



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 <https://etf.wi.gov/contact-us> or 1-877-533-5020. 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.healthcare.gov/sbc-glossary/> or call 1-877-533-5020 to request a copy.

| Important Questions                                                             | Answers                                                                                                                      | Why This Matters:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
|---------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| What is the overall <a href="#">deductible</a> ?                                | Combined medical and pharmacy <a href="#">in-network provider</a> /services/pharmacy: \$2,000 individual/\$4,000 family      | If you have other family members on the policy, the overall family <a href="#">deductible</a> must be met before the <a href="#">plan</a> begins to pay. <a href="#">Deductible</a> exceptions include office visit <a href="#">copays</a> and for federally required <a href="#">preventive services</a> . The <a href="#">deductible</a> starts over with each plan year beginning on January 1 <sup>st</sup> .                                                                                                                                                                                                                                                                            |
| 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                                                                                                                           | You don't have to meet <a href="#">deductibles</a> for specific services.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ? | Combined medical and pharmacy <a href="#">in-network provider</a> /services/pharmacy: \$3,500 individual/ \$7,000 family     | Families must meet full family <a href="#">out-of-pocket limit</a> before your <a href="#">plan</a> pays. 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.<br><br>The federal <a href="#">maximum out-of-pocket</a> is \$12,000 individual/\$24,000 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 <a href="#">prescription drugs</a> and adult hearing aids covered under this <a href="#">plan</a> ). |
| What is not included in the <a href="#">out-of-pocket limit</a> ?               | <a href="#">Premiums</a> and health care this <a href="#">plan</a> doesn't cover.                                            | Even though you pay these expenses, they don't 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 ChooseQuartz.com or call 1-844-644-3455 for a list of <a href="#">network providers</a> .                           | This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a provider for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services                                                                                                                          |

|                                                                              |    |                                                                                                                                                                                                              |
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|                                                                              |    | (such as lab work). Check with your <a href="#">provider</a> before you get services                                                                                                                         |
| Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ? | No | You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> . However, it is recommended you get a <a href="#">referral</a> 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<br>(You will pay the least)                       | Out-of-Network Provider<br>(You will pay the most)      |                                                                                                                                                                                                                                                                                                                                                                            |
| If you visit a health care <a href="#">provider's</a> office or clinic | Primary care visit to treat an injury or illness       | \$15 <a href="#">copay</a> /visit after <a href="#">deductible</a> | Not covered                                             | You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services needed are preventive. Then check what your <a href="#">plan</a> will pay for.                                                                                                                                                                                  |
|                                                                        | <a href="#">Specialist</a> visit                       | \$25 <a href="#">copay</a> /visit after <a href="#">deductible</a> | Not covered without <a href="#">prior authorization</a> | You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services needed are preventive. Then check what your <a href="#">plan</a> will pay for.                                                                                                                                                                                  |
|                                                                        | <a href="#">Preventive care/screening/immunization</a> | No Charge                                                          | Not covered                                             | All preventive care services that have received an A or B grade <a href="#">by the United States Preventive Services Task Force</a> are covered without cost sharing. Ask your in-network <a href="#">provider</a> if the services needed are preventive. Then check what your <a href="#">plan</a> will pay for. Full coverage is <a href="#">required by federal law</a> |
| If you have a test                                                     | <a href="#">Diagnostic test</a> (x-ray, blood work)    | 10% <a href="#">coinsurance</a> after <a href="#">deductible</a>   | Not covered                                             | Full coverage if <a href="#">required by federal law</a> .                                                                                                                                                                                                                                                                                                                 |
|                                                                        | Imaging (CT/PET scans, MRIs)                           | 10% <a href="#">coinsurance</a> after <a href="#">deductible</a>   | Not covered                                             | Prior <a href="#">authorization required</a> or benefits not payable.                                                                                                                                                                                                                                                                                                      |

