State of Wisconsin and WPE Local – IYC Health Plan Uniform Benefit: PREVEA360 health plan℠ Group Type: Individual & Family Plan Type: HMO

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?	$250 individual/$500 family	If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible. 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?	Medical: $1,250 individual/$2,500 family Prescription drug: Level 1 and 2: $600 Individual $1,200 Family	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 $9,200 individual/$18,400 family. This applies to all essential health benefits, including 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 for Level 3 and Level 4 non-preferred specialty drugs. 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 https://www.prevea360.com/Find-A-Doctor or call 1 (877) 230-7555	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

	(TTY: 711) for a list of network providers	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		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 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.
	Specialist visit	$25 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.
	Preventive care/screening/ immunization	No charge	Not covered	All preventive care services that have received an A or B grade by the United States Preventive Services Task Force are covered without cost sharing. Ask your in-network provider if the services needed are preventive. Then check what your plan will pay for. Full coverage is 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 and https://benefitplans.navitus.com/etf	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. Out-of-pocket-limit of $600 for an individual and $1,200 for a family.
	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. Out-of-pocket-limit of $600 for an individual and $1,200 for a family.
	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.	Federal maximum out-of-pocket-limit of $9,200 for an individual and $18,400 for a family applies for some Level 3 drugs.
	Level 4: Specialty drugs at preferred specialty pharmacy provider	$50 copay per prescription for preferred drugs to specialty 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,	Federal maximum out-of-pocket-limit of $9,200 for an individual and $18,400 for a family applies for some Level 4 drugs.

			you should pay for the prescription in full and submit a reimbursement form to Navitus.	
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 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	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, deductible then 10% coinsurance	$75 copay, deductible then 10% coinsurance	Copay is waived if admitted. Additional services (e.g. equipment, etc.) during the visit are subject to applicable deductible and coinsurance.
	Emergency medical transportation	10% coinsurance after deductible	10% coinsurance after deductible	None
	Urgent care	$25 copay/visit	$25 copay/visit	Deductible does not apply. Additional services (e.g., labs, x-rays, etc.) during the visit are subject to applicable deductible and coinsurance.
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)	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	Not covered	Additional services (e.g. labs, x-rays, etc.) during the visit are subject to applicable deductible and coinsurance.
	Inpatient services	10% coinsurance after deductible	Not covered	Additional services (e.g. labs, x-rays, etc.) during the visit are subject to applicable deductible and coinsurance.

If you are pregnant	Office visits	$15 copay/visit	Not covered	Deductible does not apply for copay visits. Deductible and 10% coinsurance apply if prenatal and/or postnatal care billed as a package.
	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	Not covered	Deductible 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 therapy, per participant, per year.
	Habilitation services	$15 copay/visit	Not covered	Deductible 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 therapy, per participant, per year.
	Skilled nursing care	10% coinsurance after deductible	Not covered	Facility coverage is limited to 120 days per benefit period.
	Durable medical equipment	20% coinsurance after deductible	Not covered	Hearing aids (adults) plan maximum payment $1,000 per ear every 3 years. Children's hearing aids have no plan maximum payment.
	Hospice services	10% coinsurance after deductible	Not covered	None

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 your child needs dental or eye care	Children's eye exam	$25 copay	Not covered	Limited to one per individual per year. Contact lens fitting not covered. Full coverage if required by federal law. Deductible 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.)			
• Cosmetic surgery	• Infertility treatment	• Non-emergency care when traveling outside US	• Routine foot care
• Dental care (Adult)	• Long-term care	• Private-duty nursing	• 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: Prevea360 Health Plan at 1 (877) 230-7555 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 (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).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية المجان لك تتوافر. بالبكم الصم هاتف برقم اتصل 1 (877) 230-7555 (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 [Deitsch (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, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 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).

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

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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	$250
Specialist *[copay]*	*$25*
Hospital (facility) *[coinsurance]*	*10%*
Other *[coinsurance]*	*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	$12,700

In this example, Peg would pay:

Cost Sharing	
Deductibles	$250
Copayments	$200
Coinsurance	$800
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	$1,250

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$250
Specialist *[copay]*	$25
Hospital (facility) *[coinsurance]*	*10%*
Other *[coinsurance]*	*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	$5,600

In this example, Joe would pay:

Cost Sharing	
Deductibles	$250
Copayments	$300**
Coinsurance	$400**
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	$950**

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

The plan's overall deductible	$250
Specialist *[copay]*	$25
Hospital (facility) *[coinsurance]*	*10%*
Other *[coinsurance]*	*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	$2,800

In this example, Mia would pay:

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

**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 contact: https://www.webmdhealth.com/wellwisconsin/ or 1-800-821-6591