Mondovi School District - 2017 Renewal
Effective on: September 1, 2017

BENEFIT DESCRIPTION	Option: 1 - HMO
Lifetime Maximum	Unlimited
Deductible	$2250/$4500
Employer Funded	$1000/$2000
Coinsurance	100%
Coinsurance Out-of-Pocket Limit	N/A
Emergency Room	100% after deductible
Ambulance	100% after deductible
Surgical Services	100% after deductible
Office Visits: Primary Care, PT/OT/ST, Chiropractic, Maternity	100% after deductible
Preventive Care Office Visits	100%
Specialist Care Office Visits	100% after deductible
Urgent Care Office Visits	100% after deductible
Immunizations	100%
Lab & X-Ray in Clinic Setting	100%
Diagnostic Services	100% after deductible
Home Health Care	100% after deductible
Hospice Care	100% after deductible
Oral Surgery	100% after deductible
Organ Transplant Service	100% after deductible
Kidney Disease Treatment	100% after deductible
Hospital Inpatient Services	100% after deductible
Hospital Outpatient - Surgery or Surgi-Center	100% after deductible
Skilled Nursing Facilities/Services (30 day limit)	100% after deductible
Mental Health/AODA Inpatient	100% after deductible
Mental Health/AODA Outpatient	100% after deductible
Prescription Drugs	$0 / $25 / $50
Durable Medical Equipment	100% after deductible
TMJ Services (non-surgical max 11 visits)	
Office Visits	100% after deductible
Appliances & Therapy	100% after deductible
Dependency Criteria	To age 26

GROUP SUMMARY	RENEWAL RATES
Total Monthly Premium	$171,126.00
Employee	$902.80
Employee/Child(ren)	$2,049.36
Employee/Spouse	$2,049.36
Full Family	$2,049.36
Medicare Single Over Age 65	$722.24
Medicare 2 Over Age 65	$1,444.48
Medicare 1 Over Age 65, 1 Under Age 65	$1,625.04
Medicare 1 Over Age 65, 1 Under Age 65 w/ deps	$1,904.91
Medicare 2 Over Age 65 w/ deps	$1,697.26

HealthEOS network for out of state providers. Available for all employees. Provider Network Note: Mayo Clinic, St. Mary's and Methodist Hospital in Rochester, Minnesota are available to GHC members only after receiving a prior event/network authorization by the health plan. This provision does not apply to Mayo Clinic affiliated providers in Wisconsin.

To access our provider directory , visit: www.group-health.com.

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 Member Services at: (888) 203-7770. 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 www.healthcare.gov, www.group-health.com or call 1-888-203-7770 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$2,250 individual/$4,500 family. Deductible is calendar year. Does not apply to preventive care.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. [For embedded deductibles: 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.
Are there services covered before you meet your deductible?	Yes.	This plan covers some items and services even if you haven't yet met the deductible amount. 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.heatlhcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet other deductibles for specific services.
What is the out-of-pocket limit for this plan?	For in-network providers $2,250 individual/$4,500 family. Out-of-pocket is calendar year.	The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for covered services.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges (when applicable), out-of-network services, 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 https://www.group-health.com/Directories/Providers.aspx 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 that 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?	No. Out-of-Network providers are not covered.	You can see the specialist you choose without a referral, so long as that specialist is a network provider.

