network health **PRESTIGE_23_GOLD_50**

**Coverage for:** Individual or Individual + Family | **Plan Type:** IFP_HMO_AC

**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-2023/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? | **$1,000** per Member / **$2,000** 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 is covered before you meet your Deductible. | 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 **$4,300** per Member / **$8,600** 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. |

(DT - OMB control number: 1545-0047/Expiration DATE: 12/31/2019)(DOL - OMB control number: 1210-0147/Expiration DATE: 5/31/2022)
(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 | 50% Coinsurance | Not Covered | ----------None---------- |
| | Specialist visit | 50% Coinsurance | 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) | 50% Coinsurance | Not Covered | ----------None---------- |
| | Imaging (CT/PET scans, MRIs) | 50% Coinsurance | Not Covered | ----------None---------- |
| If you need drugs to treat your illness or condition<br>More information about prescription drug coverage is available at https://networkhealth.com/__assets/pdf/individual-benefits-2023/individualpolicy.pdf | Generic drugs (Tier 1) | $15 Copayment per Rx or refill retail or $40 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.<br>Covers up to a 30-day supply (retail prescription); 30-90 day supply (mail order prescription) |
| | Preferred brand drugs (Tier 2) | $50 Copayment per Rx or refill retail $135 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) | 50% Coinsurance | Not Covered | ----------None---------- |
| | Physician/surgeon fees | 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 immediate medical attention | Emergency room care | 50% Coinsurance per visit | 50% Coinsurance per visit | ----------None---------- |
| | Emergency medical transportation | 50% Coinsurance per transport | 50% Coinsurance per transport | ----------None---------- |
| | Urgent care | 50% Coinsurance per visit | 50% Coinsurance per visit | Out-of-Network 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) | 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 | 50% Coinsurance | Not Covered | ----------None---------- |
| | Inpatient services | 50% Coinsurance | Not Covered | ----------None---------- |
| If you are pregnant | Office visits | 50% Coinsurance | Not Covered | ----------None---------- |
| | Childbirth/delivery professional services | 50% 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 | 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 | 50% Coinsurance | 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 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.

*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 | $1,000 |
| Specialist Coinsurance | 50% |
| 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** | **$12,700** |

**In this example, Peg would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $1,000 |
| Copayments | $10 |
| Coinsurance | $1,550 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$2,620** |

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

| | |
|---|---|
| The plan's overall Deductible | $1,000 |
| Specialist Coinsurance | 50% |
| 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** | **$5,600** |

**In this example, Joe would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $910 |
| Copayments | $1,130 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Joe would pay is** | **$2,100** |

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

| | |
|---|---|
| The plan's overall Deductible | $1,000 |
| Specialist Coinsurance | 50% |
| 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** | **$2,800** |

**In this example, Mia would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $910 |
| Copayments | $1,130 |
| Coinsurance | $900 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$2,040** |

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.