



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-2022/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](http://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 <a href="#">deductible</a> ?	<b>\$2,800</b> per Member / <b>\$5,600</b> per Family	Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">Deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">Deductible</a> until the total amount of <a href="#">Deductible</a> expenses paid by all family members meets the overall family <a href="#">Deductible</a> .
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. <a href="#">Preventive care</a> is covered before you meet your <a href="#">Deductible</a> .	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other <a href="#">deductibles</a> for specific services?	No.	You don't have to meet <a href="#">deductibles</a> for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	For <a href="#">network providers</a> <b>\$5,000</b> per Member / <b>\$10,000</b> per Family.	The <a href="#">out-of-pocket limit</a> 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 <a href="#">out-of-pocket limit</a> ?	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 <a href="#">out of pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See <a href="http://www.networkhealth.com">www.networkhealth.com</a> or call Network Health Customer Service at 1-855-275-1400 for a listing of participating <a href="#">providers</a> .	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an <a href="#">Out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware your <a href="#">network provider</a> might use an <a href="#">Out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .



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 <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	0% <a href="#">Coinsurance</a>	Not Covered	-----None-----
	<a href="#">Specialist</a> visit	0% <a href="#">Coinsurance</a>	Not Covered	-----None-----
	<a href="#">Preventive care/screening/immunization</a>	No Charge	Not Covered	Ask your provider if the services needed are preventive.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	0% <a href="#">Coinsurance</a>	Not Covered	-----None-----
	Imaging (CT/PET scans, MRIs)	0% <a href="#">Coinsurance</a>	Not Covered	-----None-----
If you need drugs to treat your illness or condition More information about <a href="#">prescription drug coverage</a> is available at <a href="https://networkhealth.com/assets/pdf/individual-benefits-2022/individualpolicy.pdf">https://networkhealth.com/assets/pdf/individual-benefits-2022/individualpolicy.pdf</a>	Generic drugs (Tier 1)	0% <a href="#">Coinsurance</a> per Rx or refill retail or 0% <a href="#">Coinsurance</a> per Rx or refill mail order	Not Covered	Tier 1 generics include Adherence Medications. 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)	0% <a href="#">Coinsurance</a> per Rx or refill retail or 0% <a href="#">Coinsurance</a> per Rx or refill mail order	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% <a href="#">Coinsurance</a> per Rx or refill retail or 50% <a href="#">Coinsurance</a> 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 <a href="#">Specialty drugs</a> (Tier 4)	40% <a href="#">Coinsurance</a> per Rx or refill at specialty pharmacy and no mail order	Not Covered	Covers up to a 30-day supply (specialty pharmacy); No mail order
	Non-preferred <a href="#">Specialty drugs</a> (Tier 5)	50% <a href="#">Coinsurance</a> per Rx or refill at specialty pharmacy and no mail order	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)	0% <a href="#">Coinsurance</a>	Not Covered	-----None-----
	Physician/surgeon fees	0% <a href="#">Coinsurance</a>	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 immediate medical attention	<a href="#">Emergency room care</a>	0% <a href="#">Coinsurance</a> per visit	0% <a href="#">Coinsurance</a> per visit	-----None-----
	<a href="#">Emergency medical transportation</a>	0% <a href="#">Coinsurance</a> per transport	0% <a href="#">Coinsurance</a> per transport	-----None-----
	<a href="#">Urgent care</a>	0% <a href="#">Coinsurance</a> per visit	0% <a href="#">Coinsurance</a> per visit	<a href="#">Out-of-Network</a> Services are covered only when Outside the Service Area furnished by a Hospital-based Facility.
If you have a hospital stay	Facility fee (e.g., hospital room)	0% <a href="#">Coinsurance</a>	Not Covered	<a href="#">Preauthorization</a> is required.
	Physician/surgeon fees	0% <a href="#">Coinsurance</a>	Not Covered	-----None-----
If you need mental health, behavioral health, or substance abuse services	Outpatient services	0% <a href="#">Coinsurance</a>	Not Covered	-----None-----
	Inpatient services	0% <a href="#">Coinsurance</a>	Not Covered	-----None-----
If you are pregnant	Office visits	0% <a href="#">Coinsurance</a>	Not Covered	-----None-----
	Childbirth/delivery professional services	0% <a href="#">Coinsurance</a>	Not Covered	<a href="#">Cost sharing</a> does not apply for <a href="#">preventive services</a> . Maternity care may include tests and services described elsewhere in the SBC.
	Childbirth/delivery facility services	0% <a href="#">Coinsurance</a>	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	<a href="#">Home health care</a>	0% <a href="#">Coinsurance</a>	Not Covered	Limited to 60 visits per benefit year; <a href="#">Preauthorization</a> is required.
	<a href="#">Rehabilitation services</a>	0% <a href="#">Coinsurance</a>	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.
	<a href="#">Habilitation services</a>	0% <a href="#">Coinsurance</a>	Not Covered	Limited to 20 visits each per benefit year for Physical, Occupation, and Speech Therapy
	<a href="#">Skilled nursing care</a>	0% <a href="#">Coinsurance</a>	Not Covered	Limited to 30 days per benefit year; <a href="#">Preauthorization</a> is required.
	<a href="#">Durable medical equipment</a>	0% <a href="#">Coinsurance</a>	Not Covered	Limited to 20 DME devices/items per year, whether rented or purchased as indicated in the Policy.
	<a href="#">Hospice services</a>	0% <a href="#">Coinsurance</a>	Not Covered	<a href="#">Preauthorization</a> 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 <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or <a href="#">plan</a> document for more information and a list of any other <a href="#">excluded services</a> .)		
<ul style="list-style-type: none"> <li>Abortion (Excluded Service)</li> <li>Acupuncture</li> <li>Bariatric Surgery</li> <li>Cosmetic Surgery</li> </ul>	<ul style="list-style-type: none"> <li>Infertility Treatment</li> <li>Long-Term Care</li> <li>Non-Emergency Care When Traveling Outside the Country</li> <li>Oral Surgery</li> </ul>	<ul style="list-style-type: none"> <li>Private-Duty Nursing</li> <li>Routine Foot Care</li> <li>Weight Loss Programs</li> </ul>
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> document.)		
<ul style="list-style-type: none"> <li>Chiropractic Care</li> <li>Dental Care (Adult)</li> </ul>	<ul style="list-style-type: none"> <li>Hearing Aids</li> </ul>	<ul style="list-style-type: none"> <li>Routine Eye Care (Adult)</li> </ul>

