

Plan Number: 2203758
Benefits Accumulate on a
Calendar Year.

Policy Coinsurance

In-Network: 0%
Out-of-Network: 20%

	MEMBER	FAMILY
In-Network Deductible	\$100	\$200
Out-of-Network Deductible	\$250	\$500
In-Network Maximum Out-of-Pocket (MOOP)	\$6,600	\$13,200
Out-of-Network Maximum Out-of-Pocket (MOOP)	\$1,000	\$2,000

Clinic Services	Prior Auth	You Pay In-Network	You Pay Out-of-Network	Benefit Notes
Primary Care Office Visits	No	\$20	20% after Deductible	Example: Office visits with Your Primary Care Provider (PCP)
Chiropractic Office Visits	No	\$20	20% after Deductible	
Preventive Health Examinations	No	No Charge	20% after Deductible	Coverage is limited to USPSTF guidelines and Women's Preventive Health
Specialist Care Office Visits	No	\$20	20% after Deductible	Example: Specialist Hearing Exams
Preventive Immunizations	No	No Charge	20% after Deductible	Coverage is limited to USPSTF guidelines and Women's Preventive Health
Prenatal and Postnatal Maternity Care	No	No Charge	20% after Deductible	Coverage is limited to USPSTF guidelines and Women's Preventive Health
Diagnostic X-Ray and Laboratory Tests	Yes	No Charge after Deductible	No Charge after Deductible	Examples: Lab tests, blood work, or x-rays ordered by Your Provider; Prior Authorization is not required for routine labs and x-rays
Advanced Radiology	Yes	No Charge after Deductible	20% after Deductible	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	\$20	\$20	
Emergency Ambulance Service (air/ground)	No	No Charge after Deductible	No Charge after Deductible	Coverage is limited to emergency care
Emergency Room Visits	No	\$150	\$150	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	\$6	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
	Tier 2	\$15	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
	Tier 3	Not Covered	Not Covered	Tier 3 Outpatient Prescription Drugs are not covered for this plan
	Tier 4 (Specialty)	\$30	Not Covered	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 www.ghcscw.com.

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	Member pays Coinsurance up to \$250 maximum
Durable Medical Equipment	Yes	20%	20% after Deductible	
Hearing Aids for Members age 18 and over	Yes	20%	20% after Deductible	Limited to one hearing aid per ear per 36 months; GHC-SCW coverage is for the basic model
Hearing Aids for children age 17 and under	Yes	20%	20% after Deductible	Limited to one hearing aid per ear per 36 months; GHC-SCW coverage is for the basic model

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In-Network Maximum Out-of-Pocket (MOOP)	\$6,600	\$13,200
Out-of-Network Maximum Out-of-Pocket (MOOP)	\$1,000	\$2,000

Supplies and Equipment	Prior Auth	You Pay In-Network	You Pay Out-of-Network	Benefit Notes
Cochlear Implants and Bone Anchored Hearing Aids	Yes	No Charge after Deductible	20% after Deductible	
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	20% after Deductible	
Outpatient Hospital Surgical/Non-Surgical Services, Facility Fees	Yes	No Charge after Deductible	20% after Deductible	Certain oral surgeries do not require Prior Authorization
Skilled Nursing Facility Services	Yes	No Charge after Deductible	20% after Deductible	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	20% after Deductible	Routine Eye Examinations must be provided by an Optometrist (OD); 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	No	\$20	20% after Deductible	
Mental Health/Substance Use Disorder Inpatient Services	Yes	No Charge after Deductible	20% after Deductible	
Mental Health/Substance Use Disorder Transitional Services	Yes	No Charge after Deductible	20% after Deductible	
Complementary Medicine Services	Prior Auth	You Pay In-Network	You Pay Out-of-Network	Benefit Notes
Acupuncture (Initial Visit)	No	\$83	Not Covered	\$53 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	\$53	Not Covered	60-minute session; Coverage at GHC-SCW Clinics only
Massage Therapy	No	\$33	Not Covered	30-minute session; Coverage at GHC-SCW Clinics only
Reiki Therapy	No	\$53	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	20% after Deductible	Initial repair of accidental injury to sound, natural teeth
Oral Surgeries	Yes	No Charge after Deductible	20% after Deductible	Certain oral surgeries do not require Prior Authorization
Additional Services	Prior Auth	You Pay In-Network	You Pay Out-of-Network	Benefit Notes
Hospice	Yes	No Charge after Deductible	20% after Deductible	Example: End of Life Services
Home Health Services	Yes	No Charge after Deductible	20% after Deductible	Limited to 60 visits per Member per year
Health Counseling Education	No	No Charge	20% after Deductible	Coverage is limited to USPSTF guidelines and Women's Preventive Health

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Out-of-Network Deductible	\$250	\$500
In-Network Maximum Out-of-Pocket (MOOP)	\$6,600	\$13,200
Out-of-Network Maximum Out-of-Pocket (MOOP)	\$1,000	\$2,000

Additional Services	Prior Auth	You Pay In-Network	You Pay Out-of-Network	Benefit Notes
Infertility Services	No	50% up to maximum	50% up to maximum	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	20% after Deductible	Includes Rehabilitation and Habilitation Therapy; Limited to 20 visits per therapy per Member per year
Outpatient Habilitation Therapy	Yes	No Charge after Deductible	20% after Deductible	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	20% after Deductible	Limited to 36 visits per Member per year
Outpatient Rehabilitation Therapy	Yes	No Charge after Deductible	20% after Deductible	Includes Physical and Occupational Therapy; Limited to 40 combined visits per Member per year; See Certificate for additional information

Benefit Summary Notes

Office Visit Copayments are waived for children under age 19.

