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://www.prevea360.com/Quote-Buy-Insurance/Employer-Group-Plans/Sample-group-certificates/** 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?	$2000/individual $4000/family	Generally, you must pay all the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the policy, the overall family deductible must be met before the plan begins to pay.
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 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?	$3000 individual / $6000 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, the overall family out-of-pocket limit must be 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 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	20% coinsurance after deductible	Not covered	No coverage for Chiropractic maintenance or long-term therapy.
	Specialist visit	20% coinsurance after deductible	Not covered	No coverage for infertility services. 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. 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)	20% coinsurance after deductible	Not covered	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance after deductible	Not covered	
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)	20% coinsurance after deductible / prescription (retail)	Not covered (retail and mail order)	For mail order maintenance prescriptions, a 90-day supply (Tiers 1 - 3) policy coinsurance after deductible; Tier 4 & Tier 5 not covered.
	Non-preferred generic, Preferred brand drugs (Tier 2)	20% coinsurance after deductible / prescription (retail)	Not covered (retail and mail order)	
	Non-preferred generic, Non-preferred brand drugs (Tier 3)	20% coinsurance after deductible / prescription (retail)	Not covered (retail and mail order)	
	Non-preferred brand drugs (Tier 4) Specialty Drugs (Tier 5)	20% coinsurance after deductible / prescription (retail) 20% coinsurance after deductible / prescription (retail)	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

* For more information about limitations and exceptions, see the plan or policy document at https://www.prevea360.com/Quote-Buy-Insurance/Employer-Group-Plans/Sample-group-certificates/.

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)	
				order)
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance after deductible	Not covered	None
	Physician/surgeon fees	20% coinsurance after deductible	Not covered	
If you need immediate medical attention	Emergency room care	20% coinsurance after deductible	20% 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	20% coinsurance after deductible	20% coinsurance after deductible	None
	Urgent care	20% coinsurance after deductible	20% coinsurance after deductible	Initial urgent care services are covered with out-of-network providers.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance after deductible	Not covered	None
	Physician/surgeon fees	20% coinsurance after deductible	Not covered	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance after deductible	Not covered	None
	Inpatient services	20% coinsurance after deductible	Not covered	None
If you are pregnant	Office visits	20% 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	20% coinsurance after deductible	Not covered	
	Childbirth/delivery facility services	20% coinsurance after deductible	Not covered	
If you need help recovering or have other special health needs	Home health care	20% coinsurance after deductible	Not covered	60 visits/contract period.
	Rehabilitation services	20% coinsurance after deductible	Not covered	Rehabilitation care - 90 days/contract period PT/OT/ST - 60 visits/contract period Services for custodial care are a policy exclusion.
	Habilitation services	20% coinsurance after	Not covered	Habilitative therapies - 60 visits/contract

* For more information about limitations and exceptions, see the plan or policy document at https://www.prevea360.com/Quote-Buy-Insurance/Employer-Group-Plans/Sample-group-certificates/.

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)	
		deductible		period. Services for custodial care are a policy exclusion.
	Skilled nursing care	20% coinsurance after deductible	Not covered	30 days/confinement.
	Durable medical equipment	20% coinsurance after deductible	Not covered	None
	Hospice services	20% coinsurance after deductible	Not covered	None
If your child needs dental or eye care	Children's eye exam	20% coinsurance after deductible	Not covered	None
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

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
- Cosmetic services including surgery
- Dental care (Adult)
- Glasses
- Infertility Treatment
- Long-term care
- Non-emergency care when travelling outside the U.S.
- Private-duty nursing
- Routine foot care

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- 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: 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/ebsa/healthreform. Other coverage

* For more information about limitations and exceptions, see the plan or policy document at https://www.prevea360.com/Quote-Buy-Insurance/Employer-Group-Plans/Sample-group-certificates/.

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 (800) 236-8517 or http://oci.wi.gov/ or the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or https://www.dol.gov/ebsa/healthreform.

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:
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 section.

* For more information about limitations and exceptions, see the plan or policy document at https://www.prevea360.com/Quote-Buy-Insurance/Employer-Group-Plans/Sample-group-certificates/.

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	$2,000
Specialist coinsurance	20%
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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	**$**12,800

In this example, Peg would pay:

Cost Sharing	
Deductibles	$2,000
Copayments	$0
Coinsurance	$1,000
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,060**

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

The plan's overall deductible	$2,000
Specialist coinsurance	20%
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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	**$**7,400

In this example, Joe would pay:

Cost Sharing	
Deductibles	$2,000
Copayments	$0
Coinsurance	$1,000
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$3,020**

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

The plan's overall deductible	$2,000
Specialist coinsurance	20%
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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	**$**1,900

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,900
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,900**

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

Language Assistance – General Taglines

Prevea360 Health Plan is required by federal law to provide the following information.

