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 deductible?	$500 Individual $1,000 Family	If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible. Deductible exceptions include office visit copays and for federally required preventive services. The deductible starts over with each plan year beginning on January 1st.
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	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	For Durable Medical Equipment You pay 20% up to $500 per individual Prescription drug: Level 1 and 2: $600 Individual $1,200 Family	If you have other family members in this plan, the overall family out-of-pocket limit must be met. 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 $9,450 individual/$18,900 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 adult hearing aids covered under this plan).
What is not included in the out-of-pocket limit?	Copayments for Level 3 and Level 4 non-preferred specialty drugs, coinsurance paid for adult 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.ghcscw.com or call 1-800-605-4327 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	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.

(DT - OMB control number: 1545-0047/Expiration Date: 12/31/2019)(DOL - OMB control number: 1210-0147/Expiration date: 5/31/2022) (HHS - OMB control number: 0938-1146/Expiration date: 10/31/2022)

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: Network Provider (You will pay the least)	What You Will Pay: Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
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	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
	Specialist visit	No charge after deductible	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
	Preventive care/screening/ immunization	No charge	Not covered	All preventive care services that have received an A or B grade by the United States Preventive Services Task Force are covered without cost sharing. Ask your in-network provider if the services needed are preventive. Then check what your plan will pay for. Full coverage is required by federal law.
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 authorization required or benefits not payable.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at navitus.com and etf.benefits.navitus.com	Level 1: Preferred generic drugs and certain lower cost preferred brand name drugs	$5/prescription to out-of-pocket limit. (2 copays apply to certain 90-day supply mail orders)	Prescriptions may be filled at an out-of-network pharmacy in emergency situations only. At the out-of-network pharmacy, during the emergency situation, you should pay for the prescription in full and submit a reimbursement form to Navitus.	In-network covers most up to a 30-day supply (90-day for certain prescriptions) retail and mail order. Out-of-pocket-limit of $600 for an individual and $1,200 for a family.
	Level 2: Preferred brand drugs and certain higher cost preferred generic drugs	20% coinsurance ($50 max) per prescription to out-of-pocket limit. (2 copays apply to certain 90-day supply mail order)	Prescriptions may be filled at an out-of-network pharmacy in emergency situations only. At the out-of-network pharmacy, during the emergency situation, you should pay for the prescription in full and submit a reimbursement form to Navitus.	In-network covers most up to a 30-day supply (90-day for certain prescriptions) retail and mail order. Out-of-pocket-limit of $600 for an individual and $1,200 for a family.

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)	
	Level 3: Non-preferred brand name and certain high cost generic drugs	40% coinsurance ($150 max) per prescription. Member must pay the cost difference between the non-preferred brand drug and the preferred generic equivalent drug if not medically necessary.	Prescriptions may be filled at an out-of-network pharmacy in emergency situations only. At the out-of-network pharmacy, during the emergency situation, you should pay for the prescription in full and submit a reimbursement form to Navitus.	Federal maximum out-of-pocket-limit of $9,450 for an individual and $18,900 for a family applies for some Level 3 drugs.
	Level 4: Specialty drugs at preferred specialty pharmacy provider	$50 copay per prescription for preferred drugs to federal maximum out-of-pocket limit. 40% coinsurance ($200 max) per prescription for non-preferred drugs. No out-of-pocket limit.	Prescriptions may be filled at an out-of-network pharmacy in emergency situations only. At the out-of-network pharmacy, during the emergency situation, you should pay for the prescription in full and submit a reimbursement form to Navitus.	Federal maximum out-of-pocket-limit of $9,450 for an individual and $18,900 for a family applies for some Level 4 drugs.
	Level 4: Specialty drugs at participating pharmacy provider	40% coinsurance ($200 max) per prescription for preferred drugs to federal maximum out-of-pocket limit. 40% coinsurance ($200 max) per prescription for non-preferred drugs. No out-of-pocket limit.	Prescriptions may be filled at an out-of-network pharmacy in emergency situations only. At the out-of-network pharmacy, during the emergency situation, you should pay for the prescription in full and submit a reimbursement form to Navitus.	Federal maximum out-of-pocket-limit of $9,450 for an individual and $18,900 for a family applies for some Level 4 drugs.
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	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.

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 need immediate medical attention	Emergency room care	$60 copay/visit	$60 copay/visit	Copay 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	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)	No charge after deductible	Not covered	Prior approval recommended
	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 mental health, behavioral health, or substance abuse services	Outpatient services	No charge after deductible	Not covered	None
	Inpatient services	No charge after deductible	Not covered	None
If you are pregnant	Office visits	No charge after deductible	Not covered	Deductible applies if prenatal and/or postnatal care is billed as a package. Full coverage if required by federal law.
	Childbirth/delivery professional services	No charge after deductible	Not covered	None
	Childbirth/delivery facility services	No charge after deductible	Not covered	None
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 therapy, per participant, per year.

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
	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 therapy, per participant, 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	Not covered	Hearing aids (adults) plan maximum payment $1,000 per ear every 3 years. Children's hearing aids have no plan maximum payment.
	Hospice services	No charge after deductible	Not covered	None
If your child needs dental or eye care	Children's eye exam	No charge 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 service.

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.)

- Cosmetic surgery
- Dental care (Adult)
- 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.)

- 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 and the Wisconsin Office of the Commissioner of Insurance at (800) 236-8517 or 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 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

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.

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 اتصل برقم. إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية هاتف الصم والبكم تتوافر لك بالمجان (ملحوظة: رقم or 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 [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 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

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** **$500**
- **Specialist copay** **$0**
- **Hospital (facility) coinsurance** **0%**
- **Other coinsurance** **0%**

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	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$500
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$500**

Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible** **$500**
- **Specialist copay** **$0**
- **Hospital (facility) coinsurance** **0%**
- **Other coinsurance** **20%**

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	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$500
Copayments	$0
Coinsurance	$400**
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$900****

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

- **The plan's overall deductible** **$500**
- **Specialist copay** **$0**
- **Hospital (facility) coinsurance** **0%**
- **Other coinsurance** **20%**

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	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$500
Copayments	$60
Coinsurance	$40
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$600**

**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 contact: https://www.webmdhealth.com/wellwisconsin/ or 1-800-821-6591