**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](http://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](http://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](http://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](#).

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

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## 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)		Managing Joe's type 2 Diabetes (a year of routine in-network care of a well-controlled condition)		Mia's Simple Fracture (in-network emergency room visit and follow up care)	
■ The plan's overall <a href="#">Deductible</a>	\$2,800	■ The plan's overall <a href="#">Deductible</a>	\$2,800	■ The plan's overall <a href="#">Deductible</a>	\$2,800
■ <a href="#">Specialist Coinsurance</a>	0%	■ <a href="#">Specialist Coinsurance</a>	0%	■ <a href="#">Specialist Coinsurance</a>	0%
■ <a href="#">Hospital (facility) Coinsurance</a>	0%	■ <a href="#">Hospital (facility) Coinsurance</a>	0%	■ <a href="#">Hospital (facility) Coinsurance</a>	0%
■ <a href="#">Other Coinsurance</a>	0%	■ <a href="#">Other Coinsurance</a>	0%	■ <a href="#">Other Coinsurance</a>	0%
<p><b>This EXAMPLE event includes services like:</b>                      Specialist office visits (<i>prenatal care</i>)                      Childbirth/Delivery Professional Services                      Childbirth/Delivery Facility Services                      Diagnostic tests (<i>ultrasounds and blood work</i>)                      Specialist visit (<i>anesthesia</i>)</p>		<p><b>This EXAMPLE event includes services like:</b>                      Primary care physician office visits (<i>including disease education</i>)                      Diagnostic tests (<i>blood work</i>)                      Prescription drugs                      Durable medical equipment (<i>glucose meter</i>)</p>		<p><b>This EXAMPLE event includes services like:</b>                      Emergency room care (<i>including medical supplies</i>)                      Diagnostic test (<i>x-ray</i>)                      Durable medical equipment (<i>crutches</i>)                      Rehabilitation services (<i>physical therapy</i>)</p>	
<b>Total Example Cost</b>	<b>\$12,700</b>	<b>Total Example Cost</b>	<b>\$5,600</b>	<b>Total Example Cost</b>	<b>\$2,800</b>
<b>In this example, Peg would pay:</b>		<b>In this example, Joe would pay:</b>		<b>In this example, Mia would pay:</b>	
<i>Cost Sharing</i>		<i>Cost Sharing</i>		<i>Cost Sharing</i>	
Deductibles	\$2,800	Deductibles	\$2,800	Deductibles	\$2,800
Copayments	\$0	Copayments	\$0	Copayments	\$0
Coinsurance	\$0	Coinsurance	\$0	Coinsurance	\$0
<i>What isn't covered</i>		<i>What isn't covered</i>		<i>What isn't covered</i>	
Limits or exclusions	\$60	Limits or exclusions	\$60	Limits or exclusions	\$0
<b>The total Peg would pay is</b>	<b>\$2,860</b>	<b>The total Joe would pay is</b>	<b>\$2,860</b>	<b>The total Mia would pay is</b>	<b>\$2,800</b>

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.