Group Health Cooperative of South Central Wisconsin

Better Together HMO Gold 2500 Ded/8600 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?	**$2,500/Individual** or **$5,000/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?	**$8,600/Individual** or **$17,200/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?	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 (deductible does not apply)	Not Covered	Example: Office visits with Your Primary Care Provider (PCP)
	Specialist visit	$60 (deductible does not apply)	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	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
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

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 drugs to treat your illness or condition More information about prescription drug coverage is available at http://planfinder.ghcscw.com/	Generic drugs **(Tier 1)**	$15 (deductible does not apply)	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)**	$30 (deductible does not apply)	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)**	$60 (deductible does not apply)	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)**	$250 (deductible does not apply)	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 (deductible does not apply)	$45 (deductible does not apply)	
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.

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 (deductible does not apply)	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.

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	25% after Deductible	Not Covered	Prior authorization is required.Limited to 60 visits per Member per year
	Rehabilitation services	$30 (deductible does not apply)	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 (deductible does not apply)	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% (deductible does not apply)	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

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

- 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 -- $2,500
- 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	$2500.00
Copayments	$50.00
Coinsurance	$1530.00

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

The total Peg would pay is -- $4130.00

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

- The plan's overall deductible -- $2,500
- 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 -- $2,500
- 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.**

NOTICE OF AVAILABILITY OF LANGUAGE ASSISTANCE SERVICES AND AUXILIARY AIDS AND SERVICES

English:
ATTENTION: If you speak English, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1-608-828-4853 or 1-800-605-4327, ext. 4504 (TTY: 1-608-828-4815) or speak to your provider.

Español (Spanish):
ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al 1-608-828-4853 or 1-800-605-4327, ext. 4504 (TTY: 1-608-828-4815) o hable con su proveedor..

中文 (Simplified Chinese):
注意：如果您说[中文]，我们将免费为您提供语言协助服务。我们还免费提 供适当的辅助工具和服务，以无障碍格式提供信息。致电 608-828-4853 or 1-800-605-4327, ext. 4504 (TTY: 1-608-828-4815) 或咨询您的服务提供商。

繁體中文 (Traditional Chinese):
注意：如果您說[中文]，我們可以為您提供免費語言協助服務。也可以免費 提供適當的輔助工具與服務，以無障礙格式提供資訊。請致電 608-828-4853 or 1-800-605-4327, ext. 4504 (TTY: 1-608-828-4815) 或與您的提供者討論。

Hmoob (Hmong):
LUS CEEB TOOM: Yog tias koj hais lus Hmoob, muaj cov kev pab cuam txhais lus pub dawb rau koj. Muaj cov cav zoo thiab cov kev pab cuam txhais ntaub ntawv ua lwm hom lus nrog rau cov kev pab dawb tsis kom them nqi rau. Hu 1-608-828-4853 los sis 1-800-605-4327 los sis tus leb txuas ntxiv (ext), 4504 (TTY: 1-608-828-4815) los sis hais qhia tau rau koj tus kws kho mob.

Русский **(Russian):**
ВНИМАНИЕ: Если вы говорите на русский, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 1-608-828-4853 or 1-800-605-4327, ext. 4504 (TTY: 1-608-828-4815) или обратитесь к своему поставщику услуг.

Tiếng Việt (Vietnamese):
LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ dịch vụ phù hợp để cung cấp thông tin theo các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi theo số 1-608-828-4853 or 1-800-605-4327, ext. 4504 (TTY: 1-608-828-4815) hoặc trao đổi với người cung cấp dịch vụ của bạn.

ລາວ (Laotian):
ເຊີນຊາບ: ຖ້າທ່ານເວ ້າພາສາ ລາວ, ຈະມີ ບໍ ລິ ການຊ່ວຍດ້ານພາສາແບບບໍ່ ເສຍຄ່າໃຫ້ ທ່ານ.
ມີ ເຄ ່ອງຊ່ວຍ ແລະ ການບໍ ລິ ການແບບບໍ່ ເສຍຄ່າທີ່ ເໝາະສ ມເພ ່ອໃຫ້ຂໍ້ມູ ນໃນຮູ ບແບບທີ່ ສາມາດເຂ ້າເຖິ ງໄດ້.
ໂທຫາເບ 1-608-828-4853 or 1-800-605-4327, ext. 4504 (TTY: 1-608-828-4815) ຫ ລ ມກັ ບຜ້ໃຫູ້ ບໍ ລິ ການຂອງທ່ານ.

