Group Health Cooperative of South Central Wisconsin

2016 Benefits Summary *$10 Co-payment Plan*

For a complete description of covered services, please also see your Member Certificate and any amendments to your Benefit plan. This document does not reflect all the terms of your Benefits. Call Member Services at (608) 828-4853 with Benefit questions.

	In-Network Member	In-Network Family	Out-of-Network Member	Out-of-Network Family
Policy Annual Deductible (Plan Year) - Co-payments do not apply to Policy Deductible	None, unless specified below		N/A	
Policy Co-insurance	None, unless specified below		N/A	
Policy Annual Maximum Out-of-Pocket (MOOP) (Plan Year)	$6,350	$12,700	N/A	
Policy Lifetime Benefit Maximum	No Limit			
Qualified Maximum Dependent Age	Covered until the end of the month at age 26 if an eligible Dependent			

Clinic Services	*Prior Authorization	In-Network, You Pay	Out-of-Network, You Pay	*** Penalty for not obtaining Prior Authorization	** Applies to Care Plus Package	Applies to policy Deductible	Applies to policy MOOP
Primary Care Office Visits for Adults	No	$10	Not Covered	N/A	N/A	No	Yes
Preventive Health Examinations for Adults **(P)**	No	No Charge	Not Covered	N/A	N/A	No	No
Specialist Care Office Visits for Adults	Yes	$10	Not Covered	N/A	N/A	No	Yes
Chiropractic Care for Adults	No	$10	Not Covered	N/A	N/A	No	Yes
Prenatal and Postnatal Maternity Care **(P)**	No	No Charge	Not Covered	N/A	N/A	No	No
Primary Care Office Visits (Pediatric Care)	No	No Charge	Not Covered	N/A	N/A	No	No
Preventive Health Examinations (Pediatric Care) **(P)**	No	No Charge	Not Covered	N/A	N/A	No	No
Specialist Care Office Visits (Pediatric Care)	Yes	No Charge	Not Covered	N/A	N/A	No	No
Chiropractic Care (Pediatric Care)	No	No Charge	Not Covered	N/A	N/A	No	No
Preventive Immunizations **(P)**	No*	No Charge	Not Covered	N/A	N/A	No	No
Diagnostic X-rays and Laboratory Tests	No	No Charge	Not Covered	N/A	N/A	No	No
Advanced Radiology (CT/ PET scans, MRIs)	Yes	No Charge	Not Covered	N/A	N/A	No	No
Vision Examinations - Contact lens services provided at an additional fee - Copay waived for children **(P)**	No	$10	Not Covered	N/A	N/A	No	Yes
Specialist Hearing Examinations for Adults	Yes	$10	Not Covered	N/A	N/A	No	Yes
Specialist Hearing Examinations (Pediatric Care)	Yes	No Charge	Not Covered	N/A	N/A	No	No

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Urgent and Emergency Care Services	***Prior Authorization**	**In-Network, You Pay**	**Out-of-Network, You Pay**	***** Penalty for not obtaining Prior Authorization**	**** Applies to Care Plus Package**	**Applies to policy Deductible**	**Applies to policy MOOP**
Urgent Care Visits for Adults	No	$10	$10	N/A	N/A	No	Yes
Urgent Care Visits (Pediatric Care)	No	No Charge	No Charge	N/A	N/A	No	No
Emergency Room Visits	No	$75	$75	N/A	N/A	No	Yes
Emergency Ambulance Service (air/ground)	No	No Charge	No Charge	N/A	N/A	No	No

Hospital Services ***Includes Outpatient Hospital Services***	***Prior Authorization**	**In-Network, You Pay**	**Out-of-Network, You Pay**	***** Penalty for not obtaining Prior Authorization**	**** Applies to Care Plus Package**	**Applies to policy Deductible**	**Applies to policy MOOP**
Inpatient Hospital Services (Physician Services)	Yes	No Charge	Not Covered	N/A	N/A	No	No
Inpatient Facility Fees	Yes	No Charge	Not Covered	N/A	N/A	No	No
Outpatient Surgical/Non-Surgical Services	Yes	No Charge	Not Covered	N/A	N/A	No	No
Outpatient Surgical Facility Fees	Yes	No Charge	Not Covered	N/A	N/A	No	No
Skilled Nursing Facility Services - Limited to 100 skilled days per Plan year	Yes	No Charge up to maximum	Not Covered	N/A	N/A	No	No
Specified Oral Surgical Procedures	Yes	No Charge	Not Covered	N/A	N/A	No	No

