



Partners HMO Silver 3200 Ded/6200 MOOP with Vision 73% (4100/7500)

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 ?	\$3,200/Individual or \$6,400/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 ?	\$6,200/Individual or \$12,400/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 , 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)	\$20	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)	\$65	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)	50% 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
	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>

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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 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>

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

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

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](#) -- \$3,200
- [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	\$3200.00
Copayments	\$60.00
Coinsurance	\$1620.00

What isn't covered

Limits or exclusions -- \$50.00

The total Peg would pay is -- \$4930.00

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

- The [plan's](#) overall [deductible](#) -- \$3,200
- [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	\$820.00
Coinsurance	\$500.00

What isn't covered

Limits or exclusions -- \$20.00

The total Joe would pay is -- \$1450.00

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

- The [plan's](#) overall [deductible](#) -- \$3,200
- [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

*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, 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.

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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):

1-608-828-4853, 1-800-605-4327, ext. 4504 فإن خدمات المساعدة اللغوية، إذا كنت تتحدث العربية، اتصل برقم هاتف الصم والبكم (تتوافر لك بالمجان. ملحوظة: 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: ຖ້າວ່າທ່ານເວົ້າ ພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີ ພ້ອມໃຫ້ ທ່ານ. ໂທ 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).

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