



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: |
|--|--|---|
| <p>What is the overall deductible?</p> | <p>\$ 1,500 Individual / \$3,000 Family Combined medical and prescription drug deductible.</p> | <p>You must pay all the costs up to the deductible amount before the policy begins to pay for covered services you use, with the exception of federally required preventive services. The deductible starts over with each plan year beginning January 1st. For family coverage, the full family deductible must be met. See the chart starting on page 2 for your costs for services this plan covers.</p> |
| <p>Are there services covered before you meet your deductible?</p> | <p>Yes. Preventive care and primary care services are covered before you meet your deductible.</p> | <p>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/.</p> |
| <p>Are there other deductibles for specific services?</p> | <p>No</p> | <p>There are no other deductibles.</p> |
| <p>What is the out-of-pocket limit for this plan?</p> | <p>\$2,500 Individual / \$5,000 Family Combined medical and prescription drug out-of-pocket limit.</p> | <p>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. See https://www.healthcare.gov/glossary/essential-healthbenefits/ for details.</p> |
| <p>What is not included in the out-of-pocket limit?</p> | <p>Coinsurance paid by adults for hearing aids, premiums and health care this plan doesn't cover.</p> | <p>Even though you pay these expenses, they don't count toward the out-of-pocket limit.</p> |
| <p>Will you pay less if you use a network provider?</p> | <p>Yes. See www.mercycarehealthplans.com or call 1-800-895-2421- Option 5 for a list of network providers.</p> | <p>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.</p> |
| <p>Do you need a referral to see a specialist?</p> | <p>Yes.</p> | <p>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.</p> |

 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 <u>provider's</u> office or clinic | Primary care visit to treat an injury or illness | \$15 copay /visit after deductible | Not covered | Additional services (e.g. labs, x-rays, etc.) during the visit are subject to applicable coinsurance . |
| | Specialist visit | \$25 copay /visit after deductible | Not covered unless prior authorized | Additional services (e.g. labs, x-rays, etc.) during the visit are subject to applicable coinsurance . |
| | Other practitioner office visit | \$15 copay /visit after deductible (includes chiropractic visits) | No covered | Maintenance care and acupuncture not covered. Additional services (e.g. labs, x-rays, etc.) during the visit are subject to applicable coinsurance . |
| | Preventive care/screening/immunization | After deductible \$15 primary care visit copay and 10% coinsurance for related services. | Not covered | Full coverage if required by federal law. For details, visit: https://www.healthcare.gov/preventive-care-benefits/ |
| 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. |

* For more information about limitations and exceptions, see the plan or policy document at www.etf.wi.gov

| 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) | |
| <p>If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.[insert].com</p> | Level 1: Preferred generic drugs and certain lower cost preferred brand name drugs | \$5/prescription after deductible. (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. Full coverage if required by federal law. |
| | Level 2: Preferred brand drugs and certain higher cost preferred generic drugs | 20% coinsurance (\$50 max) per prescription after deductible (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. Full coverage if required by federal law. |
| | Level 3: Non-preferred brand name and certain high cost generic drugs | 40% coinsurance (\$150 max) per prescription after deductible. 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. Full coverage if required by federal law. |
| | Level 4: Specialty drugs at preferred specialty pharmacy provider | \$50 copay per prescription after deductible for preferred drugs 40% coinsurance (\$200 max) per prescription after deductible for non-preferred drugs | Not covered | Out-of-network care allowed but if your ID card is not used, you will pay more than the copay. Full coverage if required by federal law. |
| | Level 4: Specialty drugs at | 40% coinsurance (\$200 | | |

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| 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) | |
| | non-participating pharmacy provider | max) per prescription after deductible for preferred and non-preferred drugs | | |
| 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 after deductible \$25 copay for specialist office visit after deductible | 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 | <u>Emergency room care</u> | \$75 copay after deductible | \$75 copay after deductible | Copay is waived if admitted. |
| | <u>Emergency medical transportation</u> | 10% coinsurance after deductible | 10% coinsurance after deductible | -----NONE----- |
| | <u>Urgent care</u> | \$25 copay/visit after deductible | \$25 copay/visit after deductible | 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 fees | 10% coinsurance after deductible | Not covered | Prior approval required for low back surgeries and MRI, CT and PET scans |

* For more information about limitations and exceptions, see the plan or policy document at www.etf.wi.gov

| 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 | \$15 copay/visit after deductible | Not covered | -----NONE----- |
| | Mental/Behavioral health inpatient services | 10% coinsurance after deductible | Not covered | -----NONE----- |
| | Substance use disorder outpatient services | \$15 copay/visit after deductible | Not covered | -----NONE----- |
| | Substance use disorder inpatient services | 10% coinsurance after deductible | Not covered | -----NONE----- |
| If you are pregnant | Office visits | \$15 copay/visit after deductible | Not covered | Deductible and 10% coinsurance apply if prenatal and/or postnatal care billed as a package. Full coverage if required by federal law. |
| | 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 after deductible | 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 after deductible | 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 services | 10% coinsurance after deductible | Not covered | -----NONE----- |

* For more information about limitations and exceptions, see the plan or policy document at www.etf.wi.gov

| 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 | | |
| If your child needs dental or eye care | Children's eye exam | \$25 copay after deductible | Not covered | Limited to one per individual per year. Contact lens fitting not covered. Full coverage if required by federal law. |
| | 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 | • Infertility treatment | • Private duty nursing |
| • Bariatric surgery | • Long-term care | • Routine foot care |
| • Cosmetic surgery | • Non-emergency care when traveling outside US | • 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 | • Routine eye care, limited to one eye exam per calendar year by a plan provider |
| • Dental care, limited to certain oral surgical services and treatment of injuries | • Telemedicine | • E-visit services |
| | • Telehealth | |

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

* For more information about limitations and exceptions, see the plan or policy document at www.etf.wi.gov

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.

رقم 1-800-895-2421 ملحوظة إذا: اللغة انكر تتحدث نبتك إذا: ملحوظة 1-800-895-2421 (رقم
برقم اتصل. بالمجان لك تتوافر واليكم الصم هاتف: (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 [Deutsch (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, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີຮ່ວມໃຫ້ທ່ານ. ໂທ 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.

* For more information about limitations and exceptions, see the plan or policy document at www.etf.wi.gov

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](#) \$1500
- [Specialist copayment](#) \$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 | \$12,731 |
|---------------------------|-----------------|

In this example, Peg would pay:

| <i>Cost Sharing</i> | |
|-----------------------------------|----------------|
| Deductibles | \$1,500 |
| Copayments | \$30 |
| Coinsurance | \$1,000 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$11 |
| The total Peg would pay is | \$2,541 |

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

- The [plan's](#) overall [deductible](#) \$1500
- [Specialist copayment](#) \$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 | \$7,389 |
|---------------------------|----------------|

In this example, Joe would pay:

| <i>Cost Sharing</i> | |
|-----------------------------------|----------------|
| Deductibles | \$1,500 |
| Copayments | \$200 |
| Coinsurance | \$800 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$0 |
| The total Joe would pay is | \$2,500 |

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

- The [plan's](#) overall [deductible](#) \$1500
- [Specialist copayment](#) \$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 | \$1,925 |
|---------------------------|----------------|

In this example, Mia would pay:

| <i>Cost Sharing</i> | |
|-----------------------------------|----------------|
| Deductibles | \$1,500 |
| Copayments | \$60 |
| Coinsurance | \$10 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$0 |
| The total Mia would pay is | \$1,570 |