Group Health Cooperative of South Central Wisconsin

$2,000 Deductible 0% Coinsurance 4-Tier Rx HMO Plan

Plan Number: 2101863
Benefits Accumulate on a Plan Year.

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

	MEMBER	FAMILY
In-Network Deductible	$2,000	$4,000
Out-of-Network Deductible	Not Covered	Not Covered
Medical In-Network Maximum Out-of-Pocket (MOOP)	$4,850	$9,700
Pharmacy In-Network Maximum Out-of-Pocket (MOOP)	$1,500	$3,000
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
Diabetic Disposable Supplies	No	20% up to maximum	Not Covered	Applies to Pharmacy Maximum Out-of-Pocket; Member pays Coinsurance up to $500 maximum
Durable Medical Equipment	Yes	20%	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 only
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 only
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	Vision examinations must be provided by an In-Network Provider; 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	No Charge after Deductible	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	$79	Not Covered	$49 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	$49	Not Covered	60-minute session; Coverage at GHC-SCW Clinics only
Massage Therapy	No	$29	Not Covered	30-minute session; Coverage at GHC-SCW Clinics only
Reiki Therapy	No	$49	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
Accidental Dental	No	No Charge after Deductible	Not Covered	Initial repair of accidental injury to sound, natural teeth
Oral Surgeries	Yes	No Charge after	Not Covered	Certain oral surgeries do not require Prior

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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	No Charge after Deductible	Not Covered	Example: Office visits with Your Primary Care Provider (PCP)
Chiropractic Office Visits	No	No Charge after Deductible	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	No Charge after Deductible	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	No Charge after Deductible	No Charge after Deductible	
Emergency Ambulance Service (air/ground)	No	No Charge after Deductible	No Charge after Deductible	Coverage is limited to emergency care
Emergency Room Visits	No	$100	$100	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 Prior Authorizations, quantity limits, step therapy, age restrictions and other limits may apply	Tier 1	$10	Not Covered	Applies to Pharmacy Maximum Out-of-Pocket; 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	$20	Not Covered	Applies to Pharmacy Maximum Out-of-Pocket; 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	$30	Not Covered	Applies to Pharmacy Maximum Out-of-Pocket; 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
	Tier 4 (Specialty)	$30	Not Covered	Applies to Pharmacy Maximum Out-of-Pocket; 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

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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

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.