




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> ?	\$250 individual/\$500 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> ?	<p><u>Medical:</u> \$1,250 individual/\$2,500 family</p> <p><u>Prescription drug:</u> Level 1 and 2: \$600 Individual \$1,200 Family Level 4: \$1,200 Individual \$2,400 family</p>	If you have other family members in this <a href="#">plan</a> , the overall family <a href="#">out-of-pocket limit</a> must be met. 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. This plan's maximum out-of-pocket is capped at \$6,850 Individual/\$13,700 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="#">Copayments</a> for Level 3 and Level 4 non-preferred <a href="#">specialty drugs</a> , <a href="#">coinsurance</a> paid for adult hearing aids, <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 <a href="http://www.ghcscw.com">www.ghcscw.com</a> or call 1-800-605-4327 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 different 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 (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 (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<b>If you visit a health care <a href="#">provider's</a> office or clinic</b>	Primary care visit to treat an injury or illness	\$15 <a href="#">copay</a> /visit	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	Not covered without <a href="#">preauthorization</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>	\$15 <a href="#">copay</a> /visit 10% <a href="#">coinsurance</a> after <a href="#">deductible</a> for related services	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. Full coverage if <a href="#">required by federal law</a> .
<b>If you have a test</b>	<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		
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
<p><b>If you need drugs to treat your illness or condition</b></p> <p>More information about <a href="#">prescription drug coverage</a> is available at <a href="http://navitus.com">navitus.com</a></p>	Level 1: Preferred <a href="#">generic drugs and certain lower cost preferred brand name drugs</a>	\$5/prescription to <a href="#">out-of-pocket limit</a> . (2 <a href="#">copays</a> apply to certain 90-day supply <a href="#">mail orders</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 and submit a reimbursement form to <a href="#">Navitus</a> .	<a href="#">In-network</a> covers most up to a 30-day supply (90-day for certain prescriptions) retail and <a href="#">mail order</a> .
	Level 2: Preferred <a href="#">brand drugs and certain higher cost preferred generic drugs</a>	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 <a href="#">mail order</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 and submit a reimbursement form to <a href="#">Navitus</a> .	<a href="#">In-network</a> covers most up to a 30-day supply (90-day for certain prescriptions) retail and <a href="#">mail order</a> .
	Level 3: <a href="#">Non-preferred brand name and certain high cost generic drugs</a>	40% <a href="#">coinsurance</a> (\$150 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 and submit a reimbursement form to <a href="#">Navitus</a> .	<a href="#">Out-of-pocket limit</a> of \$6,850 for an individual and \$13,700 for a family
	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 drugs</a> to specialty <a href="#">out-of-pocket limit</a> . 40% <a href="#">coinsurance</a> (\$200 max) per prescription for non-preferred drugs. No <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 and submit a reimbursement form to <a href="#">Navitus</a> .	<a href="#">Out-of-pocket limit</a> of \$1,200 for an individual and \$2,400 for a family
	Level 4: <a href="#">Specialty drugs</a> at participating pharmacy provider	40% <a href="#">coinsurance</a> (\$200 max) per prescription for <a href="#">preferred drugs</a> to specialty <a href="#">out-of-pocket limit</a> . 40% <a href="#">coinsurance</a> (\$200 max) per prescription for non-preferred drugs. No <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 and submit a reimbursement form to <a href="#">Navitus</a> .	<a href="#">Out-of-pocket limit</a> of \$1,200 for an individual and \$2,400 for a family

