

**Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services**

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 <a href="#">deductible</a> ?	For In-Network Providers <b>\$0</b> ; For Out-of-Network Providers <b>\$250/Individual</b> or <b>\$500/Family</b>	See the Common Medical Events chart below for your costs for services this <a href="#">plan</a> covers.
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. Complementary Medicine, Preventive Care, Certain Office Visits, and Pharmacy Drugs are covered before the deductible is met. Office Visit Copayments are waived for children under age 19.	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other <a href="#">deductibles</a> for specific services?	No.	You don't have to meet <a href="#">deductibles</a> for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	For In-Network Providers <b>\$6,600/Individual</b> or <b>\$13,200/Family</b> ; For Out-of-Network Providers <b>\$1,250/Individual</b> or <b>\$2,500/Family</b>	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members on this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
What is not included in the <a href="#">out-of-pocket limit</a> ?	<a href="#">Copayments</a> on certain services, <a href="#">premiums</a> , <a href="#">balance-billing charges</a> , infertility services, and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See <a href="http://www.ghcsw.com">www.ghcsw.com</a> or call 1-800-605-4327 for a list of <a href="#">network providers</a> .	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance-billing</a> ). Be aware your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	Yes.	This <a href="#">plan</a> will pay some or all of the costs to see a <a href="#">specialist</a> for covered services but only if you have a <a href="#">referral</a> before you see the <a href="#">specialist</a> .

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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)	
<b>If you visit a health care <a href="#">provider's office</a> or clinic</b>	Primary care visit to treat an injury or illness	\$20	20% after Deductible	Example: Office visits with Your Primary Care Provider (PCP)
	<a href="#">Specialist visit</a>	\$20	20% after Deductible	Prior authorization is required. Examples: Specialist Hearing Exams, Autism Spectrum Specialist Office Visit
	<a href="#">Preventive care/screening/immunization</a>	No Charge	20% after Deductible	Coverage is limited to USPSTF guidelines and Women's Preventive Health
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	No Charge after Deductible	No Charge after Deductible	Prior authorization is required. Examples: Lab tests, blood work, or x-rays ordered by Your Provider; Prior Authorization is not required when routine labs and x-rays are performed at Your Primary Care Provider's clinic
	Imaging (CT/PET scans, MRIs)	No Charge after Deductible	No Charge after Deductible	Prior authorization is required. Examples: CT, PET Scans, MRIs
<b>If you need drugs to treat your illness or condition</b> 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 <b>(Tier 1)</b>	\$6	Not Covered	Covers up to a 30-day supply; 31-90 day supply available for multiple Copays - subject to a maximum cost limit
	Preferred brand drugs <b>(Tier 2)</b>	\$15	Not Covered	Covers up to a 30-day supply; 31-90 day supply available for multiple Copays - subject to a maximum cost limit
	Non-preferred brand drugs <b>(Tier 3)</b>	Not Covered	Not Covered	Not Covered
	<a href="#">Specialty drugs</a> <b>(Tier 4)</b>	\$15	Not Covered	Covers up to a 30-day supply; 31-90 day supply not available
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	No Charge after Deductible	20% after Deductible	Prior authorization is required.

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

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	Physician/surgeon fees	No Charge after Deductible	20% after Deductible	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>	\$150	\$150	Coverage is limited to emergency care; Copayment waived if admitted as a hospital inpatient
	<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>	\$20	\$20	
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	No Charge after Deductible	20% after Deductible	Prior authorization is required.
	Physician/surgeon fees	No Charge after Deductible	20% after Deductible	Prior authorization is required.
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	\$20	20% after Deductible	Prior authorization is required. Prior Authorization is not required when services are provided at a GHC-SCW Clinic or at UW Health Behavioral Health and Recovery Clinic
	Inpatient services	No Charge after Deductible	20% after Deductible	Prior authorization is required.
<b>If you are pregnant</b>	Office visits	No Charge	20% after Deductible	Coverage is limited to USPSTF guidelines and Women's Preventive Health
	Childbirth/delivery professional services	No Charge after Deductible	20% after Deductible	Prior authorization is required.
	Childbirth/delivery facility services	No Charge after Deductible	20% after Deductible	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	20% after Deductible	Prior authorization is required. Limited to 60 visits per Member per year

