Group Health Cooperative of South Central Wisconsin

# $20 Copayment $100 Deductible Plan

Plan Number: 2201815
Benefits Accumulate on a Calendar Year.

*Policy Coinsurance*
In-Network: 0%
Out-of-Network: Not Covered

| | MEMBER | FAMILY |
|---|---|---|
| In-Network Deductible | $100 | $200 |
| Out-of-Network Deductible | Not Covered | Not Covered |
| In-Network Maximum Out-of-Pocket (MOOP) | $6,600 | $13,200 |
| Out-of-Network Maximum Out-of-Pocket (MOOP) | Not Covered | Not Covered |

| Clinic Services | Prior Auth | You Pay In-Network | You Pay Out-of-Network | Benefit Notes |
|---|---|---|---|---|
| Primary Care Office Visits | No | $20 | Not Covered | Example: Office visits with Your Primary Care Provider (PCP) |
| Chiropractic Office Visits | No | $20 | Not Covered | |
| Preventive Health Examinations | No | No Charge | Not Covered | Coverage is limited to USPSTF guidelines and Women's Preventive Health |
| Specialist Care Office Visits | Yes | $20 | Not Covered | Examples: Specialist Hearing Exams, Autism Spectrum Specialist Office Visit |
| Preventive Immunizations | No | No Charge | Not Covered | Coverage is limited to USPSTF guidelines and Women's Preventive Health |
| Prenatal and Postnatal Maternity Care | No | No Charge | Not Covered | Coverage is limited to USPSTF guidelines and Women's Preventive Health |
| Diagnostic X-Ray and Laboratory Tests | Yes | No Charge after Deductible | Not Covered | 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 |
| Advanced Radiology | Yes | No Charge after Deductible | Not Covered | Examples: CT, PET Scans, MRIs |
| **Emergency and Urgent Care** | **Prior Auth** | **You Pay In-Network** | **You Pay Out-of-Network** | **Benefit Notes** |
| Urgent Care Visits | No | $20 | $20 | |
| Emergency Ambulance Service (air/ground) | No | No Charge after Deductible | No Charge after Deductible | Coverage is limited to emergency care |
| Emergency Room Visits | No | $150 | $150 | Coverage is limited to emergency care; Copayment waived if admitted as a hospital inpatient |
| **Prescription Drugs** | **Tier** | **You Pay In-Network** | **You Pay Out-of-Network** | **Benefit Notes** |
| Outpatient Prescription Drugs on GHC-SCW Formulary<br><br>Prior Authorizations, quantity limits, step therapy, age restrictions and other limits may apply | Tier 1 | $6 | Not Covered | Covers up to a 30-day supply; 31-90 day supply available for multiple Copays - subject to a maximum cost limit; Some brand names and many generics; Drugs in Tier 1 are the greatest value |
| | Tier 2 | $15 | Not Covered | Covers up to a 30-day supply; 31-90 day supply available for multiple Copays - subject to a maximum cost limit; Many brand names and some generics |
| | Tier 3 | Not Covered | Not Covered | Tier 3 Outpatient Prescription Drugs are not covered for this plan |
| | Tier 4 (Specialty) | $30 | Not Covered | Covers up to a 30-day supply; 31-90 day supply not available; May require the use of a specialty-designated pharmacy |
| *The Prescription Drugs Benefit is administered by GHC-SCW Clinic pharmacies and Navitus. Prescription Drugs are NOT COVERED outside of the GHC-SCW network of providers. For a list of formulary drugs, tier ($) placement, prior authorization requirements and other limitations that may apply, see www.ghcscw.com.* | | | | |
| **Supplies and Equipment** | **Prior Auth** | **You Pay In-Network** | **You Pay Out-of-Network** | **Benefit Notes** |
| Diabetic Disposable Supplies | No | No Charge | Not Covered | |
| Durable Medical Equipment | Yes | No Charge | Not Covered | |
| Hearing Aids for Members age 18 and over | Yes | 20% | Not Covered | Limited to one hearing aid per ear per 36 months; GHC-SCW coverage is for the basic model |

