




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](http://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.

Important Questions	Answers	Why This Matters:
<b>What is the overall <a href="#">deductible</a>?</b>	\$0	See the chart on page 2 for your costs for service this plan covers.
<b>Are there services covered before you meet your <a href="#">deductible</a>?</b>	No	There are no deductibles for this plan, however, <a href="#">copayments</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> .
<b>Are there other <a href="#">deductibles</a> for specific services?</b>	No	There are no <a href="#">deductibles</a> .
<b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b>	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	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 cost of covered services. This limit helps you plan for health care expenses. The federal <a href="#">maximum out-of-pocket</a> is \$6,850 individual/\$13,700 family. This applies to all essential health benefits, including some services not included in the <a href="#">out-of-pocket limit</a> . (i.e. certain level 3 & 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.
<b>What is not included in the <a href="#">out-of-pocket limit</a>?</b>	<a href="#">Copays</a> for Level 3 and Level 4 non-preferred <a href="#">specialty</a> drugs; <a href="#">coinsurance</a> paid by adults for hearing aids, <a href="#">premiums</a> and health care this plan doesn't cover.	Even though you pay these expenses, they do not count toward the <a href="#">out-of-pocket limit</a> .
<b>Will you pay less if you use a <a href="#">network provider</a>?</b>	Yes. See <a href="http://www.networkhealth.com">www.networkhealth.com</a> or call 1-844-625-2208 or TTY 1-800-947-3529 for a list of network providers.	This <a href="#">plan</a> uses a provider <a href="#">network</a> . You will pay less if you use a <a href="#">provider</a> in the plan's <a href="#">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 provider's 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.

<b>Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a>?</b>	No, you don't need a <a href="#">referral</a> to see a <a href="#">specialist</a>	You can see the <a href="#">specialist</a> you choose without permission from the health plan. However, you should get a <a href="#">referral</a> 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.

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)	
<b>If you visit a health care <a href="#">provider's</a> office or clinic</b>	Primary care visit to treat an injury or illness	No charge	Not covered	-----NONE-----
	<a href="#">Specialist</a> visit	No charge	Not covered	-----NONE-----
	Other practitioner office visit	No charge	Not covered	Maintenance care and acupuncture not covered
	<a href="#">Preventive care/screening/immunization</a>	No charge	Not covered	-----NONE-----
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	No charge	Not covered	-----NONE-----
	Imaging (CT/PET scans, MRIs)	No charge	Not covered	Prior approval required or benefits not payable
<b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.navitus.com">www.navitus.com</a>	Level 1: Preferred generic drugs and certain lower cost preferred brand name drugs	\$5/prescription to <a href="#">out-of-pocket limit</a> . (2 <a href="#">copays</a> apply to certain 90-day supply mail orders)	Not covered	<a href="#">In-network</a> covers most up to a 30-day supply (90-day for certain prescriptions) retail and mail order. <a href="#">Out-of-network</a> care allowed but if your ID card is not used, you will pay more than the copay.
	Level 2: <a href="#">Preferred</a> brand drugs and certain higher cost preferred generic drugs	20% <a href="#">coinsurance</a> (\$50 max) per prescription to <a href="#">out-of-pocket limit</a> . (2 <a href="#">copays</a> apply to certain 90-day supply mail order)	Not covered	<a href="#">In-network</a> covers most up to a 30-day supply (90-day for certain prescriptions) retail and mail order. <a href="#">Out-of-network</a> care allowed but if your ID card is not used, you will pay more than the copay.
	Level 3: <a href="#">Non-preferred</a> brand name and certain high cost generic drugs	40% <a href="#">coinsurance</a> (\$150 max) per prescription. No <a href="#">out-of-pocket limit</a> .	Not covered	Federal <a href="#">out-of-pocket limit</a> applies. <a href="#">Out-of-network</a> care allowed, but if your ID card is not used, you will pay more than the copay.
	Level 4*: <a href="#">Specialty drugs</a>	\$50 <a href="#">copay</a> * per prescription for drugs to specialty <a href="#">out-of-pocket limit</a> .	Not covered	Level 4 prescriptions must be filled at Lumicera or UW Specialty Pharmacy*.  Level 4 Out-of-Pocket Limit and Federal <a href="#">maximum out-of-pocket</a> applies.  *Non-Medicare participants only.

