Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Service

State of Wisconsin – IYC Health Plan Uniform Benefit

Group Type: Individual & Family | Plan Type: HMO

Coverage Period: 1/1/2023 - 12/31/2023

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, Contact ETF at https://etf.wi.gov/contact-us or 1-877-533-5020. 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 https://www.healthcare.gov/sbc-glossary/ or call 1-877-533-5020 to request a copy.

Important Questions | Answers | Why This Matters:
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**What is the overall deductible?** | $250 individual/$500 family | 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. Deductible exceptions include office visit copays and for federally required preventive services. The deductible starts over with each plan year beginning on January 1st.

**Are there services covered before you meet your deductible?** | Yes. Preventive care and primary care services are 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?**
Medical: $1,250 individual/$2,500 family
Prescription drug: Level 1 and 2: $600 Individual $1,200 Family

If you have other family members in this plan, the overall family out-of-pocket limit must be met. The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses. The federal maximum out-of-pocket is $9,100 individual/$18,200 family. This applies to all essential health benefits, including services not included in the out-of-pocket limit, (i.e. certain level 3 & 4 prescription drugs and adult hearing aids covered under this plan).

**What is not included in the out-of-pocket limit?**
Copayments for Level 3 and Level 4 non-preferred specialty drugs, Premiums and health care this plan doesn’t cover.

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 1-844-625-2208, TTY 1-800-947-3529 for a list of network 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**. However, it is recommended you get a **referral** to an orthopedist or neurosurgeon for low back pain |

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All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>Network Provider (You will pay the least)</th>
<th>Out-of-Network Provider (You will pay the most)</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you visit a health care provider’s office or clinic</td>
<td>Primary care visit to treat an injury or illness</td>
<td>$15 <strong>copay</strong>/visit</td>
<td>Not covered</td>
<td>You may have to pay for services that aren’t preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.</td>
</tr>
<tr>
<td></td>
<td><strong>Specialist</strong> visit</td>
<td>$25 <strong>copay</strong>/visit</td>
<td>Not covered without preauthorization</td>
<td>You may have to pay for services that aren’t preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.</td>
</tr>
<tr>
<td></td>
<td><strong>Preventive care/screening/immunization</strong></td>
<td>No charge</td>
<td>Not covered</td>
<td>All preventive care services that have received an A or B grade by the United States Preventive Services Task Force are covered without cost sharing. Ask your in-network provider if the services needed are preventive. Then check what your plan will pay for. Full coverage is required by federal law.</td>
</tr>
<tr>
<td>If you have a test</td>
<td><strong>Diagnostic test</strong> (x-ray, blood work)</td>
<td>10% <strong>coinsurance</strong> after deductible</td>
<td>Not covered</td>
<td>Full coverage if required by federal law.</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>10% <strong>coinsurance</strong> after deductible</td>
<td>Not covered</td>
<td>Prior authorization required or benefits not payable.</td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>What You Will Pay</td>
<td>Limitations, Exceptions, &amp; Other Important Information</td>
<td></td>
</tr>
<tr>
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<td></td>
</tr>
<tr>
<td>If you need drugs to treat your illness or condition</td>
<td>Level 1: Preferred <strong>generic drugs and certain lower cost preferred brand name drugs</strong></td>
<td><strong>Network Provider</strong> (You will pay the least) $5/prescription to <strong>out-of-pocket limit.</strong> (2 copays apply to certain 90-day supply mail orders)</td>
<td>Prescriptions may be filled at an <strong>out-of-network</strong> pharmacy in emergency situations only. At the <strong>out-of-network</strong> pharmacy, during the emergency situation, you should pay for the prescription in full and submit a reimbursement form to <strong>Navitus.</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Out-of-Network Provider</strong> (You will pay the most)</td>
<td>Federal maximum <strong>out-of-pocket-limit</strong> of $9,100 for an individual and $18,200 for a family.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Level 2: Preferred <strong>brand drugs and certain higher cost preferred generic drugs</strong></td>
<td>20% <strong>coinsurance</strong> ($50 max) per prescription to <strong>out-of-pocket limit.</strong> (2 copays apply to certain 90-day supply mail order)</td>
<td>Prescriptions may be filled at an <strong>out-of-network</strong> pharmacy in emergency situations only. At the <strong>out-of-network</strong> pharmacy, during the emergency situation, you should pay for the prescription in full and submit a reimbursement form to <strong>Navitus.</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Federal maximum <strong>out-of-pocket-limit</strong> of $9,100 for an individual and $18,200 for a family.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Level 3: <strong>Non-preferred brand name and certain high cost generic drugs</strong></td>
<td>40% <strong>coinsurance</strong> ($150 max) per prescription. Member must pay the cost difference between the <strong>non-preferred</strong> brand drug and the <strong>preferred generic equivalent drug if not medically necessary.</strong></td>
<td>Prescriptions may be filled at an <strong>out-of-network</strong> pharmacy in emergency situations only. At the <strong>out-of-network</strong> pharmacy, during the emergency situation, you should pay for the prescription in full and submit a reimbursement form to <strong>Navitus.</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Federal maximum <strong>out-of-pocket-limit</strong> of $9,100 for an individual and $18,200 for a family applies for some Level 3 drugs.</td>
<td></td>
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</tr>
<tr>
<td></td>
<td>Level 4: <strong>Specialty drugs at preferred specialty pharmacy provider</strong></td>
<td><strong>$50 copay</strong> per prescription for <strong>preferred drugs</strong> to specialty <strong>out-of-pocket limit.</strong> <strong>40% coinsurance</strong> ($200 max) per prescription for <strong>preferred drugs</strong></td>
<td>Prescriptions may be filled at an <strong>out-of-network</strong> pharmacy in emergency situations only. At the <strong>out-of-network</strong> pharmacy, during the emergency situation, you should pay for the prescription in full and submit a reimbursement form to <strong>Navitus.</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Federal maximum <strong>out-of-pocket-limit</strong> of $9,100 for an individual and $18,200 for a family applies for some Level 4 drugs.</td>
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</tr>
</tbody>
</table>