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In-Network: 0%
Out-of-Network: Not Covered

| | MEMBER | FAMILY |
|---|---|---|
| In-Network Deductible | $100 | $200 |
| Out-of-Network Deductible | Not Covered | Not Covered |
| In-Network Maximum Out-of-Pocket (MOOP) | $6,600 | $13,200 |
| Out-of-Network Maximum Out-of-Pocket (MOOP) | Not Covered | Not Covered |

| Supplies and Equipment | Prior Auth | You Pay In-Network | You Pay Out-of-Network | Benefit Notes |
|---|---|---|---|---|
| Hearing Aids for children age 17 and under | Yes | 20% | Not Covered | Limited to one hearing aid per ear per 36 months; GHC-SCW coverage is for the basic model |
| Cochlear Implants and Bone Anchored Hearing Aids | Yes | No Charge after Deductible | Not Covered | |
| **Hospital Services** | **Prior Auth** | **You Pay In-Network** | **You Pay Out-of-Network** | **Benefit Notes** |
| Inpatient Hospital Services: Physician Services, Surgery, Facility Fees | Yes | No Charge after Deductible | Not Covered | |
| Outpatient Hospital Surgical/Non-Surgical Services, Facility Fees | Yes | No Charge after Deductible | Not Covered | Certain oral surgeries do not require Prior Authorization |
| Skilled Nursing Facility Services | Yes | No Charge after Deductible | Not Covered | Limited to 30 days per inpatient stay per Member |
| **Vision Services** | **Prior Auth** | **You Pay In-Network** | **You Pay Out-of-Network** | **Benefit Notes** |
| Vision Examinations | No | 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 |
| **Mental Health & Substance Use Disorder** | **Prior Auth** | **You Pay In-Network** | **You Pay Out-of-Network** | **Benefit Notes** |
| Mental Health/Substance Use Disorder Outpatient Services | Yes | $20 | Not Covered | Prior Authorization is not required when services are provided at a GHC-SCW Clinic or at UW Health Behavioral Health and Recovery Clinic |
| Mental Health/Substance Use Disorder Inpatient Services | Yes | No Charge after Deductible | Not Covered | |
| Mental Health/Substance Use Disorder Transitional Services | Yes | No Charge after Deductible | Not Covered | |
| **Complementary Medicine Services** | **Prior Auth** | **You Pay In-Network** | **You Pay Out-of-Network** | **Benefit Notes** |
| Acupuncture (Initial Visit) | No | $83 | Not Covered | $53 per visit for follow up visits of Acupuncture; Coverage at GHC-SCW Clinics only |
| Naturopathy (Initial Visit) | No | $75 | Not Covered | $45 per visit for follow up visits of Naturopathy; Coverage at GHC-SCW Clinics only |
| Massage Therapy | No | $53 | Not Covered | 60-minute session; Coverage at GHC-SCW Clinics only |
| Massage Therapy | No | $33 | Not Covered | 30-minute session; Coverage at GHC-SCW Clinics only |
| Reiki Therapy | No | $53 | Not Covered | 60-minute session; Coverage at GHC-SCW Clinics only |
| **Dental Services** | **Prior Auth** | **You Pay In-Network** | **You Pay Out-of-Network** | **Benefit Notes** |
| Preventive Dental Cleanings | No | No Charge | Not Covered | Preventive Dental Cleanings for Members (all ages) twice per year; Fluoride treatments for children age 15 and under twice per year |
| Accidental Dental | No | No Charge after Deductible | Not Covered | Initial repair of accidental injury to sound, natural teeth |
| Oral Surgeries | Yes | No Charge after Deductible | Not Covered | Certain oral surgeries do not require Prior Authorization |

Group Health Cooperative of South Central Wisconsin

# $20 Copayment $100 Deductible Plan

Plan Number: 2201815
Benefits Accumulate on a Calendar Year.

