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:
What is the overall deductible?	$1,500 Individual/$3,000 Family Combined medical and prescription drug deductible	If you have other family members on the policy, the overall family deductible must be met before the plan begins to pay. 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?	$2,500 Individual/ $5,000 Family Combined medical and prescription drug out-of-pocket limit	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 $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 & 4 prescription drugs and adult hearing aids covered under this plan).
What is not included in the out-of-pocket limit?	Copayments paid by for adult hearing aids, 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 1-800-947-3529for 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 different 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

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 Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$15 copay/visit	Not covered	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. Deductible does not apply
	Specialist visit	$25 copay/visit	Not covered without prior authorization	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. Deductible does not apply
	Preventive care/screening/ immunization	$15 copay/visit 10% coinsurance after deductible for related services	Not covered	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. Deductible does not apply. Full coverage if required by federal law.
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance after deductible	Not covered	Full coverage if required by federal law.
	Imaging (CT/PET scans, MRIs)	10% coinsurance after deductible	Not covered	Prior authorization required or benefits not payable.

Common Medical Event	Services You May Need	What You Will Pay Network Provider (You will pay the least)	What You Will Pay Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at navitus.com	Level 1: Preferred generic drugs and certain lower cost preferred brand name drugs	$5/prescription to out-of-pocket limit. (2 copays apply to certain 90-day supply mail orders)	Prescriptions may be filled at an out-of-network pharmacy in emergency situations only. At the out-of-network pharmacy, during the emergency situation, you should pay for the prescription in full and submit a reimbursement form to Navitus.	In-network covers most up to a 30-day supply (90-day for certain prescriptions) retail and mail order.
	Level 2: Preferred brand drugs and certain higher cost preferred generic drugs	20% coinsurance ($50 max) per prescription to out-of-pocket limit. (2 copays apply to certain 90-day supply mail order)	Prescriptions may be filled at an out-of-network pharmacy in emergency situations only. At the out-of-network pharmacy, during the emergency situation, you should pay for the prescription in full and submit a reimbursement form to Navitus.	In-network covers most up to a 30-day supply (90-day for certain prescriptions) retail and mail order.
	Level 3: Non-preferred brand name and certain high cost generic drugs	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.	Prescriptions may be filled at an out-of-network pharmacy in emergency situations only. At the out-of-network pharmacy, during the emergency situation, you should pay for the prescription in full and submit a reimbursement form to Navitus.	In-network covers most up to a 30-day supply (90-day for certain prescriptions) retail and mail order
	Level 4: Specialty drugs at preferred specialty pharmacy provider	$50 copay per prescription for preferred drugs to specialty out-of-pocket limit. 40% coinsurance ($200 max) per prescription for	Prescriptions may be filled at an out-of-network pharmacy in emergency situations only. At the out-of-network pharmacy, during the emergency situation,	Out-of-pocket limit of $1,200 for an individual and $2,400 for a family

		non-preferred drugs. No out-of-pocket limit.	you should pay for the prescription in full and submit a reimbursement form to Navitus.	
	Level 4: Specialty drugs at participating pharmacy provider	40% coinsurance ($200 max) 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.	Prescriptions may be filled at an out-of-network pharmacy in emergency situations only. At the out-of-network pharmacy, during the emergency situation, you should pay for the prescription in full and submit a reimbursement form to Navitus.	Out-of-pocket limit of $1,200 for an individual and $2,400 for a family

Common Medical Event	Services You May Need	What You Will Pay Network Provider (You will pay the least)	What You Will Pay Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance after deductible.	Not covered	None
	Physician/surgeon fees	$15 copay for primary doctor office visit $25 copay for specialist office visit after deductible	Not covered	Additional services provided (e.g. costs of surgery, equipment, etc.) are subject to applicable deductible and coinsurance. Prior approval required for low back surgeries and MRI, CT and PET scans.
If you need immediate medical attention	Emergency room care	$75 copay after deductible then 10% coinsurance	$75 copay, deductible then 10% coinsurance	Copay is waived if admitted.
	Emergency medical transportation	10% coinsurance after deductible	10% coinsurance after deductible	None
	Urgent care	$25 copay/visit after deductible	$25 copay/visit after deductible	None
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance after deductible	Not covered	Prior approval recommended
	Physician/surgeon fees	10% coinsurance after deductible	Not covered	Prior approval required for low back surgeries and MRI, CT and PET scans

