

Plan Number: 2001815  
Benefits Accumulate on a  
Calendar Year.

Policy Coinsurance

In-Network: 0%  
Out-of-Network: Not Covered

|   | MEMBER      | FAMILY      |
|---|-------------|-------------|
| In-Network Deductible                       | \$100       | \$200       |
| Out-of-Network Deductible                   | Not Covered | Not Covered |
| In-Network Maximum Out-of-Pocket (MOOP)     | \$6,600     | \$13,200    |
| Out-of-Network Maximum Out-of-Pocket (MOOP) | Not Covered | Not Covered |

| Clinic Services                       | Prior Auth | You Pay In-Network         | You Pay Out-of-Network | Benefit Notes  |
|---------------------------------------|------------|----------------------------|------------------------|--|
| Primary Care Office Visits            | No         | \$20                       | Not Covered            | Example: Office visits with Your Primary Care Provider (PCP)   |
| Chiropractic Office Visits            | No         | \$20                       | Not Covered            |  |
| Preventive Health Examinations        | No         | No Charge                  | Not Covered            | Coverage is limited to USPSTF guidelines and Women's Preventive Health   |
| Specialist Care Office Visits         | Yes        | \$20                       | Not Covered            | Examples: Specialist Hearing Exams, Autism Spectrum Specialist Office Visit  |
| Preventive Immunizations              | No         | No Charge                  | Not Covered            | Coverage is limited to USPSTF guidelines and Women's Preventive Health   |
| Prenatal and Postnatal Maternity Care | No         | No Charge                  | Not Covered            | Coverage is limited to USPSTF guidelines and Women's Preventive Health   |
| Diagnostic X-Ray and Laboratory Tests | Yes        | No Charge after Deductible | Not Covered            | Examples: Lab tests, blood work, or x-rays ordered by Your Provider; Prior Authorization is not required when routine labs and x-rays are performed at Your Primary Care Provider's clinic |
| Advanced Radiology                    | Yes        | No Charge after Deductible | Not Covered            | Examples: CT, PET Scans, MRIs  |

| Emergency and Urgent Care                | Prior Auth | You Pay In-Network         | You Pay Out-of-Network     | Benefit Notes   |
|--|------------|----------------------------|----------------------------|---|
| Urgent Care Visits                       | No         | \$20                       | \$20                       |   |
| Emergency Ambulance Service (air/ground) | No         | No Charge after Deductible | No Charge after Deductible | Coverage is limited to emergency care   |
| Emergency Room Visits                    | No         | \$150                      | \$150                      | Coverage is limited to emergency care; Copayment waived if admitted as a hospital inpatient |

| Prescription Drugs   | Tier               | You Pay In-Network | You Pay Out-of-Network | Benefit Notes  |
|--|--------------------|--------------------|------------------------|--|
| Outpatient Prescription Drugs on <a href="#">GHC-SCW Formulary</a><br><br>Prior Authorizations, quantity limits, step therapy, age restrictions and other limits may apply | Tier 1             | \$6                | Not Covered            | Covers up to a 30-day supply; 31-90 day supply available for multiple Copays - subject to a maximum cost limit; Some brand names and many generics; Drugs in Tier 1 are the greatest value |
|  | Tier 2             | \$15               | Not Covered            | Covers up to a 30-day supply; 31-90 day supply available for multiple Copays - subject to a maximum cost limit; Many brand names and some generics   |
|  | Tier 3             | Not Covered        | Not Covered            | Tier 3 Outpatient Prescription Drugs are not covered for this plan   |
|  | Tier 4 (Specialty) | \$30               | Not Covered            | Covers up to a 30-day supply; 31-90 day supply not available; May require the use of a specialty-designated pharmacy   |

*The Prescription Drugs Benefit is administered by GHC-SCW Clinic pharmacies and Navitus. Prescription Drugs are NOT COVERED outside of the GHC-SCW network of providers. For a list of formulary drugs, tier (\$) placement, prior authorization requirements and other limitations that may apply, see [www.ghcscw.com](http://www.ghcscw.com).*

| Supplies and Equipment                   | Prior Auth | You Pay In-Network | You Pay Out-of-Network | Benefit Notes  |
|--|------------|--------------------|------------------------|--|
| Diabetic Disposable Supplies             | No         | No Charge          | Not Covered            |  |
| Durable Medical Equipment                | Yes        | No Charge          | Not Covered            |  |
| Hearing Aids for Members age 18 and over | Yes        | 20%                | Not Covered            | Limited to one hearing aid per ear per 36 months; GHC-SCW coverage is for the basic model only |

