

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 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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Prescription Drugs	Tier	You Pay In-Network	You Pay Out-of-Network	Benefit Notes
<i>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.</i>				

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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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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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, 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).