*Policy Coinsurance*
In-Network: 0%
Out-of-Network: Not Covered

| | MEMBER | FAMILY |
|---|---|---|
| In-Network Deductible | $100 | $200 |
| Out-of-Network Deductible | Not Covered | Not Covered |
| In-Network Maximum Out-of-Pocket (MOOP) | $6,600 | $13,200 |
| Out-of-Network Maximum Out-of-Pocket (MOOP) | Not Covered | Not Covered |

| Additional Services | Prior Auth | You Pay In-Network | You Pay Out-of-Network | Benefit Notes |
|---|---|---|---|---|
| Hospice | Yes | No Charge after Deductible | Not Covered | Example: End of Life Services |
| Home Health Services | Yes | No Charge after Deductible | Not Covered | Limited to 60 visits per Member per year |
| Health Counseling Education | No | No Charge | Not Covered | Coverage is limited to USPSTF guidelines and Women's Preventive Health |
| Infertility Services | No | 50% up to maximum | Not Covered | Lifetime Benefit maximum payment of $2,000 by GHC-SCW, which is accrued by GHC-SCW paying 50% Coinsurance of the first $4,000 of Infertility Services |
| Speech Therapy | Yes | No Charge after Deductible | Not Covered | Includes Rehabilitation and Habilitation Therapy; Limited to 20 visits per therapy per Member per year |
| Outpatient Habilitation Therapy | Yes | No Charge after Deductible | Not Covered | Includes Physical and Occupational Therapy; Limited to 40 combined visits per Member per year; See Certificate for additional information |
| Cardiac Rehabilitation Therapy | Yes | No Charge after Deductible | Not Covered | Limited to 36 visits per Member per year |
| Outpatient Rehabilitation Therapy | Yes | No Charge after Deductible | Not Covered | Includes Physical and Occupational Therapy; Limited to 40 combined visits per Member per year; See Certificate for additional information |

## Benefit Summary Notes

**Office Visit Copayments are waived for children under age 19.**

Prior Authorizations

- Prior Authorization is required when services are not provided in a primary care setting by an In-Network Provider. Call (608) 257-5294 for Prior Authorization. Failure to obtain Prior Authorization when required will result in the Member receiving a lesser or no Benefit. Please refer to www.ghcscw.com and your Member Certificate for a list of specific Benefits that require Prior Authorization.

Provider Information

- For Providers see the *"Find a Provider"* link at www.ghcscw.com or contact Member Services at (608) 828-4853 or (800) 605-4327, ext. 4504.
- *In-Network Providers:* For a list of In-Network Providers, see the *"Find a Provider"* link at www.ghcscw.com or contact Member Services at (608) 828-4853 or (800) 605-4327, ext. 4504.
- *Out-of-Network Providers:* Out-of-Network Providers are not covered under an HMO plan, unless Prior Authorization has been acquired for such services.

GHC-SCW Notices to Members

- Qualified Maximum Dependent Age: Dependents are covered until the end of the month at age 26.
- This is only a summary. You are responsible for knowing the full Benefits and provisions of your policy. Please read all documents carefully including your *Member Certificate, Formulary, Benefit Summary and Summary of Benefits and Coverage (SBC).* To find these documents, visit www.ghcscw.com or contact Member Services at (608) 828-4853 or (800) 605-4327, ext. 4504.

Questions or Concerns?

- For any questions or concerns regarding your benefits, please visit www.ghcscw.com, or contact Member Services at (608) 828-4853 or (800) 605-4327, ext. 4504.

