



Select Gold 2800 Ded/2800 MOOP HSA

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/](http://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 <u>deductible</u> ?                             | <b>\$2,800/Individual</b> or <b>\$5,600/Family</b>  | If you have other family members on the policy, the overall family <u>deductible</u> must be met before the <b>plan</b> begins to pay.   |
| Are there services covered before you meet your <u>deductible</u> ? | Yes. Preventive Care is covered before the deductible is met.   | This <b>plan</b> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <b>plan</b> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .   |
| Are there other <u>deductibles</u> for specific services?           | No.   | You don't have to meet <u>deductibles</u> for specific services.   |
| What is the <u>out-of-pocket limit</u> for this <b>plan</b> ?       | <b>\$2,800/Individual</b> or <b>\$5,600/Family</b>  | The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members on this <b>plan</b> , the overall family <u>out-of-pocket limit</u> must be met.   |
| What is not included in the <u>out-of-pocket limit</u> ?            | <u>Premiums</u> , <u>balance-billing charges</u> , and health care this <b>plan</b> doesn't cover.                          | Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .   |
| Will you pay less if you use a <u>network provider</u> ?            | Yes. See <a href="http://www.ghcscw.com">www.ghcscw.com</a> or call 1-800-605-4327 for a list of <u>network providers</u> . | This <b>plan</b> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <b>plan's network</b> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <b>plan</b> pays ( <u>balance-billing</u> ). Be aware your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services. |
| Do you need a <u>referral</u> to see a <u>specialist</u> ?          | Yes.  | This <b>plan</b> will pay some or all of the costs to see a <u>specialist</u> for covered services but only if you have a <u>referral</u> before you see the <u>specialist</u> .   |

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



All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

| Common Medical Event   | Services You May Need                                  | What You Will Pay                            |  | Limitations, Exceptions, Other Important Information   |
|--|--|--|--|--|
|  |  | Network Provider<br>(You will pay the least) | Out-of-Network Provider<br>(You will pay the most) |  |
| <b>If you visit a health care <a href="#">provider's office or clinic</a></b>  | Primary care visit to treat an injury or illness       | No Charge after Deductible                   | Not Covered  | Example: Office visits with Your Primary Care Provider (PCP)   |
|  | <a href="#">Specialist visit</a>                       | No Charge after Deductible                   | Not Covered  | Prior authorization is required.Examples: Specialist Hearing Exams, Autism Spectrum Specialist Office Visit; Most Specialists do not require Prior Authorization   |
|  | <a href="#">Preventive care/screening/immunization</a> | No Charge                                    | Not Covered  | Coverage is limited to preventive services as defined by the Affordable Care Act.  |
| <b>If you have a test</b>  | <a href="#">Diagnostic test</a> (x-ray, blood work)    | No Charge after Deductible                   | Not Covered  | Prior authorization is required.X-rays and routine lab tests ordered by Your Provider do not require Prior Authorization.  |
|  | Imaging (CT/PET scans, MRIs)                           | No Charge after Deductible                   | Not Covered  | Prior authorization is required.Examples: CT, PET Scans, MRIs  |
| <b>If you need drugs to treat your illness or condition</b><br>More information about <a href="#">prescription drug coverage</a> is available at <a href="http://planfinder.ghcscw.com/">http://planfinder.ghcscw.com/</a> | Generic drugs<br><b>(Tier 1)</b>                       | No Charge 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; Some brand names and many generics; Drugs in Tier 1 are the greatest value |
|  | Preferred brand drugs<br><b>(Tier 2)</b>               | No Charge 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   |
|  | Non-preferred brand drugs<br><b>(Tier 3)</b>           | No Charge 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   |
|  | <a href="#">Specialty drugs</a><br><b>(Tier 4)</b>     | No Charge 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   |

\*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<br>(You will pay the least) | Out-of-Network Provider<br>(You will pay the most) |   |
| <b>If you have outpatient surgery</b>  | 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  |
| <b>If you need immediate medical attention</b>                                   | <a href="#">Emergency room care</a>              | No Charge after Deductible                   | No Charge after Deductible                         | Coverage is limited to emergency care   |
|  | <a href="#">Emergency medical transportation</a> | No Charge after Deductible                   | No Charge after Deductible                         | Coverage is limited to emergency care   |
|  | <a href="#">Urgent care</a>                      | No Charge after Deductible                   | No Charge after Deductible                         |   |
| <b>If you have a hospital stay</b>   | 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.  |
| <b>If you need mental health, behavioral health, or substance abuse services</b> | Outpatient services                              | No Charge after Deductible                   | 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.   |
|  | Inpatient services                               | No Charge after Deductible                   | Not Covered  | Prior authorization is required.  |
| <b>If you are pregnant</b>   | Office visits                                    | No Charge                                    | Not Covered  | In-Network cost-sharing value is limited to preventive services. Cost-sharing described elsewhere in this SBC may apply depending on the maternity-related test or service.   |
|  | 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.  |
| <b>If you need help recovering or have other special health needs</b>            | <a href="#">Home health care</a>                 | No Charge after Deductible                   | Not Covered  | Prior authorization is required. Limited to 60 visits per Member per year   |
|  | <a href="#">Rehabilitation services</a>          | 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 |