Prior Authorizations

- Prior Authorization is required for services specified in this Benefit Summary. Please refer to www.ghcscw.com and your Member Certificate for a list of specific Benefits that require Prior Authorization.
- If a Member fails to obtain written Prior Authorization for Covered Health Services from GHC-SCW, a Prior Authorization penalty shall apply (the "Prior Authorization Penalty"). The Prior Authorization Penalty requires the Member to pay 50% of the Reasonable and Customary Fees and Charges billed to GHC-SCW for the Covered Health Service(s) that required Prior Authorization. The maximum Prior Authorization Penalty shall be \$500. The Prior Authorization Penalty shall be assessed prior to any applicable Deductible, Coinsurance and/or Copayment. The Prior Authorization Penalty does not apply toward the Member's Maximum Out-of-Pocket. All Covered Health Services remain subject to the Member's Deductible, Coinsurance and/or Copayment following assessment of the Prior Authorization Penalty. To obtain Prior Authorization, call (608) 257-5294.

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 any Providers not included in the "Find a Provider" link at www.ghcscw.com. Out-of-Network coinsurance applies after the deductible has been met. For further assistance, contact Member Services at (608) 828-4853 or (800) 605-4327, ext. 4504. When applicable, Prior Authorization is still required for Out-of-Network 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.



\$20 Copayment \$100 Deductible 100/80 PPO Plan

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, please call 1-800-605-4327. 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 view the Glossary at

www.healthcare.gov/sbc-glossary/ or call 1-800-605-4327 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	For In-Network Providers \$100/Individual or \$200/Family ; For Out-of-Network Providers \$250/Individual or \$500/Family	If you have other family members on the plan , each family member must meet their own individual deductible . 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. Complementary Medicine, Preventive Care, Certain Office Visits, and Pharmacy Drugs are covered before the deductible is met. Office Visit Copayments are waived for children under age 19.	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 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 ?	For In-Network Providers \$6,600/Individual or \$13,200/Family ; For Out-of-Network Providers \$1,000/Individual or \$2,000/Family	The out-of-pocket limit 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 reached.
What is not included in the out-of-pocket limit ?	Copayments on certain services, 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 more 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 may use an out-of-network provider for some services (such as lab work). Check with your provider before you receive services.
Do you need a referral to see a specialist ?	No.	You can see the specialist you choose without a referral .



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)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$20	20% after Deductible	Example: Office visits with Your Primary Care Provider (PCP)
	Specialist visit	\$20	20% after Deductible	Example: Specialist Hearing Exams
	Preventive care/screening /immunization	No Charge	20% after Deductible	Coverage is limited to USPSTF guidelines and Women's Preventive Health
If you have a test	Diagnostic test (x-ray, blood work)	No Charge after Deductible	No Charge after Deductible	Prior authorization is required. Example: Lab tests, blood work, or x-rays ordered by Your Provider; Prior Authorization is not required for routine labs and x-rays
	Imaging (CT/PET scans, MRIs)	No Charge after Deductible	20% after Deductible	Prior authorization is required. Example: 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/	Generic drugs (Tier 1)	\$6	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
	Preferred brand drugs (Tier 2)	\$15	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
	Non-preferred brand drugs (Tier 3)	Not Covered	Not Covered	Not Covered
	Specialty drugs (Tier 4)	\$30	Not Covered	Covers up to a 30-day supply; 31-90 day supply not available; May require the specialty-designated pharmacy
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No Charge after Deductible	20% after Deductible	Prior authorization is required.
	Physician/surgeon fees	No Charge after Deductible	20% after Deductible	Prior authorization is required. Certain surgeries do not require Prior Authorization

*For more information about limitations and exceptions, see the plan or policy document at <http://planfinder.ghcscw.com>