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

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)	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	No charge	Not covered	-----NONE-----
	Physician/surgeon fees	No charge	Not covered	Prior approval required for low back surgeries and MRI, CT and PET scans.
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	\$60 copay/visit	\$60 copay/visit	<b>Copay</b> does not apply to <b>out-of-pocket limit</b> and is waived if admitted.
	<a href="#">Emergency medical transportation</a>	No charge	Not covered	-----NONE-----
	<a href="#">Urgent care</a>	No charge	Not covered	-----NONE-----
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	No charge	Not covered	Prior approval recommended
	Physician/surgeon fees	No charge	Not covered	Prior approval required for low back surgeries and MRI, CT and PET scans
<b>If you need mental health, behavioral health, or substance abuse services</b>	Mental/Behavioral health outpatient services	No charge	Not covered	-----NONE-----
	Mental/Behavioral health inpatient services	No charge	Not covered	-----NONE-----
	Substance use disorder outpatient services	No charge	Not covered	-----NONE-----
	Substance use disorder inpatient services	No charge	Not covered	-----NONE-----
<b>If you are pregnant</b>	Office visits	No charge	Not covered	-----NONE-----
	Childbirth/delivery professional services	No charge	Not covered	-----NONE-----
	Childbirth/delivery facility services	No charge	Not covered	-----NONE-----
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	No charge	Not covered	Limited to 50 visits per year. Plan may approve 50 more per year.
	<a href="#">Rehabilitation services</a>	No charge	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.
	<a href="#">Habilitation services</a>	No charge	Not covered	Physical, speech and occupational therapy limited to 50 visits per year, combined rehabilitation and habilitation services. Plan

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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)	
				may approve 50 more per year.
	<a href="#">Skilled nursing care</a>	No charge	Not covered	Facility coverage is limited to 120 days per benefit period.
	<a href="#">Durable medical equipment</a>	20% coinsurance (child's hearing aids no charge)	Not covered	Hearing aids (adults) plan maximum payment \$1,000 per ear every 3 years.
	<a href="#">Hospice services</a>	No charge	Not covered	-----NONE-----
<b>If your child needs dental or eye care</b>	Children's eye exam	No charge	Not covered	Limited to one per individual per year. Contact lens fitting not covered. Full coverage if required by federal law. <b>Deductible</b> does not apply.
	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 |
| • Bariatric surgery | • Long-term care                               | • Routine foot care    |
| • Cosmetic surgery  | • 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.)

- |  |                |  |
|--|----------------|--|
| • Chiropractic care  | • Hearing aids | • Routine eye care, limited to one eye exam per calendar year by a plan provider |
| • Dental care, limited to certain oral surgical services and treatment of injuries |                |  |

**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](http://www.dol.gov/ebsa), or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.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](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

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

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](http://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**

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 (1-844-625-2208) ملحوظة: إذا لقيت حدث انكرا لالغفة فان خدم اتل م س اع د ل ل غوة  
هتفلل صحو اليا فتمت ف ل ر ل ل فبال م ج ان تبا صل ل ب رقم: 1-800-947-3529 TTY.

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 số 1-844-625-2208, TTY 1-800-947-3529.

Wann du [Deitsch (Pennsylvania German / Dutch)] schwetzsch, 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, ໂດຍບໍ່ເສັຽຄ່າ, ຄຸ່ມນີ້ມີພ້ອມໃຫ້ທ່ານ. ໂທສ 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.

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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](mailto: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.* —————

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



## 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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$0
■ <a href="#">Specialist copayment</a>	\$0
■ Hospital (facility) <a href="#">coinsurance</a>	0%
■ Other <a href="#">coinsurance</a>	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*)

<b>Total Example Cost</b>	<b>\$12,731</b>
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#### In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$40
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$10
<b>The total Peg would pay is</b>	<b>\$50</b>

### Managing Joe's type 2 Diabetes

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$0
■ <a href="#">Specialist copayment</a>	\$0
■ Hospital (facility) <a href="#">coinsurance</a>	0%
■ Other <a href="#">coinsurance</a>	0%

#### 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*)

<b>Total Example Cost</b>	<b>\$7,389</b>
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#### In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$200
Coinsurance	\$400
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Joe would pay is</b>	<b>\$600</b>

### Mia's Simple Fracture

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$0
■ <a href="#">Specialist copayment</a>	\$0
■ Hospital (facility) <a href="#">coinsurance</a>	0%
■ Other <a href="#">coinsurance</a>	0%

#### This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)  
 Diagnostic test (*x-ray*)  
 Durable medical equipment (*crutches*)  
 Rehabilitation services (*physical therapy*)

<b>Total Example Cost</b>	<b>\$1,925</b>
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#### In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$60
Coinsurance	\$40
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$100</b>