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		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	<a href="#">Rehabilitation services</a>	No Charge after Deductible	20% after Deductible	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
	<a href="#">Habilitation services</a>	No Charge after Deductible	20% after Deductible	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	20% after Deductible	Prior authorization is required. Limited to 30 days per inpatient stay per Member
	<a href="#">Durable medical equipment</a>	20%	20% after Deductible	Prior authorization is required. See Certificate for additional Limitations and Exclusions
	<a href="#">Hospice services</a>	No Charge after Deductible	20% after Deductible	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	Not Covered	Vision examinations must be provided by an In-Network Provider; Limited to one eye exam per Member per year
	Children's glasses	Not Covered	Not Covered	Not Covered
	Children's dental check-up	Not Covered	Not Covered	Not Covered

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

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

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

- Acupuncture
- Infertility Treatment (specific procedures and services at In-Network facilities only)
- Chiropractic Care
- Routine Eye Care (Adult)
- 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: GHC-SCW Member Services at 1-800-605-4327 or Wisconsin's Office of the Commissioner of Insurance at 1-800- 236-8517 or 608-266-0103. 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**

If you don't have [Minimum Essential Coverage](#) for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

**Does this plan meet the Minimum Value Standards? Yes**

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](#).

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----- 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)	Managing Joe's type 2 Diabetes (a year of routine in-network care of a well-controlled condition)	Mia's Simple Fracture (in-network emergency room visit and follow up care)
<ul style="list-style-type: none"> <li>The plan's overall deductible -- \$0</li> <li>Specialist -- \$20</li> <li>Hospital (facility) -- No Charge after Deductible</li> <li>Other -- 0%</li> </ul>	<ul style="list-style-type: none"> <li>The plan's overall deductible -- \$0</li> <li>Specialist -- \$20</li> <li>Hospital (facility) -- No Charge after Deductible</li> <li>Other -- 0%</li> </ul>	<ul style="list-style-type: none"> <li>The plan's overall deductible -- \$0</li> <li>Specialist -- \$20</li> <li>Hospital (facility) -- No Charge after Deductible</li> <li>Other -- 0%</li> </ul>
<b>This EXAMPLE event includes services like:</b>	<b>This EXAMPLE event includes services like:</b>	<b>This EXAMPLE event includes services like:</b>
Specialist office visits (prenatal care)	Primary care physician office visits (including disease education)	Emergency room care (including medical supplies)
Childbirth/Delivery Professional Services	Diagnostic tests (blood work)	Diagnostic test (x-ray)
Childbirth/Delivery Facility Services	Prescription drugs	Durable medical equipment (crutches)
Diagnostic tests (ultrasounds and blood work)	Durable medical equipment (glucose meter)	Rehabilitation services (physical therapy)
Specialist visit (anesthesia)		
<b>Total Example Cost -- \$12,800.00</b>	<b>Total Example Cost -- \$7,400.00</b>	<b>Total Example Cost -- \$1,930.00</b>
<b>In this example, Peg would pay:</b>	<b>In this example, Joe would pay:</b>	<b>In this example, Mia would pay</b>
<i>Cost sharing</i>	<i>Cost sharing</i>	<i>Cost sharing</i>
Deductibles \$0	Deductibles \$0	Deductibles \$0
Copayments \$50.00	Copayments \$490.00	Copayments \$190.00
Coinsurance \$0	Coinsurance \$250.00	Coinsurance \$50.00
<i>What isn't covered</i>	<i>What isn't covered</i>	<i>What isn't covered</i>
Limits or exclusions -- \$10.00	Limits or exclusions -- \$20.00	Limits or exclusions -- \$0
<b>The total Peg would pay is -- \$60.00</b>	<b>The total Joe would pay is -- \$760.00</b>	<b>The total Mia would pay is -- \$240.00</b>

\*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. 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).