




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: \$2,400 Individual / \$4,800 Family. Non-network: \$4,800 Individual / \$9,600 Family. | Generally, you must pay all of the costs from <u>providers</u> up to the deductible amount before this <u>plan</u> begins to pay. If you have other family members on the policy, the overall family deductible must be met before the <u>plan</u> begins to pay. |
| Are there services covered before you meet your deductible? | Network Providers: Yes. <u>Preventive Care</u> , <u>Certain Office Visits</u> , <u>Emergency Room Care</u> , <u>Urgent Care</u> , <u>Prescription Drugs</u> and <u>Certain therapies</u> . Non-Network Providers: Yes. <u>Emergency Room Care</u> and <u>Prescription Drugs</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 care services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive care 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? | For <u>Network Providers</u> : \$3,400 Individual / \$6,800 Family. For <u>Non-network providers</u> : \$6,950 Individual / \$13,650 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> , the overall family <u>out-of-pocket limit</u> must be 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, penalties, <u>Non-network transplant</u> , <u>non-network prescription drugs</u> , <u>non-network specialty drugs</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 866-4ASSIST (427-7478) for a list of <u>network providers</u> . | This <u>plan</u> uses a <u>network provider</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-pocket limit provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> 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) | Non-Network Provider (You will pay the most) | |
| If you visit a health care <u>provider's</u> office or clinic | Primary care visit to treat an injury or illness | Primary care visit: No charge after <u>deductible</u> Virtual visit: No charge after <u>deductible</u> | 30% after <u>deductible</u> | Includes telehealth or telemedicine services. |
| | <u>Specialist</u> visit | No charge after <u>deductible</u> | 30% after <u>deductible</u> | Includes tele-mental health or telemedicine services. |
| | <u>Preventive care/screening/immunization</u> | No charge; <u>deductible</u> does not apply | 30% after <u>deductible</u> | You may have to pay for services that aren't <u>preventive care</u> . Ask your <u>provider</u> if the services needed are <u>preventive care</u> . Then check what your <u>plan</u> 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 | <u>Diagnostic test</u> (x-ray, blood work) | No charge after <u>deductible</u> | 30% after <u>deductible</u> | <u>Cost sharing</u> may vary based on where service is performed. |
| | Imaging (CT/PET scans, MRIs) | No charge after <u>deductible</u> | 30% after <u>deductible</u> | <u>Cost sharing</u> may vary based on where service is performed. <u>Preauthorization</u> 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 - after deductible \$24.00 / 90 day supply – after deductible | N/A | Prescription drug co-pays accumulate to the out-of-pocket maximum after your deductible has been met. Prescriptions are processed through Serve Your 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 – after deductible \$70.00 / 90 day supply – after deductible | N/A | |
| | Non-preferred brand drugs (Tier 3) | \$60.00 / 30 day supply– after deductible \$120.00 / 90 day supply– after deductible | N/A | |
| | Specialty Drugs | Retail Tiers apply – after deductible | Not covered | |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | No charge 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 | No charge after <u>deductible</u> | 30% after <u>deductible</u> | None |
| If you need immediate medical attention | <u>Emergency room care</u> <u>True Emergency</u> | No charge after <u>deductible</u> | No charge after <u>network deductible</u> | None |
| | <u>Non True Emergency</u> | No charge after <u>deductible</u> | 30% after <u>network deductible</u> | |
| | <u>Emergency medical transportation</u> | No charge after <u>deductible</u> | No charge after <u>network deductible</u> | None |
| | <u>Urgent care</u> | No charge after <u>deductible</u> | 30% after <u>deductible</u> | None |
| If you have a hospital stay | Facility fee (e.g., hospital room) | No charge after <u>deductible</u> | 30% after <u>deductible</u> | <u>Preauthorization</u> 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) | |
| | Physician/surgeon fees | No charge after <u>deductible</u> | 30% after <u>deductible</u> | None |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | Therapy: No charge after <u>deductible</u> Other outpatient non-surgical services: No charge after <u>deductible</u> | 30% after <u>deductible</u> | None |
| | Inpatient services | No charge 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 | <u>Primary care visit</u> : No charge after <u>deductible</u> | 30% after <u>deductible</u> | <u>Cost-sharing</u> does not apply for <u>preventive care</u> services. |
| | Childbirth/delivery professional services | No charge after <u>deductible</u> | 30% after <u>deductible</u> | Depending on the type of services, a <u>copayment</u> , <u>coinsurance</u> or <u>deductible</u> may apply. |

| 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) | |
| | Childbirth/delivery facility services | No charge after <u>deductible</u> | 30% after <u>deductible</u> | 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 | <u>Home health care</u> | No charge 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> | No charge after <u>deductible</u> | 30% after <u>deductible</u> | Therapies: Physical, occupational, speech, cognitive and audiology therapy 15 visits per year. <u>Preauthorization</u> may be required - if not obtained, penalty will be \$75 Inpatient only. |
| | <u>Habilitation services</u> | No charge after <u>deductible</u> | 30% after <u>deductible</u> | Therapies: Physical, occupational, speech, cognitive and audiology therapy 15 visits per year. <u>Preauthorization</u> may be required - if not obtained, penalty will be \$75 Inpatient only. |
| | <u>Skilled nursing care</u> | No charge after <u>deductible</u> | 30% after <u>deductible</u> | 180 days per admission. <u>Preauthorization</u> may be required - if not obtained, penalty will be \$75 Inpatient only. |
| | <u>Durable medical equipment</u> | No charge 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. |

| 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) | |
| | <u>Hospice services</u> | No charge 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 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 <u>Plan</u> Generally Does NOT Cover (Check your policy or <u>plan</u> document for more information and a list of any other <u>excluded services</u>.) | | |
|--|--|---|
| <ul style="list-style-type: none"> • Acupuncture (unless prescribed by physician) • Bariatric surgery • Child dental check-up • Child dental check-up • Child eye exam • Child glasses | <ul style="list-style-type: none"> • 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 | <ul style="list-style-type: none"> • Private duty nursing • Routine eye care (Adult) • Routine foot care • Weight loss programs |

| Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <u>plan</u> document.) | | |
|--|---|---|
| <ul style="list-style-type: none"> • Manipulations | • | • |

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 \$2,400
- Specialist coinsurance 0%
- Hospital (facility) coinsurance 0%
- Other coinsurance 0%

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:

| <i>Cost Sharing</i> | |
|-----------------------------------|----------------|
| <u>Deductibles</u> | \$2,400 |
| <u>Copayments</u> | \$0 |
| <u>Coinsurance</u> | \$0 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$20 |
| The total Peg would pay is | \$2,420 |

Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

- The plan's overall deductible \$2,400
- Specialist coinsurance 0%
- Hospital (facility) coinsurance 0%
- Other coinsurance 0%

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:

| <i>Cost Sharing</i> | |
|-----------------------------------|----------------|
| <u>Deductibles</u> | \$1,100 |
| <u>Copayments</u> | \$0 |
| <u>Coinsurance</u> | \$0 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$0 |
| The total Joe would pay is | \$1,100 |

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

- The plan's overall deductible 2,400
- Specialist coinsurance 0%
- Hospital (facility) coinsurance 0%
- Other coinsurance 0%

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:

| <i>Cost Sharing</i> | |
|-----------------------------------|----------------|
| <u>Deductibles</u> | \$2,400 |
| <u>Copayments</u> | \$0 |
| <u>Coinsurance</u> | \$0 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$0 |
| The total Mia would pay is | \$2,400 |

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