WALWORTH COUNTY
HEALTH PLAN
TIER 2

Amendment #2

Effective January 1, 2016, the Walworth County Health Plan established January 1, 2012, and restated on January 1, 2014 and June 1, 2014, and last amended October 27, 2014 shall be amended as described herein.

*With regards to the **SCHEDULE OF BENEFITS** section on page 13 of this Master Plan Document, the section **prior to the Schedule of Benefits** shall be deleted in its entirety and replaced with the following:*

The Plan utilizes a Preferred Provider Organization (PPO) that, through negotiation, offers discounts for using the preferred providers for medical care. If the Covered Person utilizes the PPO providers for eligible services, the Covered Person will receive the in-network benefit listed below. To obtain a list of the preferred providers, please reference the information provided on the ID card.

Note: If Participants elect to use designated Preferred Plus Providers, the Plan Sponsor may offer incentives for use of FocusHealth providers for applicable services where available. Preferred Plus Providers are those identified as providing the best overall hospital value as measured by FocusHealth Transparency cost and quality. Please contact the Plan Sponsor for additional detail.

Note: If the Participant elects to use diagnostic imaging services through a list of select providers identified by the County, the Plan Sponsor may offer an incentive for applicable services. Please contact the Plan Sponsor for additional detail.

ALL services under the PPO Plan must be provided by participating providers to be covered at the Network benefit level. Services received elsewhere will be paid at the Non-Network level. If any of the following circumstances apply, benefits will be payable at the Network level, however, Usual, Reasonable and Customary will not apply to those Non-Network fees:

- *Charges for pathologist, independent lab, Emergency room Physicians, anesthesiologist, or radiologist when services are provided at a Network facility or referred by a Network provider, even when the provider is a Non-Network Provider.*
- *If Emergency Services are received from a Non-Network Hospital, qualified treatment facility, or qualified practitioner, all covered expenses are payable under the Network Provider level of benefits.*
- *If the Covered Person has no choice of Network Providers in the specialty that the Covered Person is seeking for Preventive Care services within the Network service area.*

Claims Audit

In addition to the Plan's Medical Record Review process, the *Plan Administrator* may use its discretionary authority to utilize an independent bill review and/or claim audit program or service for a complete claim. While every claim may not be subject to a bill review or audit, the *Plan*

Administrator has the sole discretionary authority for selection of claims subject to review or audit.
The analysis will be employed to identify charges billed in error and/or charges that are not *Usual, Reasonable and Customary* and/or *Medically Necessary* and *Reasonable*, if any, and may include a patient medical billing records review and/or audit of the patient's medical charts and records.

Upon completion of an analysis, a report will be submitted to the *Plan Administrator* or its agent to identify the charges deemed in excess of the *Usual, Reasonable and Customary* and *Reasonable* amounts or other applicable provisions, as outlined in this Plan Document.

Despite the existence of any agreement to the contrary, the *Plan Administrator* has the discretionary authority to reduce any charge to a *Usual, Reasonable and Customary* and *Reasonable* charge, in accord with the terms of this Plan Document.

Medical Record Review
The process by which the Plan, based upon a Medical Record Review and audit, determines that a different treatment or different quantity of a drug or supply was provided which is not supported in the billing, then the *Plan Administrator* may determine the ***Maximum Allowable Charge*** according to the Medical Record Review and audit results.

With regards to the ***SCHEDULE OF BENEFITS*** *section on pages 14-20 of this Master Plan Document,* ***Deductible and Maximum Out-of-Pocket Amount*** *sections shall be deleted in their entirety and replaced with the following:*

DEDUCTIBLE, **PER *CALENDAR YEAR***		
Per *Plan Participant*	$1,500	$3,000
Per *Family Unit*	$3,000	$6,000
Members of family plans must satisfy the entire family deductible before any one member has benefits paid.		
The *Deductible* does not apply to: • Pre-admission Testing; • Health Risk Management; and • Network Routine services.		
MAXIMUM OUT-OF-POCKET AMOUNT, PER *CALENDAR YEAR*		
The Out-of-Pocket is the *Maximum Amount* paid by the *Plan Participant* in the *Calendar Year*. Charges noted below as not applying to the Out-of-Pocket do not calculate toward the Out-of-Pocket amount.		
For *Deductible/Coinsurance*		
Per *Plan Participant*	$2,000	$4,500
Per *Family Unit*	$4,000	$9,000
Members of family plans must satisfy the entire family deductible/coinsurance Out-of-Pocket before any one member has benefits paid.		
For Prescription *Co-payments*		
Per *Plan Participant*	$2,550	Unlimited
Per *Family Unit*	$5,100	Unlimited

Members in a family plan only required to satisfy the Per Covered Person **Prescription** *Co-payments Out-of-Pocket before benefits will pay.*
The Plan will pay the designated percentage of Covered Charges until out-of-pocket amounts are reached, at which time the Plan will pay 100% of the remainder of Covered Charges for the rest of the *Calendar Year* unless stated otherwise.
The following charges do not apply toward the out-of-pocket maximum and are never paid at 100%: • Ineligible charges; and • Amounts over the *Usual, Reasonable & Customary*, • Prescription Drug copays (after the deductible has been met).

