



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 health care services. **NOTE: Information about the cost of this [plan](#) (called the [premium](#)) will be provided separately. This is only a summary.** Please read the FEHB Plan brochure (73-061) that contains the complete terms of this plan. **All benefits are subject to the definitions, limitations, and exclusions set forth in the FEHB Plan brochure.** Benefits may vary if you have other coverage, such as Medicare. 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 get the FEHB Plan brochure at <https://ghcscw.com/health-insurance/government-employees>, and view the Glossary at <https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/UG-Glossary-508-MM.pdf>. You can call 1-800-605-4327 to request a copy of either document.

Important Questions	Answers	Why this Matters:
What is the overall <a href="#">deductible</a> ?	\$1,000/Self Only \$2,000/Self Plus One \$2,000/Self and Family	If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. Primary Care Office Visits, Preventive Care, and Pharmacy Drugs are covered before the deductible is met.	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> ?	\$7,150/Self Only \$14,300/Self Plus One \$14,300/Self and Family	The <a href="#">out-of-pocket limit</a> , or catastrophic maximum, 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 <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="#">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.ghcscw.com">www.ghcscw.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 provider's charge and what your plan pays (balance billing). 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> .





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, plus you may be balance billed)	
<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	\$20	Not Covered	Example: Office visits with your Primary Care Provider (PCP)
	<a href="#">Specialist Visit</a>	\$40	Not Covered	Prior authorization is required. Examples: Specialist Hearing Exams, Autism Spectrum Specialist Office Visit; Most specialists do not require Prior Authorization
	<a href="#">Preventive care/screening/immunization</a>	No Charge	Not Covered	Coverage is limited to preventive services as defined by the Affordable Care Act.
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	20% 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)	20% after Deductible	Not Covered	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 (Tier 1)	\$5 per 30-day supply; \$15 per 90-day supply/ mail order	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. Mail-order: 90-day supply available for three Copays
	Preferred brand drugs (Tier 2)	\$20 per 30-day supply; \$60 per 90-day supply/ mail order	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. Mail-order: 90-day supply available for three Copays
	Non-preferred brand drugs (Tier 3)	\$50 per 30-day supply; \$150 per 90-day supply/ mail order	Not Covered	Covers up to a 30-day supply; 31-90 day supply sometimes not available; There are often similar or equivalent drugs in either Tier 1 or Tier 2. Mail-order: 90-day supply available for three Copays
	<a href="#">Specialty drugs</a> (Tier 4)	\$100 per 30-day supply; \$300 per 90-day supply/ mail order	Not Covered	Covers up to a 30-day supply; 31-90 day supply usually not available; May require the use of a specialty-designated pharmacy. Mail-order: 90-day supply available for three Copays

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, plus you may be balance billed)	
<b>If you have outpatient surgery</b>	Facility Fee (e.g., ambulatory surgery center)	20% after Deductible	Not Covered	Prior authorization is required.
	Physician/surgeon fees	20% after Deductible	Not Covered	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>	\$100	\$100	Coverage is limited to emergency care; Copayment waived if admitted as a hospital inpatient
	<a href="#">Emergency medical transportation</a>	20% after Deductible	20% after Deductible	Coverage is limited to emergency care
	<a href="#">Urgent care</a>	\$40	\$40	Coverage is limited to treatment for an Urgent Condition
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	20% after Deductible	Not Covered	Prior authorization is required.
	Physician/surgeon fees	20% after Deductible	Not Covered	Prior authorization is required.
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	\$20	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	20% after Deductible	Not Covered	Prior authorization is required.
<b>If you are pregnant</b>	Office visits	No Charge	Not Covered	Coverage is limited to preventive services as defined by the Affordable Care Act. After the first postpartum care visit, postpartum care visits are \$20 per office visit
	Childbirth/delivery professional services	20% after Deductible	Not Covered	Prior authorization is required.
	Childbirth/delivery facility services	20% after Deductible	Not Covered	Prior authorization is required.

For more information about limitations and exceptions, see the FEHB Plan brochure 73-061 at <https://ghcscw.com/health-insurance/government-employees>.