For more information about limitations and exceptions, see the plan or policy document at [www.etf.wi.gov](http://www.etf.wi.gov)
<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Network Provider (You will pay the least)</td>
<td>Out-of-Network Provider (You will pay the most)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>10% coinsurance after deductible.</td>
<td></td>
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<tr>
<td>If you have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>$15 copay for primary doctor office visit</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td></td>
<td>$25 copay for specialist office visit</td>
<td></td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room care</td>
<td>$75 copay, deductible then 10% coinsurance</td>
<td>$75 copay, deductible then 10% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>10% coinsurance after deductible</td>
<td>10% coinsurance after deductible</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>$25 copay/visit</td>
<td>$25 copay/visit</td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>10% coinsurance after deductible</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>10% coinsurance after deductible</td>
<td>Not covered</td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
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<td>What You Will Pay Out-of-Network Provider (You Will Pay the Most)</td>
</tr>
<tr>
<td>----------------------------------------------------------</td>
<td>--------------------------------</td>
<td>------------------------------------------</td>
<td>-----------------------------------------------------------------</td>
</tr>
<tr>
<td>If you need mental health, behavioral health, or substance abuse services</td>
<td>Outpatient services</td>
<td>$15 <strong>copay</strong>/visit</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>10% <strong>coinsurance</strong> after deductible</td>
<td>Not covered</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Office visits</td>
<td>$15 <strong>copay</strong>/visit</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>10% <strong>coinsurance</strong> after deductible</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>10% <strong>coinsurance</strong> after deductible</td>
<td>Not covered</td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td><strong>Home health care</strong></td>
<td>10% <strong>coinsurance</strong> after deductible</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td><strong>Rehabilitation services</strong></td>
<td>$15 <strong>copay</strong>/visit</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td><strong>Habilitation services</strong></td>
<td>$15 <strong>copay</strong>/visit</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td><strong>Skilled nursing care</strong></td>
<td>10% <strong>coinsurance</strong> after deductible</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td><strong>Durable medical equipment</strong></td>
<td>20% <strong>coinsurance</strong> after deductible</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td><strong>Hospice services</strong></td>
<td>10% <strong>coinsurance</strong> after deductible</td>
<td>Not covered</td>
</tr>
</tbody>
</table>
### What You Will Pay

