

# Vilas County Health Plan- \$2,000/\$4,000 Plan

Coverage Period: 01-01-2016 to 12-31-2016

Summary of Benefits and Coverage: What this Plan Covers & What it Costs Coverage for: Individuals & Families Plan Type: HSA

 **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 [www.auxiant.com](http://www.auxiant.com) or by calling **1-800-279-6772**.

Important Questions	Answers	Why this Matters:
<p><b>What is the overall deductible?</b></p>	<p>For Network: Individual <b>\$2,000</b> for Calendar Year / Family <b>\$4,000</b> for Calendar Year</p> <p>For Non-Network: Individual <b>\$2,000</b> for Calendar Year/ Family <b>\$4,000</b> for Calendar Year</p>	<p>You must pay all the costs up to the <i>deductible</i> amount before this plan begins to pay for covered services you use. The <i>deductible</i> starts over annually on January 1st. See the chart starting on page 3 for how much you pay for covered services after you meet the <i>deductible</i>. Network/Non Network Deductible cross-satisfy one another.</p> <p><i>Deductible</i> does not apply to Network Routine care. The entire family deductible must be met before benefits will be paid.</p>
<p><b>Are there other deductibles for specific services?</b></p>	<p>Covered Person <b>\$100</b> for Calendar Year for Dental Extraction.</p>	<p>Member will have to meet specific <i>deductible</i> for Dental Extraction before this plan starts to cover costs.</p>
<p><b>Is there an out-of-pocket limit on my expenses?</b></p>	<p>For Network: Individual <b>\$2,000</b> Per Calendar Year/ Family <b>\$4,000</b> per Calendar Year</p> <p>For Non-Network: Individual <b>\$2,400</b> per Calendar Year/ Family <b>\$4,400</b> per Calendar Year</p>	<p>The <i>out-of-pocket limit</i> 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. Network/Non Network Out-of-Pocket max do cross-satisfy one another.</p> <p>The deductible is included in the <i>out-of-pocket limit</i>. All <i>Out-of-pocket limit</i> costs are combined and shall not exceed the federal maximum of \$6,550 per Person and \$13,100 per Family per year.</p>

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<b>What is not included in the <i>out-of-pocket limit</i>?</b>	Ineligible Charges, cost containment penalties, and Amounts over the Usual & Customary.	Even though you pay these expenses, they don't count toward the <i>out-of-pocket limit</i> .
<b>Is there an overall annual limit on what the plan pays?</b>	No.	The chart starting on page 3 describes any limits on what the insurer will pay for specific covered services, such as office visits.
<b>Does this plan use a <i>network of providers</i>?</b>	Yes. Please contact your Employer for a list of these providers.	If you use an in-network doctor or other health care <i>provider</i> , 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 <i>provider</i> for some services. Plans use the term in-network, <i>preferred</i> , or participating for <i>providers</i> in their <i>network</i> . See the chart starting on page 3 for how this plan pays different kinds of <i>providers</i> .
<b>Do I need a referral to see a <i>specialist</i>?</b>	No, you do not need a referral to see a specialist.	You can see the specialist you choose without permission from this plan. If the specialist is not in your network, the coverage is at an out of network cost.
<b>Are there services this plan doesn't cover?</b>	Yes.	Some of the services this plan doesn't cover are listed on page 11. See your plan document for additional information about excluded services under <i>General Limitations</i> .

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- **Co-payments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
  - **Co-insurance** 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 **co-insurance** 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 network **providers** by charging you lower **deductibles**, **co-payments** and **co-insurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use an		Limitations & Exceptions
		In-network Provider	Out-of-network Provider	
<b>If you visit a health care provider's office or clinic</b>	Primary care visit to treat an injury or illness	Deductible then 0% coinsurance	Deductible then 20% coinsurance	_____none_____
	Specialist visit	Deductible then 0% coinsurance	Deductible then 20% coinsurance	_____none_____
	Other practitioner office visit  Includes: Chiropractic, Chemo/Radiation therapy, Cardiac Rehab therapy, Hemodialysis, Home Infusion therapy, Occupational therapy, Physical therapy, and Speech therapy.	Deductible then 0% coinsurance	Deductible then 20% coinsurance	Chemo/Radiation – Pre-authorization is required.  Cardiac Rehab– Only Phase I & II are covered.  Dialysis is limited to \$10,000 maximum per month; begins the first month of treatment for Home treatment and begins the fourth month of treatment for Outpatient treatment.

