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-2021/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?	**$4,000** per Member / **$8,000** 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 **$8,550** per Member / **$17,100** 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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(HHS - OMB control number: 0938-1146/Expiration DATE: 10/31/2022)

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	$25 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	$80 Copayment per visit; Deductible does not apply.	Not Covered	----------None----------
	Preventive care/screening/ immunization	No Charge	Not Covered	Ask your provider if the services needed are preventive.
If you have a test	Diagnostic test (x-ray, blood work)	$30 Copayment per Lab procedure Deductible does not apply and $60 Copayment per X-Ray procedure; Deductible does not apply.	Not Covered	----------None----------
	Imaging (CT/PET scans, MRIs)	40% Coinsurance per procedure	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 drugs to treat your illness or condition More information about **prescription drug coverage** is available at https://networkhealth.com/ assets/pdf/individual-benefits-2021/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)	50% Coinsurance per Rx or refill retail or 50% 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)	40% 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
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	40% Coinsurance	Not Covered	----------None----------
	Physician/surgeon fees	40% 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	$300 Copayment per transport; Deductible does not apply.	$300 Copayment per transport; Deductible does not apply.	----------None----------
	Urgent care	$80 Copayment per visit; Deductible does not apply.	$80 Copayment per visit; Deductible does not apply.	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)	40% Coinsurance	Not Covered	Preauthorization is required.
	Physician/surgeon fees	40% 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 mental health, behavioral health, or substance abuse services	Outpatient services	$25 Copayment per office visit; Deductible does not apply and 40% Coinsurance other outpatient services	Not Covered	First three visits covered at No Charge: combined with primary care and maternity office visits.
	Inpatient services	40% Coinsurance	Not Covered	----------None----------
If you are pregnant	Office visits	$25 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	40% Coinsurance	Not Covered	Cost sharing does not apply for preventive services. Maternity care may include tests and services described elsewhere in the SBC.
	Childbirth/delivery facility services	40% Coinsurance	Not Covered	----------None----------
If you need help recovering or have other special health needs	Home health care	40% Coinsurance	Not Covered	Limited to 60 visits per benefit year; Preauthorization is required.
	Rehabilitation services	40% 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	40% Coinsurance	Not Covered	Limited to 20 visits each per benefit year for Physical, Occupation, and Speech Therapy
	Skilled nursing care	40% Coinsurance	Not Covered	Limited to 30 days per benefit year; Preauthorization is required.
	Durable medical equipment	40% 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.

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 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 Member Experience Team 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 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: 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 Member Experience Team at 1-855-275-1400.

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 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	$4,000
Specialist Copay	$80
Hospital (facility) Coinsurance	40%
Other Coinsurance	40%

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:

Cost Sharing	
Deductibles	$4,000
Copayments	$250
Coinsurance	$2,830
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$7,140**

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

The plan's overall Deductible	$4,000
Specialist Copay	$80
Hospital (facility) Coinsurance	40%
Other Coinsurance	40%

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:

Cost Sharing	
Deductibles	$0
Copayments	$1,850
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$1,910**

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

The plan's overall Deductible	$4,000
Specialist Copay	$80
Hospital (facility) Coinsurance	40%
Other Coinsurance	40%

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:

Cost Sharing	
Deductibles	$1,790
Copayments	$350
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,140**

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: 1-855-275-1400.

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