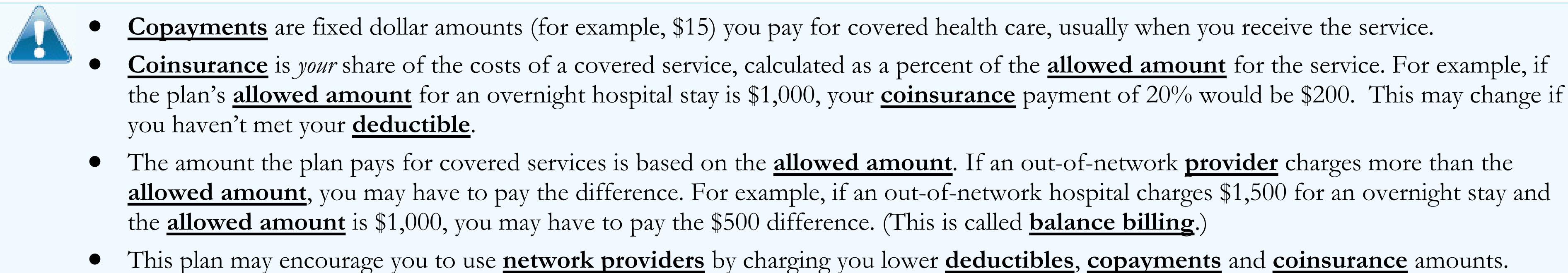
This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.prevea360.com or by calling (877) 230-7555 or TTY 711.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$1500** /per person per contract period **$3000** /per family per contract period Copays do not apply toward the deductible.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. The total **out-of-pocket** limit for covered services is **$2500** person/**$5000** family. Included in the **out-of-pocket** limit is a deductible and coinsurance limit, which for covered services is **$1500** person/ **$3000** family.	The total **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 network services. This limit helps you plan for health care expenses. The deductible and coinsurance limit does not include copayments. Once the deductible and coinsurance limit is met, the plan pays 100% of allowed amounts, not including copayments; the members pay copayments until they reach the total **out-of-pocket** limit.
What is not included in the out–of–pocket limit?	Premiums, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket** limit.
Does this plan use a network of providers?	Yes. For a list of **plan providers**, see www.prevea360.com or call **(877) 230-7555 or TTY 711**.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the terms in-network, **preferred**, or participating for providers in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No.	You can see the **specialist** you choose without permission from this plan.
Are there services this	Yes.	Some of the services this plan doesn't cover are listed on page 6. See your

plan doesn't cover?		policy or plan document for additional information about **excluded services**.



- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use **network providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	0% coinsurance after deductible	Not covered	---none---
	Specialist visit	0% coinsurance after deductible	Not covered	No coverage for infertility services.
	Other practitioner office visit	0% coinsurance after deductible for chiropractor	Not covered	No coverage for Chiropractic maintenance or long-term therapy. No coverage for acupuncture.
	Preventive care/screening/immunization	$0 copay/visit	Not covered	Services under the ACA guidelines will be covered as preventive. Services may have a limit on number of visits and/or specific age requirements. For additional information please see the Preventive Services section in your Member Certificate.
If you have a test	Diagnostic test (x-ray, blood work)	0% coinsurance after deductible	Not covered	---none---
	Imaging (CT/PET scans, MRIs)	0% coinsurance after deductible	Not covered	

