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 www.etf.wi.gov.

For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other terms see the Glossary. You can view the Glossary at https://www.healthcare.gov/glossary/essential-health-benefits/ or call 1-877-533-5020 to request a copy.

<table>
<thead>
<tr>
<th>Important Questions</th>
<th>Answers</th>
<th>Why This Matters:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>What is the overall deductible?</strong></td>
<td>$500 individual / $1,000 family</td>
<td>You must pay all the costs up to the deductible amount before the policy begins to pay for covered services you use, with the exceptions of office visit copays and for federally required preventive services. The deductible starts over with each plan year beginning on January 1st. See the chart starting on page 2 for your costs for services this plan covers.</td>
</tr>
<tr>
<td><strong>Are there services covered before you meet your deductible?</strong></td>
<td>Yes. Preventive care and primary care services are covered before you meet your deductible.</td>
<td>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 <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>.</td>
</tr>
<tr>
<td><strong>Are there other deductibles for specific services?</strong></td>
<td>No</td>
<td>There are no deductibles.</td>
</tr>
<tr>
<td><strong>What is the out-of-pocket limit for this plan?</strong></td>
<td>After medical deductible, Durable Medical Supplies (DME): $500 per individual. Prescription drug: Level 1 and 2: $600 individual / $1,200 family Level 4: $1,200 individual / $2,400 family</td>
<td>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 $8,150 individual/$16,300 family. This applies to all essential health benefits, including some services not included in the out-of-pocket limit. (i.e. certain level 3 &amp; 4 prescription drugs and certain hearing aids covered under this plan). See <a href="https://www.healthcare.gov/glossary/essential-health-benefits/">https://www.healthcare.gov/glossary/essential-health-benefits/</a> for details.</td>
</tr>
<tr>
<td><strong>What is not included in the out-of-pocket limit?</strong></td>
<td>Copays for Level 3 and Level 4 non-preferred specialty drugs; coinsurance paid by adults for hearing aids, premiums and health care this plan doesn’t cover.</td>
<td>Even though you pay these expenses, they do not count toward the out-of-pocket limit.</td>
</tr>
</tbody>
</table>

Options for full plan benefits are available on https://www.healthcare.gov or by calling 1-877-533-5020.
**Will you pay less if you use a network provider?**
Yes. See [www.networkhealth.com](http://www.networkhealth.com) or call 1-844-625-2208 or TTY 1-800-947-3529 for a list of network providers.

**Do you need a referral to see a specialist?**
No, you don’t need a referral to see a specialist

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.

---

**Common Medical Event**

<table>
<thead>
<tr>
<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><strong>If you visit a health care provider’s office or clinic</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary care visit to treat an injury or illness</td>
<td>No charge after deductible</td>
<td>Not covered</td>
<td>-----------------------NONE-----------------------</td>
</tr>
<tr>
<td>Specialist visit</td>
<td>No charge after deductible</td>
<td>Not covered unless prior authorized</td>
<td>-----------------------NONE-----------------------</td>
</tr>
<tr>
<td>Other practitioner office visit</td>
<td>No charge after deductible</td>
<td>Not covered</td>
<td>Maintenance care and acupuncture not covered.</td>
</tr>
<tr>
<td>Preventive care/screening/immunization</td>
<td>No charge after deductible</td>
<td>Not covered</td>
<td>-----------------------NONE-----------------------</td>
</tr>
<tr>
<td><strong>If you have a test</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diagnostic test (x-ray, blood work)</td>
<td>No charge after deductible</td>
<td>Not covered</td>
<td>Full coverage if required by federal law.</td>
</tr>
<tr>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>No charge after deductible</td>
<td>Not covered</td>
<td>Prior approval required or benefits not payable</td>
</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>If you need drugs to treat your illness or condition</td>
<td>Level 1: Preferred generic drugs and certain lower cost preferred brand name drugs</td>
<td>$5/prescription to out-of-pocket limit. (2 copays apply to certain 90-day supply mail orders)</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Level 2: Preferred brand drugs and certain higher cost preferred generic drugs</td>
<td>20% coinsurance ($50 max) per prescription to out-of-pocket limit. (2 copays apply to certain 90-day supply mail order)</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Level 3: Non-preferred brand name and certain high cost generic drugs</td>
<td>40% coinsurance ($150 max) per prescription. Member must pay the cost difference between the non-preferred brand drug and the preferred generic equivalent drug if not medically necessary.</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Level 4: Specialty drugs at preferred specialty pharmacy provider</td>
<td>$50 copay per prescription for preferred drugs to specialty out-of-pocket limit.  40% coinsurance ($200 max) per prescription for non-preferred drugs. No out-of-pocket limit.</td>
<td>Not covered</td>
</tr>
</tbody>
</table>