With regards to the ***SCHEDULE OF BENEFITS*** *section on pages 14-20 of this Master Plan Document,* ***Diagnostic Lab/X-ray Office & Diagnostic X-Ray Office Radiologist Fees*** *shall be deleted in their entirety and replaced with the following:*

	NETWORK PROVIDERS % of Network negotiated fee	**NON-NETWORK PROVIDERS % of Usual & Customary**
Diagnostic Lab/X-ray Office	90% after *Deductible*	70% after *Deductible*
Diagnostic X-ray Office Radiologist Fees	90% after *Deductible*	70% after *Deductible*
Please contact the Plan Sponsor for information on applicable incentives for services through diagnostic imaging services through a list of select providers identified by the County.		

With regards to the ***SCHEDULE OF BENEFITS*** *section on pages 14-20 of this Master Plan Document,* ***Lactation Counseling Services*** *shall be added as follows:*

	NETWORK PROVIDERS % of Network negotiated fee	**NON-NETWORK PROVIDERS % of Usual & Customary**
Lactation Counseling Services	100% *Deductible* waived	70% after *Deductible*

*With regards to the **SCHEDULE OF BENEFITS** section on pages 14-20 of this Master Plan Document, **Preventive Care Routine Well-Care** shall be deleted in its entirety and replaced with the following:*

	NETWORK PROVIDERS % of Network negotiated fee	**NON-NETWORK PROVIDERS % of Usual & Customary**
Preventive Care Routine *Well-Care* The following are considered routine: Mammograms: Ages 0-39 – one (1) baseline exam only if family history in immediate family Ages 40+ - one (1) per *Calendar Year* OB/GYN exam – one (1) per *Calendar Year* Prostate exam – one (1) per *Calendar Year* Routine surgeries (colonoscopy) – one (1) baseline exam at age 50 and then one (1) exam per five (5) years EKG – one (1) baseline for age 18+. Other EKGs covered when *Medically Necessary.* Well Child Care exams through age six (6) – no visit limit Routine exams ages seven (7) and older – one (1) per *Calendar Year* Routine vision exam to age (5) Mental Health screening – one (1) per *Calendar Year* Smoking cessation – office visits/counseling fees Fecal Occult Blood Test – one (1) per *Calendar Year* for ages 50+ Pap Smear Immunizations – limited to those approved by the Centers for Disease Control and Prevention Lab/x-rays Well Child blood lead tests to age six (6)	100% *Deductible* waived	70% after *Deductible*

With regards to the ***SCHEDULE OF BENEFITS*** *section on pages 14-20 of this Master Plan Document,* ***Psychiatric Care - Diagnostic Lab/X-ray Office and Diagnostic Lab & X-ray other than Office*** *shall be deleted in their entirety and replaced with the following:*

	NETWORK PROVIDERS % of Network negotiated fee	**NON-NETWORK PROVIDERS % of Usual & Customary**
Diagnostic Lab & X-ray-Office	90% after *Deductible*	70% after *Deductible*
Diagnostic Lab & X-ray-other than office	90% after *Deductible*	70% after *Deductible*
Please contact the Plan Sponsor for information on applicable incentives for services through diagnostic imaging services through a list of select providers identified by the County.		

With regards to the ***ELIGIBILITY*** *section on pages 25-30 of this Master Plan Document,* ***Eligibility*** *shall be deleted in its entirety and replaced with the following:*

ELIGIBILITY: The following *Employees* will be eligible for coverage under the Plan.

- Full-time, Active *Employees*: *Employees* designated by the Walworth County as Full-time, Active *Employees*. Coverage for Regular Full-time *Employees*, if properly elected, will be effective following any applicable waiting period.

- Variable Hour (Non seasonal) *Employees:* Any other *Employees*, who have qualified for coverage through a measurement period as defined by the *Employer* as Full-time, Active *Employees* for a stability period after completing a measurement period for determining Eligibility.

