group health Cooperative™ of eau claire

2024

Cooperative Advantage (HMO D-SNP)

Summary of Benefits

To Enroll in Cooperative Advantage (HMO D-SNP) you

- ☐ Are entitled to Medicare Part A.
- ☐ Enrolled in Medicare Part B.
- ☐ Reside in the service area of Cooperative Advantage.
- ☐ Are a U.S. citizen or lawfully present in the United States.
- ☐ Eligible and enrolled in Wisconsin Medicaid.

Pre-Enrollment Checklist

Before making an enrollment decision it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a customer service representative at 1-800-460-4641. (TTY users call 711).

Understanding the Benefits

- ☐ The Evidence of Coverage (EOC) provides a complete list of all coverage and services. It is important to review plan coverage, costs, and benefits before you enroll. Visit group-health.com/Cooperative-Advantage or call 1-800-460-4641 to view a copy of the EOC.
- ☐ Review the provider directory (or ask your doctor) to make sure the doctors you see now are in the network. If they are not listed, it means you will likely have to select a new doctor.
- ☐ Review the pharmacy directory to make sure the pharmacy you use for any prescription medicine is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.
- ☐ Review the formulary to make sure your drugs are covered.

Understanding Important Rules

- ☐ In addition to your monthly plan premium, you must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.
- ☐ Benefits, premiums and/or copayments/co-insurance may change on January 1, 2025
- ☐ Except in emergency or urgent situations, we do not cover services by out-of-network providers (doctors who are not listed in the provider directory). Cooperative Advantage's network of doctors, hospitals, other providers, and pharmacies can be found in the provider or pharmacy directory on our website at group-health.com/cooperative-advantage.
- ☐ This plan is a dual eligible special needs plan (D-SNP). Your ability to enroll will be based on verification that you are entitled to both Medicare and medical assistance from a state plan under Medicaid. D-SNPs may provide additional information if they impose restrictions to specific Medicaid eligibility category(ies).
- ☐ This is a summary of health and prescription drug services covered by Cooperative Advantage (HMO D-SNP) January 1, 2024 - December 31, 2024.
- ☐ Cooperative Advantage (HMO D-SNP) is a Medicare Advantage Health Maintenance Organization (HMO) Plan with a Medicare contract. Enrollment in the plan depends on contract renewal.
- ☐ The benefit information provided is a summary of what the plan covers and what you pay. It does not list every service that we cover or list every limitation or exclusion. This information is not a complete description of benefits. The complete list of services we cover is found in the Evidence of Coverage. You can review the Evidence of Coverage at group-health.com/cooperative-advantage. If you would like a printed copy of the Evidence of Coverage mailed to you, please call our Member Services Department at 1-800-460-4641, TTY users can call 711.

Your eligibility to enroll in this plan depends on your type of Medicaid. You can enroll in this plan if you are in one of these Medicaid categories:

- ☐ **Qualified Medicare Beneficiary Plus (QMB+):** You get Medicaid coverage of Medicare cost-share and are also eligible for full Medicaid benefits. Medicaid pays your Part A and Part B premiums, deductibles, coinsurance, and copayment amounts for Medicare covered services. You pay nothing, except for Part D prescription drug copays (if applicable).
- ☐ **Qualified Medicare Beneficiary (QMB):** You get Medicaid coverage of Medicare cost-share but are not eligible for full Medicaid benefits. Medicaid pays your Part A and Part B premiums, deductibles, coinsurance, and copayment amounts only for Medicare covered services. You pay nothing, except for Part D prescription drug copays (if applicable).
- ☐ **Full Benefits Dual Eligible (FBDE):** Medicaid may provide limited assistance with Medicare cost-sharing. Medicaid also provides full Medicaid benefits. You are eligible for full Medicaid benefits. At times you may also be eligible for limited assistance from the State Medicaid Office in paying your Medicare cost share amounts. Generally, your cost share is 0% when the service is covered by both Medicare and Medicaid. There may be cases where you must pay cost sharing when a service or benefit is not covered by Medicaid.

If your category of Medicaid eligibility changes, your cost share may also increase or decrease. You must recertify your Medicaid enrollment to continue to receive your Medicare coverage.

Contact Us

- ☐ Toll free 1-800-460-4641, TTY users can call 711
- ☐ Hours of operation from April 1 - September 30 are Monday through Friday, 8:00 A.M. to 8:00 P.M. From October 1 - March 31, hours of operation are 8:00 A.M. to 8:00 P.M., seven days a week.

