Group Health Cooperative of South Central Wisconsin

# Better Together HMO Gold 1500 Ded/7800 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? | **$1,500/Individual** or **$3,000/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, Certain Office Visits, and Pharmacy Drugs 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? | **$7,800/Individual** or **$15,600/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 https://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 | $30 | Not Covered | Example: Office visits with Your Primary Care Provider (PCP) |
| | Specialist visit | $60 | 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) | 25% 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) | 25% after Deductible | Not Covered | Prior authorization is required.Examples: CT, PET Scans, MRIs |

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|---|---|---|---|---|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| **If you need drugs to treat your illness or condition**<br>More information about prescription drug coverage is available at http://planfinder.ghcscw.com/ | Generic drugs<br>**(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 |
| | Preferred brand drugs<br>**(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 |
| | Non-preferred brand drugs<br>**(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 |
| | Specialty drugs<br>**(Tier 4)** | $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 |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 25% after Deductible | Not Covered | Prior authorization is required. |
| | Physician/surgeon fees | 25% 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 | 25% after Deductible | 25% after Deductible | Coverage is limited to emergency care |
| | Emergency medical transportation | 25% after Deductible | 25% after Deductible | Coverage is limited to emergency care |
| | Urgent care | $45 | $45 | |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 25% after Deductible | Not Covered | Prior authorization is required. |
| | Physician/surgeon fees | 25% after Deductible | Not Covered | Prior authorization is required. |

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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 need mental health, behavioral health, or substance abuse services** | Outpatient services | $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. |
| | Inpatient services | 25% 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 | 25% after Deductible | Not Covered | Prior authorization is required. |
| | Childbirth/delivery facility services | 25% after Deductible | Not Covered | Prior authorization is required. |

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|---|---|---|---|---|
| | | 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 | 25% after Deductible | Not Covered | Prior authorization is required.Limited to 60 visits per Member per year |
| | Rehabilitation services | $30 | 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 | $30 | 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 | 25% 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 | 25% after Deductible | Not Covered | Prior authorization is required.Example: End of Life Services |

| 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 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 |

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

**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 https://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 -- $1,500
- Specialist [cost sharing] -- $60
- Hospital (facility) [cost sharing] -- 25% after Deductible
- Other [cost sharing] -- 25%

**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 | $1500.00 |
| Copayments | $50.00 |
| Coinsurance | $1780.00 |

| *What isn't covered* |
|---|
| Limits or exclusions -- $50.00 |

**The total Peg would pay is -- $3380.00**

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

- The plan's overall deductible -- $1,500
- Specialist [cost sharing] -- $60
- Hospital (facility) [cost sharing] -- 25% after Deductible
- Other [cost sharing] -- 25%

**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 | $630.00 |
| Coinsurance | $620.00 |

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

**The total Joe would pay is -- $1380.00**

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

- The plan's overall deductible -- $1,500
- Specialist [cost sharing] -- $60
- Hospital (facility) [cost sharing] -- 25% after Deductible
- Other [cost sharing] -- 25%

**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 | $1430.00 |
| Copayments | $150.00 |
| Coinsurance | $60.00 |

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

**The total Mia would pay is -- $1650.00**

*For more information about limitations and exceptions, see the plan or policy document at https://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.**

# 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 إذا كنت تتحدث العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم ملحوظة: (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 ທ່ານເວົ້ າພາສາ ລາວ, ການບໍລິ ການຊ່ວຍເຫຼື ອດ້ ານພາສາ, ໂດຍບໍ່ເສັ ຽຄ່າ, ແມ່ນມີ ພ້ ອມໃຫ້ ທ່ານ. 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).