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, plus you may be balance billed)	
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	20% after Deductible	Not Covered	Prior authorization is required. Limited to 60 visits per Member per year
	<a href="#">Rehabilitation services</a>	20% after Deductible	Not Covered	Prior authorization is required. Includes Physical, Occupational, and Speech Therapy; Limited to 60 visits per therapy per Member per year
	<a href="#">Habilitation services</a>	20% after Deductible	Not Covered	Prior Authorization is required. Includes Physical, Occupation, and Speech Therapy; Limited to 60 visits per therapy per Member per year
	<a href="#">Skilled nursing care</a>	20% after Deductible	Not Covered	Prior authorization is required. Limited to 30 days per inpatient stay per Member
	<a href="#">Durable medical equipment</a>	20%	Not Covered	Prior authorization is required.
	<a href="#">Hospice services</a>	20% after Deductible	Not Covered	Prior authorization is required. Example: End of Life Services
<b>If your child needs dental or eye care</b>	Children's eye exam	\$40	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 FEHB Plan brochure 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)
- Long-term care
- Private-Duty Nursing
- Acupuncture
- Custodial care
- Non-emergency care when traveling outside the U.S.
- Routine Foot Care
- Cosmetic surgery
- Drug Screening
- Personal Comfort Items
- Weight Loss programs

### Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your FEHB Plan brochure.)

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

**Your Rights to Continue Coverage:** You can get help if you want to continue your coverage after it ends. See the FEHB Plan brochure, contact your HR office/retirement system, contact your plan at [contact number] or visit [www.opm.gov/insure/health](http://www.opm.gov/insure/health). Generally, if you lose coverage under the plan, then, depending on the circumstances, you may be eligible for a 31-day free extension of coverage, a conversion policy (a non-FEHB individual policy), spouse equity coverage, or receive temporary continuation of coverage (TCC). 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:** If you are dissatisfied with a denial of coverage for claims under your [plan](#), you may be able to appeal. For information about your [appeal](#) rights please see Section 3, “How you get care,” and Section 8 “The disputed claims process,” in your FEHB Plan brochure. If you need assistance, you can 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**

[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.*

## 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](#) – \$1,000
- [Specialist](#) – \$40
- Hospital (facility) – 20% after Deductible
- Other – 20%

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:**

<i>Cost sharing</i>	
<a href="#">Deductibles</a>	\$1000.00
<a href="#">Copayments</a>	\$20.00
<a href="#">Coinsurance</a>	\$1520.00

*What isn't covered*

Limits or exclusions -- \$50.00

**The total Peg would pay is -- \$2590.00**

### Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

- The [plan's](#) overall [deductible](#) – \$1,000
- [Specialist](#) – \$40
- Hospital (facility) – 20% after Deductible
- Other – 20%

This EXAMPLE event includes services like:

[Primary care physician](#) (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:**

<i>Cost sharing</i>	
<a href="#">Deductibles</a>	\$110.00
<a href="#">Copayments</a>	\$310.00
<a href="#">Coinsurance</a>	\$500.00

*What isn't covered*

Limits or exclusions -- \$20.00

**The total Joe would pay is -- \$940.00**

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

- The [plan's](#) overall [deductible](#) – \$1,000
- [Specialist](#) – \$40
- Hospital (facility) – 20% after Deductible
- Other – 20%

This EXAMPLE event includes services like:

[Emergency room care](#) (including medical supplies)  
[Diagnostic tests](#) (x-ray)  
[Durable medical equipment](#) (crutches)  
[Rehabilitation services](#) (physical therapy)

**Total Example Cost -- \$2,800.00**

**In this example, Mia would pay:**

<i>Cost sharing</i>	
<a href="#">Deductibles</a>	\$1000.00
<a href="#">Copayments</a>	\$120.00
<a href="#">Coinsurance</a>	\$150.00

*What isn't covered*

Limits or exclusions -- \$10.00

**The total Mia would pay is -- \$1280.00**

## 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](mailto: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](mailto: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](https://ghcscw.com/SiteCollectionDocuments/Nondiscrimination_Notice_and_Language_Assistance_Services.pdf).

## 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).



**Deutsch (Pennsylvania Dutch):**

Wann du [Deutsch (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).