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Prescription Drugs, Supplies and Equipment		***Prior Authorization**	**In-Network, You Pay**	**Out-of-Network, You Pay**	***** Penalty for not obtaining Prior Authorization**	**** Applies to Care Plus Package**	**Applies to policy Deductible**	**Applies to policy MOOP**
Outpatient Prescription Drugs on GHC-SCW Formulary -Up to a 30-day supply	Tier 1	No (Unless specified on Formulary)	$5	Not Covered	N/A	N/A	No	Yes
	Tier 2		$20	Not Covered	N/A	N/A	No	Yes
	Tier 3 (Non-preferred)		$50	Not Covered	N/A	N/A	No	Yes
	Tier MSP (Specialty)		$100	Not Covered	N/A	N/A	No	Yes
Diabetic Disposable Supplies and Glucose Meters on GHC-SCW Formulary - Maximum Out-of-Pocket $250 Per Member Per Plan year		No	20% up to the maximum	Not Covered	N/A	N/A	No	Yes
Durable Medical Equipment (DME), Prosthetic Appliances and Disposable Supplies Including Infusion Pump Supplies - Maximum Member Out-of-Pocket of $2,500 per Member per Plan Year		Yes	20%	Not Covered	N/A	N/A	No	Yes
Cochlear Implants and Bone Anchored Hearing Aids for children		Yes	No Charge	Not Covered	N/A	N/A	No	No
Hearing Aids for children - Limited to one aid per ear every 36 months		Yes	No Charge	Not Covered	N/A	N/A	No	No
Hearing Aids & Repair of Existing Hearing Aids - Limited to one aid per ear every 36 months		Yes	20%	Not Covered	N/A	N/A	No	Yes

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Complementary Medicine Services	***Prior Authorization**	**In-Network, You Pay**	**Out-of-Network, You Pay**	***** Penalty for not obtaining Prior Authorization**	**** Applies to Care Plus Package**	**Applies to policy Deductible**	**Applies to policy MOOP**
Coverage for select procedures by a GHC-SCW Complementary Medicine Practitioner at GHC-SCW Clinics	No	$75 for Initial Visit of Acupuncture and Naturopathy $45 for One-Hour Personal Sessions, as well as Acupuncture and Naturopathy Follow-Up $23 for 30-Minute Sessions See Class Schedule for price	Not Covered	N/A	N/A	No	No

Dental Services	***Prior Authorization**	**In-Network, You Pay**	**Out-of-Network, You Pay**	***** Penalty for not obtaining Prior Authorization**	**** Applies to Care Plus Package**	**Applies to policy Deductible**	**Applies to policy MOOP**
Preventive Dental Cleanings for members (one in any six-month period) - Fluoride treatments for members age 15 and under	No	No Charge	Not Covered	N/A	N/A	No	No
Initial Repair of Accidental Injury to Sound and Natural Teeth - Up to $1,500 per accident	No	No Charge	Not Covered	N/A	N/A	No	No
Non-Surgical Treatment of Temporomandibular Joint (TMJ)	Yes	No Charge	Not Covered	N/A	N/A	No	No
Surgical Treatment of TMJ	Yes	No Charge	Not Covered	N/A	N/A	No	No

