This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at http://www.ghcscw.com or by calling 1-800-605-4327.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$0**	See the chart starting on page 2 for other costs for services this plan covers.
Are there other deductibles for specific services?	No	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses?	Yes. Medical: **$500** member/**$1,000** family. Prescription drug Level 1 and Level 2: **$410**/member **$820**/family. Formulary speciality drugs: **$1,000**/member **$2,000**/family.	The **out-of-pocket limit** 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.
What is not included in the out-of-pocket limit?	Emergency room, prescription drug Level 3 and non-formulary specialty drug copayments; coinsurance paid by adults for hearing aids, premiums, balanced-billed charges and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for specific covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of In-Network providers, see www.ghcscw.com or call 1-800-605-4327.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	Yes. Written Prior Authorization is required. To obtain Prior Authorization call (608) 257-5294.	This plan will pay some or all of the costs to see a specialist for covered services but only if you have the plan's permission before you see the specialist.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about excluded services. See your policy or plan document for information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use In-Network providers by charging you lower deductibles, copayments and coinsurance amounts.

Common Medical Events	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you visit a health care providers office or clinic	Primary care visit to treat an injury or illness	10% coinsurance	Not Covered	——————none——————
	Specialist Visit	10% coinsurance	Not Covered	Written Prior Authorization is required.
	Other practitioner office visit	10% coinsurance for Chiropractic care.	Not Covered	Maintenance care and acupuncture are not covered.
	Preventive care/screening/immunization	10% coinsurance	Not Covered	Full coverage if required by federal law.
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance	Not Covered	Full coverage if required by federal law.
	Imaging (CT/PET scans, MRIs)	10% coinsurance	Not Covered	Written Prior Authorization is required.

Common Medical Events	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More Information about Prescription drug coverage is available at www.ghcscw.com	Generic drugs	Level 1 Formulary generic drugs and certain low cost brand name drugs. **$5**/prescription to **out-of-pocket** limit. (2 copays apply to certain 90-day supply mail order.)	Not Covered	In-network covers most up to a 30 day supply (90-day for certain prescriptions) retail and mail order. Out-of-network emergency or urgent care allowed but if you ID card is not used, you may have to pay more than the copay.
	Preferred brand drugs	Level 2 Formulary brand name drugs and cerain high cost generic drugs. **$15**/prescription to out-of-pocket limit. (2 copays apply to certain 90-day supply mail order.)	Not Covered	In-network covers most up to a 30-day supply (90-day for certian prescriptions) retail and mail order. Out-of-network emergency or urgent care allowed but if your ID cards is not used, you may have to pay more than the copay.
	Non-preferred brand drugs	Level 3 Non-formulary prescription drugs $35/prescription.	Not covered	No **out-of-pocket limit**. Out-of-network emergency or urgent care allowed but if you ID card is not used, you may have to pay more than the copay.
	Specialty drugs	Preferred Provider: Formulary drugs to **out-of-pocket limit**; **$50** non-formulary no **out-of-pocket limit**. Non-Preferred Provider: **$50** formulary drugs to **out-of-pocket limit**; **$50** non-formulary no **out-of-pocket limit**.	Not Covered	Out-of-network emergency or urgent care allowed but if your ID card is not used, you may have to pay more than the copay.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	Not Covered	Written Prior Authorization is required.
	Physician/surgeon fees	10% coinsurance	Not Covered	Written Prior Authorization is required.
If you need immediate medical attention	Emergency room services	$75 copay/visit then 10% coinsurance	$75 copay/visit then 10% coinsurance	Copay does not apply to the out-of-pocket limit and is waived if admitted as a hospital inpatient.

Common Medical Events	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you need immediate medical attention	Emergency medical transportation	10% coinsurance	No charge	————————none————————
	Urgent care	10% coinsurance	10% coinsurance	-------none-------
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	Not Covered	Written Prior Authorization is required.
	Physician/surgeon fee	10% coinsurance	Not Covered	Written Prior Authorization is required.
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	10% coinsurance	Not Covered	Written Prior Authorization is required.
	Mental/Behavioral health inpatient services	10% coinsurance	Not Covered	Written Prior Authorization is required.
	Substance use disorder outpatient services	10% coinsurance	Not Covered	Written Prior Authorization is required.
	Substance use disorder inpatient services	10% coinsurance	Not Covered	Written Prior Authorization is required.
If you are pregnant	Prenatal and postnatal care	10% coinsurance	Not Covered	————————none————————
	Delivery and all inpatient services	10% coinsurance	Not Covered	Written Prior authorization is required.
If you need help recovering or have other special health needs	Home health care	10% coinsurance	Not Covered	Written Prior Authorization is required. Limited to 50 visits per year. An additional 50 visits may be auhorized.
	Rehabilitation services	10% coinsurance	Not Covered	Written Prior Authorization is required. Limited to 50 combined visits/member per calendar year. An additional 50 visits may be authorized.
	Habilitation services	Not Covered	Not Covered	-------none-------
	Skilled nursing care	10% coinsurance	Not Covered	Written Prior Authorization is required. Limited to 120 skilled days/member per benefit period.
	Durable medical equipment	20% coinsurance (child's hearing aids 10%)	Not Covered	Written Prior Authorization is required.
	Hospice service	10% coinsurance	Not Covered	Written Prior Authorization is required.
If your child needs dental or eye care	Eye exam	10% coinsurance	Not Covered	Full coverage if required by federal law. Limited to one per person per year. Vision examinations must be provided at GHC-SCW Optometry.
	Glasses	Not covered	Not Covered	-------none-------

Common Medical Events	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If your child needs dental or eye care	Dental check-up	No Charge	Not Covered	Services include cleanings twice per calendar year. Also covers exams, x-rays, and extractions for all ages. Includes fluoride treatments twice per calendar year for members through age 15. Topical application of sealants are covered through age 18 and space maintanance and steel crowns are covered for primary teeth. Composite fillings are covered for anterior teeth. Composite and Amalgam fillings for posterior teeth will be covered. Composite fillings for posterior teeth are subject to patient liability. Orthodontia is covered for eligible dependent children through age 18 at 50% of the first $3,500 of billed charges.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Bariatric Surgery
- Cosmetic Surgery
- Habilitation services
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the US
- Private duty nursing
- Routine eye care (glasses)
- Routine foot care
- Weight loss programs (except nutritional counseling)

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Chiropractic Care
- Dental Care
- Hearing Aids
- Routine Eye Care (exam)

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-800-605-4327.You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov

Your Grievance and Appeals Rights:

If you have a complaint, a grievance or are dissatisfied with the denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice or assistance, you may 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.

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

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby

(normal delivery)

- **Amount owed to providers**: $7,540
- **Plan pays**: $6,950
- **Patient pays**: $590

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$0
Copays	$0
Coinsurance	$590
Limits or exclusions	$0
Total	**$590**

Note: These numbers assume the patient has given notice of her pregnancy to the plan. If you are pregnant and have not given notice of your pregnancy, your costs may be higher. For more information, please contact: 1-800-605-4327.

Managing type 2 diabetes

(routine maintenance of a well-controlled condition)

- **Amount owed to providers** : $5,400
- **Plan pays** : $4,740
- **Patient pays** : $660

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$0
Copays	$410
Coinsurance	$250
Limits or exclusions	$0
Total	**$660**

Note: These numbers assume the patient is participating in our diabetes wellness program. If you have diabetes and do not participate in the wellness program, your costs may be higher. For more information about the diabetes wellness program, please contact: 1-800-605-4327.

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

No. Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

No. Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

Yes. When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

Yes. An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.