Service Area Counties

Adams	Crawford	Jackson	Pepin	Shawano
Ashland	Douglas	Juneau	Pierce	St. Croix
Barron	Dunn	La Crosse	Polk	Taylor
Bayfield	Eau Claire	Lafayette	Portage	Trempealeau
Buffalo	Forest	Langlade	Price	Vernon
Burnett	Grant	Lincoln	Richland	Vilas
Chippewa	Green	Marathon	Rusk	Washburn
Clark	Iowa	Monroe	Sauk	Wood
Columbia	Iron	Oneida	Sawyer	

Out-of-network/non-contracted providers are under no obligation to treat Cooperative Advantage's members, except in emergency situations. Please call our Member Services at 1-800-460-4641, TTY users can call 711 or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services.

The formulary, pharmacy network, and/or provider network may change at any time. You will receive notice when necessary.

Benefits, premium, deductible and/or copayments/coinsurance may change at any time. You will receive notice when necessary.

To know more about your coverage and costs of Original Medicare, look in your current "Medicare & You" handbook. View it online at www.medicare.gov or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users call 1-877-486-2048.

This information is not a complete description of benefits. Call Member Services at 1-800-460-4641, TTY users can call 711 for more information.

Plans may offer supplemental benefits in addition to Part C benefits and Part D benefits.

Your Part B premium is covered by your state's Medicaid agency for D-SNP enrollees

Premium and benefits	Cooperative Advantage (HMO D-SNP)
Monthly Plan Premium and Deductible	$0.00
Premium – Part B If you pay a Medicare Part B Premium, you must continue to do so.	$0
Maximum Out-of-Pocket Responsibility	$8,850 annually

Benefits

		In-Network
Inpatient Hospital Care[1]		$0 copayment Review your Evidence of Coverage for more detailed information.
Outpatient Hospital Coverage[1]	Ambulatory Surgery Center (ASC)	$0 copayment
	Outpatient services	$0 copayment
	Outpatient Blood Services	$0 copayment

	Outpatient Observation	$0 copayment
Doctor's Office Visits	Primary Care Physician (PCP) visit	$0 copayment
	Specialist visit	$0 copayment
	Virtual Medical Visits	$0 copayment to talk with a network telehealth provider online through live audio and video
Preventive Services		$0 copayment
Emergency Care		$0 copayment
Urgently Needed Services		$0 copayment
Outpatient Diagnostic Services/ Labs/Imaging[1]	Diagnostic tests and procedures	$0 copayment
	Labs	$0 copayment
	Diagnostic radiology, therapeutic radiology, X-rays	$0 copayment Prior authorization required for generic testing and CT, MRI, and PET scans.

Hearing Services	Medicare-covered hearing exam	$0 copayment
	Routine Hearing Exam	$0 copayment, one (1) per year
	Hearing Aids	Maximum plan benefit of $2,000 every three (3) years. Plan covers up to two (2) covered hearing aids (one (1) hearing aid for $0 copayment out of pocket per ear)
Dental Services	Medicare-covered	$0 copayment
	Preventive	$0 copayment for exams, cleanings, X-rays and fluoride treatments every year for up to 2 visits.
	Comprehensive	Maximum benefit of $1,000 per year. Plan covers non-routine diagnostic, and restorative services, endodontics, periodontics, and extractions.
Vision Services	Medicare-covered exams	$0 copayment
	Routine eye exams	$0 copayment, one (1) routine eye exam, including refraction, every calendar year.

	Eyeglasses (Lens and Frames) Contact Lenses	Plan pays up to $500 for eyeglasses or contact lenses every year.
	Medicare-covered Eyeglasses (Lens and Frames) after Cataract surgery Contact Lenses after Cataract surgery	$0 copayment
Mental Health Services[1]	Outpatient Mental Health Services	$0 copayment
	Psychological and neuropsychological testing	$0 copayment
	Intensive outpatient services.	$0 copayment
Medicare-covered Chiro[1]	Medicare covered chiropractic care (manual manipulation of the spine to correct subluxation when one or more of the bones of your spine move out of position)	$0 copayment
Skilled Nursing Facility[1]	Requires member to need daily skilled nursing and/or skilled rehabilitation services.	$0 copayment