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		In-network Provider	Out-of-network Provider	
	Preventive care Includes: Routine Well Care, Routine exams, X-rays, All other lab tests, Smoking cessation counseling/office visits, immunizations, Mammograms, Pap Smear, Prostate/colon screening, and routine hearing exam	0% coinsurance and no deductible	Deductible then 30% coinsurance	<p>The following are limited to 1 exam per calendar year: Well Woman Exam; Mammograms (regardless of diagnosis); Routine mammogram for ages 40 and older; Pap Smear; prostate screening; fecal blood test; &amp; Routine lab test.</p> <p>Well Child Blood Lead Tests limited to age 6.</p> <p>Lab tests performed on the same day as the routine exam will be paid at 100% deductible waived when billed with an illness diagnosis for the initial type of test per Calendar Year. After the initial test, any remaining tests of the same type when billed with an illness diagnosis will be paid as any other illness lab procedure.</p>
	Preventive Care: Routine Surgeries (colonoscopy, etc.)	0% coinsurance and no deductible	Deductible then 30% coinsurance	<p>Colonoscopies are limited to 1 every 2 years for ages 50 and older.</p> <p>When services are performed at a Preferred Plus Provider, employee will be eligible for reimbursement to a level determined by the Plan Sponsor. Preferred Plus Providers are those identified as providing the best overall hospital value – as measured by FocusHealth cost and quality.</p>

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		In-network Provider	Out-of-network Provider	
	Preventive care – Routine Vision Exam	0% coinsurance and no deductible	Deductible then 30% coinsurance	Exams for Ages 5 and older are limited to one exam per 24 months.
<b>If you have a test</b>	Diagnostic test (x-ray, blood work)	Deductible then 0% coinsurance	Deductible then 20% coinsurance	_____none_____
	Imaging (CT/PET scans, MRIs)	Deductible then 0% coinsurance	Deductible then 20% coinsurance	_____none_____

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Common Medical Event	Services You May Need	Your cost if you use an		Limitations & Exceptions
		In-network Provider	Out-of-network Provider	
<p><b>If you need drugs to treat your illness or condition</b></p> <p>More information about <b>prescription drug coverage</b> is available at <a href="http://www.serve-you-rx.com/">www.serve-you-rx.com/</a></p>	Generic drugs	Deductible then 0% coinsurance (Retail and Mail order)	N/A	<p>Prescription costs shall not exceed the federal maximum of \$6,550 per Person and \$13,100 per Family per year.</p> <p>No co-pay for tobacco cessation medications (includes both prescription and over the counter medications) up to 90-day treatment; two smoking cessation attempts are allowed per year.</p>
	Preferred Brand Name drugs	Deductible then 0% coinsurance (Retail and Mail order)	N/A	<p>Covers up to a 34-day supply (retail); 90-day supply (mail order prescription)</p>
	Non-formulary drugs	Deductible then 0% coinsurance (Retail and Mail order)	N/A	<p>Aspirin, Generic only and OTC requires a prescription (Men age 45 to 79 and Women age 55 to 79), Folic acid, Generic only and OTC requires a prescription (Women to age 55), Iron supplements, OTC requires a prescription (Children age 6 to 12 months), Oral fluoride pills (Children 6 months to 6 years), and Erythromycin ophthalmic ointment (Newborn 0 to 3 months)</p> <p>No co-pay for generic women's contraceptives.</p>

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		In-network Provider	Out-of-network Provider	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	Deductible then 0% coinsurance	Deductible then 20% coinsurance	When services are performed at a Preferred Plus Provider, employee will be eligible for reimbursement to a level determined by the Plan Sponsor. Preferred Plus Providers are those identified as providing the best overall hospital value – as measured by FocusHealth cost and quality.
	Physician/surgeon fees	Deductible then 0% coinsurance	Deductible then 20% coinsurance	_____none_____
<b>If you need immediate medical attention</b>	Emergency room services	Deductible then 0% coinsurance	Paid at Network level	_____none_____
	Emergency medical transportation	Deductible then 0% coinsurance	Paid at Network level	_____none_____
	Urgent Care Room – Hospital Billed	Deductible then 0% coinsurance	Deductible then 20% coinsurance	_____none_____
	Urgent Care Clinic – Free-standing Facility	Deductible then 0% coinsurance	Deductible then 20% coinsurance	_____none_____

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		In-network Provider	Out-of-network Provider	
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	Deductible then 0% coinsurance	Deductible then 20% coinsurance	When services are performed at a Preferred Plus Provider, employee will be eligible for reimbursement to a level determined by the Plan Sponsor. Preferred Plus Providers are those identified as providing the best overall hospital value – as measured by FocusHealth cost and quality.
	Physician/surgeon fee	Deductible then 0% coinsurance	Deductible then 20% coinsurance	—————none—————

