

 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](http://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 <a href="#">deductible</a> ?	\$500 individual / \$1,000 family	You must pay all the costs up to the <a href="#">deductible</a> amount before the policy begins to pay for covered services you use, with the exceptions of office visit <a href="#">copays</a> and for federally required preventive services. The deductible starts over with each plan year beginning on January 1 <sup>st</sup> . See the chart starting on page 2 for your costs for services this plan covers.
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. <a href="#">Preventive care</a> and primary care services are covered before you meet your <a href="#">deductible</a> .	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other <a href="#">deductibles</a> for specific services?	No	There are no <a href="#">deductibles</a> .
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	After medical deductible, 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 <a href="#">out-of-pocket limit</a> 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 <a href="#">maximum out-of-pocket</a> is \$8,150 individual/\$16,300 family. This applies to all essential health benefits, including some services not included in the <a href="#">out-of-pocket limit</a> . (i.e. certain level 3 & 4 prescription drugs and certain hearing aids covered under this plan). See <a href="https://www.healthcare.gov/glossary/essential-health-benefits/">https://www.healthcare.gov/glossary/essential-health-benefits/</a> for details.
What is not included in the <a href="#">out-of-pocket limit</a> ?	<a href="#">Copays</a> for Level 3 and Level 4 non-preferred <a href="#">specialty</a> drugs; <a href="#">coinsurance</a> paid by adults for hearing aids, <a href="#">premiums</a> and health care this plan doesn't cover.	Even though you pay these expenses, they do not count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See	This <a href="#">plan</a> uses a provider <a href="#">network</a> . You will pay less if you use a <a href="#">provider</a> in the plan's <a href="#">network</a> .

	<a href="http://www.healthpartners.com/stateofwis">www.healthpartners.com/stateofwis</a> or call 1-855-542-6922 for a list of network providers.	You will pay the most if you use an <b>out-of-network provider</b> , and you might receive a bill from a <b>provider</b> for the difference between the provider's charge and what your <b>plan</b> pays ( <b>balance billing</b> ). Be aware, your <b>network provider</b> might use an <b>out-of-network provider</b> for some services (such as lab work). Check with your <b>provider</b> before you get services.
Do you need a <b>referral</b> to see a <b>specialist</b> ?	No, you don't need a <b>referral</b> to see a <b>specialist</b>	You can see the <b>specialist</b> you choose without permission from the health plan. However, you should get a <b>referral</b> to an orthopedist or neurosurgeon for low back pain.

 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 <b>provider's</b> office or clinic	Primary care visit to treat an injury or illness	No charge after <b>deductible</b>	Not covered	-----NONE-----
	<b>Specialist</b> visit	No charge after <b>deductible</b>	Not covered unless prior authorized	-----NONE-----
	Other practitioner office visit	No charge after <b>deductible</b>	Not covered	Maintenance care and acupuncture not covered.
	<b>Preventive care/screening/immunization</b>	No charge after <b>deductible</b>	Not covered	-----NONE-----
If you have a test	<b>Diagnostic test</b> (x-ray, blood work)	No charge after <b>deductible</b>	Not covered	Full coverage if required by federal law.
	Imaging (CT/PET scans, MRIs)	No charge after <b>deductible</b>	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](http://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><b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is available at <a href="#">www.[insert].com</a></p>	Level 1: Preferred generic drugs and certain lower cost preferred brand name drugs	\$5/prescription to <a href="#">out-of-pocket limit</a> . (2 <a href="#">copays</a> apply to certain 90-day supply mail orders)	Not covered	<a href="#">In-network</a> covers most up to a 30-day supply (90-day for certain prescriptions) retail and mail order. <a href="#">Out-of-network</a> care allowed but if your ID card is not used, you will pay more than the copay.
	Level 2: <a href="#">Preferred</a> brand drugs and certain higher cost preferred generic drugs	20% <a href="#">coinsurance</a> (\$50 max) per prescription to <a href="#">out-of-pocket limit</a> . (2 <a href="#">copays</a> apply to certain 90-day supply mail order)	Not covered	<a href="#">In-network</a> covers most up to a 30-day supply (90-day for certain prescriptions) retail and mail order. <a href="#">Out-of-network</a> care allowed but if your ID card is not used, you will pay more than the copay.
	Level 3: <a href="#">Non-preferred</a> brand name and certain high cost generic drugs	40% <a href="#">coinsurance</a> (\$150 max) per prescription. <a href="#">Member must pay the cost difference between the non-preferred brand drug and the preferred generic equivalent drug if not medically necessary.</a>	Not covered	Federal <a href="#">out-of-pocket limit</a> applies. <a href="#">Out-of-network</a> care allowed, but if your ID card is not used, you will pay more than the copay.
	Level 4: <a href="#">Specialty drugs</a> at <a href="#">preferred</a> specialty pharmacy provider	\$50 <a href="#">copay</a> per prescription for <a href="#">preferred</a> drugs to specialty <a href="#">out-of-pocket limit</a> . 40% <a href="#">coinsurance</a> (\$200 max) per prescription for <a href="#">non-preferred</a> drugs. No <a href="#">out-of-pocket limit</a> .	Not covered	<a href="#">Out-of-network</a> care allowed but if your ID card is not used, you will pay more than the copay. Federal <a href="#">maximum out-of-pocket</a> applies.
	Level 4: <a href="#">Specialty drugs</a> at participating pharmacy provider	40% <a href="#">coinsurance</a> (\$200 max) per prescription for <a href="#">preferred</a> drugs to specialty <a href="#">out-of-pocket limit</a> .	Not covered	<a href="#">Out-of-network</a> care allowed but if your ID card is not used, you will pay more than the copay. Federal <a href="#">maximum out-of-pocket</a> applies.

