Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, please call 1-800-605-4327. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment , deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary/ or call 1-800-605-4327 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$100/Individual** or **$200/Family**	If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Complementary Medicine, Preventive Care, Certain Office Visits, and Pharmacy Drugs are covered before the deductible is met. Office Visit Copayments are waived for children under age 19.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	**$6,600/Individual** or **$13,200/Family**	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members on this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Copayments on certain services, premiums, balance-billing charges, infertility services, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.ghcscw.com or call 1-800-605-4327 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance-billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	Yes.	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20	Not Covered	Example: Office visits with Your Primary Care Provider (PCP)
	Specialist visit	$20	Not Covered	Prior authorization is required. Examples: Specialist Hearing Exams, Autism Spectrum Specialist Office Visit
	Preventive care/screening/immunization	No Charge	Not Covered	Coverage is limited to USPSTF guidelines and Women's Preventive Health
If you have a test	Diagnostic test (x-ray, blood work)	No Charge after Deductible	Not Covered	Prior authorization is required. 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
	Imaging (CT/PET scans, MRIs)	No Charge after Deductible	Not Covered	Prior authorization is required. Examples: CT, PET Scans, MRIs
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at http://planfinder.ghcscw.com/	Generic drugs **(Tier 1)**	$6	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
	Preferred brand drugs **(Tier 2)**	$15	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
	Non-preferred brand drugs **(Tier 3)**	Not Covered	Not Covered	Not Covered

*For more information about limitations and exceptions, see the plan or policy document at http://planfinder.ghcscw.com

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Specialty drugs **(Tier 4)**	$30	Not Covered	Covers up to a 30-day supply; 31-90 day supply not available; May require the use of a specialty-designated pharmacy
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No Charge after Deductible	Not Covered	Prior authorization is required.
	Physician/surgeon fees	No Charge after Deductible	Not Covered	Prior authorization is required. Certain oral surgeries do not require Prior Authorization
If you need immediate medical attention	Emergency room care	$150	$150	Coverage is limited to emergency care; Copayment waived if admitted as a hospital inpatient
	Emergency medical transportation	No Charge after Deductible	No Charge after Deductible	Coverage is limited to emergency care
	Urgent care	$20	$20	
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge after Deductible	Not Covered	Prior authorization is required.
	Physician/surgeon fees	No Charge after Deductible	Not Covered	Prior authorization is required.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$20	Not Covered	Prior authorization is required. Prior Authorization is not required when services are provided at a GHC-SCW Clinic or at UW Health Behavioral Health and Recovery Clinic
	Inpatient services	No Charge after Deductible	Not Covered	Prior authorization is required.
If you are pregnant	Office visits	No Charge	Not Covered	Coverage is limited to USPSTF guidelines and Women's Preventive Health
	Childbirth/delivery professional services	No Charge after Deductible	Not Covered	Prior authorization is required.
	Childbirth/delivery facility services	No Charge after Deductible	Not Covered	Prior authorization is required.

*For more information about limitations and exceptions, see the plan or policy document at http://planfinder.ghcscw.com

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	No Charge after Deductible	Not Covered	Prior authorization is required. Limited to 60 visits per Member per year
	Rehabilitation services	No Charge after Deductible	Not Covered	Prior authorization is required. Limited to 40 combined visits per Member per year for Occupational and Physical; Limited to 20 visits per Member per year for Speech; Limited to 36 visits per Member per year for Cardiac
	Habilitation services	No Charge after Deductible	Not Covered	Prior authorization is required. Limited to 40 combined visits per Member per year for Occupational and Physical; Limited to 20 visits per Member per year for Speech
	Skilled nursing care	No Charge after Deductible	Not Covered	Prior authorization is required. Limited to 30 days per inpatient stay per Member
	Durable medical equipment	No Charge	Not Covered	Prior authorization is required. See Certificate for additional Limitations and Exclusions
	Hospice services	No Charge after Deductible	Not Covered	Prior authorization is required. Example: End of Life Services
If your child needs dental or eye care	Children's eye exam	No Charge	Not Covered	Vision examinations must be provided by an In-Network Provider; Limited to one eye exam per Member per year
	Children's glasses	Not Covered	Not Covered	Not Covered
	Children's dental check-up	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

*For more information about limitations and exceptions, see the plan or policy document at http://planfinder.ghcscw.com

Excluded Services and Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Abortion (except in cases of rape, incest, or when the life of the mother is endangered)
- Bariatric surgery
- Cosmetic surgery
- Custodial Care
- Drug Screening
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Personal Comfort Items
- Private-Duty Nursing
- Routine Foot Care
- Weight Loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture
- Chiropractic Care
- Dental Care (Adult)
- Hearing Aids
- Infertility Treament (specific procedures and services at In-Network facilities only)
- Routine Eye Care (Adult)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: GHC-SCW Member Services at 1-800-605-4327 or Wisconsin's Office of the Commissioner of Insurance at 1-800- 236-8517 or 608-266-0103. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: GHC-SCW Member Services at 1-800-605-4327 or 608-828-4853. You may also contact Wisconsin's Office of the Commissioner of Insurance at 1-800- 236-8517 or 608-266-0103. In addition, you may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? Yes

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? Yes

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

*For more information about limitations and exceptions, see the plan or policy document at http://planfinder.ghcscw.com

---------- To see examples of how this plan might cover costs for a sample medical situation, see the next section. ----------

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is having a baby
(9 months of in-network pre-natal care and a hospital delivery)

- The plan's overall deductible -- $100
- Specialist -- $20
- Hospital (facility) -- No Charge after Deductible
- Other -- 0%

This EXAMPLE event includes services like:

Specialist office visits (prenatal care)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (ultrasounds and blood work)
Specialist visit (anesthesia)

Total Example Cost -- $12,800.00

In this example, Peg would pay:

Cost sharing	
Deductibles	$100.00
Copayments	$50.00
Coinsurance	$0

What isn't covered
Limits or exclusions -- $10.00

The total Peg would pay is -- $160.00

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- The plan's overall deductible -- $100
- Specialist -- $20
- Hospital (facility) -- No Charge after Deductible
- Other -- 0%

This EXAMPLE event includes services like:

Primary care physician office visits (including disease education)
Diagnostic tests (blood work)
Prescription drugs
Durable medical equipment (glucose meter)

Total Example Cost -- $7,400.00

In this example, Joe would pay:

Cost sharing	
Deductibles	$100.00
Copayments	$490.00
Coinsurance	$0

What isn't covered
Limits or exclusions -- $20.00

The total Joe would pay is -- $610.00

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- The plan's overall deductible -- $100
- Specialist -- $20
- Hospital (facility) -- No Charge after Deductible
- Other -- 0%

This EXAMPLE event includes services like:

Emergency room care (including medical supplies)
Diagnostic test (x-ray)
Durable medical equipment (crutches)
Rehabilitation services (physical therapy)

Total Example Cost -- $1,930.00

In this example, Mia would pay

Cost sharing	
Deductibles	$100.00
Copayments	$190.00
Coinsurance	$0

What isn't covered
Limits or exclusions -- $0

The total Mia would pay is -- $290.00

*For more information about limitations and exceptions, see the plan or policy document at http://planfinder.ghcscw.com

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).