



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.healthtradition.com or by calling 1-877-832-1823.

Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u> ?	\$ 5,000 person / \$10,000 family Doesn't apply to preventative care or prescription drugs.	You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the deductible starts over (usually, but not always, January 1 st). See the chart starting on page 2 for how much you pay for covered services after you meet the deductible .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an <u>out-of-pocket limit</u> on my expenses?	Yes. \$5,500 person / \$11,000 family.	The out-of-pocket limit 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.
What is not included in the <u>out-of-pocket limit</u> ?	Premiums, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit .
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for <i>specific</i> covered services, such as office visits.
Does this plan use a <u>network of providers</u> ?	Yes. See www.healthtradition.com or call 1-877-832-1823 for a list of in-network providers.	If you use an in-network doctor or other health care provider , 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 provider for some services. Plans use the term in-network, preferred , or participating for providers in their network . See the chart starting on page 2 for how this plan pays different kinds of providers .
Do I need a referral to see a <u>specialist</u> ?	No and Yes.	You can see the in-network specialist you choose without permission from this plan. This plan will pay some or all of the costs to see an out-of-network specialist for covered services but only if you have the plan's written permission before you see the specialist .
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 4. See your policy or plan document for additional information about excluded services .

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- **Copayments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** 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 **coinsurance** 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 in-network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If		Limitations & Exceptions
		You Use an In-network Provider	You Use an Out-of-network Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% coinsurance	Not covered.	----- none -----
	Specialist visit	20% coinsurance	Not covered.	----- none -----
	Other practitioner office visit	20% coinsurance for chiropractor	Not covered.	----- none -----
	Preventive care/screening/immunization	No charge.	Not covered.	Deductible does not apply.
	Diagnostic test (x-ray, blood work)	20% coinsurance	Not covered.	----- none -----
If you have a test	Imaging (CT/PET scans, MRIs)	20% coinsurance	Not covered.	Prior authorization is required.
	Generic Formulary drugs	\$15 copay/34 day supply	Not covered.	Deductible does not apply. Generic drugs required when available.
	Brand Formulary drugs	\$30 copay/34 day supply	Not covered.	Deductible does not apply. Penalty applied if brand is chosen when generic is available.
If you need drugs to treat your illness or condition	Non-Formulary drugs	\$50 copay / 34 day supply	Not covered.	Deductible does not apply.
	Specialty and Self-administered injectable drugs	20% coinsurance	Not covered.	Deductible does not apply. Specialty drugs must be purchased at a Wisconsin Mayo Clinic Health System pharmacy.
	More information about prescription drug coverage is available at www.healthtradition.com			

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Health Tradition Health Plan: Jackson County – Plan B – L246 Coverage Period: 01/01/2016–12/31/2016
Summary of Benefits and Coverage: What this Plan Covers & What it Costs Coverage for: Individual & Family | Plan Type: HMO

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
	Diabetic supplies	\$10 copay/ 50 test strips, 100 syringes or 200 lancets	Not covered.	Deductible does not apply.
	Diabetic drugs	\$15 copay/ 2 vials of Formulary insulin; \$30 copay/ 2 vials of Non-Formulary insulin	Not covered.	Deductible does not apply.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center) Physician/surgeon fees	20% coinsurance 20% coinsurance	Not covered. Not covered.	none none
If you need immediate medical attention	Emergency room services Emergency medical transportation Urgent care	\$100 copay/visit and 20% coinsurance 20% coinsurance 20% coinsurance	\$100 copay/visit and 20% coinsurance 20% coinsurance 20% coinsurance	No copay if admitted to hospital within 24 hours. Notify plan within 48 hours or as soon as medically possible. none none
If you have a hospital stay	Facility fee (e.g., hospital room) Physician/surgeon fee	20% coinsurance 20% coinsurance	Not covered. Not covered.	Prior authorization is required. none
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services Mental/Behavioral health inpatient services Substance use disorder outpatient services	20% coinsurance 20% coinsurance 20% coinsurance	Not covered. Not covered. Not covered.	Prior authorization required for some services. Prior authorization is required. Prior authorization required for some services.
If you are pregnant	Substance use disorder inpatient services Prenatal and postnatal care Delivery and all inpatient services	20% coinsurance 20% coinsurance 20% coinsurance	Not covered. Not covered. Not covered.	Prior authorization is required. none none

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Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	20% coinsurance	Not covered.	Prior authorization is required. 60 visits per member per year.
	Rehabilitation services	20% coinsurance	Not covered.	Maximum 60 visits per year.
	Habilitation services	20% coinsurance	Not covered.	Prior authorization is required.
	Skilled nursing care	20% coinsurance	Not covered.	Prior authorization is required. 60 days per member per illness.
	Durable medical equipment	20% coinsurance	Not covered.	Prior authorization is required for all items over \$750 and some items under \$750.
If your child needs dental or eye care	Hospice service	20% coinsurance	Not covered.	Prior authorization is required.
	Eye exam	No charge.	Not covered.	One exam per member per year.
	Glasses	20% coinsurance	Not covered.	Limited to one pair of glasses per year
	Dental check-up	Not covered.	Not covered.	Oral health assessment only.

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 excluded services.)

<ul style="list-style-type: none"> • Acupuncture • Bariatric surgery • Cosmetic surgery • Dental care (Adult and Child) 	<ul style="list-style-type: none"> • Infertility treatment (except for medical cause to restore function) • Long-term care • Non-emergency care when traveling outside the US 	<ul style="list-style-type: none"> • Private duty nursing • Routine eye care (glasses) - Adult • Routine foot care • Weight loss programs (except nutritional counseling)
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This policy does not include pediatric dental services as required under the federal Patient Protection and Affordable Care Act. This coverage is available in the insurance market and can be purchased as a stand-alone product. Please contact your insurance carrier, agent, or the Federally Facilitated Exchange if you wish to purchase pediatric dental coverage or a stand-alone dental services product.

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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.)

- Chiropractic care
- Routine eye care (exam)

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-877-832-1823. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323x61565 or www.cchio.cms.gov.

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: Customer Service at 1-877-832-1823. You may also contact your state insurance department at 1-800-236-8517 or www.oai.wi.gov or the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform.

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.**

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Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-877-832-1823.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-877-832-1823.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码1-877-832-1823.

Navajo (Dine): Dinek'ehgo shika at'ohwol minisingo, kwijijigo holne' 1-877-832-1823.

_____ *To see examples of how this plan might cover costs for a sample medical situation, see the next page.* _____

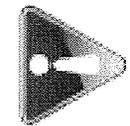
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About these Coverage Examples:

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: \$7,540
- Plan pays \$1,290
- Patient pays \$ 6,250

Sample care costs:

Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
Total	\$7,540

Patient pays:

Deductibles	\$5,900
Copays	\$70
Coinsurance	\$280
Limits or exclusions	\$0
Total	\$6,250

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

- Amount owed to providers: \$5,400
- Plan pays \$2,565
- Patient pays \$ 2,835

Sample care costs:

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
Total	\$5,400

Patient pays:

Deductibles	\$2,400
Copays	\$435
Coinsurance	\$0
Limits or exclusions	\$0
Total	\$2,835

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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**, **copayments**, and **coinsurance** 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 **copayments**, **deductibles**, and **coinsurance**. 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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