PREVEA360 health plan℠ Prevea360 Catastrophic Safety Net01

Coverage for: 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, visit https://sbc.prevea360.com/Individual or call (877) 230-7555 or TTY 711. 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.dol.gov/ebsa/healthreform or https://www.healthcare.gov/sbc-glossary or call (877) 230-7555 or TTY 711 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$8,550/Individual $17,100/Family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. 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.
Are there services covered before you meet your deductible?	Yes. Preventive 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?	$8,550 individual / $17,100 family.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balanced-billing 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.
Will you pay less if you use a network provider?	Yes. See http://www.prevea360.com/About-Prevea360-Health-Plan/Find-a-Prevea360-Provider-Doctor.aspx or call 1-877-230-7555 or TTY 711 for 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 difference 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.

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	$0 copay/visit for the first 3 visits then 0% coinsurance after deductible	Not Covered	No coverage for Chiropractic maintenance or long-term therapy. This plan offers a combined copay limit on various office visit services. Each service does not offer a separate office visit copay limit.
	Specialist visit	0% coinsurance after deductible	Not Covered	No coverage for infertility services. No coverage for acupuncture.
	Preventive care/screening/ immunization	No charge	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. 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.
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	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 need drugs to treat your illness or condition More information about prescription drug coverage is available at www.prevea360.com/pharmacy	Preferred generic drugs (Tier 1)	0% coinsurance after deductible / prescription (retail); Mail order maintenance prescriptions, a 90-day supply at coinsurance listed above.	Not Covered (retail and mail order)	None
	Non-preferred generic, Preferred brand drugs (Tier 2)	0% coinsurance after deductible / prescription (retail); Mail order maintenance prescriptions, a 90-day supply at coinsurance listed above.	Not Covered (retail and mail order)	
	Non-preferred generic, Non-preferred brand drugs (Tier 3)	0% coinsurance after deductible / prescription (retail); Mail order maintenance prescriptions, a 90-day supply at coinsurance listed above.	Not Covered (retail and mail order)	
	Specialty drugs (Tier 4)	0% coinsurance after deductible / prescription (retail); Mail order maintenance prescriptions not covered.	Not Covered (retail and mail order)	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 care	0% coinsurance after deductible	0% coinsurance after deductible	Initial emergency services are covered with out-of-network 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 out-of-network providers.

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 have a hospital stay	Facility fee (e.g., hospital room)	0% coinsurance after deductible	Not Covered	None
	Physician/surgeon fees	0% coinsurance after deductible	Not Covered	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$0 copay/visit for the first 3 visits then 0% coinsurance after deductible	Not Covered	This plan offers a combined copay limit on various office visit services. Each service does not offer a separate office visit copay limit.
	Inpatient services	0% coinsurance after deductible	Not Covered	None
If you are pregnant	Office visits	Primary Care Visit: $0 copay/visit for the first 3 visits then 0% coinsurance after deductible; Specialist Visit: 0% coinsurance after deductible	Not Covered	Home or intentional out of hospital deliveries are not covered. Cost sharing does not apply for preventive services. Depending on the type of services, a copayment, coinsurance, or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	0% coinsurance after deductible	Not Covered	
	Childbirth/delivery facility 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	60 visits/contract period.
	Rehabilitation services	Inpatient Rehabilitation services: 0% coinsurance after deductible; PT/OT/ST: $0 copay/visit for the first 3 visits then 0% coinsurance after deductible	Not Covered	Inpatient Rehabilitation care - 90 days/contract period. Physical, Occupational, and Speech Therapy - 20 visits per therapy type/ contract period. Services for custodial care are a policy exclusion.
	Habilitation services	$0 copay/visit for the first 3 visits then 0% coinsurance after deductible	Not Covered	Habilitative therapies - 20 visits per therapy type/contract period. Services for custodial care are a policy exclusion. This plan offers a combined copay limit on various office visit services. Each service does not offer a separate office visit copay limit.
	Skilled nursing care	0% coinsurance after deductible	Not Covered	30 days/confinement.

* For more information about limitations and exceptions, see the plan or policy document at https://sbc.prevea360.com/Individual.

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)	
	Durable medical equipment	0% coinsurance after deductible	Not Covered	None
	Hospice services	0% coinsurance after deductible	Not Covered	None
If your child needs dental or eye care	Children's eye exam	$0 copay/visit for the first 3 visits then 0% coinsurance after deductible	Not Covered	Exams performed by an ophthalmologist will incur the specialty office visit cost share. This plan offers a combined copay limit on various office visit services. Each service does not offer a separate office visit copay limit.
	Children's glasses	0% coinsurance after deductible	Not Covered	One pair per contract year.
	Children's dental check-up	Not Covered	Not Covered	This policy does not include pediatric dental services as required under the federal Patient Protection and Affordable Care Act. This coverage is available in the insurance market and can be purchased as a stand-alone product. Please contact your insurance carrier, agent, or the Federally Facilitated Exchange if you wish to purchase pediatric dental coverage or a stand-alone dental services product.

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.)

- Abortion (except in cases of rape, incest, or when the life of the mother is endangered)
- Acupuncture
- Bariatric Surgery
- Cosmetic services including surgery
- Dental care (Adult)
- Infertility Treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Pediatric Dental Care
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care
- 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 (Limited to one aid per ear every 36 months)

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-EBSA (3272) or https://www.dol.gov/agencies/ebsa/about-ebsa/ask-a-question/ask-ebsa; Wisconsin Office of the Commissioner of Insurance at (800) 236-8517 or http://oci.wi.gov/consinfo.htm; Office of Personnel Management Multi State Plan Program at https://www.opm.gov/healthcare-insurance/multi-state-plan-program/external-review/; or Healthcare.gov at www.Healthcare.gov or call 1-800-318-2596. 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 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: Wisconsin Office of the Commissioner of Insurance at P.O. Box 7873, Madison, WI 53707-7873, http://oci.wi.gov/ or call (800) 236-8517.

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? Not Applicable.
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:

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

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

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

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

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

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 plan's overall deductible	$8,550
Specialist coinsurance	0%
Hospital (facility) coinsurance	0%
Other coinsurance	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)*

Total Example Cost	$12,700

In this example, Peg would pay:

Cost Sharing	
Deductibles	$8,550
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$8,610

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

The plan's overall deductible	$8,550
Specialist coinsurance	0%
Hospital (facility) coinsurance	0%
Other coinsurance	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)*

Total Example Cost	$5,600

In this example, Joe would pay:

Cost Sharing	
Deductibles	$5,000
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	$5,020

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

The plan's overall deductible	$8,550
Specialist coinsurance	0%
Hospital (facility) coinsurance	0%
Other coinsurance	0%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)s*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	$2,800

In this example, Mia would pay:

Cost Sharing	
Deductibles	$2,500
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$2,500

The plan would be responsible for the other costs of these EXAMPLE covered services.