If you, or someone you're helping, have questions about Prevea360 Health Plan, you have the right to get help and information in your preferred language at no cost. To talk with an interpreter, call Customer Care at 877.230.7555.

Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de Prevea360 Health Plan, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al Customer Care. 877.230.7555.

Yog koj, los yog tej tus neeg uas koj pab ntawd, muaj lus nug txog Prevea360 Health Plan, koj muaj cai kom lawv muab cov ntshiab lus qhia uas tau muab sau ua koj hom lus pub dawb rau koj. Yog koj xav nrog ib tug neeg txhais lus tham, hu rau Customer Care. 877.230.7555.

如果您，或是您正在協助的對象，有關於[插入SBM項目的名稱 Prevea360 Health Plan 方面的問題，您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥電話 [在此插入數字 Customer Care. 877.230.7555。

Falls Sie oder jemand, dem Sie helfen, Fragen zum Prevea360 Health Plan haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 877.230.7555 an.

إن كان لديك أو لدى شخص تساعده أسئلة بخصوص Prevea Plan Health360 فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون اية تكلفة. للتحدث مع مترجم اتصل بـ 877.230.7555

Если у вас или лица, которому вы помогаете, имеются вопросы по поводу Prevea360 Health Plan, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону Customer Care. 877.230.7555.

만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 Prevea360 Health Plan 에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 877.230.7555 로 전화하십시오.

Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Prevea360 Health Plan, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi Customer Care. 877.230.7555.

Wann du hoscht en Froog, odder ebber, wu du helfscht, hot en Froog baut Prevea360 Health Plan, hoscht du es Recht fer Hilf un Information in deinre eegne Schprooch griege, un die Hilf koschtet nix. Wann du mit me Interpreter schwetze witt, kannscht du 877.230.7555 uffrufe.

ຖ້າທ່ານ, ຫຼືບຸກຄົນທີ່ທ່ານກໍາລັງຊ່ວຍເຫຼືອ, ມີຄໍາຖາມກ່ຽວກັບ Prevea360 Health Plan, ທ່ານມີສິດທີ່ຈະໄດ້ຮັບການຊ່ວຍເຫຼືອແລະຂໍ້ມູນຂ່າວສານເປັນພາສາຂອງທ່ານບໍ່ຄິດໄລ່ຈ່າຍ. ການໂອ້ລົມກັບນາຍພາສາ, ໃຫ້ໂທຫາ Customer Care. 877.230.7555.

Si vous, ou quelqu'un que vous êtes en train d'aider, a des questions à propos de Prevea360 Health Plan, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez Customer Care. 877.230.7555.

Jeśli Ty lub osoba, której pomagasz ,macie pytania odnośnie Prevea360 Health Plan, masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku .Aby porozmawiać z tłumaczem, zadzwoń pod numer Customer Care. 877.230.7555.

यदि आपके ,या आप द्वारा सहायता किए जा रहे किसी व्यक्ति के Prevea360 Health Plan के बारे में प्रश्न हैं ,तो आपके पास अपनी भाषा में मुफ्त में सहायता और सूचना प्राप्त करने का अधिकार है। किसी दुभाषिए से बात करने के लिए ,877.230.7555 पर कॉल करें।

Nëse ju, ose dikush që po ndihmoni, ka pyetje për Prevea360 Health Plan, keni të drejtë të merrni ndihmë dhe informacion falas në gjuhën tuaj. Për të folur me një përkthyes, telefononi numrin Customer Care. 877.230.7555.

Kung ikaw, o ang iyong tinutulangan, ay may mga katanungan tungkol sa Prevea360 Health Plan, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa Customer Care. 877.230.7555.

Non-Discrimination Statement: Prevea360 Health Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. Prevea360 Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability or sex. Prevea360 Health Plan 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 (large print, audio, accessible electronic formats, other formats). Prevea360 Health Plan 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 the Prevea360 Health Plan Customer Care Center at 877.230.7555. If you believe that Prevea360 Health Plan 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. If you need help filing a grievance, Megan Simpson, Civil Rights Coordinator for Prevea360 Health Plan is available to help you. You can file a grievance in person or by mail, fax, or email:

Megan Simpson, Civil Rights Coordinator
1277 Deming Way
Madison, Wisconsin 53717
Phone: 608.828.2216
Email: civilrightscoordinator@deancare.com

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, D.C. 20201
1.800.368.1019, 800.537.7697 (TDD)