Common Medical Event	Services You May Need	What You Will Pay		
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
<b>If you have outpatient surgery</b>	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  \$25 <a href="#">copay</a> for <a href="#">specialist</a> office visit	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.
	<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	\$25 <a href="#">copay</a> /visit	<a href="#">Deductible</a> does not apply. Additional services (e.g. labs, x-rays, etc.) during the visit are subject to applicable <a href="#">deductibles</a> and <a href="#">coinsurance</a> .
	Physician/surgeon fees	10% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Not covered	<a href="#">Prior approval</a> required for low back surgeries and MRI, CT and PET scans
<b>If you have a hospital stay</b>	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 <a href="#">deductible</a>	Not covered	<a href="#">Prior approval</a> required for low back surgeries and MRI, CT and PET scans
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	\$15 <a href="#">copay</a> /visit	Not covered	<a href="#">Deductible</a> does not apply.
	Inpatient services	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 (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<b>If you are pregnant</b>	Office visits	\$15 <a href="#">copay</a> /visit	Not covered	<a href="#">Deductible</a> does not apply for copay visits.  <a href="#">Deductible</a> and 10% <a href="#">coinsurance</a> apply if prenatal and/or postnatal care billed as a package.
	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	Not covered	<a href="#">Deductible</a> does not apply. Physical, speech and occupational therapy limited to 50 visits per year, combined <a href="#">rehabilitation</a> and <a href="#">habilitation services</a> . Plan may approve 50 more per year.
	<a href="#">Habilitation services</a>	\$15 <a href="#">copay</a> /visit	Not covered	<a href="#">Deductible</a> does not apply. Physical, speech and occupational therapy limited to 50 visits per year, combined <a href="#">rehabilitation</a> and <a href="#">habilitation services</a> . Plan may approve 50 more per year.
	<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, per condition.
	<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. Child's hearing aids 10% <a href="#">coinsurance</a> after <a href="#">deductible</a>
	<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 (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	\$25 <a href="#">copay</a>	Not covered	Limited to one per individual per year. Contact lens fitting not covered. Full coverage if required by federal law. <a href="#">Deductible</a> does not apply.
	Children's glasses	Not covered	Not covered	Excluded service.
	Children's dental check-up	Not covered	Not covered	Excluded service.

### Excluded Services & Other Covered Services:

Services Your <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> .)			
•Acupuncture	•Infertility treatment	•Private-duty nursing	
•Cosmetic surgery	•Long-term care	•Routine foot care	
•Dental care (Adult)	•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 <a href="#">plan</a> document.)			
•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: GHC-SCW Member Services at 1-800-605-4327 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](#).

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

## Language Access Services:

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-608-828-4853 or 1-800-605-4327, ext. 4504, (TTY: 1-608-828-4815).

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-608-828-4853 or 1-800-605-4327, ext. 4504, (TTY: 1-608-828-4815).

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 1-608-828-4853 or 1-800-605-4327, ext. 4504, (TTY: 1-608-828-4815)。

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-608-828-4853 or 1-800-605-4327, ext. 4504, (TTY: 1-608-828-4815)

4853-828-608-1 رقم (ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية هاتف الصم والبكم تتوافر لك بالمجان. اتصل برقم 1-800-605-4327, ext. 4504, (TTY: 1-608-828-4815)

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-608-828-4853 or 1-800-605-4327, ext. 4504, (TTY: 1-608-828-4815)

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-608-828-4853 or 1-800-605-4327, ext. 4504, (TTY: 1-608-828-4815). 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 1-608-828-4853 or 1-800-605-4327, ext. 4504, (TTY: 1-608-828-4815)

Wann du [Deutsch (Pennsylvania German / Dutch)] schwetzsch, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: 1-608-828-4853 or 1-800-605-4327, ext. 4504, (TTY: 1-608-828-4815).

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທ 1-608-828-4853 or 1-800-605-4327, ext. 4504, (TTY: 1-608-828-4815).

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-608-828-4853 or 1-800-605-4327, ext. 4504, (TTY: 1-608-828-4815).

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-608-828-4853 or 1-800-605-4327, ext. 4504, (TTY: 1-608-828-4815).

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-608-828-4853 or 1-800-605-4327, ext. 4504, (TTY: 1-608-828-4815) पर कॉल करें।

KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1-608-828-4853 or 1-800-605-4327, ext. 4504, (TTY: 1-608-828-4815).

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa [1-608-828-4853 or 1-800-605-4327, ext. 4504, (TTY: 1-608-828-4815)].

**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

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



**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 [plan's](#) overall [deductible](#) \$250
- [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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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**In this example, Peg would pay:**

<i>Cost Sharing</i>	
Deductibles	\$250
Copayments	\$300
Coinsurance	\$800
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Peg would pay is</b>	<b>\$1,350</b>

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

- The [plan's](#) overall [deductible](#) \$250
- [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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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**In this example, Joe would pay:**

<i>Cost Sharing</i>	
Deductibles	\$250
Copayments	\$300**
Coinsurance	\$400**
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Joe would pay is</b>	<b>\$950**</b>

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

- The [plan's](#) overall [deductible](#) \$250
- [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*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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**In this example, Mia would pay:**

<i>Cost Sharing</i>	
Deductibles	\$250
Copayments	\$100
Coinsurance	\$200
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$550</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: [wellwisconsin.staywell.com](http://wellwisconsin.staywell.com) or 1-800-821-6591