




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) or call 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/glossary/essential-health-benefits/> or call 1-877-533-5020 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	\$250 individual / \$500 family	You must pay all the costs up to the <a href="#">deductible</a> amount before the policy begins to pay for covered services you use, with the exceptions of office visit <a href="#">copays</a> and for federally required preventive services. The <a href="#">deductible</a> starts over with each plan year beginning on January 1 <sup>st</sup> . See the chart starting on page 2 for your costs for services this plan covers.
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. <a href="#">Preventive care</a> and primary care services are covered before you meet your <a href="#">deductible</a> .	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</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> .
Are there other <a href="#">deductibles</a> for specific services?	No	There are no other <a href="#">deductibles</a> .
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	<p><u>Medical:</u> \$1,250 individual/\$2,500 family</p> <p><u>Prescription drug:</u> Level 1 and 2: \$600 individual/\$1,200 family Level 4: \$1,200 individual/\$2,400 family</p>	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 \$8,150 individual/\$16,300 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.
What is not included in the <a href="#">out-of-pocket limit</a> ?	<a href="#">Copays</a> for Level 3 and Level 4 <a href="#">non-preferred specialty drugs</a> ; <a href="#">coinsurance</a> paid by adults for hearing aids, premiums and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .

Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See <a href="http://www.prevea360.com/About-Prevea360-Health-Plan/Find-a-Prevea360-Provider-Doctor.aspx">http://www.prevea360.com/About-Prevea360-Health-Plan/Find-a-Prevea360-Provider-Doctor.aspx</a> or call 1-877-230-7555 (TTY: 711) for a list of network <a href="#">providers</a> .	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.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	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.

 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 <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	\$15 <a href="#">copay</a> /visit	Not covered	<a href="#">Deductible</a> does not apply. Additional services (e.g. labs, x-rays, etc.) during the visit are subject to applicable <a href="#">deductibles</a> and <a href="#">coinsurance</a> .
	<a href="#">Specialist</a> visit	\$25 <a href="#">copay</a> /visit	Not covered unless prior-authorized	<a href="#">Deductible</a> does not apply. Additional services (e.g. labs, x-rays, etc.) during the visit are subject to applicable <a href="#">deductibles</a> and <a href="#">coinsurance</a> .
	Other practitioner office visit	\$15 <a href="#">copay</a> /visit (includes chiropractic visits)	Not covered	<a href="#">Deductible</a> does not apply. Maintenance care and acupuncture not covered. Additional services (e.g. labs, x-rays, etc.) during the visit are subject to applicable <a href="#">deductibles</a> and <a href="#">coinsurance</a> .
	<a href="#">Preventive care/screening/immunization</a>	\$15 primary care visit <a href="#">copay</a> and 10% <a href="#">coinsurance</a> after <a href="#">deductible</a> for related services.	Not Covered	Full coverage if required by federal law. For details visit: <a href="https://www.healthcare.gov/preventive-care-benefits/">https://www.healthcare.gov/preventive-care-benefits/</a>
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	10% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Not covered	Full coverage if required by federal law.

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)	
	Imaging (CT/PET scans, MRIs)	10% <a href="#">coinsurance</a> after <a href="#">deductible</a>	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. <a href="#">Member must pay the cost difference between the non-preferred brand drug and the preferred generic equivalent drug if not medically necessary.</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> at <a href="#">preferred</a> specialty pharmacy provider	\$50 <a href="#">copay</a> per prescription for <a href="#">preferred</a> drugs to specialty <a href="#">out-of-pocket limit</a> .  40% <a href="#">coinsurance</a> (\$200 max) per prescription for <a href="#">non-preferred</a> drugs. No <a href="#">out-of-pocket limit</a> .	Not covered	<a href="#">Out-of-network</a> care allowed but if your ID card is not used, you will pay more than the copay.  Federal <a href="#">maximum out-of-pocket</a> 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)	
	Level 4: <a href="#">Specialty drugs</a> at participating pharmacy provider	40% <a href="#">coinsurance</a> (\$200 max) per prescription for <a href="#">preferred</a> drugs to specialty <a href="#">out-of-pocket limit</a> .  40% <a href="#">coinsurance</a> (\$200 max) per prescription for <a href="#">non-preferred</a> drugs. No <a href="#">out-of-pocket limit</a> .		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% <a href="#">coinsurance</a> after <a href="#">deductible</a> .	Not covered	-----NONE-----
	Physician/surgeon fees	\$15 <a href="#">copay</a> for primary doctor office visit  \$25 <a href="#">copay</a> for <a href="#">specialist</a> office visit	Not covered	Additional services provided (e.g. costs of surgery, equipment, etc.) are subject to applicable <a href="#">deductible</a> and <a href="#">coinsurance</a> . Prior approval required for low back surgeries and MRI, CT and PET scans.
If you need immediate medical attention	<a href="#">Emergency room care</a>	\$75 <a href="#">copay</a> , <a href="#">deductible</a> then 10% <a href="#">coinsurance</a>	\$75 <a href="#">copay</a> , <a href="#">deductible</a> then 10% <a href="#">coinsurance</a>	<a href="#">Copay</a> is waived if admitted.
	<a href="#">Emergency medical transportation</a>	10% <a href="#">coinsurance</a> after <a href="#">deductible</a>	10% <a href="#">coinsurance</a> after <a href="#">deductible</a>	-----NONE-----
	<a href="#">Urgent care</a>	\$25 <a href="#">copay</a> /visit	\$25 <a href="#">copay</a> /visit	<a href="#">Deductible</a> does not apply. Additional services (e.g. labs, x-rays, etc.) during the visit are subject to applicable <a href="#">deductibles</a> and <a href="#">coinsurance</a> .
If you have a hospital stay	Facility fee (e.g., hospital room)	10% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Not covered	Prior approval recommended
	Physician/surgeon fees	10% <a href="#">coinsurance</a> after <a href="#">deductible</a>	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		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<b>If you need mental health, behavioral health, or substance abuse services</b>	Mental/Behavioral health outpatient services	\$15 <a href="#">copay</a> /visit	Not covered	<a href="#">Deductible</a> does not apply.
	Mental/Behavioral health inpatient services	10% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Not covered	-----NONE-----
	Substance use disorder outpatient services	\$15 <a href="#">copay</a> /visit	Not covered	<a href="#">Deductible</a> does not apply.
	Substance use disorder inpatient services	10% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Not covered	-----NONE-----
<b>If you are pregnant</b>	Office visits	\$15 <a href="#">copay</a> /visit	Not covered	<a href="#">Deductible</a> does not apply for copay visits.  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% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Not covered	-----NONE-----
	Childbirth/delivery facility services	10% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Not covered	-----NONE-----
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	10% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Not covered	Limited to 50 visits per year. Plan may approve 50 more per year.
	<a href="#">Rehabilitation services</a>	\$15 <a href="#">copay</a> /visit	Not covered	<a href="#">Deductible</a> does not apply. 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>	\$15 <a href="#">copay</a> /visit	Not covered	<a href="#">Deductible</a> does not apply. 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="#">Skilled nursing care</a>	10% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Not covered	Facility coverage is limited to 120 days per benefit period.
	<a href="#">Durable medical equipment</a>	20% <a href="#">coinsurance</a> after	Not covered	Hearing aids (adults) plan maximum payment

