Group Health Cooperative of South Central Wisconsin

# Partners HMO Gold 2500 Ded/8600 MOOP

Plan Number: 2731231
Benefits Accumulate on a Plan Year.

*Policy Coinsurance*
In-Network: 25%
Out-of-Network: Not Covered

| | MEMBER | FAMILY |
|---|---|---|
| In-Network Deductible | $2,500 | $5,000 |
| Out-of-Network Deductible | Not Covered | Not Covered |
| In-Network Maximum Out-of-Pocket (MOOP) | $8,600 | $17,200 |
| 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 | $30 | Not Covered | Example: Office visits with Your Primary Care Provider (PCP) |
| Chiropractic Office Visits | No | $30 | Not Covered | |
| Preventive Health Examinations | No | No Charge | Not Covered | You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for. |
| Specialist Care Office Visits | Yes | $60 | 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 | You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for. |
| 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 | 25% after Deductible | Not Covered | X-rays and routine lab tests ordered by Your Provider do not require Prior Authorization. |
| Advanced Radiology | Yes | 25% after Deductible | Not Covered | Examples: CT, PET Scans, MRIs |
| Travel-Related Immunizations | Not Applicable | Not Covered | Not Covered | |
| **Emergency and Urgent Care** | **Prior Auth** | **You Pay In-Network** | **You Pay Out-of-Network** | **Benefit Notes** |
| Urgent Care Visits | No | $45 | $45 | |
| Emergency Ambulance Service (air/ground) | No | 25% after Deductible | 25% after Deductible | Coverage is limited to emergency care |
| Emergency Room Visits | No | 25% after Deductible | 25% 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 | $15 | 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 | $30 | 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 | $60 | 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) | $250 | Not Covered | Covers up to a 30-day supply; 31-90 day supply not available; May require the use of a specialty-designated pharmacy |

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| 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% | 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 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 | 25% 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 | 25% after Deductible | Not Covered | |
| Inpatient Facility Fees | Yes | 25% after Deductible | Not Covered | |
| Outpatient Hospital Surgical/Non-Surgical Services | Yes | 25% after Deductible | Not Covered | Certain oral surgeries do not require Prior Authorization |
| Outpatient Surgical Facility Fees | Yes | 25% after Deductible | Not Covered | |
| Skilled Nursing Facility Services | Yes | 25% after Deductible | Not Covered | Limited to 30 days per inpatient stay per Member |
| Bariatric Surgery | Not Applicable | Not Covered | Not Covered | |
| **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 | $30 | 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 | 25% after Deductible | Not Covered | |
| Mental Health/Substance Use Disorder Transitional Services | Yes | 25% after Deductible | 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 |
|---|---|---|---|---|
| Accidental Dental | No | 25% after Deductible | Not Covered | Initial repair of accidental injury to sound, natural teeth |
| Oral Surgeries | Yes | 25% 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 | 25% after Deductible | Not Covered | Example: End of Life Services |
| Home Health Services | Yes | 25% 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. |
| Conception Services | Not Applicable | Not Covered | Not Covered | |
| Speech Therapy | Yes | $30 | Not Covered | Includes Rehabilitation and Habilitation Therapy; Limited to 20 visits per therapy per Member per year |
| Outpatient Habilitation Therapy | Yes | $30 | 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 | Not Covered | Limited to 36 visits per Member per year |
| Outpatient Rehabilitation Therapy | Yes | $30 | 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.

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. 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.**

# 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.

**ลาว (Laotian):**
ເຊີ້ນຊາບ: ຖ້າທ່ານເວ ້າພາສາ ລາວ, ຈະມີ້ບໍ ລິ ການຊ່ວຍດ້ານພາສາແບບບໍ່ ເສຍຄ່າໃຫ້ ທ່ານ.
ມີ້ເຄ ່ອງຊ່ວຍ ແລະ ການບໍ ລິ ການແບບບໍ່ ເສຍຄ່າທີ່ ເໝາະສ ມເພ ່ອໃຫ້ ຂໍ້ມູ ນໃນຮູ ບແບບທີ່ ສາມາດເຂ ້າເຖິ ງໄດ້.
ໂທຫາເບ 1-608-828-4853 or 1-800-605-4327, ext. 4504 (TTY: 1-608-828-4815) ຫ ລ ມກັ ບຜ້ໃຫູ້ ບໍ ລິ ການຂອງທ່ານ.

