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?	$500 per individual/$1,000 per family	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 on January 1st. See the chart starting on page 2 for your costs for services this plan covers.
Are there other deductibles for specific services?	No.	There are no other deductibles.
Is there an out–of–pocket limit on my expenses?	Yes. Durable Medical Supplies (DME): $500 per individual. Prescription drug Level 1 and 2: $600 individual/$1,200 family. Level 4: $1,200 individual/$2,400 family	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 individual/$13,700 family. This applies to all essential health benefits, including some services not included in the out-of-pocket limit. (i.e. certain level 3 & 4 prescription drugs, and certain hearing aids covered under this plan). See https://www.healthcare.gov/glossary/essential-health-benefits/ for details.
What is not included in the out–of–pocket limit?	Copays for Level 3 and Level 4 non-preferred specialty drugs; 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.**
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 a list of in-network providers, see www.ghcscw.com or call 1-800-605-4327 (TTY: 1-608-828-4815) for a list of participating providers.	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**.

Questions: Call **1-800-533-5020** or visit us at **www.etf.wi.gov**.
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at **https://www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf** or call 1-877-533-5020 to request a copy.

OMB Control Numbers 1545-2229, 1210-0147, and 0938-1146

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Do I need a referral to see a specialist?	Yes.	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral 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**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** 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 **coinsurance** 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**, **copayments** and **coinsurance** amounts.

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 visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	No charge after deductible	Not covered	——none——
	Specialist visit	No charge after deductible	Not covered unless prior-authorized	——none——
	Other practitioner office visit	No charge after deductible	Not covered	Maintenance care and acupuncture not covered.
	Preventive care/screening/immunization	No charge after deductible	Not covered	Full coverage if required by federal law. For details, visit: https://www.healthcare.gov/preventive-care-benefits/

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 have a test	Diagnostic test (x-ray, blood work)	No charge after deductible	Not covered	Full coverage if required by federal law.
	Imaging (CT/PET scans, MRIs)	No charge 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 per 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 care allowed but if your ID card is not used, you will pay more than the copay.
	Level 2 Preferred brand name drugs and certain higher cost preferred generic drugs	20% coinsurance ($50 maximum) per 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 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 maximum) per prescription. No out-of-pocket limit	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.

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
	Level 4 Specialty drugs at preferred specialty pharmacy provider	$50 copay per prescription for **preferred** drugs to specialty out-of-pocket limit. 40% coinsurance ($200 maximum) **non-preferred** drugs. No out-of-pocket limit.	Not covered	Out-of-network care allowed but if your ID card is not used, you will pay more than the copay. Federal maximum out-of-pocket applies.
	Level 4 Specialty drugs at participating pharmacy provider	40% coinsurance ($200 maximum) per prescription for **preferred** drugs to specialty out-of-pocket limit. 40% coinsurance ($200 maximum) per prescription for **non-preferred** drugs. No out-of-pocket limit		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge after deductible	Not Covered	——————none——————
	Physician/surgeon fees	No charge after deductible	Not Covered	Prior approval required for low back surgeries and MRI, CT and PET scans
If you need immediate medical attention	Emergency room services	$60 copay/visit	$60 copay/visit	Copay does not apply to out-of-pocket limit and is waived if admitted.
	Emergency medical transportation	No charge after deductible	No charge after deductible	——————none——————
	Urgent care	No charge after deductible	No charge after deductible	——————none——————

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 have a hospital stay	Facility fee (e.g., hospital room)	No charge after deductible	Not covered	Prior approval recommended
	Physician/surgeon fee	No charge after deductible	Not Covered	Prior approval required for low back surgeries and MRI, CT and PET scans
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	No charge after deductible	Not Covered	——————none——————
	Mental/Behavioral health inpatient services	No charge after deductible	Not Covered	——————none——————
	Substance use disorder outpatient services	No charge after deductible	Not Covered	——————none——————
	Substance use disorder inpatient services	No charge after deductible	Not Covered	——————none——————
If you are pregnant	Prenatal and postnatal care	No charge after deductible	Not Covered	Full coverage if required by federal law.
	Delivery and all inpatient services	No charge after deductible	Not Covered	——————none——————

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	No charge after deductible	Not Covered	Limited to 50 visits per year. Plan may approve 50 more per year.
	Rehabilitation services	No charge 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	No charge 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	No charge after deductible	Not Covered	Facility coverage is limited to 120 days per benefit period.
	Durable medical equipment	20% coinsurance after deductible (child's hearing aids no charge after deductible)	Not Covered	Hearing aids (adults) plan maximum payment $1,000 per ear every 3 years.
	Hospice service	No charge after deductible	Not Covered	——————none——————
If your child needs dental or eye care	Eye exam	No charge after deductible	Not Covered	Full coverage if required by federal law. Limited to one per individual per year. Contact lens fittings not covered.
	Glasses	Not Covered	Not Covered	Excluded service.
	Dental check-up	Not Covered	Not Covered	Excluded service.

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

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

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 covered 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 1-888-915-4001. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security 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: Group Health Cooperative of South Central Wisconsin at 1-800-605-4327 or 608-828-4853 or ETF at 1-877-533-5020 or www.etf.wi.gov.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Questions: Call **1-800-533-5020** or visit us at **www.etf.wi.gov.**
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at **https://www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf** or call 1-877-533-5020 to request a copy.

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Discrimination is Against the Law

Group Health Cooperative of South Central Wisconsin 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 South Central Wisconsin does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Group Health Cooperative of South Central Wisconsin 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 South Central Wisconsin 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 Group Health Cooperative of South Central Wisconsin's Member Services at (608) 828-4853 or (800) 605-4327, ext. 4504 (TTY: 1-608-828-4815).

If you believe that GHC-SCW 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 GHC-SCW's Corporate Compliance Officer, 1265 John Q. Hammons Drive, Madison, WI 53717, Telephone: (608) 251-4156, TTY: (608) 828-4815, Fax: (608) 257-3842, or e-mail member_services@ghcscw.com. If you need help filing a grievance GHC-SCW's Corporate Compliance Officer 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 1-608-828-4853 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).

الـ لغويـ ة الـ مـ ساعدة خدمات نـ فـ إ الـ لغة، اذكـ ر تـ تحدث كـ نت إذا :مـ لحوظة -telephone #1-800-605-4327 (رقـ م
بـ رقـ م اتـ صل بـ الـ مجان لـ كـ تـ توافـ ر والـ بـ كم الـ صم هاتـ فـ: 1-608-828-4853 - TTY #).

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 [Deitsch (Pennsylvania German / Dutch)] schwetzscht, 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, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 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 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** $6,540
- **Patient pays** $1,000

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,300
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$1,000
Copays	$0
Coinsurance	$0
Limits or exclusions	$0
Total	**$1,000**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $4,300
- **Patient pays** $ 1,100

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	$500
Copays	$600
Coinsurance	$0
Limits or exclusions	$0
Total	**$1,100**

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**, **copayments**, and **coinsurance** 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 **copayments**, **deductibles**, and **coinsurance**. 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 **1-800-533-5020** or visit us at **www.etf.wi.gov**.
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