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$20 Copayment $100 Deductible Plan

**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? | **$100/Individual** or **$200/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. 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 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? | **$6,600/Individual** or **$13,200/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? | Copayments on certain services, premiums, balance-billing charges, infertility 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 | $20 | Not Covered | Example: Office visits with Your Primary Care Provider (PCP) |
| | Specialist visit | $20 | Not Covered | Prior authorization is required. Examples: Specialist Hearing Exams, Autism Spectrum Specialist Office Visit |
| | Preventive care/screening/immunization | No Charge | Not Covered | Coverage is limited to USPSTF guidelines and Women's Preventive Health |
| **If you have a test** | Diagnostic test (x-ray, blood work) | No Charge after Deductible | Not Covered | 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 | 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)** | $6 | Not Covered | Covers up to a 30-day supply; 31-90 day supply available 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)** | $15 | Not Covered | Covers up to a 30-day supply; 31-90 day supply available for multiple Copays - subject to a maximum cost limit; Many brand names and some generics |
| | Non-preferred brand drugs **(Tier 3)** | Not Covered | Not Covered | Not Covered |
| | Specialty drugs **(Tier 4)** | $30 | 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) | No Charge after Deductible | Not Covered | Prior authorization is required. |
| | Physician/surgeon fees | No Charge 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 | $150 | $150 | Coverage is limited to emergency care; Copayment waived if admitted as a hospital inpatient |
| | Emergency medical transportation | No Charge after Deductible | No Charge after Deductible | Coverage is limited to emergency care |
| | Urgent care | $20 | $20 | |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | No Charge after Deductible | Not Covered | Prior authorization is required. |
| | Physician/surgeon fees | No Charge after Deductible | Not Covered | Prior authorization is required. |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | $20 | Not Covered | 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 | Not Covered | Prior authorization is required. |
| **If you are pregnant** | Office visits | No Charge | Not Covered | Coverage is limited to USPSTF guidelines and Women's Preventive Health |
| | Childbirth/delivery professional services | No Charge after Deductible | Not Covered | Prior authorization is required. |
| | Childbirth/delivery facility services | No Charge after Deductible | Not Covered | Prior authorization is required. |
| **If you need help recovering or have other special health needs** | Home health care | No Charge after Deductible | Not Covered | Prior authorization is required. Limited to 60 visits per Member per year |
| | Rehabilitation services | No Charge 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 | No Charge 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 | No Charge after Deductible | Not Covered | Prior authorization is required. Limited to 30 days per inpatient stay per Member |
| | Durable medical equipment | No Charge | Not Covered | Prior authorization is required. See Certificate for additional Limitations and Exclusions |
| | Hospice services | No Charge 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 | Not Covered | Not Covered | Not Covered |
| | Children's dental check-up | No Charge | Not Covered | Preventive Dental Cleanings for Members (all ages) twice per year; Fluoride treatments for children age 15 and under twice per year |

## 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)
- Bariatric surgery
- Cosmetic surgery
- Custodial Care
- Drug Screening
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Personal Comfort Items
- Private-Duty Nursing
- 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.)**

- Acupuncture
- Chiropractic Care
- Dental Care (Adult)
- Hearing Aids
- Infertility Treament (specific procedures and services at In-Network facilities only)
- Routine Eye Care (Adult)

**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? 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.

***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 -- $100
- Specialist [cost sharing] -- $20
- Hospital (facility) [cost sharing] -- No Charge after Deductible
- Other [cost sharing] -- 0%

**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 | $100.00 |
| Copayments | $20.00 |
| Coinsurance | $0 |

*What isn't covered*

Limits or exclusions -- $50.00

**The total Peg would pay is -- $170.00**

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

- The plan's overall deductible -- $100
- Specialist [cost sharing] -- $20
- Hospital (facility) [cost sharing] -- No Charge after Deductible
- Other [cost sharing] -- 0%

**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 | $100.00 |
| Copayments | $280.00 |
| Coinsurance | $0 |

*What isn't covered*

Limits or exclusions -- $20.00

**The total Joe would pay is -- $400.00**

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

- The plan's overall deductible -- $100
- Specialist [cost sharing] -- $20
- Hospital (facility) [cost sharing] -- No Charge after Deductible
- Other [cost sharing] -- 0%

**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 | $100.00 |
| Copayments | $170.00 |
| Coinsurance | $0 |

*What isn't covered*

Limits or exclusions -- $10.00

**The total Mia would pay is -- $280.00**

*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. 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)] 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 ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. 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).