Group Health Cooperative of South Central Wisconsin

# FEHB: Group Health Cooperative of South Central Wisconsin - High Option (Code WJ)

Plan Number: 2201706
Benefits Accumulate on a Plan Year.

*Policy Coinsurance*
In-Network: 0%
Out-of-Network: Not Covered

| | MEMBER | FAMILY |
|---|---|---|
| In-Network Deductible | $0 | $0 |
| Out-of-Network Deductible | Not Covered | Not Covered |
| In-Network Maximum Out-of-Pocket (MOOP) | $7,150 | $14,300 |
| 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 | No Charge | Not Covered | Example: Office visits with Your Primary Care Provider (PCP) |
| Chiropractic Office Visits | No | $10 | 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 | $10 | 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. After the first postpartum care visit, postpartum care visits are $10 per office visit. |
| Diagnostic X-Ray and Laboratory Tests | Yes | No Charge | 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 | 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 | $10 | $10 | Coverage is limited to treatment for an Urgent Condition |
| Emergency Ambulance Service (air/ground) | No | No Charge | No Charge | Coverage is limited to emergency care |
| Emergency Room Visits | No | $75 | $75 | 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 GHC-SCW Formulary<br><br>Prior Authorizations, quantity limits, step therapy, age restrictions and other limits may apply | Tier 1 | $5 per 30-day supply; $15 per 90-day supply/mail order | 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. Mail-order: 90-day supply available for three Copays |
| | Tier 2 | $20 per 30-day supply; $60 per 90-day supply/mail order | 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. Mail-order: 90-day supply available for three Copays |
| | Tier 3 | $50 per 30-day supply; $150 per 90-day supply/mail order | Not Covered | Covers up to a 30-day supply; 31-90 day supply sometimes not available; There are often similar or equivalent drugs in either Tier 1 or Tier 2. Mail-order: 90-day supply available for three Copays |
| | Tier 4 (Specialty) | $100 per 30-day supply; $300 per 90-day supply/mail order | Not Covered | Covers up to a 30-day supply; 31-90 day supply usually not available; May require the use of a specialty-designated pharmacy. Mail order: 90-day supply available for three Copays |

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|---|---|---|
| In-Network Deductible | $0 | $0 |
| Out-of-Network Deductible | Not Covered | Not Covered |
| In-Network Maximum Out-of-Pocket (MOOP) | $7,150 | $14,300 |
| Out-of-Network Maximum Out-of-Pocket (MOOP) | Not Covered | Not Covered |

| Prescription Drugs | Tier | You Pay In-Network | You Pay Out-of-Network | Benefit Notes |
|---|---|---|---|---|
| *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 https://www.ghcscw.com.* | | | | |
| **Supplies and Equipment** | **Prior Auth** | **You Pay In-Network** | **You Pay Out-of-Network** | **Benefit Notes** |
| Diabetic Disposable Supplies | No | 20% up to maximum | Not Covered | Member pays Coinsurance up to $500 maximum |
| Durable Medical Equipment | Yes | 20% up to maximum | Not Covered | Member pays Coinsurance up to $2,500 maximum |
| 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; Member payment accumulates toward DME MOOP |
| Hearing Aids for children age 17 and under | Yes | No Charge | Not Covered | Limited to one hearing aid per 36 months; GHC-SCW coverage is for the basic model |
| Cochlear Implants and Bone Anchored Hearing Aids | Yes | 20% up to maximum | Not Covered | Member payment accumulates toward DME MOOP |
| **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 | Not Covered | |
| Outpatient Hospital Surgical/Non-Surgical Services, Facility Fees | Yes | No Charge | Not Covered | Certain oral surgeries do not require Prior Authorization |
| Skilled Nursing Facility Services | Yes | No Charge | Not Covered | Limited to 30 days per inpatient stay per year |
| Bariatric Surgery | Yes | No Charge | Not Covered | See FEHB Brochure for the requirements for coverage |
| **Vision Services** | **Prior Auth** | **You Pay In-Network** | **You Pay Out-of-Network** | **Benefit Notes** |
| Vision Examinations | No | $10 | 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 | No Charge | 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 | Not Covered | |
| Mental Health/Substance Use Disorder Transitional Services | Yes | No Charge | 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 |

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| In-Network Deductible | $0 | $0 |
| Out-of-Network Deductible | Not Covered | Not Covered |
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| Out-of-Network Maximum Out-of-Pocket (MOOP) | Not Covered | Not Covered |

| 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 up to maximum | Not Covered | Initial repair of accidental injury to sound, natural teeth; Maximum payment by GHC-SCW of $1,500 per accident |
| Oral Surgeries | Yes | No Charge | Not Covered | Certain oral surgeries do not require Prior Authorization |
| **Additional Services** | **Prior Auth** | **You Pay In-Network** | **You Pay Out-of-Network** | **Benefit Notes** |
| Hospice | Yes | No Charge | Not Covered | Example: End of Life Services |
| Home Health Services | Yes | No Charge | 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% | Not Covered | |
| Speech Therapy | Yes | No Charge | Not Covered | Includes Rehabilitation and Habilitation; Limited to 60 consecutive days per condition per therapy per Member per year |
| Outpatient Habilitation Therapy | Yes | No Charge | Not Covered | Includes Physical, Occupational, and Vision Therapy; Limited to 60 visits per therapy per Member per year |
| Cardiopulmonary Rehabilitation Therapy | Yes | No Charge | Not Covered | Includes Rehabilitation and Habilitation; Limited to 36 visits per therapy per Member per year |
| Outpatient Rehabilitation Therapy | Yes | No Charge | Not Covered | Includes Physical, Occupational, and Vision Therapy; Limited to 60 visits per therapy per Member per year |

## Benefit Summary Notes

**Office visit copayments are waived for children under age 18.**

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 https://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 https://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 https://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.

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|---|---|---|
| In-Network Deductible | $0 | $0 |
| Out-of-Network Deductible | Not Covered | Not Covered |
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| Out-of-Network Maximum Out-of-Pocket (MOOP) | Not Covered | Not Covered |

## Benefit Summary Notes

GHC-SCW Notices to Members

- Qualified Maximum Dependent Age: Dependents are covered until the end of the month at 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 https://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 https://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, 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).