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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)	
If you need immediate medical attention	Emergency room care	\$150	\$150	Limited to emergency care; Copay waived if admitted as hospital inpatient
	Emergency medical transportation	No Charge after Deductible	No Charge after Deductible	Coverage is limited to emergency care
	Urgent care	\$20	\$20	
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge after Deductible	20% after Deductible	Prior authorization is required.
	Physician/surgeon fees	No Charge after Deductible	20% after Deductible	Prior authorization is required.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$20	20% after Deductible	
	Inpatient services	No Charge after Deductible	20% after Deductible	Prior authorization is required.
If you are pregnant	Office visits	No Charge	20% after Deductible	Coverage is limited to USPSTF guidelines and Women's Preventive Health
	Childbirth/delivery professional services	No Charge after Deductible	20% after Deductible	Prior authorization is required.
	Childbirth/delivery facility services	No Charge after Deductible	20% after Deductible	Prior authorization is required.
If you need help recovering or have other special health needs	Home health care	No Charge after Deductible	20% after Deductible	Prior authorization is required. Limited to 36 visits per Member per year
	Rehabilitation services	No Charge after Deductible	20% after Deductible	Prior authorization is required. Limited to 36 combined visits per Member per year for Occupational and Physical; Limited to 36 visits per Member per year for Speech; Limited to 36 visits per Member per year for Cardiac
	Habilitation services	No Charge after Deductible	20% after Deductible	Prior authorization is required. Limited to 36 combined visits per Member per year for Occupational and Physical; Limited to 36 visits per Member per year for Speech
	Skilled nursing care	No Charge after Deductible	20% after Deductible	Prior authorization is required. Limited to 30 days per inpatient stay per Member
	Durable medical equipment	20%	20% after Deductible	Prior authorization is required. See Certificate for additional Limitations and Exclusions

*For more information about limitations and exceptions, see the plan or policy document at <http://planfinder.ghcscw.com>

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)	
	Hospice services	No Charge after Deductible	20% after Deductible	Prior authorization is required. Example of Life Services
If your child needs dental or eye care	Children's eye exam	No Charge	20% after Deductible	Routine Eye Examinations must be performed by an Optometrist (OD); Limited to one exam per Member per year
	Children's glasses	Not Covered	Not Covered	Not Covered
	Children's dental check-up	Not Covered	Not Covered	Not Covered

*For more information about limitations and exceptions, see the plan or policy document at <http://planfinder.ghcscw.com>

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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](#).)

- Abortion (except in cases of rape, incest, or when the life of the mother is endangered)
- Drug Screening
- Personal Comfort Items
- Weight Loss programs
- Bariatric surgery
- Custodial Care
- Long-term care
- Private-Duty Nursing
- Cosmetic surgery
- Dental Care (Adult)
- Non-emergency care when traveling outside the U.S.
- Routine Foot Care

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

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

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: Office of the Commissioner of Insurance, Complaints Department, PO Box 7873, Madison, WI 53707-7873, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov. 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: 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 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 types of 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-insured coverage.

Peg is having a baby (9 months of in-network pre-natal care and a hospital delivery)	Managing Joe's type 2 Diabetes (a year of routine in-network care of a well-controlled condition)	Mia's Simple Fracture (in-network emergency room visit and follow up care)
<ul style="list-style-type: none"> The plan's overall deductible -- \$100 Specialist [cost sharing] -- \$20 Hospital (facility) [cost sharing] -- No Charge after Deductible Other [cost sharing] -- 0% 	<ul style="list-style-type: none"> The plan's overall deductible -- \$100 Specialist [cost sharing] -- \$20 Hospital (facility) [cost sharing] -- No Charge after Deductible Other [cost sharing] -- 0% 	<ul style="list-style-type: none"> The plan's overall deductible -- \$100 Specialist [cost sharing] -- \$20 Hospital (facility) [cost sharing] -- No Charge after Deductible Other [cost sharing] -- 0%
This EXAMPLE event includes services like:	This EXAMPLE event includes services like:	This EXAMPLE event includes services like:
Specialist office visits (prenatal care)	Primary care physician office visits (including disease education)	Emergency room care (including medical supplies)
Childbirth/Delivery Professional Services	Diagnostic tests (blood work)	Diagnostic test (x-ray)
Childbirth/Delivery Facility Services	Prescription drugs	Durable medical equipment (crutches)
Diagnostic tests (ultrasounds and blood work)	Durable medical equipment (glucose meter)	Rehabilitation services (physical therapy)
Specialist visit (anesthesia)		
Total Example Cost -- \$12,700.00	Total Example Cost -- \$5,600.00	Total Example Cost -- \$2,800.00
In this example, Peg would pay:	In this example, Joe would pay:	In this example, Mia would pay
<i>Cost sharing</i>	<i>Cost sharing</i>	<i>Cost sharing</i>
Deductibles \$100.00	Deductibles \$100.00	Deductibles \$100.00
Copayments \$20.00	Copayments \$280.00	Copayments \$170.00
Coinsurance \$0	Coinsurance \$250.00	Coinsurance \$60.00
<i>What isn't covered</i>	<i>What isn't covered</i>	<i>What isn't covered</i>
Limits or exclusions -- \$50.00	Limits or exclusions -- \$20.00	Limits or exclusions -- \$10.00
The total Peg would pay is -- \$170.00	The total Joe would pay is -- \$650.00	The total Mia would pay is -- \$340.00

*For more information about limitations and exceptions, see the plan or policy document at <http://planfinder.ghcscw.com>

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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>.

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).

Deitsch (Pennsylvania Dutch):

Wann du [Deitsch (Pennsylvania German / Dutch)] schwetzscht, 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. ໂທ 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).