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)	
		<a href="#">deductible</a> (child's hearing aids 10%)		\$1,000 per ear every 3 years.
	<a href="#">Hospice services</a>	10% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Not covered	-----NONE-----
If your child needs dental or eye care	Children's eye exam	\$25 <a href="#">copay</a>	Not covered	Limited to one per individual per year. Contact lens fitting not covered. Full coverage if required by federal law. <a href="#">Deductible</a> does not apply.
	Children's glasses	Not covered	Not covered	Excluded service.
	Children's dental check-up	Not covered	Not covered	Excluded services.

#### 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 Cleanings | • Non-emergency care when traveling outside US |                        |

##### 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   | • Routine eye care, limited to one eye exam per calendar year by a plan provider |
| • Vaccines at in-network retail pharmacies  | • Telemedicine   | • E-visit service  |
|   | • Telehealth   | • Chiropractic care  |
|   | • 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 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: Prevea360 Health Plan at 1-877-230-7555 (TTY: 711) 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 1-877-230-7555 (TTY: 711).

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-877-230-7555 (TTY: 711).

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1-877-230-7555 (TTY: 711)。

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-877-230-7555 (TTY: 711).

ال لغوية المساعدة خدمات ف إنة، ال لغ اذكر ت تحدث ك نت إذا :ملحوظة 1-877-230-7555 (رقم  
ب رقم ات صل ي الامجان لك ت توافر وال بكم ال صم هات ف (TTY: 711) .

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-877-230-7555 (TTY: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-877-230-7555 (TTY: 711). 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 1-877-230-7555 (TTY: 711).

Wann du [Deutsch (Pennsylvania German / Dutch)] schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: 1-877-230-7555 (TTY: 711).

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີຮັບໃຫ້ທ່ານ. ໂທ 1-877-230-7555 (TTY: 711).

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-877-230-7555 (TTY: 711).

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-877-230-7555 (TTY: 711).

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-877-230-7555 (TTY: 711) पर कॉल करें।



KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1-877-230-7555 (TTY: 711).

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-877-230-7555 (TTY: 711).

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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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## 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>	\$250
■ <a href="#">Specialist copayment</a>	\$25
■ Hospital (facility) <a href="#">coinsurance</a>	10%
■ Other <a href="#">coinsurance</a>	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*)

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

Cost Sharing	
Deductibles	\$250
Copayments	\$300
Coinsurance	\$800
What isn't covered	
Limits or exclusions	\$10
<b>The total Peg would pay is</b>	<b>\$1,360</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>	\$250
■ <a href="#">Specialist copayment</a>	\$25
■ Hospital (facility) <a href="#">coinsurance</a>	10%
■ Other <a href="#">coinsurance</a>	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*)

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

Cost Sharing	
Deductibles	\$100
Copayments	\$300
Coinsurance	\$400
What isn't covered	
Limits or exclusions	\$0
<b>The total Joe would pay is</b>	<b>\$800</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>	\$250
■ <a href="#">Specialist copayment</a>	\$25
■ Hospital (facility) <a href="#">coinsurance</a>	10%
■ Other <a href="#">coinsurance</a>	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*)

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

Cost Sharing	
Deductibles	\$250
Copayments	\$100
Coinsurance	\$200
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$550</b>