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| Supplies and Equipment   | Prior Auth | You Pay In-Network         | You Pay Out-of-Network | Benefit Notes  |
|--|------------|----------------------------|------------------------|--|
| Hearing Aids for children age 17 and under                                     | Yes        | 20%                        | Not Covered            | Limited to one hearing aid per ear per 36 months; GHC-SCW coverage is for the basic model only   |
| Cochlear Implants and Bone Anchored Hearing Aids for children age 17 and under | Yes        | No Charge after Deductible | Not Covered            |  |
| Hospital Services  | Prior Auth | You Pay In-Network         | You Pay Out-of-Network | Benefit Notes  |
| Inpatient Hospital Services: Physician Services, Surgery, Facility Fees        | Yes        | No Charge after Deductible | Not Covered            |  |
| Outpatient Hospital Surgical/Non-Surgical Services, Facility Fees              | Yes        | No Charge after Deductible | Not Covered            | Certain oral surgeries do not require Prior Authorization  |
| Skilled Nursing Facility Services  | Yes        | No Charge after Deductible | Not Covered            | Limited to 30 days per inpatient stay per Member   |
| Vision Services  | Prior Auth | You Pay In-Network         | You Pay Out-of-Network | Benefit Notes  |
| Vision Examinations  | No         | No Charge                  | Not Covered            | Vision examinations must be provided by an In-Network Provider; Limited to one eye exam per Member per year                              |
| Mental Health & Substance Use Disorder   | Prior Auth | You Pay In-Network         | You Pay Out-of-Network | Benefit Notes  |
| Mental Health/Substance Use Disorder Outpatient Services                       | Yes        | \$20                       | Not Covered            | Prior Authorization is not required when services are provided at a GHC-SCW Clinic or at UW Health Behavioral Health and Recovery Clinic |
| Mental Health/Substance Use Disorder Inpatient Services                        | Yes        | No Charge after Deductible | Not Covered            |  |
| Mental Health/Substance Use Disorder Transitional Services                     | Yes        | No Charge after Deductible | Not Covered            |  |
| Complementary Medicine Services  | Prior Auth | You Pay In-Network         | You Pay Out-of-Network | Benefit Notes  |
| Acupuncture (Initial Visit)  | No         | \$79                       | Not Covered            | \$49 per visit for follow up visits of Acupuncture; Coverage at GHC-SCW Clinics only   |
| Naturopathy (Initial Visit)  | No         | \$75                       | Not Covered            | \$45 per visit for follow up visits of Naturopathy; Coverage at GHC-SCW Clinics only   |
| Massage Therapy  | No         | \$49                       | Not Covered            | 60-minute session; Coverage at GHC-SCW Clinics only  |
| Massage Therapy  | No         | \$29                       | Not Covered            | 30-minute session; Coverage at GHC-SCW Clinics only  |
| Reiki Therapy  | No         | \$49                       | Not Covered            | 60-minute session; Coverage at GHC-SCW Clinics only  |
| Dental Services  | Prior Auth | You Pay In-Network         | You Pay Out-of-Network | Benefit Notes  |
| Preventive Dental Cleanings  | No         | No Charge                  | Not Covered            | Preventive Dental Cleanings for Members (all ages) twice per year; Fluoride treatments for children age 15 and under twice per year      |
| Accidental Dental  | No         | No Charge after Deductible | Not Covered            | Initial repair of accidental injury to sound, natural teeth  |
| Oral Surgeries   | Yes        | No Charge after Deductible | Not Covered            | Certain oral surgeries do not require Prior Authorization  |

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| Additional Services               | Prior Auth | You Pay In-Network         | You Pay Out-of-Network | Benefit Notes   |
|-----------------------------------|------------|----------------------------|------------------------|---|
| Hospice                           | Yes        | No Charge after Deductible | Not Covered            | Example: End of Life Services   |
| Home Health Services              | Yes        | No Charge after Deductible | Not Covered            | Limited to 60 visits per Member per year  |
| Health Counseling Education       | No         | No Charge                  | Not Covered            | Coverage is limited to USPSTF guidelines and Women's Preventive Health  |
| Infertility Services              | No         | 50% up to maximum          | Not Covered            | Lifetime Benefit maximum payment of \$2,000 by GHC-SCW, which is accrued by GHC-SCW paying 50% Coinsurance of the first \$4,000 of Infertility Services |
| Speech Therapy                    | Yes        | No Charge after Deductible | Not Covered            | Includes Rehabilitation and Habilitation Therapy; Limited to 20 visits per therapy per Member per year  |
| Outpatient Habilitation Therapy   | Yes        | No Charge after Deductible | Not Covered            | Includes Physical and Occupational Therapy; Limited to 40 combined visits per Member per year; See Certificate for additional information               |
| Cardiac Rehabilitation Therapy    | Yes        | No Charge after Deductible | Not Covered            | Limited to 36 visits per Member per year  |
| Outpatient Rehabilitation Therapy | Yes        | No Charge after Deductible | Not Covered            | Includes Physical and Occupational Therapy; Limited to 40 combined visits per Member per year; See Certificate for additional information               |

**Benefit Summary Notes**

**Office Visit Copayments are waived for children under age 19.**

Prior Authorizations

- Prior Authorization is required when services are not provided in a primary care setting by an In-Network 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. Please refer to [www.ghcscw.com](http://www.ghcscw.com) and your Member Certificate for a list of specific Benefits that require Prior Authorization.

Provider Information

- For Providers see the "Find a Provider" link at [www.ghcscw.com](http://www.ghcscw.com) or contact Member Services at (608) 828-4853 or (800) 605-4327, ext. 4504.
- In-Network Providers: For a list of In-Network Providers, see the "Find a Provider" link at [www.ghcscw.com](http://www.ghcscw.com) or contact Member Services at (608) 828-4853 or (800) 605-4327, ext. 4504.
- Out-of-Network Providers: Out-of-Network Providers are not covered under an HMO plan, unless Prior Authorization has been acquired for such services.

GHC-SCW Notices to Members

- Qualified Maximum Dependent Age: Dependents are covered until the end of the Calendar Year in which they turn age 26.
- This is only a summary. You are responsible for knowing the full Benefits and provisions of your policy. Please read all documents carefully including your *Member Certificate, Formulary, Benefit Summary and Summary of Benefits and Coverage (SBC)*. To find these documents, visit [www.ghcscw.com](http://www.ghcscw.com) or contact Member Services at (608) 828-4853 or (800) 605-4327, ext. 4504.

Questions or Concerns?

- For any questions or concerns regarding your benefits, please visit [www.ghcscw.com](http://www.ghcscw.com), or contact Member Services at (608) 828-4853 or (800) 605-4327, ext. 4504.

## 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 العربية، 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. ໂທ 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).