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.prevea360.com	TIER 1 drugs	$10 copay/prescription (retail)	Not covered (retail and mail order)	For mail order maintenance prescriptions, a 90-day supply (Tiers 1 & 2) for 2 copays; 90-day supply (Tier 3) for 3 copays; Tier 4 and Tier 5 Not Covered.
	TIER 2 drugs	$25 copay/prescription (retail)	Not covered (retail and mail order)	
	TIER 3 drugs	$50 copay/prescription (retail)	Not covered (retail and mail order)	
	Specialty drugs	Not covered	Not covered (retail and mail order)	Tobacco cessation products will be covered with a $0 copay if member enrolls in the Quit for Life program. Failure to enroll in Quit for Life will result in not covered Tobacco cessation products. Infertility drugs not covered (retail and mail order)
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% coinsurance after deductible	Not covered	---none---
	Physician/surgeon fees	0% coinsurance after deductible	Not covered	
If you need immediate medical attention	Emergency room services	0% coinsurance after deductible	0% coinsurance after deductible	Initial emergency services are covered with non-plan providers. Copay is waived if admitted for observation or inpatient.
	Emergency medical transportation	0% coinsurance after deductible	0% coinsurance after deductible	---none---
	Urgent care	0% coinsurance after deductible	0% coinsurance after deductible	Initial urgent care services are covered with non-plan providers.
If you have a hospital stay	Facility fee (e.g., hospital room)	0% coinsurance after deductible	Not covered	---none---
	Physician/surgeon fee	0% coinsurance after deductible	Not covered	
If you have mental health, behavioral	Mental/Behavioral health outpatient	0% coinsurance after deductible	Not covered	---none---

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
health, or substance abuse needs	services			
	Mental/Behavioral health inpatient services	0% coinsurance after deductible	Not covered	---none---
	Substance use disorder outpatient services	0% coinsurance after deductible	Not covered	---none---
	Substance use disorder inpatient services	0% coinsurance after deductible	Not covered	---none---
If you are pregnant	Prenatal and postnatal care	0% coinsurance after deductible	Not covered	Home or intentional out of hospital deliveries are not covered.
	Delivery and all inpatient services	0% coinsurance after deductible	Not covered	
If you need help recovering or have other special health needs	Home health care	0% coinsurance after deductible	Not covered	Services for home health are limited to 60 visits per contract period.
	Rehabilitation services	0% coinsurance after deductible	Not covered	Services for rehabilitation care are limited to 90 days per contract period. Services for PT/OT/ST are limited to 60 visits per contract period. Services for custodial care are a policy exclusion.
	Habilitation services	0% coinsurance after deductible	Not covered	Services for habilitation are limited to 60 visits per contract period. Services for custodial care are a policy exclusion.
	Skilled nursing care	0% coinsurance after deductible	Not covered	Services for skilled nursing are limited to 30 days per contract period.
	Durable medical equipment	0% coinsurance after deductible	Not covered	---none---
	Hospice service	0% coinsurance after deductible	Not covered	---none---
If your child needs dental or eye care	Eye exam	0% coinsurance after deductible	Not covered	---none---
	Glasses	Not covered	Not covered	---none---

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
	Dental check-up	Not covered	Not covered	---none---

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)		
• Acupuncture • Cosmetic services including surgery • Dental care (Adult) • Glasses	• Infertility treatment • Long-term care • Non-emergency care when traveling outside the U.S.	• Private-duty nursing • Routine foot care

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)		
• Bariatric Surgery after written approval and completion of Weight Management program. • Chiropractic care	• Hearing aids	• Routine eye care • Weight Loss Programs as part of our Comprehensive Weight Management Program

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at (877) 230-7555 or TTY 711. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at (866) 444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at (877) 267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact the insurer at: (877) 230-7555 or TTY 711. You may also contact your state insurance department at (800) 236-8517 or http://oci.wi.gov/."For plans subject to ERISA you may also contact the Department of Labor's Employee Benefit Security Administration at (866) 444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

SPANISH (Español): Para obtener asistencia en Español, llame al: (877) 230-7555 or TTY 711.

TAGALOG (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa: (877) 230-7555 or TTY 711.

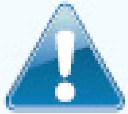
CHINESE (中文): 如果需要中文的帮助，**请拨打这个号码**: (877) 230-7555 or TTY 711.

NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne': (877) 230-7555 or TTY 711.

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

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $5,820
- **Patient pays** $1,720

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$1,500
Copays	$20
Coinsurance	$0
Limits or exclusions	$200
Total	**$1,720**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $3,500
- **Patient pays** $1,900

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$1,000
Copays	$700
Coinsurance	$0
Limits or exclusions	$200
Total	**$1,900**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✗ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.