
 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, contact ETF at [www.etf.wi.gov](http://www.etf.wi.gov). For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other terms see the Glossary. You can view the Glossary at <https://www.healthcare.gov/glossary/essential-health-benefits/> or call 1-877-533-5020 to request a copy.

Important Questions	Answers	Why This Matters:
<p><b>What is the overall <a href="#">deductible</a>?</b></p>	<p>\$250 individual / \$500 family</p>	<p>You must pay all the costs up to the <a href="#">deductible</a> amount before the policy begins to pay for covered services you use, with the exceptions of office visit <a href="#">copays</a> and for federally required preventive services. The <a href="#">deductible</a> starts over with each plan year beginning on January 1<sup>st</sup>. See the chart starting on page 2 for your costs for services this plan covers.</p>
<p><b>Are there services covered before you meet your <a href="#">deductible</a>?</b></p>	<p>Yes. <a href="#">Preventive care</a> and primary care services are covered before you meet your <a href="#">deductible</a>.</p>	<p>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>.</p>
<p><b>Are there other <a href="#">deductibles</a> for specific services?</b></p>	<p>No.</p>	<p>There are no other <a href="#">deductibles</a>.</p>
<p><b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b></p>	<p><u>Medical:</u> \$1,250 individual/\$2,500 family <u>Prescription drug:</u> Level 1 and 2: \$600 individual/\$1,200 family Level 4: \$1,200 individual/\$2,400 family</p>	<p>The <a href="#">out-of-pocket limit</a> is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses. The federal <a href="#">maximum out-of-pocket</a> is \$6,850 individual/\$13,700 family. This applies to all essential health benefits, including some services not included in the <a href="#">out-of-pocket limit</a>. (i.e. certain level 3 &amp; 4 prescription drugs and certain hearing aids covered under this plan). See <a href="https://www.healthcare.gov/glossary/essential-health-benefits/">https://www.healthcare.gov/glossary/essential-health-benefits/</a> for details.</p>
<p><b>What is not included in the <a href="#">out-of-pocket limit</a>?</b></p>	<p><a href="#">Copays</a> for Level 3 and Level 4 <a href="#">non-preferred specialty drugs</a>; <a href="#">coinsurance</a> paid by adults for hearing aids, premiums and health care this plan doesn't cover.</p>	<p>Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a>.</p>

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

<p>Will you pay less if you use a <a href="#">network provider</a>?</p>	<p>Yes. See <a href="http://www.ghcscw.com">www.ghcscw.com</a> or call 1-800-605-4327 for a list of <a href="#">network providers</a>.</p>	<p>This <a href="#">plan</a> uses a provider <a href="#">network</a>. You will pay less if you use a <a href="#">provider</a> in the plan's <a href="#">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 provider's 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.</p>
<p>Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a>?</p>	<p>Yes.</p>	<p>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>.</p>

 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)	
<b>If you visit a health care <a href="#">provider's</a> office or clinic</b>	Primary care visit to treat an injury or illness	\$15 <a href="#">copay</a> /visit	Not covered	<a href="#">Deductible</a> does not apply. Additional services (e.g. labs, x-rays, etc.) during the visit are subject to applicable <a href="#">deductibles</a> and <a href="#">coinsurance</a> .
	<a href="#">Specialist</a> visit	\$25 <a href="#">copay</a> /visit	Not covered unless prior-authorized	<a href="#">Deductible</a> does not apply. Additional services (e.g. labs, x-rays, etc.) during the visit are subject to applicable <a href="#">deductibles</a> and <a href="#">coinsurance</a> .
	Other practitioner office visit	\$15 <a href="#">copay</a> /visit (includes chiropractic visits)	Not covered	<a href="#">Deductible</a> does not apply. Maintenance care and acupuncture not covered. Additional services (e.g. labs, x-rays, etc.) during the visit are subject to applicable <a href="#">deductibles</a> and <a href="#">coinsurance</a> .
	<a href="#">Preventive care/screening/immunization</a>	\$15 primary care visit <a href="#">copay</a> and 10% <a href="#">coinsurance</a> after <a href="#">deductible</a> for related services.	Not Covered	Full coverage if required by federal law. For details visit: <a href="https://www.healthcare.gov/preventive-care-benefits/">https://www.healthcare.gov/preventive-care-benefits/</a>
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	10% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Not covered	Full coverage if required by federal law.
	Imaging (CT/PET scans, MRIs)	10% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Not covered	Prior approval required or benefits not payable.