| Common Medical Event                                                                                                                                                                                                                                                                       | Services You May Need                                                                                 | What You Will Pay                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                                                      | Limitations, Exceptions, & Other Important Information                                                                                                                       |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                                                                                                                                                                                                                            |                                                                                                       | Network Provider<br>(You will pay the least)                                                                                                                                                                                                                                                                                 | Out-of-Network Provider<br>(You will pay the most)                                                                                                                                                                                                                                                                                   |                                                                                                                                                                              |
| <b>If you need drugs to treat your illness or condition</b><br>More information about <a href="#">prescription drug coverage</a> is available at <a href="https://navitus.com">navitus.com</a> and <a href="https://benefitplans.navitus.com/etf">https://benefitplans.navitus.com/etf</a> | Level 1: Preferred <a href="#">generic drugs and certain lower cost preferred brand name drugs</a>    | 100% until <a href="#">deductible</a> is met. After <a href="#">deductible</a> \$10/prescription to <a href="#">out-of-pocket limit</a> .                                                                                                                                                                                    | Prescriptions may be filled at an <a href="#">out-of-network</a> pharmacy in emergency situations only. At the <a href="#">out-of-network</a> pharmacy, during the emergency situation, you should pay for the prescription in full, even after your deductible is met, and submit a reimbursement form to <a href="#">Navitus</a> . | <a href="#">In-network</a> covers most up to a 30-day supply<br><br>Combined medical and pharmacy out-of-pocket limit of \$3,500 for an individual and \$7,000 for a family. |
|                                                                                                                                                                                                                                                                                            | Level 2: Preferred <a href="#">brand drugs and certain higher cost preferred generic drugs</a>        | 100% until <a href="#">deductible</a> is met. After <a href="#">deductible</a> 25% <a href="#">coinsurance</a> (\$60 max) per prescription to <a href="#">out-of-pocket limit</a> .                                                                                                                                          | Prescriptions may be filled at an <a href="#">out-of-network</a> pharmacy in emergency situations only. At the <a href="#">out-of-network</a> pharmacy, during the emergency situation, you should pay for the prescription in full, even after your deductible is met, and submit a reimbursement form to <a href="#">Navitus</a> . | <a href="#">In-network</a> covers most up to a 30-day supply<br><br>Combined medical and pharmacy out-of-pocket limit of \$3,500 for an individual and \$7,000 for a family. |
|                                                                                                                                                                                                                                                                                            | Level 3: <a href="#">Non-preferred</a> brand name and <a href="#">certain high cost generic drugs</a> | 100% until <a href="#">deductible</a> is met. After <a href="#">deductible</a> 45% <a href="#">coinsurance</a> (\$175 max) per prescription. Member must pay the cost difference between the <a href="#">non-preferred</a> brand drug and the <a href="#">preferred generic equivalent drug if not medically necessary</a> . | Prescriptions may be filled at an <a href="#">out-of-network</a> pharmacy in emergency situations only. At the <a href="#">out-of-network</a> pharmacy, during the emergency situation, you should pay for the prescription in full, even after your deductible is met, and submit a reimbursement form to <a href="#">Navitus</a> . | Combined medical and pharmacy out-of-pocket limit of \$3,500 for an individual and \$7,000 for a family.                                                                     |
|                                                                                                                                                                                                                                                                                            | Level 4: <a href="#">Specialty drugs</a> at <a href="#">preferred</a> specialty pharmacy              | 100% until <a href="#">deductible</a> is met. After <a href="#">deductible</a> \$60 <a href="#">copay</a> per prescription for                                                                                                                                                                                               | Prescriptions may be filled at an <a href="#">out-of-network</a> pharmacy in emergency                                                                                                                                                                                                                                               | Combined medical and pharmacy out-of-pocket limit of \$3,500 for an individual and \$7,000 for a family.                                                                     |

|  |                                  |                                                                                                                                                        |                                                                                                                                                                                                                                               |                                                                                                          |
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|  | provider                         | <a href="#">preferred drugs</a> to specialty <a href="#">out-of-pocket limit</a> .                                                                     | situations only. At the <a href="#">out-of-network</a> pharmacy, during the emergency situation, you should pay for the prescription in full, even after your deductible is met, and submit a reimbursement form to <a href="#">Navitus</a> . |                                                                                                          |
|  | Level 5: Anti-Obesity Medication | 100% until <a href="#">deductible</a> is met. After <a href="#">deductible</a> , \$200 copay per prescription to <a href="#">out-of-pocket limit</a> . | At the out-of-network pharmacy, during the emergency situation, after you have met your HDHP deductible, you should pay for the prescriptions in full, even after your deductible is met, and submit a reimbursement form to Navitus          | Combined medical and pharmacy out-of-pocket limit of \$3,500 for an individual and \$7,000 for a family. |