Deutsch (German):
ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzdienste zur Verfügung. Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten stehen ebenfalls kostenlos zur Verfügung. Rufen Sie 1-608-828-4853 or 1-800-605-4327, ext. 4504 (TTY: 1-608-828-4815) an oder sprechen Sie mit Ihrem Provider.

NOTICE OF AVAILABILITY OF LANGUAGE ASSISTANCE SERVICES AND AUXILIARY AIDS AND SERVICES

Deitsch (Pennsylvania Dutch):
LET OP: als je Nederlands spreekt, zijn er gratis taalhulpdiensten voor je beschikbaar. Passende hulpmiddelen en diensten om informatie in toegankelijke formaten te verstrekken, zijn ook gratis beschikbaar. Bell 1-608-828-4853 or 1-800-605-4327, ext. 4504 (TTY: 1-608-828-4815) of spreek met je provider.

العربيّة (Arabic):
تنبيه: إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر وسائل مساعدة وخدمات مناسبة لتوفير المعلومات بتنسيقات يمكن الوصول إليها مجانا. اتصل على الرقم (TTY: 1-608-828-4815) -1-800-605-4327, ext 4504; 1-608-828-4853- أو تحدث إلى مقدم الخدمة

Polski (Polish):
UWAGA: Osoby mówiące po polsku mogą skorzystać z bezpłatnej pomocy językowej. Dodatkowe pomoce i usługi zapewniające informacje w dostępnych formatach są również dostępne bezpłatnie. Zadzwoń pod numer 1-608-828-4853 or 1-800-605-4327, ext. 4504 (TTY: 1-608-828-4815) lub porozmawiaj ze swoim dostawcą.

Français (French):
ATTENTION : Si vous parlez Français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 1-608-828-4853 or 1-800-605-4327, ext. 4504 (TTY: 1-608-828-4815) ou parlez à votre fournisseur.

हिंदी (Hindi):
ध्यान दें: यदि आप हिंदी बोलते हैं, तो आपके लिए निःशुल्क भाषा सहायता सेवाएं उपलब्ध होती हैं। सुलभ प्रारूपों में जानकारी प्रदान करने के लिए उपयुक्त सहायक साधन और सेवाएँ भी निःशुल्क उपलब्ध हैं।1-608-828-4853 or 1-800-605-4327, ext. 4504 (TTY: 1-608-828-4815) पर कॉल करें या अपने प्रदाता से बात करें।

한국어 (Korean):
주의: [한국어]를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. 1-608-828-4853 or 1-800-605-4327, ext. 4504 (TTY: 1-608-828-4815) 번으로 전화하거나 서비스 제공업체에 문의하십시오.

Shqip (Albanian):
VINI RE: Nëse flisni [shqip], shërbime falas të ndihmës së gjuhës janë në dispozicion për ju. Ndihma të përshtatshme dhe shërbime shtesë për të siguruar informacion në formate të përdorshme janë gjithashtu në dispozicion falas.Telefononi 1-608-828-4853 or 1-800-605-4327, ext. 4504 (TTY: 1-608-828-4815) ose bisedoni me ofruesin tuaj të shërbimit.

Tagalog (Tagalog – Filipino):
PAALALA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyong tulong sa wika. Magagamit din nang libre ang mga naaangkop na auxiliary na tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 1-608-828-4853 or 1-800-605-4327, ext. 4504 (TTY: 1-608-828-4815) o makipag-usap sa iyong provider.

Soomaali (Somali):
FIIRO GAAR AH: Haddaad ku hadasho Soomaali, adeegyo kaalmada luuqadda ah oo bilaash ah ayaad heli kartaa. Qalab caawinaad iyo adeegyo oo habboon si loogu bixiyo macluumaadka qaabab la adeegsan karo ayaa sidoo kale bilaa lacag heli karaa. Wac 1-608-828-4853 or 1-800-605-4327, ext. 4504 (TTY: 1-608-828-4815) ama la hadal bixiyahaaga.