\* For more information about limitations and exceptions, see the plan or policy document at [www.etf.wi.gov](http://www.etf.wi.gov)

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 need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.navitus.com">www.navitus.com</a>	Level 1: Preferred generic drugs and certain lower cost preferred brand name drugs	\$5/prescription to <a href="#">out-of-pocket limit</a> . (2 <a href="#">copays</a> apply to certain 90-day supply mail orders)	Not covered	<a href="#">In-network</a> covers most up to a 30-day supply (90-day for certain prescriptions) retail and mail order. <a href="#">Out-of-network</a> care allowed but if your ID card is not used, you will pay more than the copay.
	Level 2: <a href="#">Preferred</a> brand drugs and certain higher cost preferred generic drugs	20% <a href="#">coinsurance</a> (\$50 max) per prescription to <a href="#">out-of-pocket limit</a> . (2 <a href="#">copays</a> apply to certain 90-day supply mail order)	Not covered	<a href="#">In-network</a> covers most up to a 30-day supply (90-day for certain prescriptions) retail and mail order. <a href="#">Out-of-network</a> care allowed but if your ID card is not used, you will pay more than the copay.
	Level 3: <a href="#">Non-preferred</a> brand name and certain high cost generic drugs	40% <a href="#">coinsurance</a> (\$150 max) per prescription. No <a href="#">out-of-pocket limit</a> .	Not covered	Federal <a href="#">out-of-pocket limit</a> applies. <a href="#">Out-of-network</a> care allowed, but if your ID card is not used, you will pay more than the copay.
	Level 4*: <a href="#">Specialty drugs</a>	\$50 <a href="#">copay</a> * per prescription for drugs to specialty <a href="#">out-of-pocket limit</a> .	Not covered	Level 4 prescriptions must be filled at Lumicera or UW Specialty Pharmacy*.  Level 4 Out-of-Pocket Limit and Federal <a href="#">maximum out-of-pocket</a> applies.  *Non-Medicare participants only.
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	10% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Not covered	-----NONE-----
	Physician/surgeon fees	\$15 <a href="#">copay</a> for primary doctor office visit  \$25 <a href="#">copay</a> for <a href="#">specialist</a> office visit	Not covered	Additional services provided (e.g. costs of surgery, equipment, etc.) are subject to applicable <a href="#">deductible</a> and <a href="#">coinsurance</a> . Prior approval required for low back surgeries and MRI, CT and PET scans.
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	\$75 <a href="#">copay</a> , <a href="#">deductible</a> then 10% <a href="#">coinsurance</a>	\$75 <a href="#">copay</a> , <a href="#">deductible</a> then 10% <a href="#">coinsurance</a>	<a href="#">Copay</a> is waived if admitted.
	<a href="#">Emergency medical transportation</a>	10% <a href="#">coinsurance</a> after <a href="#">deductible</a>	10% <a href="#">coinsurance</a> after <a href="#">deductible</a>	-----NONE-----
	<a href="#">Urgent care</a>	\$25 <a href="#">copay</a> /visit	\$25 <a href="#">copay</a> /visit	<a href="#">Deductible</a> does not apply. Additional services (e.g. labs, x-rays, etc.) during the visit are subject to applicable <a href="#">deductibles</a> and <a href="#">coinsurance</a> .

\* For more information about limitations and exceptions, see the plan or policy document at [www.etf.wi.gov](http://www.etf.wi.gov)

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 have a hospital stay</b>	Facility fee (e.g., hospital room)	10% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Not covered	Prior approval recommended
	Physician/surgeon fees	10% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Not covered	Prior approval required for low back surgeries and MRI, CT and PET scans
<b>If you need mental health, behavioral health, or substance abuse services</b>	Mental/Behavioral health outpatient services	\$15 <a href="#">copay</a> /visit	Not covered	<a href="#">Deductible</a> does not apply.
	Mental/Behavioral health inpatient services	10% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Not covered	-----NONE-----
	Substance use disorder outpatient services	\$15 <a href="#">copay</a> /visit	Not covered	<a href="#">Deductible</a> does not apply.
	Substance use disorder inpatient services	10% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Not covered	-----NONE-----
<b>If you are pregnant</b>	Office visits	\$15 <a href="#">copay</a> /visit	Not covered	<a href="#">Deductible</a> does not apply for copay visits. Deductible and 10% coinsurance apply if prenatal and/or postnatal care billed as a package. Full coverage if required by federal law.
	Childbirth/delivery professional services	10% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Not covered	-----NONE-----
	Childbirth/delivery facility services	10% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Not covered	-----NONE-----
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	10% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Not covered	Limited to 50 visits per year. Plan may approve 50 more per year.
	<a href="#">Rehabilitation services</a>	\$15 <a href="#">copay</a> /visit	Not covered	<a href="#">Deductible</a> does not apply. Physical, speech and occupational therapy limited to 50 visits per year, combined rehabilitation and habilitation services. Plan may approve 50 more per year.
	<a href="#">Habilitation services</a>	\$15 <a href="#">copay</a> /visit	Not covered	<a href="#">Deductible</a> does not apply. Physical, speech and occupational therapy limited to 50 visits per year, combined rehabilitation and habilitation services. Plan may approve 50 more per year.