\* For more information about limitations and exceptions, see the plan or policy document at [www.etf.wi.gov](http://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)	
		40% coinsurance (\$200 max) per prescription for non-preferred drugs. No out-of-pocket limit.		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge after deductible	Not covered	-----NONE-----
	Physician/surgeon fees	No charge after deductible	Not covered	Prior approval required for low back surgeries and MRI, CT and PET scans
If you need immediate medical attention	<a href="#">Emergency room care</a>	\$60 copay/visit	\$60 copay/visit	Copay does not apply to out-of-pocket limit and is waived if admitted.
	<a href="#">Emergency medical transportation</a>	No charge after deductible	Not charge after deductible	-----NONE-----
	<a href="#">Urgent care</a>	No charge after deductible	Not charge after deductible	-----NONE-----
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge after deductible	Not covered	Prior approval recommended
	Physician/surgeon fees	No charge after deductible	Not covered	Prior approval required for low back surgeries and MRI, CT and PET scans
If you need mental health, behavioral health, or substance abuse services	Mental/Behavioral health outpatient services	No charge after deductible	Not covered	-----NONE-----
	Mental/Behavioral health inpatient services	No charge after deductible	Not covered	-----NONE-----
	Substance use disorder outpatient services	No charge after deductible	Not covered	-----NONE-----
	Substance use disorder inpatient services	No charge after deductible	Not covered	-----NONE-----
If you are pregnant	Office visits	No charge after deductible	Not covered	Full coverage if required by federal law.
	Childbirth/delivery professional services	No charge after deductible	Not covered	-----NONE-----
	Childbirth/delivery facility	No charge after	Not covered	-----NONE-----

\* For more information about limitations and exceptions, see the plan or policy document at [www.etf.wi.gov](http://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)	
	services	deductible		
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	No charge after deductible	Not covered	Limited to 50 visits per year. Plan may approve 50 more per year.
	<a href="#">Rehabilitation services</a>	No charge 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.
	<a href="#">Habilitation services</a>	No charge 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.
	<a href="#">Skilled nursing care</a>	No charge after deductible	Not covered	Facility coverage is limited to 120 days per benefit period.
	<a href="#">Durable medical equipment</a>	20% coinsurance after deductible (child's hearing aids no charge)	Not covered	Hearing aids (adults) plan maximum payment \$1,000 per ear every 3 years.
	<a href="#">Hospice services</a>	No charge after deductible	Not covered	-----NONE-----
<b>If your child needs dental or eye care</b>	Children's eye exam	No charge 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 |
| • Cosmetic surgery | • Long-term care                               | • Routine foot care    |
| • Dental Cleanings | • Non-emergency care when traveling outside US | •                      |

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

- |  |                |   |
|--|----------------|---|
| • Bariatric surgery and weight loss services | • Hearing aids | • Routine eye care, limited to one eye exam per |
|--|----------------|---|

\* For more information about limitations and exceptions, see the plan or policy document at [www.etf.wi.gov](http://www.etf.wi.gov).



CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-855-542-6922, (TTY:711).

Wann du [Deitsch (Pennsylvania German / Dutch)] schwetzsch, kantscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: 1-855-542-6922, (TTY:711).

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ຄຸ່ມນີ້ມີພ້ອມໃຫ້ທ່ານ. ໂທສ 1-855-542-6922, (TTY:711).

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-855-542-6922, (TTY:711).

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-855-542-6922, (TTY:711).

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-855-542-6922, (TTY:711). पर कॉल करें।

KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1-855-542-6922, (TTY:711).

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-855-542-6922, (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](#) \$500
- [Specialist copayment](#) Deductible
- 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*)

<b>Total Example Cost</b>	<b>\$12,731</b>
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$500
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$10
<b>The total Peg would pay is</b>	<b>\$510</b>

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

- The [plan's](#) overall [deductible](#) \$500
- [Specialist copayment](#) Deductible
- Hospital (facility) [coinsurance](#) 0%
- 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*)

<b>Total Example Cost</b>	<b>\$7,389</b>
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$500
Copayments	\$0
Coinsurance	\$400
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Joe would pay is</b>	<b>\$900</b>

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

- The [plan's](#) overall [deductible](#) \$500
- [Specialist copayment](#) Deductible
- Hospital (facility) [coinsurance](#) 0%
- Other [coinsurance](#) 20%

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

<b>Total Example Cost</b>	<b>\$1,925</b>
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$500
Copayments	\$60
Coinsurance	\$40
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$600</b>