| Common Medical Event                    | Services You May Need                            | What You Will Pay                                                                                                                                                                                           |                                                                                                     | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                                  |
|-----------------------------------------|--------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                         |                                                  | Network Provider<br>(You will pay the least)                                                                                                                                                                | Out-of-Network Provider<br>(You will pay the most)                                                  |                                                                                                                                                                                                                                                         |
| If you have outpatient surgery          | Facility fee (e.g., ambulatory surgery center)   | 10% <a href="#">coinsurance</a> after <a href="#">deductible</a> .                                                                                                                                          | Not covered                                                                                         | None                                                                                                                                                                                                                                                    |
|                                         | Physician/surgeon fees                           | \$15 <a href="#">copay</a> for primary doctor office visit after <a href="#">deductible</a><br><br>\$25 <a href="#">copay</a> for <a href="#">specialist</a> office visit. after <a href="#">deductible</a> | Not covered                                                                                         | Additional services provided (e.g. costs of surgery, equipment, etc.) are subject to applicable <a href="#">deductible</a> and <a href="#">coinsurance</a> . <a href="#">Prior approval</a> required for low back surgeries and MRI, CT, and PET scans. |
| If you need immediate medical attention | <a href="#">Emergency room care</a>              | \$125 <a href="#">copay</a> after <a href="#">deductible</a> then 10% <a href="#">coinsurance</a>                                                                                                           | \$125 <a href="#">copay</a> , after <a href="#">deductible</a> then 10% <a href="#">coinsurance</a> | <a href="#">Copay</a> is waived if admitted.                                                                                                                                                                                                            |
|                                         | <a href="#">Emergency medical transportation</a> | 10% <a href="#">coinsurance</a> after <a href="#">deductible</a>                                                                                                                                            | 10% <a href="#">coinsurance</a> after <a href="#">deductible</a>                                    | None                                                                                                                                                                                                                                                    |
|                                         | <a href="#">Urgent care</a>                      | \$25 <a href="#">copay</a> /visit after <a href="#">deductible</a>                                                                                                                                          | \$25 <a href="#">copay</a> /visit after <a href="#">deductible</a>                                  | None                                                                                                                                                                                                                                                    |
| If you have a hospital stay             | Facility fee (e.g., hospital room)               | 10% <a href="#">coinsurance</a> after <a href="#">deductible</a>                                                                                                                                            | Not covered                                                                                         | <a href="#">Prior approval</a> recommended                                                                                                                                                                                                              |
|                                         | Physician/surgeon fees                           | 10% <a href="#">coinsurance</a> after                                                                                                                                                                       | Not covered                                                                                         | <a href="#">Prior approval</a> required for low back surgeries                                                                                                                                                                                          |