Common Medical Event	Services You May Need	What You Will Pay Network Provider (You will Pay the Least)	What You Will Pay Out-of-Network Provider (You Will Pay the Most)	Limitations, Exceptions, & Other Important Information

If you need mental health, behavioral health, or substance abuse services	Outpatient services	$15 copay/visit after deductible	Not covered	None
	Inpatient services	10% coinsurance after deductible	Not covered	None
If you are pregnant	Office visits	$15 copay/visit after deductible	Not covered	Deductible and 10% coinsurance apply if prenatal and/or postnatal care billed as a package. Full coverage if required by federal law
	Childbirth/delivery professional services	10% coinsurance after deductible	Not covered	None
	Childbirth/delivery facility services	10% coinsurance after deductible	Not covered	None
If you need help recovering or have other special health needs	Home health care	10% coinsurance after deductible	Not covered	Limited to 50 visits per year. Plan may approve 50 more per year.
	Rehabilitation services	$15 copay/visit after deductible	Not covered	Physical, speech and occupational therapy limited to 50 visits per year, combined rehabilitation and habilitation services. Plan may approve 50 more per year.
	Habilitation services	$15 copay/visit after deductible	Not covered	Physical, speech and occupational therapy limited to 50 visits per year, combined rehabilitation and habilitation services. Plan may approve 50 more per year.
	Skilled nursing care	10% coinsurance after deductible	Not covered	Facility coverage is limited to 120 days per benefit period, per condition.
	Durable medical equipment	20% coinsurance after deductible	Not covered	Hearing aids (adults) plan maximum payment $1,000 per ear every 3 years. Child's hearing aids 10% coinsurance after deductible
	Hospice services	10% coinsurance after deductible	Not covered	None

Common Medical Event	Services You May Need	What You Will Pay Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If your child needs	Children's eye exam	$25 copay after deductible	Not covered	Limited to one per individual per year. Contact lens fitting not covered. Full coverage if

dental or eye care				required by federal law.
	Children's glasses	Not covered	Not covered	Excluded service.
	Children's dental check-up	Not covered	Not covered	Excluded service.

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	•Infertility treatment	•Private-duty nursing
•Cosmetic surgery	•Long-term care	•Routine foot care
•Dental care (Adult)	•Non-emergency care when traveling outside US	•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 and the Wisconsin Office of the Commissioner of Insurance at (800) 236-8517 or www.oci.wi.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 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

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 the 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.

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.

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 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.

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-844-625-2208, TTY 1-800-947-3529.

رقم (ملحوظة :إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية هاتف الصم والبكم تتوافر لك بالمجان .اتصل برقم
1-844-625-2208 ملحوظة TTY 3529-947-800-1

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-844-625-2208, TTY 1-800-947-3529.

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-844-625-2208, TTY 1-800-947-3529.번으로 전화해 주십시오.

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số1-844-625-2208, TTY 1-800-947-3529.

Wann du [Deitsch (Pennsylvania German / Dutch)] schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: 1-844-625-2208, TTY 1-800-947-3529.

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-844-625-2208, TTY 1-800-947-3529.

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-844-625-2208, TTY 1-800-947-3529.

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-844-625-2208, TTY 1-800-947-3529.

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-844-625-2208, TTY 1-800-947-3529.पर कॉल करें।

KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1-844-625-2208, TTY 1-800-947-3529.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-844-625-2208, TTY 1-800-947-3529.

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).

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

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

PRA Disclosure Statement: According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-1146**. The time required to complete this information collection is estimated to average **0.08** hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland

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	$1,500
Specialist *[cost sharing]*	*$25*
Hospital (facility) *[cost sharing]*	*10%*
Other *[cost sharing]*	*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	**$12,731**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,500
Copayments	$30
Coinsurance	$1,000
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$2,530**

Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$1,500
Specialist *[cost sharing]*	$25
Hospital (facility) *[cost sharing]*	*10%*
Other *[cost sharing]*	*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	**$7,389**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1,500
Copayments	$200**
Coinsurance	$800**
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$2,500****

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

The plan's overall deductible	$1,500
Specialist *[cost sharing]*	$25
Hospital (facility) *[cost sharing]*	*10%*
Other *[cost sharing]*	*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	**$1,925**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,500
Copayments	$60
Coinsurance	$10
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,570**

**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: wellwisconsin.staywell.com or 1-800-821-6591