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		In-network Provider	Out-of-network Provider	
<b>If you have mental health, behavioral health, or substance abuse needs</b>	Mental/Behavioral health outpatient services	Deductible then 0% coinsurance	Deductible then 20% coinsurance	Emergency Room, Urgent Care, Office evaluation & management, Office counseling fees, and Lab/ X-ray fees are paid same as any other illness.
	Mental/Behavioral health inpatient services	Deductible then 0% coinsurance	Deductible then 20% coinsurance	When services are performed at a Preferred Plus Provider, employee will be eligible for reimbursement to a level determined by the Plan Sponsor. Preferred Plus Providers are those identified as providing the best overall hospital value – as measured by FocusHealth cost and quality.
	Substance use disorder outpatient services	Deductible then 0% coinsurance	Deductible then 20% coinsurance	Emergency Room, Urgent Care, Office evaluation & management, Office counseling fees, and Lab/ X-ray fees are paid same as any other illness.
	Substance use disorder inpatient services	Deductible then 0% coinsurance	Deductible then 20% coinsurance	When services are performed at a Preferred Plus Provider, employee will be eligible for reimbursement to a level determined by the Plan Sponsor. Preferred Plus Providers are those identified as providing the best overall hospital value – as measured by FocusHealth cost and quality.

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		In-network Provider	Out-of-network Provider	
<b>If you are pregnant</b>	Prenatal and postnatal care	Paid as any other Sickness	Paid as any other Sickness	Home births are not covered.
	Delivery and all inpatient services	Paid as any other Sickness	Paid as any other Sickness	Home births are not covered.
<b>If you need help recovering or have other special health needs</b>	Home health care	Deductible then 0% coinsurance	Deductible then 20% coinsurance	Limited to 40 visits per year.
	Rehabilitation services	Deductible then 0% coinsurance	Deductible then 20% coinsurance	_____none_____
	Habilitation services	Not Covered	Not Covered	_____none_____
	Skilled nursing care	Deductible then 0% coinsurance	Deductible then 20% coinsurance	Limited to 60 days maximum per confinement.
	Durable medical equipment	Deductible then 0% coinsurance	Deductible then 20% coinsurance	_____none_____
	Hospice service	Deductible then 0% coinsurance	Deductible then 20% coinsurance	_____none_____
<b>If your child needs eye care</b>	Eye exam	Same as Preventive Care Benefits	Same as Preventive Care Benefits	Routine Vision exams are covered under the Preventive Care benefits.
	Glasses	Not Covered	Not Covered	Only charges for initial contact lenses or eyeglasses following cataract surgery are covered.
	Dental check-up	Not Covered	Not Covered	_____none_____

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## 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 <i>excluded services</i> .)		
<ul style="list-style-type: none"><li>• Acupuncture</li><li>• Dental Care (Adult)</li><li>• Infertility treatment</li></ul>	<ul style="list-style-type: none"><li>• Long-term Care</li><li>• Non-Emergency Care When Traveling outside the U.S.</li></ul>	<ul style="list-style-type: none"><li>• Private-duty nursing</li><li>• Routine foot care</li></ul>
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.)		
<ul style="list-style-type: none"><li>• Bariatric Surgery</li><li>• Chiropractic care</li></ul>	<ul style="list-style-type: none"><li>• Cosmetic surgery to repair defect caused by an Accidental Injury or congenital anomaly.</li></ul>	<ul style="list-style-type: none"><li>• Hearing Aids</li><li>• Routine eye care (adult)</li><li>• Weight loss Programs</li></ul>

## Your Rights to Continue Coverage:

You can keep this coverage as long as you pay your premium, unless one of the following things happen:

- You commit fraud or misrepresentations of a material fact
- The plan sponsor terminates this plan
- Your employment terminates and you are not eligible to continue coverage under COBRA or state law.

## 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: the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). You can also contact Auxiant at 2450 Rimrock Road, Ste 301, Madison, WI 53713.

## 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 age.—————

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## About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



**This is not a cost estimator.**

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

### Having a baby (normal delivery)

- Amount owed to providers: \$7,444
- Plan pays \$5,944
- Patient pays \$2,000

#### Sample care costs:

Hospital charges (mother)	\$2,672
Routine obstetric care	\$2,084
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$527
Prescriptions	\$150
Radiology	\$176
Vaccines, other preventive	\$35
<b>Total</b>	<b>\$7,444</b>

#### Patient pays:

Deductibles	\$2,000
Co-pays	\$0
Co-insurance	\$0
Limits or exclusions	\$0
<b>Total</b>	<b>\$2,000</b>

### Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- Amount owed to providers: \$5,418
- Plan pays \$2,894
- Patient pays \$2,524

#### Sample care costs:

Prescriptions	\$2,849
Medical Equipment and Supplies	\$1,279
Office Visits and Procedures	\$852
Education	\$161
Laboratory tests	\$137
Vaccines, other preventive	\$140
<b>Total</b>	<b>\$5,418</b>

#### Patient pays:

Deductibles	\$2,000
Co-pays	\$0
Co-insurance	\$0
Limits or exclusions	\$524
<b>Total</b>	<b>\$2,524</b>

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## Questions and answers about the Coverage Examples:

### 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**, **co-payments**, and **co-insurance** 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 **co-payments**, **deductibles**, and **co-insurance**. 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.

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