|                                                                                  |                                           | <a href="#">deductible</a>                                         |                                                                         | and MRI, CT, and PET scans                                                                                                                                                                                    |
|----------------------------------------------------------------------------------|-------------------------------------------|--------------------------------------------------------------------|-------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Common Medical Event                                                             | Services You May Need                     | What You Will Pay<br>Network Provider<br>(You will Pay the Least)  | What You Will Pay<br>Out-of-Network Provider<br>(You Will Pay the Most) | Limitations, Exceptions, & Other<br>Important Information                                                                                                                                                     |
| <b>If you need mental health, behavioral health, or substance abuse services</b> | Outpatient services                       | \$15 <a href="#">copay</a> /visit after <a href="#">deductible</a> | Not covered                                                             | Additional services (e.g. labs, etc.) during the visit are subject to applicable <a href="#">deductible</a> and <a href="#">coinsurance</a> .                                                                 |
|                                                                                  | Inpatient services                        | 10% <a href="#">coinsurance</a> after <a href="#">deductible</a>   | Not covered                                                             | None                                                                                                                                                                                                          |
| <b>If you are pregnant</b>                                                       | Office visits                             | \$15 <a href="#">copay</a> /visit after <a href="#">deductible</a> | Not covered                                                             | 10% <a href="#">coinsurance</a> apply if in-network prenatal and/or postnatal care billed as a package. Full coverage if required by federal law.                                                             |
|                                                                                  | Childbirth/delivery professional services | 10% <a href="#">coinsurance</a> after <a href="#">deductible</a>   | Not covered                                                             | None                                                                                                                                                                                                          |
|                                                                                  | Childbirth/delivery facility services     | 10% <a href="#">coinsurance</a> after <a href="#">deductible</a>   | Not covered                                                             | None                                                                                                                                                                                                          |
| <b>If you need help recovering or have other special health needs</b>            | <a href="#">Home health care</a>          | 10% <a href="#">coinsurance</a> after <a href="#">deductible</a>   | Not covered                                                             | Limited to 50 visits per year. Plan may approve 50 more per year.                                                                                                                                             |
|                                                                                  | <a href="#">Rehabilitation services</a>   | \$15 <a href="#">copay</a> /visit after <a href="#">deductible</a> | Not covered                                                             | Physical, speech, occupational, <a href="#">rehabilitation</a> , and <a href="#">habilitation services</a> : Combined limit of 50 visits a year. Additional visits may be available when medically necessary. |
|                                                                                  | <a href="#">Habilitation services</a>     | \$15 <a href="#">copay</a> /visit after <a href="#">deductible</a> | Not covered                                                             | Physical, speech, occupational, <a href="#">rehabilitation</a> , and <a href="#">habilitation services</a> : Combined limit of 50 visits a year. Additional visits may be available when medically necessary. |
|                                                                                  | <a href="#">Skilled nursing care</a>      | 10% <a href="#">coinsurance</a> after <a href="#">deductible</a>   | Not covered                                                             | Facility coverage is limited to 120 days per benefit period.                                                                                                                                                  |
|                                                                                  | <a href="#">Durable medical equipment</a> | 20% <a href="#">coinsurance</a> after <a href="#">deductible</a>   | Not covered                                                             | Hearing aids (adults) plan maximum payment \$1,000 per ear every 3 years. Children's hearing aids have no plan maximum payment.                                                                               |

|  |                                  |                                                                  |             |      |
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|  | <a href="#">Hospice services</a> | 10% <a href="#">coinsurance</a> after <a href="#">deductible</a> | Not covered | None |
|--|----------------------------------|------------------------------------------------------------------|-------------|------|

| Common Medical Event                          | Services You May Need      | What You Will Pay                            |                                                    | Limitations, Exceptions, & Other Important Information                                                              |
|-----------------------------------------------|----------------------------|----------------------------------------------|----------------------------------------------------|---------------------------------------------------------------------------------------------------------------------|
|                                               |                            | Network Provider<br>(You will pay the least) | Out-of-Network Provider<br>(You will pay the most) |                                                                                                                     |
| <b>If your child needs dental or eye care</b> | Children's eye exam        | \$25 <a href="#">copay</a> 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:

|                                                                                                                                                                                                         |                         |                                                |                           |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|------------------------------------------------|---------------------------|
| <b>Services Your <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or <a href="#">plan</a> document for more information and a list of any other <a href="#">excluded services</a>.)</b> |                         |                                                |                           |
| • Cosmetic surgery                                                                                                                                                                                      | • Infertility treatment | • Non-emergency care when traveling outside US | • Routine foot care       |
| • Dental care (Adult)                                                                                                                                                                                   | • Long-term care        | • Private-duty nursing                         |                           |
| <b>Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> document.)</b>                                                     |                         |                                                |                           |
| •Bariatric Surgery                                                                                                                                                                                      | •Chiropractic care      | •Hearing aids                                  | •Routine eye care (Adult) |

**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: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform) and the Wisconsin Office of the Commissioner of Insurance at (800) 236-8517 or [www.oci.wi.gov](http://www.oci.wi.gov). 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](http://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 on how 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: Quartz Health Benefit Plans Corporation at 1-844-644-3455 or TTY 711 or ETF at 1-877-533-5020 or [www.etf.wi.gov](http://www.etf.wi.gov)

#### Does this plan provide Minimum Essential Coverage? Yes

[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium tax credit](#).

### 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 1-844-644-3455, TTY 711 / 1-800-877-8973.

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-844-644-3455, TTY 711 / 1-800-877-8973.

