The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.
This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, contact ETF at www.etf.wi.gov.
For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other terms see the Glossary. You can view the Glossary at https://www.healthcare.gov/glossary/essential-health-benefits/ or call 1-877-533-5020 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$1,500 Individual / $3,000 Family Combined medical and prescription drug deductible.	You must pay all the costs up to the deductible amount before the policy begins to pay for covered services you use, with the exception of federally required preventive services. The deductible starts over with each plan year beginning January 1st. For family coverage, the full family deductible must be met. See the chart starting on page 2 for your costs for services this plan covers.
Are there services covered before you meet your deductible?	Yes. Preventive care and primary care services are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No	There are no other deductibles.
What is the out-of-pocket limit for this plan?	$2,500 Individual / $5,000 Family Combined medical and prescription drug out-of-pocket limit.	The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses. The federal maximum out-of-pocket is $6,850 person/$13,700 family. This applies to all essential health benefits. See https://www.healthcare.gov/glossary/essential-healthbenefits/ for details.
What is not included in the out-of-pocket limit?	Coinsurance paid by adults for hearing aids, premiums and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.group-health.com or call 1-888-203-7770 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	Yes. Written referral required for all out-of-network care.	This plan will pay some or all of the costs to see a **specialist** for covered services but only if you have the plan's permission before you see the **specialist**. You should get a referral to an

		orthopedist or neurosurgeon for low back pain and for all out-of-network care.

OMB Control Numbers 1545-2229, 1210-0147, and 0938-1146
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All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$15 copay/visit after deductible	Not covered	Additional services (e.g. labs, x-rays, etc.) during the visit are subject to applicable coinsurance.
	Specialist visit	$25 copay/visit after deductible	Not covered unless prior authorized	Additional services (e.g. labs, x-rays, etc.) during the visit are subject to applicable coinsurance.
	Other practitioner office visit	$15 copay/visit after deductible (includes chiropractic visits)	No covered	Maintenance care and acupuncture not covered. Additional services (e.g. labs, x-rays, etc.) during the visit are subject to applicable coinsurance.
	Preventive care/screening/ immunization	After deductible $15 primary care visit copay and 10% coinsurance for related services.	Not covered	Full coverage if required by federal law. For details, visit: https://www.healthcare.gov/preventive-care-benefits/
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance after deductible	Not covered	Full coverage if required by federal law.
	Imaging (CT/PET scans, MRIs)	10% coinsurance after deductible	Not covered	Prior approval required or benefits not payable.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.navitus.com	Level 1: Preferred generic drugs and certain lower cost preferred brand name drugs	$5/prescription after deductible. (2 copays apply to certain 90-day supply mail orders)	Not covered	In-network covers most up to a 30-day supply (90-day for certain prescriptions) retail and mail order. Out-of-network care allowed but if your ID card is not used, you will pay more than the copay.
	Level 2: Preferred brand drugs and certain higher cost preferred generic drugs	20% coinsurance ($50 max) per prescription after deductible (2 copays apply to certain 90-day supply mail order)	Not covered	In-network covers most up to a 30-day supply (90-day for certain prescriptions) retail and mail order. Out-of-network care allowed but if your ID card is not used, you will pay more than the copay.
	Level 3: Non-preferred brand name and certain high cost generic drugs	40% coinsurance ($150 max) per prescription after deductible.	Not covered	Federal out-of-pocket limit applies. Out-of-network care allowed, but if your ID card is not used, you will pay more than the copay.

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
		Member must pay the cost difference between the non-preferred brand drug and the preferred generic equivalent drug if not medically necessary.		
	Level 4: Specialty drugs at preferred specialty pharmacy provider	$50 copay per prescription after deductible for preferred drugs 40% coinsurance ($200 max) per prescription after deductible for non-preferred drugs	Not covered	Out-of-network care allowed but if your ID card is not used, you will pay more than the copay. Full coverage if required by federal law.
	Level 4: Specialty drugs at non-participating pharmacy provider	40% coinsurance ($200 max) per prescription after deductible for preferred and non-preferred drugs		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance after deductible	Not covered	---------- NONE ----------
	Physician/surgeon fees	$15 copay for primary doctor office visit after deductible $25 copay for specialist office visit after deductible	Not covered	Additional services provided (e.g. costs of surgery, equipment, etc.) are subject to applicable deductible and coinsurance. Prior approval required for low back surgeries and MRI, CT and PET scans.
If you need immediate medical attention	Emergency room care	$75 copay after deductible	$75 copay after deductible	Copay is waived if admitted.
	Emergency medical transportation	10% coinsurance after deductible	10% coinsurance after deductible	----------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)	
	Urgent care	$25 copay/visit after deductible	$25 copay/visit after deductible	Additional services (e.g. labs, x-rays, etc.) during the visit are subject to applicable deductibles and coinsurance.
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance after deductible	Not covered	Prior approval recommended
	Physician/surgeon fees	10% coinsurance after deductible	Not covered	Prior approval required for low back surgeries and MRI, CT and PET scans
If you need mental health, behavioral health, or substance abuse services	Mental/Behavioral health outpatient services	$15 copay/visit after deductible	Not covered	----------NONE----------
	Mental/Behavioral health inpatient services	10% coinsurance after deductible	Not covered	----------NONE----------
	Substance use disorder outpatient services	$15 copay/visit after deductible	Not covered	----------NONE----------
	Substance use disorder inpatient services	10% coinsurance after deductible	Not covered	----------NONE----------
If you are pregnant	Office visits	$15 copay/visit after deductible	Not covered	Deductible and 10% coinsurance apply if prenatal and/or postnatal care billed as a package. Full coverage if required by federal law.
	Childbirth/delivery professional services	10% coinsurance after deductible	Not covered	----------NONE----------
	Childbirth/delivery facility services	10% coinsurance after deductible	Not covered	----------NONE----------
If you need help recovering or have other special health needs	Home health care	10% coinsurance after deductible	Not covered	Limited to 50 visits per year. Plan may approve 50 more per year.
	Rehabilitation services	$15 copay/visit after deductible	Not covered	Physical, speech and occupational therapy limited to 50 visits per year, combined rehabilitation and habilitation services. Plan may approve 50 more per year.
	Habilitation services	$15 copay/visit after deductible	Not covered	Physical, speech and occupational therapy limited to 50 visits per year, combined rehabilitation and habilitation services. Plan may approve 50 more per year.
	Skilled nursing care	10% coinsurance after deductible	Not covered	Facility coverage is limited to 120 days per benefit period.

