



Silver 4900 Ded/7900 MOOP

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 ? | \$4,900/Individual or \$9,800/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. Preventive Care and Certain Office Visits are covered before the deductible is met. | 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 ? | \$7,900/Individual or \$15,800/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 ? | Premiums , balance-billing charges , Conception 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 . |

*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 (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 | \$35 | Not Covered | Example: Office visits with Your Primary Care Provider (PCP) |
| | Specialist visit | \$80 | Not Covered | Prior authorization is required.Examples: Specialist Hearing Exams, Autism Spectrum Specialist Office Visit; Most Specialists do not require Prior Authorization |
| | Preventive care/screening/immunization | No Charge | Not Covered | Coverage is limited to preventive services as defined by the Affordable Care Act. |
| If you have a test | Diagnostic test (x-ray, blood work) | 30% 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) | 30% 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) | \$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; Some brand names and many generics; Drugs in Tier 1 are the greatest value |
| | Preferred brand drugs (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 |
| | Non-preferred brand drugs (Tier 3) | \$200 | 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 |
| | Specialty drugs (Tier 4) | 50% 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 (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | 30% after Deductible | Not Covered | Prior authorization is required. |
| | Physician/surgeon fees | 30% 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 | 30% after Deductible | 30% after Deductible | Coverage is limited to emergency care |
| | Emergency medical transportation | 30% after Deductible | 30% after Deductible | Coverage is limited to emergency care |
| | Urgent care | \$35 | \$35 | |
| If you have a hospital stay | Facility fee (e.g., hospital room) | 30% after Deductible | Not Covered | Prior authorization is required. |
| | Physician/surgeon fees | 30% after Deductible | Not Covered | Prior authorization is required. |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | \$35 | 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 | 30% after Deductible | Not Covered | Prior authorization is required. |
| If you are pregnant | 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 | 30% after Deductible | Not Covered | Prior authorization is required. |
| | Childbirth/delivery facility services | 30% after Deductible | Not Covered | Prior authorization is required. |
| If you need help recovering or have other special health needs | Home health care | 30% after Deductible | Not Covered | Prior authorization is required. Limited to 60 visits per Member per year |
| | Rehabilitation services | 30% 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 (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| | Habilitation services | 30% 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 | 30% after Deductible | Not Covered | Prior authorization is required.Limited to 30 days per inpatient stay per Member |
| | Durable medical equipment | 20% | Not Covered | Prior authorization is required.See Certificate for additional Limitations and Exclusions |
| | Hospice services | 30% 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 | 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 | 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, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or 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 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

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](#) -- \$4,900
- [Specialist \[cost sharing\]](#) -- \$80
- Hospital (facility) [[cost sharing](#)] -- 30% after Deductible
- Other [[cost sharing](#)] -- 30%

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

| | |
|-----------------------------|-----------|
| Deductibles | \$4900.00 |
| Copayments | \$90.00 |
| Coinsurance | \$1110.00 |

What isn't covered

Limits or exclusions -- \$50.00

The total Peg would pay is -- \$6150.00

Managing Joe's type 2 Diabetes

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

- The [plan's](#) overall [deductible](#) -- \$4,900
- [Specialist \[cost sharing\]](#) -- \$80
- Hospital (facility) [[cost sharing](#)] -- 30% after Deductible
- Other [[cost sharing](#)] -- 30%

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

| | |
|-----------------------------|-----------|
| Deductibles | \$110.00 |
| Copayments | \$1120.00 |
| Coinsurance | \$620.00 |

What isn't covered

Limits or exclusions -- \$20.00

The total Joe would pay is -- \$1870.00

Mia's Simple Fracture

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

- The [plan's](#) overall [deductible](#) -- \$4,900
- [Specialist \[cost sharing\]](#) -- \$80
- Hospital (facility) [[cost sharing](#)] -- 30% after Deductible
- Other [[cost sharing](#)] -- 30%

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

| | |
|-----------------------------|-----------|
| Deductibles | \$1800.00 |
| Copayments | \$40.00 |
| Coinsurance | \$60.00 |

What isn't covered

Limits or exclusions -- \$10.00

The total Mia would pay is -- \$1910.00

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).