<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>If your child needs dental or eye care</td>
<td>Children’s eye exam</td>
<td>$25 <strong>copay</strong></td>
<td>Not covered</td>
<td>Limited to one per individual per year. Contact lens fitting not covered. Full coverage if required by federal law. <strong>Deductible</strong> does not apply.</td>
</tr>
<tr>
<td></td>
<td>Children’s glasses</td>
<td>Not covered</td>
<td>Not covered</td>
<td>Excluded service.</td>
</tr>
<tr>
<td></td>
<td>Children’s dental check-up</td>
<td>Not covered</td>
<td>Not covered</td>
<td>Excluded service.</td>
</tr>
</tbody>
</table>

### 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.):**

- Cosmetic surgery
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside US
- 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.):**

- Bariatric Surgery
- Chiropractic care
- 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 is: 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) and the Wisconsin Office of the Commissioner of Insurance at (800) 236-8517 or [www.oci.wi.gov](http://www.oci.wi.gov). Other coverage options may be available to you, too, including buying individual insurance coverage through the [Health Insurance Marketplace](http://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: Network Health Plan at 1-844-625-2208 or TTY 711 or ETF at 1-877-533-5020 or [www.etf.wi.gov](http://www.etf.wi.gov)

### Minimum Essential Coverage:

- **Yes**

Minimum Essential Coverage generally includes plans, health insurance available through the [Marketplace](http://HealthCare.gov) 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.

### Minimum Value Standards:

- **Yes**

If your plan doesn’t meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the [Marketplace](http://HealthCare.gov).

### Language Access Services:

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-844-625-2208, TTY 1-800-947-3529.

For more information about limitations and exceptions, see the plan or policy document at [www.etf.wi.gov](http://www.etf.wi.gov)
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To see examples of how this plan might cover costs for a sample medical situation, see the next section.

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For more information about limitations and exceptions, see the plan or policy document at [www.etf.wi.gov](http://www.etf.wi.gov).
**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.

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

### Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- The plan’s overall deductible: $250
- Specialist [copay]: $25
- Hospital (facility) [coinsurance]: 10%
- Other [coinsurance]: 10%

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:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$250</td>
<td></td>
</tr>
<tr>
<td>Copayments</td>
<td>$200</td>
<td></td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$800</td>
<td></td>
</tr>
</tbody>
</table>

**What isn’t covered**
- Limits or exclusions: $0

**The total Peg would pay:** $1,250

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

- The plan’s overall deductible: $250
- Specialist [copay]: $25
- Hospital (facility) [coinsurance]: 10%
- Other [coinsurance]: 10%

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:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$250</td>
<td></td>
</tr>
<tr>
<td>Copayments</td>
<td>$300**</td>
<td></td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$400**</td>
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</tr>
</tbody>
</table>

**What isn’t covered**
- Limits or exclusions: $0

**The total Joe would pay:** $950**

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

- The plan’s overall deductible: $250
- Specialist [copay]: $25
- Hospital (facility) [coinsurance]: 10%
- Other [coinsurance]: 10%

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:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$250</td>
<td></td>
</tr>
<tr>
<td>Copayments</td>
<td>$100</td>
<td></td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$200</td>
<td></td>
</tr>
</tbody>
</table>

**What isn’t covered**
- Limits or exclusions: $0

**The total Mia would pay:** $550

**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 contact: [https://www.webmdhealth.com/wellwisconsin](https://www.webmdhealth.com/wellwisconsin) or 1-800-821-6591

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