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 www.etf.wi.gov. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other terms see the Glossary. You can view the Glossary at https://www.healthcare.gov/glossary/essential-health-benefits/ or call 1-877-533-5020 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$0	See the chart on page 2 for your costs for service this plan covers.
Are there services covered before you meet your deductible?	No	There are no deductibles for this plan, however, copayments 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	There are no deductibles.
What is the out-of-pocket limit for this plan?	Durable Medical Supplies (DME): $500 per individual. 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 individual/$13,700 family. This applies to all essential health benefits, including some services not included in the out-of-pocket limit. (i.e. certain level 3 & 4 prescription drugs and certain hearing aids covered under this plan). See https://www.healthcare.gov/glossary/essential-health-benefits/ for details.
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 and health care this plan doesn't cover.	Even though you pay these expenses, they do not count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.mercycarehealthplans.com or call 1-800-895-2421- Option 5 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.

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Do you 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.

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	No charge	Not covered	----------NONE----------
	Specialist visit	No charge	Not covered	----------NONE----------
	Other practitioner office visit	No charge	Not covered	Maintenance care and acupuncture not covered
	Preventive care/screening/ immunization	No charge	Not covered	----------NONE----------
If you have a test	Diagnostic test (x-ray, blood work)	No charge	Not covered	----------NONE----------
	Imaging (CT/PET scans, MRIs)	No charge	Not covered	Prior approval required or benefits not payable
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/prescription to out-of-pocket limit. (2 copays apply to certain 90-day supply mail orders)	Not covered	In-network covers most up to a 30-day supply (90-day for certain prescriptions) retail and mail order. Out-of-network care allowed but if your ID card is not used, you will pay more than the copay.
	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)	Not covered	In-network covers most up to a 30-day supply (90-day for certain prescriptions) retail and mail order. Out-of-network care allowed but if your ID card is not used, you will pay more than the copay.
	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.	Not covered	Federal out-of-pocket limit applies. Out-of-network care allowed, but if your ID card is not used, you will pay more than the copay.

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)	
	Level 4: Specialty drugs at preferred specialty pharmacy provider	$50 copay per prescription for preferred drugs to specialty out-of-pocket limit. 40% coinsurance ($200 max) per prescription for non-preferred drugs. No out-of-pocket limit.	Not covered	Out-of-network care allowed but if your ID card is not used, you will pay more than the copay. Federal maximum out-of-pocket applies.
	Level 4: Specialty drugs at participating pharmacy provider	40% coinsurance ($200 max) per prescription for preferred drugs to specialty out-of-pocket limit. 40% coinsurance ($200 max) per prescription for non-preferred drugs. No out-of-pocket limit.	Not covered	Out-of-network care allowed but if your ID card is not used, you will pay more than the copay. Federal maximum out-of-pocket applies.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	Not covered	----------NONE----------
	Physician/surgeon fees	No charge	Not covered	Prior approval required for low back surgeries and MRI, CT and PET scans.
If you need immediate medical attention	Emergency room care	$60 copay/visit	$60 copay/visit	Copay does not apply to out-of-pocket limit and is waived if admitted.
	Emergency medical transportation	No charge	Not covered	----------NONE----------
	Urgent care	No charge	Not covered	----------NONE----------
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	Not covered	Prior approval recommended
	Physician/surgeon fees	No charge	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		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Mental/Behavioral health outpatient services	No charge	Not covered	----------NONE----------
	Mental/Behavioral health inpatient services	No charge	Not covered	----------NONE----------
	Substance use disorder outpatient services	No charge	Not covered	----------NONE----------
	Substance use disorder inpatient services	No charge	Not covered	----------NONE----------
If you are pregnant	Office visits	No charge	Not covered	----------NONE----------
	Childbirth/delivery professional services	No charge	Not covered	----------NONE----------
	Childbirth/delivery facility services	No charge	Not covered	----------NONE----------
If you need help recovering or have other special health needs	Home health care	No charge	Not covered	Limited to 50 visits per year. Plan may approve 50 more per year.
	Rehabilitation services	No charge	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	No charge	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	No charge	Not covered	Facility coverage is limited to 120 days per benefit period.
	Durable medical equipment	20% coinsurance (child's hearing aids no charge)	Not covered	Hearing aids (adults) plan maximum payment $1,000 per ear every 3 years.
	Hospice services	No charge	Not covered	----------NONE----------
If your child needs dental or eye care	Children's eye exam	No charge	Not covered	Limited to one per individual per year. Contact lens fitting not covered. Full coverage if required by federal law. Deductible does not

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)	
				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.)

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

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

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: [insert State, HHS, DOL, and/or other applicable agency contact information]. 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: MercyCare Health Plans Health Plan at 1-800-895-2421-Option 5 or TTY 711 or ETF at 1-877-533-5020 or www.etf.wi.gov.

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:

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-895-2421, TTY 1-800-947-3529.

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-800-895-2421, TTY 1-800-947-3529.

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1-800-895-2421, TTY 1-800-947-3529.

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-895-2421, TTY 1-800-947-3529.

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية متاحة لك بالمجان. اتصل برقم 1-800-895-2421 (رقم الهاتف الصم والبكم: 1-800-947-3529).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните [1-800-895-2421, TTY 1-800-947-3529].

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. [1-800-895-2421, TTY 1-800-947-3529].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 1-800-895-2421, TTY 1-800-947-3529.

Wann du [Deitsch (Pennsylvania German / Dutch)] schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: 1-800-895-2421, TTY 1-800-947-3529.

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-800-895-2421, TTY 1-800-947-3529.

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-895-2421, TTY 1-800-947-3529.

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-895-2421, TTY 1-800-947-3529.

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-800-895-2421, TTY 1-800-947-3529.पर कॉल करें।

KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1-800-895-2421, TTY 1-800-947-3529.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-895-2421, TTY 1-800-947-3529.

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	$0
Specialist copayment	$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	**$12,731**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$40
Coinsurance	$0
What isn't covered	
Limits or exclusions	$10
The total Peg would pay is	**$50**

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

The plan's overall deductible	$0
Specialist copayment	$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	**$7,389**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$200
Coinsurance	$400
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$600**

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

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

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	**$1,925**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$60
Coinsurance	$40
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$100**

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