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<td>Network Provider (You will pay the least)</td>
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</tr>
<tr>
<td></td>
<td></td>
<td>40% coinsurance ($200 max) per prescription for preferred drugs to specialty out-of-pocket limit.</td>
<td>Not covered</td>
</tr>
<tr>
<td>Level 4: Specialty drugs at participating pharmacy provider</td>
<td></td>
<td>40% coinsurance ($200 max) per prescription for non-preferred drugs. No out-of-pocket limit.</td>
<td></td>
</tr>
<tr>
<td>If you have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>No charge after deductible</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>No charge after deductible</td>
<td>Not covered</td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room care</td>
<td>$60 copay/visit</td>
<td>$60 copay/visit</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>No charge after deductible</td>
<td>Not charge after deductible</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>No charge after deductible</td>
<td>Not charge after deductible</td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>No charge after deductible</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>No charge after deductible</td>
<td>Not covered</td>
</tr>
</tbody>
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<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>No charge after deductible</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Mental/Behavioral health outpatient services</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Mental/Behavioral health inpatient services</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Substance use disorder outpatient services</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Substance use disorder inpatient services</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>If you need mental health, behavioral health, or substance abuse services</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Office visits</td>
<td>No charge after deductible</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>No charge after deductible</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>No charge after deductible</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>If you are pregnant</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Home health care</td>
<td>No charge after deductible</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>No charge after deductible</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>No charge after deductible</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care</td>
<td>No charge after deductible</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment</td>
<td>20% coinsurance after deductible (child’s hearing aids no charge)</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Hospice services</td>
<td>No charge after deductible</td>
<td>Not covered</td>
</tr>
</tbody>
</table>

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</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>If your child needs dental or eye care</td>
<td>Children’s eye exam</td>
<td>No charge after deductible</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Children’s glasses</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Children’s dental check-up</td>
<td>Not covered</td>
<td>Not covered</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.)

- Acupuncture
- Cosmetic surgery
- Dental Cleanings
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside US
- Private duty nursing
- Routine foot care

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

- Bariatric surgery and weight loss services for participants with a body mass index of 35 or greater
- Hearing aids
- Telemedicine
- Telehealth
- Dental care, limited to certain oral surgical services and treatment of injuries
- Routine eye care, limited to one eye exam per calendar year by a plan provider
- E-visit services
- Chiropractic care

**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: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.ccio.cms.gov. 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: Network Health Plan at 1-844-625-2208 or TTY 711 or ETF at 1-877-533-5020 or www.etf.wi.gov.

**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 the Minimum Value Standards?** Yes

* For more information about limitations and exceptions, see the plan or policy document at www.etf.wi.gov.
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.

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.


注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-844-625-2208, TTY 1-800-947-3529.

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Discrimination is Against the Law

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 and written information in other formats.

Network Health provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages.

If you need these services, contact Network Health’s discrimination complaints coordinator at 844-625-2208.

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, 844-625-2208, 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).


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

* For more information about limitations and exceptions, see the plan or policy document at www.etf.wi.gov.
### Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- **The plan’s overall deductible**: $500
- **Specialist copayment**: Deductible
- **Hospital (facility) coinsurance**: 0%
- **Other coinsurance**: 0%

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**: $12,731

In this example, Peg would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Deductibles</strong></td>
<td>$500</td>
</tr>
<tr>
<td><strong>Copayments</strong></td>
<td>$0</td>
</tr>
<tr>
<td><strong>Coinsurance</strong></td>
<td>$0</td>
</tr>
</tbody>
</table>

**What isn’t covered**
- Limits or exclusions | $10

**The total Peg would pay is**: $510

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

- **The plan’s overall deductible**: $500
- **Specialist copayment**: Deductible
- **Hospital (facility) coinsurance**: 0%
- **Other coinsurance**: 20%

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**: $7,389

In this example, Joe would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Deductibles</strong></td>
<td>$500</td>
</tr>
<tr>
<td><strong>Copayments</strong></td>
<td>$0</td>
</tr>
<tr>
<td><strong>Coinsurance</strong></td>
<td>$400</td>
</tr>
</tbody>
</table>

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

**The total Joe would pay is**: $900

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

- **The plan’s overall deductible**: $500
- **Specialist copayment**: Deductible
- **Hospital (facility) coinsurance**: 0%
- **Other coinsurance**: 20%

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**: $1,925

In this example, Mia would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Deductibles</strong></td>
<td>$500</td>
</tr>
<tr>
<td><strong>Copayments</strong></td>
<td>$60</td>
</tr>
<tr>
<td><strong>Coinsurance</strong></td>
<td>$40</td>
</tr>
</tbody>
</table>

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

**The total Mia would pay is**: $600

---

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.

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