This is only a summary. Please read the FEHB Plan brochure RI 73-061 that contains the complete terms of this plan. **All benefits are subject to the definitions, limitations, and exclusions set forth in the FEHB Plan brochure.** Benefits may vary if you have other coverage, such as Medicare. You can get the FEHB Plan brochure at www.ghcscw.com or by calling 1-800-605-4327.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	No Deductible.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for certain covered services you use. **Copayments** and **coinsurance** amounts do not count toward your **deductible**, which generally starts over January 1st. When a covered service or supply is subject to a **deductible**, only the Plan allowance for the service or supply counts toward the **deductible**. See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible** and for which services are subject to the **deductible**.
Are there other deductibles for specific services?	No.	You must pay all of the costs for these services up to the specific **deductible** amount before this plan begins to pay for these services.
Is there an out–of–pocket limit on my expenses?	Yes. For participating providers **$6,350** Member / **$12,700** Family. **$250** Diabetic Disposable Supplies.	The **out-of-pocket limit,** or catastrophic maximum, is the most you could pay during the year for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, balance-billed charges, 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. See www.ghcscw.com or call 1-800-605-4327 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. We use the terms **preferred** or participating for **providers** in our **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	Yes. Written Prior Authorization is required. To obtain Prior Authorization call (608) 257-5294.	This plan will pay some or all of the costs to see a specialist but only if you have the plan's permission before you see the specialists.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 4. See this plan's FEHB brochure for additional information about **excluded services**.

Questions: Call 1-800-605-4327 or visit us at www.ghcscw.com.
If you aren't clear about any of the underlined terms used in this form, see the Glossary.
You can view the Glossary at www.ghcscw.com or call 1-800-605-4327 to request a copy.

- **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 participating **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non- Participating Provider (plus you may be balance billed)	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$10 copay/office visit	Not covered	No charge for children
	Specialist visit	$10 copay/office visit	Not covered	Written Prior Authorization is required. No charge for children
	Other practitioner office visit	$10 copay/office visit	Not covered	Complementary Medicine is covered at GHC-SCW clinics. No charge for children for Chiropractic Care.
	Preventive care/screening/immunization	No charge	Not covered	Coverage is limited to USPSTF guidelines and Women's Preventive Health.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	Not covered	----none----
	Imaging (CT/PET scans, MRIs)	No charge	Not covered	Written Prior Authorization is required.

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non- Participating Provider (plus you may be balance billed)	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.ghcscw.com.	Generic drugs	**Tier 1:** $5 copay/prescription (retail and mail order)	Not covered	Covers up to a 30-day supply; 31-90 day supply available for multiple copays (subject to a cost-limit)
	Preferred brand drugs	**Tier 2:** $20 copay/prescription (retail and mail order)	Not covered	Covers up to a 30-day supply; 31-90 day supply available for multiple copays (subject to a cost-limit)
	Non-preferred brand drugs	**Tier 3:** $50 copay/prescription (retail and mail order)	Not covered	Covers up to a 30-day supply; 31-90 day supply available for multiple copays (subject to a cost-limit)
	Specialty drugs	**Tier 4:** $100 copay/prescription (retail and mail order)	Not covered	Covers up to a 30-day supply; 31-90 day supply available for multiple copays (subject to a cost-limit)
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	Not covered	Written Prior Authorization is required.
	Physician/surgeon fees	No charge	Not covered	Written Prior Authorization is required.
If you need immediate medical attention	Emergency room services	$75 copay/visit	$75 copay/visit	Co-payment waived if admitted as a hospital inpatient.
	Emergency medical transportation	No charge	No charge	-----none-----
	Urgent care	$10 copay/office visit	$10 copay/office visit	-----none-----
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	Not covered	Written Prior Authorization is required.
	Physician/surgeon fee	No charge	Not covered	Written Prior Authorization is required.