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)	
	Durable medical equipment	20% coinsurance after deductible (child's hearing aids 10%)	Not covered	Hearing aids (adults) plan maximum payment $1,000 per ear every 3 years.
	Hospice services	10% coinsurance after deductible	Not covered	----------NONE----------
If your child needs dental or eye care	Children's eye exam	$25 copay after deductible	Not covered	Limited to one per individual per year. Contact lens fitting not covered. Full coverage if required by federal law.
	Children's glasses	Not covered	Not covered	Excluded service.
	Children's dental check-up	Not covered	Not covered	Excluded services.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside US
- Private duty nursing
- Routine foot care
- Weight loss programs

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

- Chiropractic care
- Dental care, limited to certain oral surgical services and treatment of injuries
- Hearing aids
- Telemedicine
- Telehealth
- Routine eye care, limited to one eye exam per calendar year by a plan provider
- E-visit services

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: [insert State, HHS, DOL, and/or other applicable agency contact information]. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Group Health Cooperative of Eau Claire at 1-888-203-7770 or TTY 1-800-947-3529 or ETF at 1-877-533-5020 or www.etf.wi.gov.

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

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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

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.

Discrimination is Against the Law

Group Health Cooperative of Eau Claire complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Group Health Cooperative of Eau Claire does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Group Health Cooperative of Eau Claire provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats.

Group Health Cooperative of Eau Claire provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages.

If you need these services, contact Shannon Darrow, Civil Rights Coordinator.

If you believe that Group Health Cooperative of Eau Claire has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Shannon Darrow, Civil Rights Coordinator, 2503 N Hillcrest Pkwy Altoona, WI 54720, 1-888-203-7770, TTY 1-800-947-3529, fax 1-715-836-7683, email compliance@group-health.com You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Shannon Darrow, Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD).

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Language Access Services:

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-203-7770, TTY 1-800-947-3529.

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-888-203-7770, TTY 1-800-947-3529.

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-888-203-7770, TTY 1-800-947-3529.

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-888-203-7770, TTY 1-800-947-3529.

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

ملحوظة :إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية 1-888-203-7770 # telephone) رقم)
. (TTY # -1-800-947-3529 هاتف الصم والبكم تتوافر لك بالمجان .اتصل برقم:

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-888-203-7770, [телетайп: 1-800-947-3529.

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-888-203-7770, TTY 1-800-947-3529.번으로 전화해 주십시오.

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-888-203-7770, TTY 1-800-947-3529.

Wann du [Deitsch (Pennsylvania German / Dutch)] schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: 1-888-203-7770, TTY 1-800-947-3529.

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-888-203-7770, TTY 1-800-947-3529.

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-888-203-7770, TTY 1-800-947-3529.

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-888-203-7770, TTY 1-800-947-3529.

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। Telephone #1-888-203-7770 (TTY: #1-800-947-3529) पर कॉल करें।

KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1-888-203-7770, TTY 1-800-947-3529.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-888-203-7770, TTY 1-800-947-3529.

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

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$1500
Specialist copayment	$25
Hospital (facility) coinsurance	10%
Other coinsurance	10%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,731**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,500
Copayments	$30
Coinsurance	$1,000
What isn't covered	
Limits or exclusions	$11
The total Peg would pay is	**$2,541**

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

The plan's overall deductible	$1500
Specialist copayment	$25
Hospital (facility) coinsurance	10%
Other coinsurance	10%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$7,389**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1,500
Copayments	$200
Coinsurance	$800
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$2,500**

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

The plan's overall deductible	$1500
Specialist copayment	$25
Hospital (facility) coinsurance	10%
Other coinsurance	10%

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

Total Example Cost	**$1,925**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,500
Copayments	$60
Coinsurance	$10
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$,1570**

The plan would be responsible for the other costs of these EXAMPLE covered services.