Outpatient Rehabilitation Services[1]	Physical Therapy	$0 copayment
	Occupational Therapy	$0 copayment
	Speech Therapy	$0 copayment
Ambulance[1]	Ground	$0 copayment
	Air	$0 copayment
Transportation[1]		$0.00 copayment This plan offers coverage for 40, one-way trips to plan-approved location every year. Trips limited to 60 miles.
Durable Medical Equipment and supplies[1]	Prosthetics/Medical Supplies	$0 copayment
	Durable Medical Equipment	$0 copayment
	Diabetic Supplies and Services, Therapeutic Shoes or Inserts	$0 copayment
Medicare Part B Drugs	Insulin Drugs	$0 copayment
	All Part B Drugs and Chemotherapy Drugs[1]	$0 copayment
Part D Prescription Drugs	Retail Pharmacy*	30, 60, 90-day supplies

[1] Prior authorization rules apply for services featuring a superscript 1.

PART D PRESCRIPTION DRUGS

Below is the cost-sharing you will pay in deductible, initial coverage and coverage gap phases for Part D prescription drugs. In the catastrophic coverage phase you pay a small coinsurance percentage or copayment for covered drugs for the rest of the year. We cover drugs filled at an out-of-network pharmacy only when you are not able to use a network pharmacy. If the cost of your drug is less than the listed copay, you will pay only the lower amount.

All part D vaccines including but not limited to the shingles vaccine, tetanus vaccine and tetanus-diphtheria-pertussis (Tdap) vaccine given as routine vaccinations, are covered for members with Part D coverage.

Important Message About What You Pay for Vaccines - Our plan covers most Part D vaccines at no cost to you. Call Member Services for more information.

Our plan groups each medication into one "tier." The amount you pay depends on what stage of the benefit you have reached. Cost- sharing may change when entering another phase of the Part D benefit or if you qualify for "Extra Help." To find out if you qualify for "Extra Help," please contact the Social Security Office at 1-800-772-1213 Monday – Friday, 7 AM – 7 PM. TTY users should call 1-800-325-0778.

COOPERATIVE ADVANTAGE (HMO D-SNP)

This table shows the Standard Retail cost sharing without Extra Help.

Tier 1	30-day	60-day	90-day
Covered Drugs	25%	25%	25%

EXTRA HELP: This table shows what your co-pay would be per prescription if you get Extra Help.

Low Income Subside (LIS) Level	Your cost sharing amount for generic/brand drugs treated like generics	Your cost-sharing amount for all other drugs
LIS 3	$0	$0
LIS 2	$1.55 (each prescription)	$4.60 (each prescription)
LIS 1	$4.50 (each prescription)	$11.20 (each prescription

Important Message About What You Pay for Insulin - You won't pay more than $35 for a one-month supply of each insulin product covered by our plan.

Important Message About What You Pay for Vaccines - Our plan covers most Part D vaccines at no cost to you, even if you haven't paid your Part D deductible. Call Customer Service for more information.

[1] **Prior authorization rules apply for services featuring a superscript 1.**

*Costs may differ based on pharmacy type or status (e.g., preferred/non-preferred, mail order, long-term care (LTC), and 30- or 90-day supply).

Additional Benefits

Fitness Program	$0.00 copayment The plan covers 32 monthly credits available to use towards a nationwide network of gyms, local fitness studio or community center.
Over-the-Counter Drugs	$0.00 copayment The plan covers up to $55.00 each month for specific Over-the-Counter (OTC) drugs or health-related items that are listed in the Over-the-Counter Item Catalog.
Meals – Post-discharge	$0.00 copayment The plan covers 28 home-delivered meals after qualifying discharge from hospital.
Special Supplemental Benefits for Chronically Ill Food Program	$100.00 allowance for food each month. Members with one or more of the chronic conditions as listed in the Evidence of Coverage qualify for the food allowance each month. Unused allowances each month DO NOT rollover to following months.

Podiatry services - Supplemental	20% coinsurance Unlimited routine foot care visits each year This plan covers additional foot care services not covered by Original Medicare: Removal or cutting of corns or calluses, trimming nails and other hygienic and preventive care in the absence of localized illness, injury, or symptoms involving the feet.

Medicaid Benefits

For members who are entitled to full benefits under Medicaid, these are benefits that you may be entitled to. These are additional Medicaid benefits that may not be covered by Cooperative Advantage.

The benefits described below are covered by Medicaid. You can see what Wisconsin Department of Health Services covers. Coverage of the benefits depends on your level of Medicaid eligibility. If Medicare doesn't cover a service or a benefit has run out, Medicaid may help, but you may have to pay a cost share. In some situations, Medicaid may pay your Medicare cost sharing amount. See your Medicaid Member Handbook for more details. If you have questions about your Medicaid eligibility and what benefits you are entitled to, call ForwardHealth Member Services, 1-800-362-3002.