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non- Participating Provider (plus you may be balance billed)	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$10 copay/office visit	Not covered	Written Prior Authorization is required when services are not provided by GHC-SCW or Gateway.
	Mental/Behavioral health inpatient services	No charge	Not covered	Written Prior Authorization is required.
	Substance use disorder outpatient services	$10 copay/office visit	Not covered	Written Prior Authorization is required when services are not provided by GHC-SCW or Gateway.
	Substance use disorder inpatient services	No charge	Not covered	Written Prior Authorization is required.
If you are pregnant	Prenatal and postnatal care	No charge	Not covered	-----none-----
	Delivery and all inpatient services	No charge	Not covered	Written Prior Authorization is required.
If you need help recovering or have other special health needs	Home health care	No charge	Not covered	Written Prior Authorization is required. Limited to 60 visits per Plan Year.
	Rehabilitation services	No charge	Not covered	Written Prior Authorization is required. Limited to 40 combined visits/member per Plan Year for Occupational/Physical/Vision Therapy. Limited to 20 visits/member per Plan year for Speech Therapy. Limited to 36 combined visits/member per Plan year for Cardiopulmonary Rehabilitation Therapy.
	Habilitation services	No charge	Not covered	N/A
	Skilled nursing care	No charge	Not covered	Written Prior Authorization is required. Limited to 100 days/member per Plan Year.
	Durable medical equipment	20% coinsurance	Not covered	Written Prior Authorization is required.
	Hospice service	No charge	Not covered	Written Prior Authorization is required.

If your child needs dental or eye care	Eye exam	No charge	Not covered	Vision examinations must be provided at GHC-SCW Optometry.
	Glasses	Not covered	Not covered	N/A
	Dental check-up	No charge	Not covered	Preventative Dental for children under age 12, cleaning and fluoride treatments twice per Plan Year.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check this plan's FEHB brochure for other excluded services.)

- Bariatric surgery
- Long-Term Care
- Non-emergency care when traveling outside of the US
- Complications, consultation services and procedures related to a non-covered procedure
- Cosmetic Surgery
- Private-Duty Nursing
- Routine Foot Care

Other Covered Services (This isn't a complete list. Check this plan's FEHB brochure for other covered services and your costs for these services.)

- Acupuncture
- Routine Eye Care (Adult)
- Chiropractic Care
- Hearing Aids
- Infertility Treatment
- Routine Dental Care (Adult)

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending on the circumstances, you may be eligible for a 31-day free extension of coverage, to convert to an individual policy, and to receive temporary continuation of coverage (TCC). Your TCC rights will 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. An individual policy may also provide different benefits than you had 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, see the FEHB Plan brochure, contact your HR office/retirement system, contact your plan at 1-800-605-4327 or visit www.opm.gov.insure/health.

Your Appeal Rights:

If you are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal**. For information about your **appeal** rights please see Section 3, "How you get care," and Section 8 "The disputed claims process," in your plan's FEHB brochure. If you need assistance, you can contact: member services at 800-605-4327.

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." **Coverage under this plan qualifies as minimum essential coverage.**

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). **The health coverage of this plan does meet the minimum value standard for the benefits the plan provides.**

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** $7,380
- **Patient pays** $ 160

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$0
Copays	$10
Coinsurance	$0
Limits or exclusions	$150
Total	**$160**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $4,830
- **Patient pays** $570

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	$0
Copays	$240
Coinsurance	$250
Limits or exclusions	$80
Total	**$570**

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 1-800-605-4327 or visit us at www.ghcscw.com.
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You can view the Glossary at www.ghcscw.com or call 1-800-605-4327 to request a copy.

FEHB

GHC-SCW Nondiscrimination Notice

Group Health Cooperative of South Central Wisconsin (GHC-SCW) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. GHC-SCW does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

GHC-SCW:

- 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 GHC-SCW 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, or Fax: (608) 257-3842. 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, 1-800-537-7697 (TDD).

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

GHC-SCW Language Assistance Services

English:
ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-608-828-4853 or 1-800-605-4327, ext. 4504 (TTY: 1-608-828-4815).

Español (Spanish):
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).

Hmoob (Hmong):
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).

繁體中文 (Chinese):
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)。

Deutsch (German):
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).

العربية (Arabic):
ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-608-828-4853, 1-800-605-4327, ext. 4504 (رقم هاتف الصم والبكم 1-608-828-4815)

Русский (Russian):
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).

한국어 (Korean):
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.

Tiếng Việt (Vietnamese):
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).

Deitsch (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 1-608-828-4853 or 1-800-605-4327, ext. 4504 (TTY: 1-608-828-4815).

ພາສາລາວ (Lao):
ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-608-828-4853 or 1-800-605-4327, ext. 4504 (TTY: 1-608-828-4815).

Français (French):
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).

Polski (Polish):
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).

हिंदी (Hindi):
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।

Shqip (Albanian):
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).

Tagalog (Tagalog – Filipino):
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).