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	0% after deductible	Not Covered	None.
	Specialist visit	0% after deductible	Not Covered	None.
	Preventive care/screening/ immunization	No charge	Not Covered	Services must be performed and billed in a clinic setting. Immunizations may be performed by a contracted pharmacy.
If you have a test	Diagnostic test (x-ray, blood work)	0% after deductible	Not Covered	None.
	Imaging (CT/PET scans, MRIs)	0% after deductible	Not Covered	Prior authorization may be required.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.[insert].com	Preferred generic drugs	$0 copay /prescription	Not Covered	Subject to Formulary.
	Preferred brand drugs	$25 copay /prescription	Not Covered	If preferred generic available, additional cost may apply. Subject to Formulary.
	Non-preferred brand or generic drugs	$50 copay /prescription	Not Covered	
	Specialty drugs	$50 copay /prescription	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% after deductible	Not Covered	Prior authorization may be required.
	Physician/surgeon fees	0% after deductible	Not Covered	Prior authorization may be required.
If you need immediate medical attention	Emergency room care	0% after deductible	0% after deductible	
	Emergency medical transportation	0% after deductible	0% after deductible	None.
	Urgent care	0% after deductible	0% after deductible	None.
If you have a hospital stay	Facility fee (e.g., hospital room)	0% after deductible	Not Covered	Prior authorization may be required.
	Physician/surgeon fees	0% after deductible	Not Covered	Prior authorization may be required.

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 mental health, behavioral health, or substance abuse services	Outpatient services	0% after deductible	Not Covered	Prior authorization may be required.
	Inpatient services	0% after deductible	Not Covered	Prior authorization may be required.
If you are pregnant	Office visits	0% after deductible	Not Covered	Depending on the type of services, cost sharing may apply.
	Childbirth/delivery professional services	0% after deductible	Not Covered	
	Childbirth/delivery facility services	0% after deductible	Not Covered	
If you need help recovering or have other special health needs	Home health care	0% after deductible	Not Covered	Prior authorization may be required. Visit limits apply.
	Rehabilitation services	0% after deductible	Not Covered	Prior authorization may be required.
	Habilitation services	Not Covered	Not Covered	Prior authorization may be required.
	Skilled nursing care	0% after deductible	Not Covered	Prior authorization may be required. Limited to 30 days.
	Durable medical equipment	0% after deductible	Not Covered	Prior authorization may be required.
	Hospice services	0% after deductible	Not Covered	Prior authorization may be required.
If your child needs dental or eye care	Children's eye exam	0% after deductible	Not Covered	Certain services paid at 100%. Limited to one exam per calendar year. Services must be provided in-network.
	Children's glasses	Not Covered	Not Covered	
	Children's dental check-up	Not Covered	Not Covered	See Policy for Pediatric Dental Disclosure.

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
- Dental Care
- Glasses (over age 18)
- Hearing Aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside US
- Private duty nursing
- Routine foot care
- Weight loss programs (except nutritional counseling)

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

- Chiropractic Care
- Dietary Counseling
- Kidney Disease Treatment
- Oral Surgery
- Speech therapy
- Organ Transplant Service
- TMJ (benefit maximum applies)

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: the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

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 Compliance Department, (888) 203-7770. Plans subject to ERISA may contact the Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. You may also contact the Wisconsin Office of the Commissioner of Insurance (OCI) by calling 1-800-236-8517 outside of the Madison, Wisconsin area or 608-266-0103 in the Madison, Wisconsin area or online at: https://ociaccess.oci.wi.gov/complaints-public/.

Members may request a formal review of any decision by the Cooperative by filing a written Grievance. The written Grievance should include as much information pertinent to the Grievance as possible. To facilitate processing, grievances should be mailed to:

Member Services Department
P.O. Box 3217

Eau Claire, WI 54702-3217

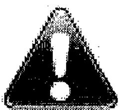
Does this plan provide Minimum Essential Coverage? Yes.
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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:
Spanish (Español): Para obtener asistencia en Español, llame al 1-888-203-7770.
Hmong (Hmoob): Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-888-203-7770.

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 $2250
- Specialist *[cost sharing]* 0%
- Hospital (facility) *[cost sharing]* 0%
- Other *[cost sharing]* 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	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$2,250
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,310**

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

- The plan's overall deductible $2250
- Specialist *[cost sharing]* 0%
- Hospital (facility) *[cost sharing]* 0%
- Other *[cost sharing]* 0%

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	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$2,000
Copayments	$250
Coinsurance	$0
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$2,305**

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

- The plan's overall deductible $2250
- Specialist *[cost sharing]* 0%
- Hospital (facility) *[cost sharing]* 0%
- Other *[cost sharing]* 0%

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	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,925
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,925**

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