Benefit	Medicaid	Cooperative Advantage Medicare
Acupuncture	Not Covered	$0 copayment Review your Evidence of Coverage for more detailed information.
Ambulance Services (Must be medically necessary)	Covered	$0 copayment

Ambulatory Surgical Services	Covered of certain surgical procedures and related lab services	$0 copayment
Cardiac and Pulmonary Rehabilitation Services	Covered	$0 copayment
Chiropractic Services	Covered Copay apply per service	$0 copayment
Dental Services	Covered Copay apply per service	Covered Preventive and Comprehensive $0 copay. $1,000 max comprehensive allowance
Diabetes Programs and Supplies	Covered Copay apply per service	$0 copayment
Diagnostic Tests, X- rays, Lab Services, and Radiology Services	Covered Copay apply per service	$0 copayment for diagnostic procedures and test/X-rays lab
Dialysis Services	Covered	$0 copayment
Durable Medical Equipment	Covered Copay apply per service	$0 copayment
Emergency Care	Covered	$0 copayment
Hearing Services	Covered Copay per services. No copay for hearing and batteries.	$0 copayment
Home Health Services	Covered: Skilled nursing, OT, PT, ST, personal care worker, and private duty nursing	$0 copayment Covered: Skilled nursing, Physical, Occupational, and Speech Therapy Not covered: Personal care

		worker and private duty nursing
Outpatient Mental Health Care: This includes psychosocial rehabilitative services, including case management services, provided by staff of a certified community support program	Covered. Not including room and board. Copay per service. Copays are not required when services are provided in a hospital setting or for residential substance use disorder treatment services	$0 copayment. Not covered: Residential Treatment
Outpatient Rehabilitation Services (Occupational Therapy, Physical Therapy, Speech and Language Therapy)	Covered Copay per service.	$0 copayment
Outpatient Hospital Services	Covered. Copay per service.	$0 copayment
Outpatient Substance Abuse Care	Covered, includes residential treatment. Not including room and board. Copays are not required when services are provided in a hospital setting or for residential	$0 copayment. Not covered: Residential Treatment
Over-the-Counter Items	Some over-the-counter drugs are covered. Copay apply.	Covered. $0 copayment $55.00 allowance each month.
Podiatry Services	Covered	$0 copayment

Physician Specialist Services	Covered Copay per service. No copay for emergency services, preventative services, anesthesia, or clozapine management.	$0 copayment
Psychiatric Services	Covered Copay per service. Copays are not required when services are provided in a hospital setting or for residential substance use disorder treatment services.	Covered. $0 copayment
Transportation Services (Routine)	Covered Copay per trip. No copay for transportation by common carrier or emergency ambulance.	Covered. $0 copayment 40 one-way transportation trips to plan approved location.
Worldwide Emergency/Urgent Coverage (out of service area)	Not Covered	Not Covered
Urgently Needed Services	Covered	Covered. $0 copayment
Vision Services	Covered No copay for eyeglasses selected from the Medicaid collection.	No copay for one routine eye exam, include refraction, every calendar year. $500.00 for eyeglasses or contact lenses every year

Inpatient Care		
	Medicaid	Cooperative Advantage Medicare
Inpatient Hospital Care (includes substance abuse and rehabilitative services)	Covered	Covered. $0 copayment
Inpatient Mental Health Services	Covered	Covered. $0 copayment
Skilled Nursing Facility	Covered	Covered
Hospice		
Hospice Services	Covered	Covered by Original Medicare
Other Services		
Kidney Disease Education	Covered	Covered. $0 copayment
Prescription Drug Benefits		
Outpatient Prescription Drugs: Part D	Covered Coverage of generic and brand name prescription drugs and some over the counter (OTC) drugs	Covered. Coverage of generic and brand name prescription drugs. Additional Over-the-Counter (OTC) items available as a supplemental benefit

Additional Medicaid Benefits

Benefit	Medicaid
Non-emergency medical transportation	Covered
Dental, except in Milwaukee, Waukesha, Racine, Kenosha, Ozaukee, and Washington counties	Covered
Prenatal care coordination	Covered
Targeted case management	Covered
School-based services	Covered
Child care coordination	Covered
Certain Tuberculosis-related services, including directly observed therapy (DOT), patient education and anticipatory guidance, symptom and treatment monitoring.	Covered
Crisis intervention benefit	Covered
Community Support Program services	Covered
Comprehensive Community services	Covered
Community Recovery services	Covered
Chiropractic services	Covered

