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.etf.wi.gov or by calling 1-877-533-5020.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	$250 per person/$500 per family	You must pay all the costs up to the **deductible** amount before the policy begins to pay for covered services you use. Check your certificate to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for your costs for services this plan covers.
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. Medical: $1,250 person/$2,500 family. Prescription drug Level 1 and 2: $600 individual/$1,200 family. Level 4: $1,200 individual/$2,400 family	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 $6,850 person/$13,700 family. This applies to all essential health benefits, including some services not included in the out-of-pocket limit.
What is not included in the out–of–pocket limit?	Copays for Level 3 and Level 4 non-preferred specialty drugs; coinsurance paid by adults for hearing aids, 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**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of in-network providers, see www.mercycarehealthplans.com or call 800-895-2421 for a list of participating providers.	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 term 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?	Yes	This plan will pay for some or all of the costs for covered services but only if you have the plan's permission before you see the specialist.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your 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 in-network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an In-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	$15 copay/visit	Not covered	Deductible does not apply. Additional services during the visit are subject to applicable deductibles and coinsurance.
	Specialist visit	$25 copay/visit	Not covered	Deductible does not apply. Additional services during the visit are subject to applicable deductibles and coinsurance.
	Other practitioner office visit	$15 copay/visit (includes chiropractic visits)	Not covered	Deductible does not apply; Maintenance care and acupuncture not covered. Additional services during the visit are subject to applicable deductibles and coinsurance.
	Preventive care/screening/immunization	10% coinsurance after deductible	Not covered	Full coverage if 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 approval required or benefits not payable

Common Medical Event	Services You May Need	Your Cost If You Use an In-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.navitus.com	Level 1 Preferred generic drugs and certain lower cost preferred brand name drugs	$5 per prescription to **out-of-pocket limit**. (2 copays apply to certain 90-day supply mail order.)	Not covered	Out-of-network emergency or urgent care allowed but if your ID card is not used, you may have to pay more than the copay.
	Level 2 Preferred brand name drugs and certain higher cost preferred generic drugs	20% coinsurance ($50 maximum) per prescription to **out-of-pocket limit**. (2 copays apply to certain 90-day supply mail order.)	Not covered	Out-of-network emergency or urgent care allowed but if your ID card is not used, you may have to pay more than the copay.
	Level 3 Non-preferred prescription drugs	40% coinsurance ($150 maximum) per prescription. No out-of-pocket limit	Not covered	Out-of-network emergency or urgent care allowed but if your ID card is not used, you may have to pay more than the copay.
	Level 4 Specialty drugs at preferred provider	$50 copay per prescription for **preferred** drugs to specialty out-of-pocket limit. 40% coinsurance ($200 maximum) **non-preferred** drugs. No out-of-pocket limit.	Not covered	Out-of-network emergency or urgent care allowed but if your ID card is not used, you may have to pay more than the copay. Federal maximum out-of-pocket applies.
	Level 4 Specialty drugs at non-preferred provider	40% coinsurance ($200 maximum) per prescription for **preferred** drugs to specialty out-of-pocket limit. 40% coinsurance ($200 maximum) per prescription for **non-preferred** drugs. No out-of-pocket limit	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance after deductible	Not covered	——————none——————
	Physician/surgeon fees	$25 copay for specialist office visit $15 copay for primary doctor office visit	Not covered	Additional services provided are subject to applicable deductibles and coinsurance. Prior approval required for low back surgeries or benefits not payable.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you need immediate medical attention	Emergency room services	$75 copay, deductible then 10% coinsurance	$75 copay, deductible then 10% coinsurance	Copay is waived if admitted.
	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 deductibles 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 fee	10% coinsurance after deductible	Not covered	Prior approval required for low back surgeries or benefits not payable
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$15 copay/visit	Not covered	Deductible does not apply
	Mental/Behavioral health inpatient services	10% coinsurance after deductible	Not covered	——————none——————
	Substance use disorder outpatient services	$15 copay/visit	Not covered	Deductible does not apply
	Substance use disorder inpatient services	10% coinsurance after deductible	Not covered	——————none——————
If you are pregnant	Prenatal and postnatal care	$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. Full coverage if required by federal

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
	Delivery and all inpatient services	10% coinsurance after deductible	Not covered	Deductible does not apply. Additional services (during the visit are subject to
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	Physical, speech and occupational therapy limited to 50 visits per year, combined rehabilitation and habilitation services. Plan may approve 50 more per year.
	Habilitation services	$15 copay/visit	Not covered	Physical, speech and occupational therapy limited to 50 visits per year, combined rehabilitation and habilitation services. Plan may approve 50 more 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 (child's hearing aids 10%)	Not covered	Hearing aids (adults) plan maximum payment $1,000 per ear every 3 years.
	Hospice service	10% coinsurance after deductible	Not covered	————————none————————
If your child needs dental or eye care	Eye exam	$25 copay	Not Covered	Limited to one per person per year. Contact lens fittings not covered. Full coverage if required by federal law.
	Glasses	Not Covered	Not Covered	Excluded service.
	Dental check-up	Not Covered	Not Covered	Excluded service.

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
- Bariatric Surgery
- Cosmetic Surgery
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside US
- Private duty nursing
- Routine foot care
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your plan documents for other covered services and your costs for these services.)

- Chiropractic Care
- Dental Care, limited to certain oral surgical services and treatment of injuries
- Hearing aids
- Routine eye care, limited to one eye exam per calendar year by a plan provider

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 a **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 1-888-915-4001. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or 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.

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: MercyCare Health Plans at 800-895-2421 or ETF at 1-877-533-5020 or www.etf.wi.gov.

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.**

Questions: Call 1-877-533-5020, visit us at **www.etf.wi.gov.** If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.**etf.wi.gov\publications\IYC\iyc2016\uniform-glossary.pdf** or call 1-877-533-5020 to request a copy.

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** $6,340
- **Patient pays** $1,200

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,300
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$500
Copays	$0
Coinsurance	$700
Limits or exclusions	$0
Total	**$1,200**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $4,180
- **Patient pays** $1,220

Sample care costs:

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

Patient pays:

Deductibles	$250
Copays *(Prescription only Tier 1,2)*	$600
Coinsurance *(20% DME, 10% other)*	$370
Limits or exclusions	$0
Total	**$1,220**

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 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.