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 deductible?	$1,000/Self Only $2,000/Self Plus One $2,000/Self and 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. Primary Care Office Visits, Preventive Care, and Pharmacy Drugs are covered before the deductible is met.	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?	$7,150/Self Only $14,300/Self Plus One $14,300/Self and Family	The out-of-pocket limit, 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 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?	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.

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)	
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	$40	Not Covered	Prior authorization is required. Examples: Specialist Hearing Exams, Autism Spectrum Specialist Office Visit; Most specialists do not require Prior Authorization
	Preventive care/screening/ immunization	No Charge	Not Covered	Coverage is limited to preventive services as defined by the Affordable Care Act.
If you have a test	Diagnostic test (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
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at http://planfinder.ghcscw.com/	Preventive Drugs and Vaccines **(Tier 0)**	No Charge	Not Covered	Includes preventive drugs and vaccines that have no cost-sharing. Up to a 30-day or 31-90 day supply available.
	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

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)	
	DME and Diabetic Testing Supplies **(Tier 3)**	20%	Not Covered	Diabetic Testing Supplies: Member pays Coinsurance up to $500 maximum; DME: Member pays 20% Coinsurance
	Non-preferred brand drugs **(Tier 4)**	$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
	Specialty drugs **(Tier 5)**	$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
If you have outpatient surgery	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.
If you need immediate medical attention	Emergency room care	$100	$100	Coverage is limited to emergency care; Copayment waived if admitted as a hospital inpatient
	Emergency medical transportation	20% after Deductible	20% after Deductible	Coverage is limited to emergency care
	Urgent care	$40	$40	Coverage is limited to treatment for an Urgent Condition
If you have a hospital stay	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.

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)	
If you need mental health, behavioral health, or substance abuse services	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.
If you are pregnant	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.
If you need help recovering or have other special health needs	Home health care	20% after Deductible	Not Covered	Prior authorization is required. Limited to 60 visits per Member per year
	Rehabilitation services	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
	Habilitation services	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
	Skilled nursing care	20% after Deductible	Not Covered	Prior authorization is required. Limited to 30 days per inpatient stay per Member
	Durable medical equipment	20%	Not Covered	Prior authorization is required.

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)	
	Hospice services	20% 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	$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. 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 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.

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 FEHB Plan brochure 73-061 at https://ghcscw.com/health-insurance/government-employees.

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:

Cost sharing	
Deductibles	$1000.00
Copayments	$20.00
Coinsurance	$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:

Cost sharing	
Deductibles	$110.00
Copayments	$310.00
Coinsurance	$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

Cost sharing	
Deductibles	$1000.00
Copayments	$120.00
Coinsurance	$150.00
What isn't covered	
Limits or exclusions -- $10.00	

The total Mia would pay is -- $1280.00

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