network health

2020 PRESTIGE BRONZE ESSENTIAL **Coverage Period: 01/01/2020–12/31/2020**

Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage for:** Individual or Individual + Family | **Plan Type:** HMO

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, call 1-855-275-1400 or visit https://networkhealth.com/__assets/pdf/individual-benefits-2020/individualpolicy.pdf. 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 www.cms.gov/CCIIO/Resources/Files/Downloads/uniform-glossary-final.pdf or call 1-855-275-1400 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$7,200** per Member / **$14,400** per 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?	Yes. Preventive care, office visits, and drugs are covered before you meet your deductible. See the specific services listed below denoted 'Deductible does not apply'.	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 services without cost sharing and before you meet your deductible. See a list of covered preventive 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 **$8,150** per Member / **$16,300** per Family.	The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the costs of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Non-covered services, denied benefits, and the benefit reduction amount when prior authorization is not obtained.	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.networkhealth.com or call Network Health Customer Service at 1-855-275-1400 for a listing of participating providers.	This plan uses a provider network. 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-network 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.

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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)	Out-of-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	$40 Copayment per visit; Deductible does not apply.	Not Covered	First three visits covered at No Charge: combined with behavioral health, substance abuse, and maternity office visits; Deductible does not apply.
	Specialist visit	$100 Copayment per visit; Deductible does not apply.	Not Covered	----------None----------
	Preventive care/screening/ immunization	No Charge	Not Covered	----------None----------
If you have a test	Diagnostic test (x-ray, blood work)	$40 Copayment per Lab procedure; Deductible does not apply and $60 Copayment per X-Ray procedure.	Not Covered	----------None----------
	Imaging (CT/PET scans, MRIs)	50% Coinsurance per procedure	Not Covered	----------None----------
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at networkhealth.com/__assets/pdf/individual-benefits-2020/individualpolicy.pdf	Generic drugs (Tier 1)	$20 Copayment per Rx or refill retail or $55 Copayment per Rx or refill mail order; Deductible does not apply.	Not Covered	Certain generics are available for a $0 Retail Copayment or a $0 Mail Order Copayment. Refer to your formulary. Covers up to a 30-day supply (retail prescription); 30-90 day supply (mail order prescription)
	Preferred brand drugs (Tier 2)	$80 Copayment per Rx or refill retail $225 Copayment per Rx or refill mail order; Deductible does not apply.	Not Covered	Covers up to a 30-day supply (retail prescription); 30-90 day supply (mail order prescription)
	Non-preferred brand drugs (Tier 3)	35% Coinsurance per Rx or refill retail or 35% Coinsurance per Rx or refill mail order	Not Covered	Covers up to a 30-day supply (retail prescription); 30-90 day supply (mail order prescription)
	Preferred Specialty drugs (Tier 4)	35% Coinsurance per Rx or refill at specialty pharmacy.	Not Covered	Covers up to a 30-day supply (specialty pharmacy); No mail order
	Non-preferred Specialty drugs (Tier 5)	50% Coinsurance per Rx or refill at specialty pharmacy.	Not Covered	Covers up to a 30-day supply (specialty pharmacy); No mail order

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	50% Coinsurance	Not Covered	----------None----------
	Physician/surgeon fees	50% Coinsurance	Not Covered	----------None----------
If you need immediate medical attention	Emergency room care	$500 Copayment per visit.	$500 Copayment per visit.	Copayment waived if admitted within 24 hours
	Emergency medical transportation	$350 Copayment per transport; Deductible does not apply.	$350 Copayment per transport; Deductible does not apply.	----------None----------
	Urgent care	$80 Copayment per visit	$80 Copayment per visit	Out-of-Network Services are covered only when Outside the Service Area and only when furnished by a Hospital-based Facility.
If you have a hospital stay	Facility fee (e.g., hospital room)	50% Coinsurance	Not Covered	Preauthorization is required.
	Physician/surgeon fees	50% Coinsurance	Not Covered	----------None----------
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$40 Copayment per office visit; Deductible does not apply and 50% Coinsurance other outpatient services	Not Covered	First three visits covered at No Charge: combined with primary care and maternity office visits.
	Inpatient services	50% Coinsurance	Not Covered	----------None----------
If you are pregnant	Office visits	$40 Copayment per visit; Deductible does not apply.	Not Covered	First three visits covered at No Charge: combined with behavioral health, substance abuse, and primary care office visits.
	Childbirth/delivery professional services	50% Coinsurance	Not Covered	Cost sharing does not apply to certain preventive services. Maternity care may include tests and services described elsewhere in the SBC.
	Childbirth/delivery facility services	50% Coinsurance	Not Covered	----------None----------

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	50% Coinsurance	Not Covered	Limited to 60 visits per benefit year; Preauthorization is required.
	Rehabilitation services	50% Coinsurance	Not Covered	Limited to 20 visits each per benefit year for Physical/Occupational/Speech/Pulmonary Therapy; Cardiac Rehab is limited to 36 visits per benefit year.
	Habilitation services	50% Coinsurance	Not Covered	Limited to 20 visits each per benefit year for Physical, Occupation, and Speech Therapy
	Skilled nursing care	50% Coinsurance	Not Covered	Limited to 30 days per benefit year; Preauthorization is required.
	Durable medical equipment	50% Coinsurance	Not Covered	Limited to 20 DME devices/items per year, whether rented or purchased as indicated in the Policy.
	Hospice services	No Charge	Not Covered	Preauthorization is required.
If your child needs dental or eye care	Children's eye exam	No Charge	Not Covered	Limited to one Routine Eye exam per 12 months.
	Children's glasses	No Charge	Not Covered	Only Frames from a pediatric exchange collection are covered.
	Children's dental check-up	No Charge	Not Covered	One exam, cleaning, and bite-wing x-ray per 12 months.