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 1-844-644-3455, TTY 711 / 1-800-877-8973.

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-844-644-3455, TTY 711 / 1-800-877-8973.

رقم (ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية هاتف الصم والبكم تتوافر لك بالمجان. اتصل برقم 1-844-644-3455, TTY 711 / 1-800-877-8973.

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-844-644-3455, TTY 711 / 1-800-877-8973.

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-844-644-3455, TTY 711 / 1-800-877-8973. 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 1-844-644-3455, TTY 711 / 1-800-877-8973.

Wann du [Deutsch (Pennsylvania German / Dutch)] schwetzscht, kannst du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: 1-844-644-3455, TTY 711 / 1-800-877-8973.

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທ 1-844-644-3455, TTY 711 / 1-800-877-8973.

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-844-644-3455, TTY 711 / 1-800-877-8973.

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-844-644-3455, TTY 711 / 1-800-877-8973.

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-844-644-3455, TTY 711 / 1-800-877-8973. पर कॉल करें।

KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1-844-644-3455, TTY 711 / 1-800-877-8973.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-844-644-3455, TTY 711 / 1-800-877-8973.

*To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.*

**PRA Disclosure Statement:** According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-1146**. The time required to complete this information collection is estimated to average **0.08** hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland



**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.

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.

### Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

|                                                                 |         |
|-----------------------------------------------------------------|---------|
| ■ The <a href="#">plan's</a> overall <a href="#">deductible</a> | \$2,000 |
| ■ <a href="#">Specialist</a> [ <a href="#">copay</a> ]          | \$25    |
| ■ Hospital (facility) [ <a href="#">coinsurance</a> ]           | 10%     |
| ■ Other [ <a href="#">coinsurance</a> ]                         | 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*)

|                           |                 |
|---------------------------|-----------------|
| <b>Total Example Cost</b> | <b>\$12,700</b> |
|---------------------------|-----------------|

In this example, Peg would pay:

| Cost Sharing                      |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles</a>       | \$2,000        |
| <a href="#">Copayments</a>        | \$30           |
| <a href="#">Coinsurance</a>       | \$1,000        |
| What isn't covered                |                |
| Limits or exclusions              | \$0            |
| <b>The total Peg would pay is</b> | <b>\$3,030</b> |

### Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

|                                                                 |         |
|-----------------------------------------------------------------|---------|
| ■ The <a href="#">plan's</a> overall <a href="#">deductible</a> | \$2,000 |
| ■ <a href="#">Specialist</a> [ <a href="#">copay</a> ]          | \$25    |
| ■ Hospital (facility) [ <a href="#">coinsurance</a> ]           | 10%     |
| ■ Other [ <a href="#">coinsurance</a> ]                         | 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*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$5,600</b> |
|---------------------------|----------------|

In this example, Joe would pay:

| Cost Sharing                      |                  |
|-----------------------------------|------------------|
| <a href="#">Deductibles</a>       | \$2,000          |
| <a href="#">Copayments</a>        | \$200**          |
| <a href="#">Coinsurance</a>       | \$800**          |
| What isn't covered                |                  |
| Limits or exclusions              | \$0              |
| <b>The total Joe would pay is</b> | <b>\$3,000**</b> |

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

|                                                                 |         |
|-----------------------------------------------------------------|---------|
| ■ The <a href="#">plan's</a> overall <a href="#">deductible</a> | \$2,000 |
| ■ <a href="#">Specialist</a> [ <a href="#">copay</a> ]          | \$25    |
| ■ Hospital (facility) [ <a href="#">coinsurance</a> ]           | 10%     |
| ■ Other [ <a href="#">coinsurance</a> ]                         | 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*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$2,800</b> |
|---------------------------|----------------|

In this example, Mia would pay:

| Cost Sharing                      |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles</a>       | \$2,000        |
| <a href="#">Copayments</a>        | \$125          |
| <a href="#">Coinsurance</a>       | \$10           |
| What isn't covered                |                |
| Limits or exclusions              | \$0            |
| <b>The total Mia would pay is</b> | <b>\$2,135</b> |

\*\*Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs.

For more Information about the wellness program please contact: <https://www.webmdhealth.com/wellwisconsin/> or 1-800-821-6591