\* For more information about limitations and exceptions, see the plan or policy document at [www.etf.wi.gov](http://www.etf.wi.gov)

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)	
	<a href="#">Skilled nursing care</a>	10% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Not covered	Facility coverage is limited to 120 days per benefit period.
	<a href="#">Durable medical equipment</a>	20% <a href="#">coinsurance</a> after <a href="#">deductible</a> (child's hearing aids 10%)	Not covered	Hearing aids (adults) plan maximum payment \$1,000 per ear every 3 years.
	<a href="#">Hospice services</a>	10% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Not covered	-----NONE-----
<b>If your child needs dental or eye care</b>	Children's eye exam	\$25 <a href="#">copay</a>	Not covered	<a href="#">Deductible</a> does not apply. Limited to one per individual per year. Contact lens fitting not covered. Full coverage if required by federal law.
	Children's glasses	Not covered	Not covered	Excluded service.
	Children's dental check-up	Not covered	Not covered	Excluded service.

#### 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](#).)

- |                     |  |                        |
|---------------------|--|------------------------|
| • Acupuncture       | • Infertility treatment                        | • Private duty nursing |
| • Bariatric surgery | • Long-term care                               | • Routine foot care    |
| • Cosmetic surgery  | • Non-emergency care when traveling outside US | • 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 | • Routine eye care, limited to one eye exam per calendar year by a plan provider |
| • Dental care, limited to certain oral surgical services and treatment of injuries |                |  |

**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: [insert State, HHS, DOL, and/or other applicable agency contact information]. 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 TTY 711 or ETF at 1-877-533-5020 or [www.etf.wi.gov](http://www.etf.wi.gov).

### 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](#).

### Language Access Services:

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).

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).

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)).

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).

رقم ( 1-608-828-4853 ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية هاتف الصم والبكم تتوافر لك بالمجان. اتصل برقم: (TTY: 1-608-828-4815) .

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 [телетайп: 1-608-828-4815].

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.

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).

Wann du [Deitsch (Pennsylvania German / Dutch)] schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: 1-608-828-4853 or 1-800-605-4327, ext. 4504, (TTY: 1-608-828-4815).



ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທ 1-608-828-4853 or 1-800-605-4327, ext. 4504, (TTY: 1-608-828-4815).

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).

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।

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).

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).

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*To see examples of how this plan might cover costs for a sample medical situation, see the next section.*

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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](#) \$250
- [Specialist](#) [*cost sharing*] \$25
- Hospital (facility) [*cost sharing*] 10%
- Other [*cost sharing*] 10%

**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*)

<b>Total Example Cost</b>	<b>\$12,731</b>
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$250
Copayments	\$300
Coinsurance	\$800
<i>What isn't covered</i>	
Limits or exclusions	\$10
<b>The total Peg would pay is</b>	<b>\$1,360</b>

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

- The [plan's](#) overall [deductible](#) \$250
- [Specialist](#) [*cost sharing*] \$25
- Hospital (facility) [*cost sharing*] 10%
- Other [*cost sharing*] 10%

**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*)

<b>Total Example Cost</b>	<b>\$7,389</b>
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$100
Copayments	\$300
Coinsurance	\$400
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Joe would pay is</b>	<b>\$800</b>

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

- The [plan's](#) overall [deductible](#) \$250
- [Specialist](#) [*cost sharing*] \$25
- Hospital (facility) [*cost sharing*] 10%
- Other [*cost sharing*] 10%

**This EXAMPLE event includes services like:**  
 Emergency room care (*including medical supplies*)  
 Diagnostic test (*x-ray*)  
 Durable medical equipment (*crutches*)  
 Rehabilitation services (*physical therapy*)

<b>Total Example Cost</b>	<b>\$1,925</b>
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$250
Copayments	\$100
Coinsurance	\$200
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$550</b>

## 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>.