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Mental Health and Substance Use Disorder	***Prior Authorization**	**In-Network, You Pay**	**Out-of-Network, You Pay**	***** Penalty for not obtaining Prior Authorization**	**** Applies to Care Plus Package**	**Applies to policy Deductible**	**Applies to policy MOOP**
Mental Health – Outpatient for Adults	No*	$10	Not Covered	N/A	N/A	No	Yes
Mental Health – Outpatient (Pediatric Care)	No*	No Charge	Not Covered	N/A	N/A	No	No
Mental Health - Inpatient	Yes	No Charge	Not Covered	N/A	N/A	No	No
Mental Health – Transitional	Yes	No Charge	Not Covered	N/A	N/A	No	No
Substance Use Disorder – Outpatient for Adults	No*	$10	Not Covered	N/A	N/A	No	Yes
Substance Use Disorder – Outpatient (Pediatric Care)	No*	No Charge	Not Covered	N/A	N/A	No	No
Substance Use Disorder – Inpatient	Yes	No Charge	Not Covered	N/A	N/A	No	No
Substance Use Disorder – Transitional	Yes	No Charge	Not Covered	N/A	N/A	No	No

Additional Services	***Prior Authorization**	**In-Network, You Pay**	**Out-of-Network, You Pay**	***** Penalty for not obtaining Prior Authorization**	**** Applies to Care Plus Package**	**Applies to policy Deductible**	**Applies to policy MOOP**
Acute Vision for Adults	No	$10	Not Covered	N/A	N/A	No	Yes
Acute Vision (Pediatric Care)	No	No Charge	Not Covered	N/A	N/A	No	No
End of Life Services	Yes	No Charge	Not Covered	N/A	N/A	No	No
Health Education Counseling **(P)**	No	No Charge	Not Covered	N/A	N/A	No	No
Home Health Services and Home Infusion - Limited to 60 visits per Plan Year	Yes	No Charge	Not Covered	N/A	N/A	No	No
Infertility Services	No	50% up to maximum	Not Covered	N/A	N/A	No	No
Organ Transplants including Kidney Transplant/Disease Treatment	Yes	No Charge	Not Covered	N/A	N/A	No	No
Hyperhidrosis - Maximum Out-of-Pocket of $1,500 per Member per Plan Year	Yes	No Charge	Not Covered	N/A	N/A	No	No
Outpatient Occupational and Physical Therapy - Limited to 60 visits per Plan Year	Yes	No Charge	Not Covered	N/A	N/A	No	No

Outpatient Speech Therapy - Limited to 60 consecutive days per condition per Plan Year	Yes	No Charge	Not Covered	N/A	N/A	No	No
Cardiopulmonary Rehabilitation Therapy-Limited to 36 combined visits per Plan year	Yes	No Charge up to the maximum	Not Covered	N/A	N/A	No	No
Habilitation Services	Yes	$10	Not Covered	N/A	N/A	No	Yes

Written Prior Authorization is required when services are not provided in a primary care setting by a GHC-SCW contracted provider.Call (608) 257-5294 for Prior Authorization. Failure to obtain Prior Authorization when required will result in the Member receiving a lesser or no Benefit.

*****Care Plus Package: Does not apply***

******Prior Authorization Penalty: Only applies to POS and PPO plans. Does not apply to HMO plans.***

In-Network Providers *= See the 'Find a Provider' link at ghcscw.com, or contact Member Services at (608) 828-4853 or (800) 605-4327ext. 4504, for a list of In-Plan Providers.*

Out-of-Network Providers *= Out-of-Network Providers are not covered under an HMO Plan unless otherwise specified above.*

(P) Preventive Health Services: when provided in a primary care setting by a GHC-SCW Contracted Provider. To include preventive health procedures as deemed appropriate by the United States Preventive Services Task Force (USPSTF) or an In-Plan Provider meeting specific GHC-SCW medical criteria with respect to the age, sex, and health status of the Member. Services and/or testing for ongoing diagnosis and treatment of a condition are not preventive services. Contact Member Services at (608) 828-4853 for a list of preventive health procedures that require Prior Authorization.

Prescription Drug Benefit administered by GHC-SCW Clinic pharmacies and Navitus.

• You are responsible for knowing the Benefits and provisions of your policy. Please read all documents carefully.
• See your Member materials for more information about Prior Authorization, and Urgent and Emergency Care instructions.
• Services not covered, or beyond Benefit maximums, are the Member's responsibility and will not apply to any Policy Annual Deductible and applicable MOOP limits.
• Deductible, Co-insurance and MOOP amounts are calculated on a Plan Year basis.

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, ໂດຍບໍ່ເສັຽຄ່າ, 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).