This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.etf.wi.gov or by calling 1-877-533-5020.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$** 0	See the chart starting on page 2 for costs for services this plan covers.
Are there other deductibles for specific services?	**$** No	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	**$**Yes,Med:**$500** Ind/**$1000** Fam. RX # 1 and 2: **$410** Ind/**$820** Fam Frmlry spclty RX: **$1000** Ind/**$2000** Fam.	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.
What is not included in the out–of–pocket limit?	ER Rm, RX #3/non frmlry spcity RX copays; hearing aid coins, bal billed chgs, prem & non covd chgs	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No	The chart starting on page 2 describes any limits on what the plan will pay for specific covered services, such as office visits.
Does this plan use a network of providers?	Yes. For In Network list see www.@mahealthcare.com or call 1-563-584-4885 or 1-866-821-1365	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network.** See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No, If in network. Yes, If out of network.	This plan will pay some of the costs to see a **specialist** for covered services but only if you have the plan's permission before you see the **specialist.**
Are there services this plan doesn't cover?	Yes	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

- **Co-payments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **co-insurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use In-Network **providers** by charging you lower **deductibles**, **co-payments** and **co-insurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use an		Limitations & Exceptions
		In-network Provider	Out-of-network Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	10% coinsurance	Not covered	None
	Specialist visit	10% coinsurance	Not covered	None
	Other practitioner office visit	10% coinsurance for Chiropractic	Not covered	Maintenance care and acupuncture not covered.
	Preventive care/screening/ immunization	10% coinsurance	Not covered	Full coverage if required by federal law.
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance	Not covered	Full coverage if required by federal law.
	Imaging (CT/PET scans, MRIs)	10% coinsurance	Not covered	Pre-authorization required for CT & MRI.

Common Medical Event	Services You May Need	Your cost if you use an In-network Provider	Your cost if you use an Out-of-network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.mahealthcare.com	Generic drugs	$5/ 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 emergency or urgent care allowed but if your ID card is not used, you may have to pay more than the copay.
	Preferred brand drugs	$15/prescription to out of pocket limit. (2 copays apply to certain 90 day supply mail order)	Not covered	In network covers mot up to a 30 day supply (90 day for certain prescriptions) retail and mail order. Out of network emergency or urgent care allowed but if your ID card is not used , you may have to pay more than the copay.
	Non-preferred brand drugs	$35/Prescription	Not covered	No out of pocket limit. Out of network emergency or urgent care allowed but if your ID card is not used, you may have to pay more than the copay.
	Specialty drugs	Preferred Provider: $15 formulary prescripton to out of pocket limit; $50 non formulary no out of pocket limit Non Preferred Provider:$50 formulary prescription to out of pocket limit; $50 non formulary no out of pocket limit	Not covered	Out of network emergency or urgent care allowed but if your ID care is not used, you may have to pay more than the copay.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	Not covered	None
	Physician/surgeon fees	10% coinsurance	Not covered	None

Common Medical Event	Services You May Need	Your cost if you use an		Limitations & Exceptions
		In-network Provider	Out-of-network Provider	
If you need immediate medical attention	Emergency room services	$75 copay then 10% insurance	$75 copay then 10% insurance	Copay does not apply to out of pocket limit and waived if admitted.
	Emergency medical transportation	10% insurance	10% insurance	None
	Urgent care	10% insurance	10% insurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	10% insurance	Not covered	Requires prior approval
	Physician/surgeon fee	10% insurance	Not covered	Requires prior approval
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	10% insurance	Not covered	None
	Mental/Behavioral health inpatient services	10% insurance	Not covered	Requires prior approval
	Substance use disorder outpatient services	10% insurance	Not covered	None
	Substance use disorder inpatient services	10% insurance	Not covered	Requires prior approval
If you are pregnant	Prenatal and postnatal care	No charge	Not covered	None
	Delivery and all inpatient services	10% insurance	Not covered	Requires prior approval

Common Medical Event	Services You May Need	Your cost if you use an In-network Provider	Your cost if you use an Out-of-network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	10% insurance	Not covered	Limited to 50 visits per year. Plan may approve 50 more/year.
	Rehabilitation services	10% insurance	Not covered	Physical speech and occupational therapy limited to 50 visits/year. Plan may approve 50 more/year.
	Habilitation services	Not covered	Not covered	Excluded service
	Skilled nursing care	10% insurance	Not covered	Facility coverage is limited to 120 days/benefit period.
	Durable medical equipment	20% coins (child's hearing aids 10%)	Not covered	Hearing aids (adults) plan max pymt $1000/ear/3 year period. Adult coins doesn't apply to out of pocket limit.
	Hospice service	10% coinsurance	Not covered	None
If your child needs dental or eye care	Eye exam	10% insurance	Not covered	Full coverage if required by federal law. Limited to one/person/yr. Contact lens fittings not covered.
	Glasses	Not Covered	Not covered	Excluded Service.
	Dental check-up	No charge	No charge	Diagnostic/Preventive Services

Excluded Services & Other Covered Services

Services Your Plan Does NOT Cover **(This isn't a complete list. Check your policy or plan document for other excluded services.)**

- Acupuncture
- Bariatric surgery
- Cosmetic Surgery
- Habilitation Services
- Infertility treatment
- Long-Term Care
- Non-Emergency care when traveling outside the U.S.
- Private Duty Nurse
- Routine eye care (glasses)
- Routine Foot Care
- Weight Loss Programs (except nutritional counseling)

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

- Chiropractic Care
- Dental Care (Adult)
- Hearing Aids
- Routine Eye Care (exam)(Adult)

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium,** which may be significantly higher than the premium you pay while coverage under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-563-584-4885 or toll free at 1-866-821-1365. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: Member Services at 563-584-4885 or toll free at 1-866-821-1365; Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Additionally, a consumer assistance program can help you file your appeal. Contact Consumer Services Division, State of Illinois, Department of Insurance, 320 W. Washington Suite 15-100, Springfield, IL 62767-0001 or at 1-217-782-4515. A list of states with Consumer Assistance Programs is available at www.dol.gov/ebsa/healthreform and http://cciio.cms.gov/prgrams/consumer/capgrants/indes.html.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $6,630
- **Patient pays** $910

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$0
Co-pays	$10
Co-insurance	$500
Limits or exclusions	$400
Total	**$910**

Note: These numbers assume the patient has given notice of her pregnancy to the plan. If you are pregnant and have not given notice of your pregnancy, your costs may be higher. For more information, please contact: 563-584-4885 or toll free at 1-866-821-1365.

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

- **Amount owed to providers:** $5,400
- **Plan pays** $4,620
- **Patient pays** $780

Sample care costs:

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

Patient pays:

Deductibles	$0
Co-pays	$300
Co-insurance	$400
Limits or exclusions	$80
Total	**$780**

Note: These numbers assume the patient is participating in our diabetes wellness program. If you have diabetes and do not participate in the wellness program, your costs may be higher. For more information about the diabetes wellness program, please contact: 563-584-4885 or toll free at 1-866-821-1365.

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **co-payments**, and **co-insurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **co-payments**, **deductibles**, and **co-insurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Questions: Call 1-877-533-5020 or visit us at **www.etf.wi.gov**.
If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at **www.etf.wi.gov\publications\IYC\iyc2013\uniform-glossary.pdf** or call 1-877-5020 to request a copy.