductible	Preauthorization may be required - if not obtained, penalty will be $75 Inpatient only.
	Hospice services	10% after deductible	30% after deductible	Preauthorization may be required - if not obtained, penalty will be $75 Inpatient only.
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 prescribed by physician)
- Child dental check-up
- Child eye exam
- Child glasses
- Cosmetic Surgery, and if to correct functional impairment
- Hearing aids
- Infertility treatment
- Long term care
- Non-emergency care when traveling outside the U.S., when traveling outside the U.S. more than 6 consecutive months in a year
- Private duty nursing
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs
- Spinal Manipulations (pend for medical necessity after 15 visits)

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

- Bariatric surgery
- Manipulations
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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:

- www.humana.com or 866-4ASSIST (427-7478).
- For group health coverage subject to ERISA, you may also contact the Department of Labor's Employee Benefits Security Administration at 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 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. If the coverage is insured, individuals should contact their State insurance regulator regarding their possible rights to continuation coverage under State law.

Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 800-318-2596.

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 on how 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 262-653-2422.
- Department of Labor Employee Benefits Security Administration: 866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? **Yes**.
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet 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 866-4ASSIST (427-7478) (TTY: 711).

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 coinsurance	**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	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$500
Copayments	$0
Coinsurance	$1,200
What isn't covered	
Limits or exclusions	$20
The total Peg would pay is	**$1,720**

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 coinsurance	**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	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$100
Copayments	$400
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$500**

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 coinsurance	**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	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$500
Copayments	$700
Coinsurance	$80
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,280**

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