  Part time *Employees* who are determined to not be considered "full time" at the completion of a measurement period will not be eligible during the subsequent stability period. Seasonal *Employees* are not eligible for coverage.

With regards to the ***ELIGIBILITY*** *section on pages 25-30 on this Master Plan Document,* ***Break in Service and Reinstatement of Employees (Returning to Service)*** *shall be added as follows:*

Break in Service and Reinstatement of Employees (Returning to Service)

If an *Employee* incurs a break in service from the employer of at least 13 consecutive weeks, they will be required to meet Eligibility requirements (including any waiting period applicable to their positon) as if they were a new *Employee*.

However, if the break in service is more than 4 weeks, but less than 13 weeks, the *Employee* will be treated as a new *Employee* as long as the break in service period was longer than the length of their actual service period before the break in service was incurred.

The length of the *Employee's* credited service period with the employer immediately preceding a break in service is determined after application of any applicable rules of *Special Unpaid Leave* as defined in this Plan.

For purposes of applying this provision, the duration of the employee's credited service with the employer immediately preceding a period during which an *Employee* was not credited with *Hours of Service* is determined after application of any applicable rules of *Special Unpaid Leave* as defined in this Plan.

*With regards to the **COVERED EXPENSES** section on pages 40-49 of this Master Plan Document, **9. Breast Feeding** shall be deleted in its entirety and replaced with the following:*

9. Charges for **breast feeding** supplies, as well as basic lactation counseling and general interventions to support and promote breast feeding are covered under the routine benefit. Lactation counseling shall be covered by any provider acting within the scope of his or her license or certification. Breast pumps will be eligible for coverage of one (1) per Calendar Year.

*With regards to the **COVERED EXPENSES** section on pages 40-49 of this Master Plan Document, **17. Colonoscopies** shall be added as follows and all following items renumbered sequentially:*

17. Charges for routine **colonoscopies** shall be covered under the routine benefit, including any associated consultation completed prior to the schedule colonoscopy as well as any subsequent polyp removal. Diagnostic colonoscopies shall be covered the same as any other illness.

*With regards to the **GENERAL LIMITATIONS** section on pages 50-57 of this Master Plan Document, **22. Genetic testing** shall be deleted in its entirety and replaced with the following:*

22. **Genetic testing.** For genetic testing, including, but not limited to tests which use DNA to determine the presence of a genetic disease or disorder. However, charges for genetic counseling and evaluation related to **breast cancer susceptibility will be covered** according to the A and B level recommendations by the US Preventive Task Force.

*With regards to the **GENERAL LIMITATIONS** section on pages 50-57 of this Master Plan Document, **53.Obesity** shall be deleted in its entirety and replaced with the following:*

53. **Obesity.** Services for weight loss or control unless for diagnosed *Morbid Obesity*. For diagnosed *Morbid Obesity*, surgical treatment is limited to one (1) surgical procedure per *Lifetime*. Charges for obesity screening/counseling shall be covered under the routine benefit.

*With regards to the **DEFINITIONS** section on pages 82-100 of this Master Plan Document, **Hour of Service** shall be inserted alphabetically as follows:*

HOUR OF SERVICE
Means (1) each hour for which an Employee is paid, or entitled to payment, for the performance of duties for the Employer, and (2) each hour for which an Employee is paid, or entitled to payment, by the Employer for a period of time during which no duties are performed due to vacation, holiday, illness, incapacity (including disability), layoff, jury duty, military duty, or leave of absence (as defined in 29 CFR §2530.200b-2(a)). The term "*Hour of Service*" does not include any hour for services to the extent the compensation for those services constitutes income from sources without the United States, within the meaning of Code §§861 through 863 and the regulations thereunder. An *Hour of Service* for one organization is treated as an *Hour of Service* for all other organizations that are part of the same Controlled or Affiliated Group for all periods during which those organizations are part of the same Controlled or Affiliated Group. *Hours of Service* for all Employees are credited using actual *Hours of Service* from records of hours worked and hours for which payment is made or due.

*With regards to the **DEFINITIONS** section on pages 82-100 of this Master Plan Document, **Special Unpaid Leave** shall be inserted alphabetically as follows:*

SPECIAL UNPAID LEAVE
Means unpaid leave that is subject to FMLA, subject to USERRA, County Leave, or on account of jury duty.

IN WITNESS WHEREOF, **Walworth County** has caused this Amendment to take effect, be attached to and form a part of its Health Plan.

April 14, 2016
Date Signed

Dale W, HR Director
Authorized Signature & Title

Elkhorn, WI
Location

Witness
David A Bretl
Corporation Counsel