Lead investigations, as defined in Wis. Stat. §254.11(8s), of persons having lead poisoning or lead exposure, as defined in Wis. Stat. §254.11(9).	Covered
Medication therapy management	Covered
Prescription, over-the-counter drugs, and diabetic and other drug related supplies	Covered
Provider administered drugs	Covered
Behavioral Treatment Services (Autism Services)	Covered
Residential Substance Use Disorder Treatment	Covered
Hub and Spoke Integrated Recovery Support Services Health Home for SUD Treatment Pilot Program	Covered

Non-Discrimination and Accessibility Policy

Group Health Cooperative of Eau Claire complies with applicable Federal civil rights laws and does not discriminate, exclude or treat people differently on the basis of race, color, national origin, age, disability, religion, or sex (including pregnancy, sexual orientation, and gender identity).

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
    - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
    - Qualified interpreters
    - Information written in other languages

If you need these services, contact our Civil Rights Coordinator: 1-800-460-4641 (TTY: 711).

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, religion, or sex (including pregnancy, sexual orientation, and gender identity), you can file a grievance with:

Civil Rights Coordinator
2503 N. Hillcrest Pkwy.
Altoona, WI 54720
Phone: 1-800-460-4641 (TTY: 711)
Fax: 1-715-836-7683
Email: compliance@group-health.com

If you need help filing a grievance, our 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, D.C. 20201
Phone: 1-800-368-1019, (TDD: 800-537-7697)
OCRComplaint@hhs.gov
https://www.hhs.gov/civil-rights

English – ATTENTION: If you speak English, language assistance services are available to you free of charge. Call 1-800-460-4641 (TTY: 711).

Spanish – ATENCIÓN: Si habla español, los servicios de asistencia de idiomas están disponibles sin cargo, llame al 1-800-460-4641(TTY: 711).

Hmong – CEEB TOOM: Yog koj hais lus Hmoob, kev pab rau lwm yam lus muaj rau koj dawb xwb. Hu 1-800-460-4641 (TTY: 711).

Chinese Mandarin – 注意：如果您说中文，您可获得免费的语言协助服务。请致电 1-800-460-4641(TTY文字电话: 711).

German – ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-460-4641 (TTY: 711).

Arabic – ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك
رقم هاتف الصم -203- بالمجان. اتصل برقم 888) 7770
والبكم 711).

Russian – ВНИМАНИЕ: Если Вы говорите по-русски, Вам будут бесплатно предоставлены услуги переводчика. Позвоните по номеру: 1-800-460-4641 (TTY: 711).

Korean – 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-460-4641(TTY: 711)번으로 전화해 주십시오.

Vietnamese – CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-460-4641(TTY: 711).

Pennsylvania Dutch – Wann du [Deitsch (Pennsylvania German / Dutch) schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-800-460-4641(TTY: 711).

Laotian – ໝາຍເຫດ: ຖ້າທ່ານເວົ້າພາສາລາວ, ທ່ານສາມາດໃຊ້ ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາໄດ້ ໂດຍບໍ່ເສຍຄ່າ. ໂທ 1-800-460-4641(TTY: 711).

French – ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-460-4641(ATS : 711).

Polish – UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-460-4641(TTY: 711).

Hindi – ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-800-460-4641(TTY: 711) पर कॉल करें।

Albanian – KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1-800-460-4641(TTY: 711).

Tagalog – PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-460-4641(TTY: 711).

Somali – DIGTOONI: Haddii aad ku hadasho afka Soomaaliha, adeegyada caawimada luqadda waxaa laguu heli karaa iyagoo bilaash ah. Wac 1-800-460-4641(TTY: 711).

Serbo-Croatian – PAŽNJA: Ako govorite srpsko-hrvatski imate pravo na besplatnu jezičnu pomoć. Nazovite 1-800-460-4641(telefon za gluhe: 711).

Burmese – သတိပြုရန် - အကယ်၍ သင်သည် မြန်မာစကား ကို ပြောပါက၊ ဘာသာစကား အကူအညီ၊ အခမဲ့၊ သင့်အတွက် စီစဉ်ဆောင်ရွက်ပေးပါမည်။ 1-800-460-4641(TTY: 711) သို့ ခေါ်ဆိုပါ။ ພາສາ, ໂດຍບໍ່ເສັຍຄ່າ, ແມ່ນມີ