Group Health Cooperative of South Central Wisconsin

# Select Bronze 7500 Ded/9000 MOOP

Plan Number: 2332420
Benefits Accumulate on a Plan Year.

*Policy Coinsurance*
In-Network: 50%
Out-of-Network: Not Covered

| | MEMBER | FAMILY |
|---|---|---|
| In-Network Deductible | $7,500 | $15,000 |
| Out-of-Network Deductible | Not Covered | Not Covered |
| In-Network Maximum Out-of-Pocket (MOOP) | $9,000 | $18,000 |
| 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 | $50 | Not Covered | Example: Office visits with Your Primary Care Provider (PCP) |
| Chiropractic Office Visits | No | $50 | 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 | $100 | Not Covered | Examples: Specialist Hearing Exams, Autism Spectrum Specialist Office Visit; Most Specialists do not require Prior Authorization |
| 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 | 50% after Deductible | Not Covered | X-rays and routine lab tests ordered by Your Provider do not require Prior Authorization. |
| Advanced Radiology | Yes | 50% 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 | $75 | $75 | |
| Emergency Ambulance Service (air/ground) | No | 50% after Deductible | 50% after Deductible | Coverage is limited to emergency care |
| Emergency Room Visits | No | 50% after Deductible | 50% after Deductible | Coverage is limited to emergency care |
| **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 | $25 | Not Covered | Covers up to a 30-day supply; 31-90 day supply available from January to September 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 | $50 after Deductible | Not Covered | Covers up to a 30-day supply; 31-90 day supply available from January to September for multiple Copays - subject to a maximum cost limit; Many brand names and some generics |
| | Tier 3 | $100 after Deductible | Not Covered | Covers up to a 30-day supply; 31-90 day supply not available; There are often similar or equivalent drugs in either Tier 1 or Tier 2 |
| | Tier 4 (Specialty) | $500 after Deductible | Not Covered | Covers up to a 30-day supply; 31-90 day supply not available; May require the use of a specialty-designated pharmacy |
| *The Prescription Drugs Benefit is administered by GHC-SCW Clinic pharmacies and Navitus. Prescription Drugs are NOT COVERED outside of the GHC-SCW network of providers. For a list of formulary drugs, tier ($) placement, prior authorization requirements and other limitations that may apply, see 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% | Not Covered | |

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| Out-of-Network Maximum Out-of-Pocket (MOOP) | Not Covered | Not Covered |

| Supplies and Equipment | Prior Auth | You Pay In-Network | You Pay Out-of-Network | Benefit Notes |
|---|---|---|---|---|
| Hearing Aids for Members age 18 and over | Yes | 20% | Not Covered | Limited to one hearing aid per ear per 36 months; GHC-SCW designates specific models or other cost limitations may apply |
| Hearing Aids for children age 17 and under | Yes | 20% | Not Covered | Limited to one hearing aid per ear per 36 months |
| Cochlear Implants and Bone Anchored Hearing Aids | Yes | 50% 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 | Yes | 50% after Deductible | Not Covered | |
| Inpatient Facility Fees | Yes | 50% after Deductible | Not Covered | |
| Outpatient Hospital Surgical/Non-Surgical Services | Yes | 50% after Deductible | Not Covered | Certain oral surgeries do not require Prior Authorization |
| Outpatient Surgical Facility Fees | Yes | 50% after Deductible | Not Covered | |
| Skilled Nursing Facility Services | Yes | 50% 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 | Routine Eye Examinations are only covered for Members through the end of the month in which they turn 19. Routine Eye Examinations must be provided by an In-Network Optometrist (OD); Limited to one eye exam per Member per year |
| Eyeglasses for Children | No | No Charge | Not Covered | Either one pair of GHC-SCW Basic lenses and Select frames or a one-year supply of contact lenses from GHC-SCW per Child per year; Please contact GHC-SCW Eyecare for covered contact lenses |
| **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 | No | $50 | Not Covered | Prior Authorization is required for Health Psychology, Diagnostic Testing, ECT, and TMS. All services may be subject to ongoing review for medical necessity. |
| Mental Health/Substance Use Disorder Inpatient Services | Yes | 50% after Deductible | Not Covered | |
| Mental Health/Substance Use Disorder Transitional Services | Yes | 50% after Deductible | Not Covered | |
| **Dental Services** | **Prior Auth** | **You Pay In-Network** | **You Pay Out-of-Network** | **Benefit Notes** |
| Accidental Dental | No | 50% after Deductible | Not Covered | Initial repair of accidental injury to sound, natural teeth |
| Oral Surgeries | Yes | 50% after Deductible | 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 | 50% after Deductible | Not Covered | Example: End of Life Services |
| Home Health Services | Yes | 50% after Deductible | Not Covered | Limited to 60 visits per Member per year |

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| Additional Services | Prior Auth | You Pay In-Network | You Pay Out-of-Network | Benefit Notes |
|---|---|---|---|---|
| Health Counseling Education | No | No Charge | Not Covered | Coverage is limited to USPSTF guidelines and Women's Preventive Health |
| Speech Therapy | Yes | $50 | Not Covered | Includes Rehabilitation and Habilitation Therapy; Limited to 20 visits per therapy per Member per year |
| Outpatient Habilitation Therapy | Yes | $50 | 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 | $50 | Not Covered | Limited to 36 visits per Member per year |
| Outpatient Rehabilitation Therapy | Yes | $50 | Not Covered | Includes Physical and Occupational Therapy; Limited to 40 combined visits per Member per year; See Certificate for additional information |

## Benefit Summary Notes

Prior Authorizations

- Prior Authorization is required when services are not provided in a primary care setting by an In-Network Provider. Prior Authorization does not guarantee that services will be fully covered. Coverage is determined by the terms and conditions of the Certificate. Please refer to your Member Certificate for Benefits that require Prior Authorization. In addition, services and items requiring Prior Authorization are listed on GHC-SCW's website at https://www.ghcscw.com.
- It is the Member's responsibility to ensure a Prior Authorization has been obtained when required. Failure to obtain Prior Authorization when required may result in the Member receiving a reduction in or no Benefit. To obtain Prior Authorization, call (608) 257-5294.

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.

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).