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.)

- Abortion (Excluded Service)
- Acupuncture
- Bariatric Surgery
- Cosmetic Surgery
- Infertility Treatment
- Long-Term Care
- Non-Emergency Care When Traveling Outside the Country
- Oral Surgery
- Private-Duty Nursing
- Routine Foot Care
- Weight Loss Programs

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

- Chiropractic Care
- Dental Care (Adult)
- Hearing Aids
- Routine Eye Care (Adult)

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 are: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform, Department of Health and Human Services Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov, or you may contact Network Health Customer Service Department at 1-855-275-1400 for more information. 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 1-800-318-2596.

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 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: Wisconsin Office of the Commissioner of Insurance at 1-800-236-8517 or http://oci.wi.gov/consinfo.htm, or you may contact Network Health Customer Service Department at 1-855-275-1400.

Does this plan provide Minimum Essential Coverage? **Yes.**
If you don't have Minimum essential coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet Minimum Value Standards? **Yes.**
If your plan doesn't meet the Minimum value standard, you may be eligible for a Premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:
----------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	$7,200
Specialist Copay	$100
Hospital (facility) Coinsurance	50%
Other Coinsurance	50%

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	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$7,200
Copayments	$0
Coinsurance	$950
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$8,210**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall Deductible	$7,200
Specialist Copay	$100
Hospital (facility) Coinsurance	50%
Other Coinsurance	50%

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	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$430
Copayments	$1,790
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$2,240**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall Deductible	$7,200
Specialist Copay	$100
Hospital (facility) Coinsurance	50%
Other Coinsurance	50%

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	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,330
Copayments	$350
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,680**

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

Multi-language Interpreter Services

If you, or someone you're helping, has questions about Network Health, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 855-275-1400.

Spanish: Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de Network Health, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 855-275-1400.

Hmong: Yog koj, los yog tej tus neeg uas koj pab ntawd, muaj lus nug txog Network Health, koj muaj cai kom lawv muab cov ntshiab lus qhia uas tau muab sau ua koj hom lus pub dawb rau koj. Yog koj xav nrog ib tug neeg txhais lus tham, hu rau 855-275-1400.

Chinese: 如果您，或是您正在協助的對象，有關於[插入SBM項目的名稱 Network Health 方面的問題，您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥電話 [在此插入數字855-275-1400.

German: Falls Sie oder jemand, dem Sie helfen, Fragen zum Network Health haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 855-275-1400 an.

Arabic:
إذا كان لديك أو لدى شخص كنت مساعدة، أسئلة حول **Health Network**، لديك الحق في الحصول على المساعدة والمعلومات باللغة الخاصة بك. للتحدث مع مترجم 855-275-1400 دون أي تكلفة. فوري، قم باستدعاء

Russian: Если у вас или лица, которому вы помогаете, имеются вопросы по поводу Network Health, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону 855-275-1400.

Korean: 만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 Network Health 에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는855-275-1400.로 전화하십시오.

Vietnamese: Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Network Health, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 855-275-1400.

Pennsylvania Dutch: "Wann du hoscht en Froog, odder ebber, wu du helfscht, hot en Froog baut Network Health, hoscht du es Recht fer Hilf un Information in deinre eegne Schprooch griege, un die Hilf koschtet nix. Wann du mit me Interpreter schwetze witt, kannscht du 855-275-1400 uffrufe.

Laotian: ຖ້າທ່ານ, ຫຼືຄົນທ່ທ່ານກໍາລັງຊ່ວຍເຫຼືອ, ມຄໍາຖາມກ່ຽວກັບ Network Health, ທ່ານມ ສິດທ່ ຈະໄດ້ຮັບການຊ່ວຍເຫຼືອແລະຂໍ້ມູນຂ່າວສານທ່ເປັນພາສາຂອງທ່ານບ່ມ ຄ່າໃຊ້ຈ່າຍ. ການໂອ້ລົມກັບນາຍພາສາ, ໃຫ້ໂທຫາ 855-275-1400.

French: Si vous, ou quelqu'un que vous êtes en train d'aider, a des questions à propos de Network Health, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 855-275-1400.

Polish: Jeśli Ty lub osoba, której pomagasz ,macie pytania odnośnie Network Health, masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku .Aby porozmawiać z tłumaczem, zadzwoń pod numer 855-275-1400.

Hindi: यदि आप, या किसी को आप की मदद कर रहे हैं, के बारे में सवाल है Network Health, आप कोई भी कीमत पर अपनी भाषा में मदद और जानकारी प्राप्त करने का अधिकार है। एक दुभाषिया के लिए बात करने के लिए, 855-275-1400 कहते हैं।.

Albanian: Nëse ju, ose dikush që po ndihmoni, ka pyetje për Network Health, keni të drejtë të merrni ndihmë dhe informacion falas në gjuhën tuaj. Për të folur me një përkthyes, telefononi numrin
855-275-1400.

Tagalog: Kung ikaw, o ang iyong tinutulangan, ay may mga katanungan tungkol sa Network Health, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa 855-275-1400.

Nondiscrimination

Network Health complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Network Health does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Network Health:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Network Health's discrimination complaints coordinator at 855-275-1400.

If you believe that Network Health has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with Network Health's discrimination complaints coordinator, 1570 Midway Place, Menasha, WI 54952, phone number 855-275-1400, TTY 800-947-3529, Fax 920-720-1907, compliance@networkhealth.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Network Health's discrimination complaints coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD).

Complaint forms are available at **http://www.hhs.gov/ocr/office/file/index.html**.