**Deutsch (German):**
ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzdienste 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.

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

**Deitsch (Pennsylvania Dutch):**
LET OP: als je Nederlands spreekt, zijn er gratis taalhulpdiensten voor je beschikbaar. Passende hulpmiddelen en diensten om informatie in toegankelijke formaten te verstrekken, zijn ook gratis beschikbaar. Bell 1-608-828-4853 or 1-800-605-4327, ext. 4504 (TTY: 1-608-828-4815) of spreek met je provider.

**العربية (Arabic):**
تنبيه: إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر وسائل مساعدة وخدمات مناسبة لتوفير المعلومات بتنسيقات يمكن الوصول إليها مجانا. اتصل على الرقم (TTY: 1-608-828-4815) -1-800-605-4327, ext 4504; 1-608-828-4853- أو تحدث إلى مقدم الخدمة

**Polski (Polish):**
UWAGA: Osoby mówiące po polsku mogą skorzystać z bezpłatnej pomocy językowej. Dodatkowe pomoce i usługi zapewniające informacje w dostępnych formatach są również dostępne bezpłatnie. Zadzwoń pod numer 1-608-828-4853 or 1-800-605-4327, ext. 4504 (TTY: 1-608-828-4815) lub porozmawiaj ze swoim dostawcą.

**Français (French):**
ATTENTION : Si vous parlez Français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 1-608-828-4853 or 1-800-605-4327, ext. 4504 (TTY: 1-608-828-4815) ou parlez à votre fournisseur.

**हिंदी (Hindi):**
**ध्यान दें: यदि आप हिंदी बोलते हैं, तो आपके लिए निःशुल्क भाषा सहायता सेवाएं उपलब्ध होती हैं। सुलभ प्रारूपों में जानकारी प्रदान करने के लिए उपयुक्त सहायक साधन और सेवाएँ भी निःशुल्क उपलब्ध हैं।1-608-828-4853 or 1-800-605-4327, ext. 4504 (TTY: 1-608-828-4815) पर कॉल करें या अपने प्रदाता से बात करें।**

**한국어 (Korean):**
주의: [한국어]를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. 1-608-828-4853 or 1-800-605-4327, ext. 4504 (TTY: 1-608-828-4815) 번으로 전화하거나 서비스 제공업체에 문의하십시오.

**Shqip (Albanian):**
VINI RE: Nëse flisni [shqip], shërbime falas të ndihmës së gjuhës janë në dispozicion për ju. Ndihma të përshtatshme dhe shërbime shtesë për të siguruar informacion në formate të përdorshme janë gjithashtu në dispozicion falas.Telefononi 1-608-828-4853 or 1-800-605-4327, ext. 4504 (TTY: 1-608-828-4815) ose bisedoni me ofruesin tuaj të shërbimit.

**Tagalog (Tagalog – Filipino):**
PAALALA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyong tulong sa wika. Magagamit din nang libre ang mga naaangkop na auxiliary na tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 1-608-828-4853 or 1-800-605-4327, ext. 4504 (TTY: 1-608-828-4815) o makipag-usap sa iyong provider.

**Soomaali (Somali):**
FIIRO GAAR AH: Haddaad ku hadasho Soomaali, adeegyo kaalmada luuqadda ah oo bilaash ah ayaad heli kartaa. Qalab caawinaad iyo adeegyo oo habboon si loogu bixiyo macluumaadka qaabab la adeegsan karo ayaa sidoo kale bilaa lacag heli karaa. Wac 1-608-828-4853 or 1-800-605-4327, ext. 4504 (TTY: 1-608-828-4815) ama la hadal bixiyahaaga.