\*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<br>(You will pay the least) | Out-of-Network Provider<br>(You will pay the most) |  |
|   | <a href="#">Habilitation services</a>     | 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   |
|   | <a href="#">Skilled nursing care</a>      | No Charge after Deductible                   | Not Covered  | Prior authorization is required.Limited to 30 days per inpatient stay per Member   |
|   | <a href="#">Durable medical equipment</a> | No Charge after Deductible                   | Not Covered  | Prior authorization is required.See Certificate for additional Limitations and Exclusions  |
|   | <a href="#">Hospice services</a>          | No Charge after Deductible                   | Not Covered  | Prior authorization is required.Example: End of Life Services  |
| <b>If your child needs dental or eye care</b> | Children's eye exam                       | No Charge after Deductible                   | 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 |
|   | Children's glasses                        | No Charge after Deductible                   | 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  |
|   | Children's dental check-up                | Not Covered                                  | Not Covered  | Not Covered  |

## Excluded Services & 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)
- Dental Care (Adult)
- Long-term care
- Private-Duty Nursing
- Weight Loss programs
- Acupuncture
- Cosmetic surgery
- Drug Screening
- Non-emergency care when traveling outside the U.S.
- Routine Eye Care (Adult)
- Bariatric surgery
- Custodial Care
- Infertility Treatment
- Personal Comfort Items
- Routine Foot Care

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

- Chiropractic Care
- Hearing Aids

**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: Office of the Commissioner of Insurance, Complaints Department, PO Box 7873, Madison, WI 53707-7873, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform), or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov). 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](http://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](http://www.dol.gov/ebsa/healthreform).

### Does this plan provide Minimum Essential Coverage? Yes

**Minimum Essential Coverage** generally includes **plans**, **health insurance** available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of **Minimum Essential Coverage**, you may not be eligible for the **premium tax credit**.

### Does this plan meet the Minimum Value Standards? Not Applicable

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](#).

*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](#) -- \$2,800
- [Specialist \[cost sharing\]](#) -- No Charge after Deductible
- Hospital (facility) [[cost sharing](#)] -- No Charge after Deductible
- Other [[cost sharing](#)] -- 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 -- \$12,700.00**

**In this example, Peg would pay:**

#### *Cost sharing*

|                             |           |
|-----------------------------|-----------|
| <a href="#">Deductibles</a> | \$2800.00 |
| <a href="#">Copayments</a>  | \$0.00    |
| <a href="#">Coinsurance</a> | \$0.00    |

#### *What isn't covered*

Limits or exclusions -- \$50.00

**The total Peg would pay is -- \$2850.00**

### Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

- The [plan's](#) overall [deductible](#) -- \$2,800
- [Specialist \[cost sharing\]](#) -- No Charge after Deductible
- Hospital (facility) [[cost sharing](#)] -- No Charge after Deductible
- Other [[cost sharing](#)] -- 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 -- \$5,600.00**

**In this example, Joe would pay:**

#### *Cost sharing*

|                             |           |
|-----------------------------|-----------|
| <a href="#">Deductibles</a> | \$2680.00 |
| <a href="#">Copayments</a>  | \$0.00    |
| <a href="#">Coinsurance</a> | \$120.00  |

#### *What isn't covered*

Limits or exclusions -- \$20.00

**The total Joe would pay is -- \$2820.00**

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

- The [plan's](#) overall [deductible](#) -- \$2,800
- [Specialist \[cost sharing\]](#) -- No Charge after Deductible
- Hospital (facility) [[cost sharing](#)] -- No Charge after Deductible
- Other [[cost sharing](#)] -- 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 -- \$2,800.00**

**In this example, Mia would pay**

#### *Cost sharing*

|                             |           |
|-----------------------------|-----------|
| <a href="#">Deductibles</a> | \$2170.00 |
| <a href="#">Copayments</a>  | \$0.00    |
| <a href="#">Coinsurance</a> | \$0.00    |

#### *What isn't covered*

Limits or exclusions -- \$10.00

**The total Mia would pay is -- \$2180.00**

## 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)] schwetzsch, 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. ໂທສ 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).