

Plan Number: 2612220  
Benefits Accumulate on a Plan Year.

Policy Coinsurance

In-Network: 30%  
Out-of-Network: Not Covered

	MEMBER	FAMILY
In-Network Deductible	\$1,500	\$3,000
Out-of-Network Deductible	Not Covered	Not Covered
In-Network Maximum Out-of-Pocket (MOOP)	\$8,000	\$16,000
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	\$10	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 preventive services as defined by the Affordable Care Act.
Specialist Care Office Visits	Yes	\$125	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 preventive services as defined by the Affordable Care Act.
Prenatal and Postnatal Maternity Care	No	No Charge	Not Covered	In-Network cost-sharing value is limited to preventive services. Cost-sharing described elsewhere in this Benefit Summary may apply depending on the maternity-related test or service.
Diagnostic X-Ray and Laboratory Tests	Yes	30% after Deductible	Not Covered	X-rays and routine lab tests ordered by Your Provider do not require Prior Authorization.
Advanced Radiology	Yes	30% 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	30% after Deductible	30% after Deductible	Coverage is limited to emergency care
Emergency Room Visits	No	\$625	\$625	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>  Prior Authorizations, quantity limits, step therapy, age restrictions and other limits may apply	Tier 1	\$10	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	\$70	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	50%	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)	50%	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	30% 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	30% after Deductible	Not Covered	
Outpatient Hospital Surgical/Non-Surgical Services, Facility Fees	Yes	30% after Deductible	Not Covered	Certain oral surgeries do not require Prior Authorization
Skilled Nursing Facility Services	Yes	30% 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 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	\$10	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	30% after Deductible	Not Covered	
Mental Health/Substance Use Disorder Transitional Services	Yes	30% after Deductible	Not Covered	
Dental Services	Prior Auth	You Pay In-Network	You Pay Out-of-Network	Benefit Notes
Accidental Dental	No	30% after Deductible	Not Covered	Initial repair of accidental injury to sound, natural teeth
Oral Surgeries	Yes	30% 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	30% after Deductible	Not Covered	Example: End of Life Services
Home Health Services	Yes	30% after Deductible	Not Covered	Limited to 60 visits per Member per year
Health Counseling Education	No	No Charge	Not Covered	Coverage is limited to preventive services as defined by the Affordable Care Act.
Speech Therapy	Yes	30% after Deductible	Not Covered	Includes Rehabilitation and Habilitation Therapy; Limited to 20 visits per therapy per Member per year

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Additional Services	Prior Auth	You Pay In-Network	You Pay Out-of-Network	Benefit Notes
Outpatient Habilitation Therapy	Yes	30% 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	30% after Deductible	Not Covered	Limited to 36 visits per Member per year
Outpatient Rehabilitation Therapy	Yes	30% 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**

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, including sex characteristics, including intersex traits; pregnancy or related conditions; sexual orientation; gender identity, and sex stereotypes. GHC-SCW does not exclude people or treat them less favorably because of race, color, national origin, age, disability, or sex.

### GHC-SCW:

- Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services 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 assistance services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, contact GHC-SCW Member Services at (608) 828-4853 or (800) 605-4327, ext. 4504 (TTY: 1-608-828-4815), or by email at [member\\_services@ghcscw.com](mailto:member_services@ghcscw.com).

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 Chief Compliance Officer, 1265 John Q. Hammons Drive, Madison, WI 53717, Telephone: (608) 251-4156, TTY: (608) 828-4815, Fax: (608) 257-3842, or Email: [compliance@ghcscw.com](mailto:compliance@ghcscw.com). You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, GHC-SCW's Chief 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>.

This notice is available at GHC-SCW's website: [https://ghcscw.com/SiteCollectionDocuments/Nondiscrimination\\_Notice\\_and\\_Language\\_Assistance\\_Services.pdf](https://ghcscw.com/SiteCollectionDocuments/Nondiscrimination_Notice_and_Language_Assistance_Services.pdf).

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Group Health Cooperative of South Central Wisconsin (GHC-SCW)  
MK24-100-1(6.25)O  
CSC25-19-01 1(06/25)F  
Version 4: 6/2025

 **Group Health  
Cooperative**

[ghcscw.com](https://ghcscw.com)

# NOTICE OF AVAILABILITY OF LANGUAGE ASSISTANCE SERVICES AND AUXILIARY AIDS AND SERVICES

## English:

ATTENTION: If you speak English, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1-608-828-4853 or 1-800-605-4327, ext. 4504 (TTY: 1-608-828-4815) or speak to your provider.

## Español (Spanish):

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al 1-608-828-4853 or 1-800-605-4327, ext. 4504 (TTY: 1-608-828-4815) o hable con su proveedor.

## 中文 (Simplified Chinese):

注意: 如果您说[中文], 我们将免费为您提供语言协助服务。我们还免费提供适当的辅助工具和服务, 以无障碍格式提供信息。致电 608-828-4853 or 1-800-605-4327, ext. 4504 (TTY: 1-608-828-4815) 或咨询您的服务提供商。

## 繁體中文 (Traditional Chinese):

注意: 如果您說[中文], 我們可以為您提供免費語言協助服務。也可以免費提供適當的輔助工具與服務, 以無障礙格式提供資訊。請致電 608-828-4853 or 1-800-605-4327, ext. 4504 (TTY: 1-608-828-4815) 或與您的提供者討論。

## Hmoob (Hmong):

LUS CEEB TOOM: Yog tias koj hais lus Hmoob, muaj cov kev pab cuam txhais lus pub dawb rau koj. Muaj cov cav zoo thiab cov kev pab cuam txhais ntaub ntawv ua lwm hom lus nrog rau cov kev pab dawb tsis kom them nqi rau. Hu 1-608-828-4853 los sis 1-800-605-4327 los sis tus leb txuas ntxiv (ext), 4504 (TTY: 1-608-828-4815) los sis hais qhia tau rau koj tus kws kho mob.

## Русский (Russian):

ВНИМАНИЕ: Если вы говорите на русский, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 1-608-828-4853 or 1-800-605-4327, ext. 4504 (TTY: 1-608-828-4815) или обратитесь к своему поставщику услуг.

## Tiếng Việt (Vietnamese):

LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ dịch vụ phù hợp để cung cấp thông tin theo các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi theo số 1-608-828-4853 or 1-800-605-4327, ext. 4504 (TTY: 1-608-828-4815) hoặc trao đổi với người cung cấp dịch vụ của bạn.

## ລາວ (Laotian):

ເຊີນຊາບ: ຖ້າທ່ານເວົ້າພາສາ ລາວ, ຈະມີ ບໍລິ ການຊ່ວຍຕ້ານພາສາແບບບໍ່ ເສຍຄ່າໃຫ້ທ່ານ. ມີ ເຄື່ອງຊ່ວຍ ແລະ ການບໍລິ ການແບບບໍ່ ເສຍຄ່າທີ່ ເໝາະສົມເພື່ອໃຫ້ຂໍ້ມູນໃນຮູບແບບທີ່ ສາມາດເຂົ້າເຖິງໄດ້. ໂທຫາເບ 1-608-828-4853 or 1-800-605-4327, ext. 4504 (TTY: 1-608-828-4815) ຫລື ມາກັບຜູ້ໃຫ້ບໍລິ ການຂອງທ່ານ.

## Deutsch (German):

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistentendienste zur Verfügung. Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten stehen ebenfalls kostenlos zur Verfügung. Rufen Sie 1-608-828-4853 or 1-800-605-4327, ext. 4504 (TTY: 1-608-828-4815) an oder sprechen Sie mit Ihrem Provider.

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