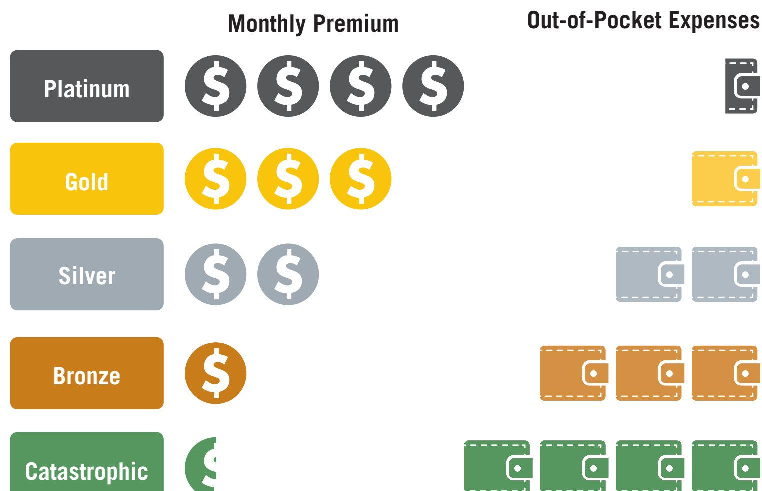
GHC-SCW Individual ACA Plans 2018

Our plans are further organized into "Metals" based on the percentage of health care costs shared between you and GHC-SCW.



Terms to Know

Copayment – A fixed amount (for example, $15) you pay for a Covered Health Service. The amount can vary by the type of Covered Health Service.

Coinsurance – The percentage of costs of Covered Health Services you pay after you've paid your Deductible.

Deductible – The amount you owe for medical Covered Health Services and/or prescription drug services your health insurance or plan covers before your health insurance or plan begins to pay. For example, if your Medical Deductible is $1,000, your plan won't pay anything until you've met your $1,000 Deductible for medical Covered Health Services that are subject to the Deductible. The Deductible may not apply to all services.

> **Prescription Drug and Medical Combined Deductible –** This is the amount you owe for both medical Covered Health Services and prescription drugs (that are subject to the Deductible) before your health insurance or plan begins to pay.
>
> **Medical Deductible –** This is the amount you owe for medical Covered Health Services (that are subject to the Deductible) before your health insurance or plan begins to pay.
>
> **Prescription Drug Deductible –** This is the amount you owe for prescription drugs (that are subject to the Deductible) before your health insurance or plan begins to pay.

GHC Select Plan Network – The GHC Select Plan Network gives individuals access to their choice of our six full-service, high-quality primary care clinics in and around Madison, plus access to specialty care close to home through our world-class specialty partners at UW Hospital and Clinics. The Primary Care Clinics are GHC-SCW Capitol Clinic, GHC-SCW DeForest Clinic, GHC-SCW East Clinic, GHC-SCW Hatchery Hill Clinic, GHC-SCW Madison College Community Clinic and GHC-SCW Sauk Trails Clinic.

In-Network – The facilities, providers and suppliers your health insurer or plan has contracted with to provide Covered Health Services. Visit **ghcscw.com** and select, "Clinic or Provider" to find In-Network Facilities and Providers.

Embedded – Each individual member has his/her own Deductible and Maximum Out-of-Pocket (MOOP) for a benefit plan. In addition, there is a shared family Deductible and MOOP. The Affordable Care Act (ACA) guidelines for 2018 stipulate that an individual cannot pay more than $7,350 in out-of-pocket expenses in a plan year.

Non-Embedded – (May also be referred to as Aggregate.) Every member on your benefit plan shares one Deductible and one Maximum Out-of-Pocket (MOOP).

Maximum Out-of-Pocket (MOOP) – This is the limit to the amount you will pay out-of-pocket during a policy period (typically one year long) for Covered Health Services. Once you've paid this maximum amount, your health insurance plan will pay 100% of the allowed amount for Covered Health Services. This limit never includes your premium, balance-billed charges or heath care your health insurance does not cover. Some health insurance or plans don't count all your Copayments, Deductibles, Coinsurance payments, Out-of-Network payments or other expenses toward this limit.

> **Prescription Drug and Medical Combined Maximum Out-of-Pocket (MOOP)**
> This is the Maximum Out-of-Pocket you will pay for Covered Health Services and prescriptions combined during a policy period.
>
> **Medical Maximum Out-of-Pocket (MOOP)**
> This is the Maximum Out-of-Pocket you will pay for Covered Health Services during a policy period.
>
> **Prescription Drug Maximum Out-of-Pocket (MOOP)**
> This is the Maximum Out-of-Pocket you will pay for prescription services during a policy period.

ghcscw.com

INDIVIDUAL ACA PLANS (2018)

For a complete description of Covered Health Services, please see your Member Certificate, Benefits Summary and any Amendments to your Benefits Plan. If you have questions regarding GHC-SCW benefits, please call Member Services at (608) 828-4853 or (800) 605-4327 and request Member Services.

CLICK ON THE PLAN NAME FOR DETAILED PLAN DESCRIPTIONS.	Platinum $500 Ded/ $1,000 MOOP	Platinum No Ded/ $3,000X MOOP	Platinum $500 Ded/ $3,000X MOOP
Plan Offered Direct and/or on the Marketplace	Direct & Marketplace	Direct & Marketplace	Direct & Marketplace
Deductible - Medical (Based on Calendar Year)	$500/Individual or $1,000/Family	$0/Individual or $0/Family	$500/Individual or $1,000/Family
Deductible - Prescription (Based on Calendar Year)	$0/Individual or $0/Family	$0/Individual or $0/Family	$0/Individual or $0/Family
Deductible - Medical & Prescription Combined (Based on Calendar Year)	N/A	N/A	N/A
Embedded/Non-Embedded	Embedded	Embedded	Embedded
Policy Coinsurance	20%	20%	20%
Maximum Out-of-Pocket - Medical (MOOP)	N/A	$1,000/Individual or $2,000/Family	$1,000/Individual or $2,000/Family
Maximum Out-of-Pocket - Prescription Drug (MOOP)	N/A	$2,000/Individual or $4,000/Family	$2,000/Individual or $4,000/Family
Maximum Out-of-Pocket Prescription Drug & Medical Combined (MOOP)	$1,000/Individual or $2,000/Family	N/A	N/A
Eligible Dependents	Dependents are covered until the end of the month at age 26.		
CLINIC SERVICES			
Primary Care Office Visits	$20	No Charge	No Charge
Chiropractic Office Visits	$20	No Charge	No Charge
Preventive Health Examinations	No Charge	No Charge	No Charge
Specialist Care Office Visits	$40	$50	$50
Preventive Immunizations	No Charge	No Charge	No Charge
Prenatal and Postnatal Maternity Care	No Charge	No Charge	No Charge
Diagnostic X-Ray and Laboratory Test	20% after Deductible	20% after Deductible	20% after Deductible
Advanced Radiology	20% after Deductible	20% after Deductible	20% after Deductible
EMERGENCY AND URGENT CARE			
Urgent Care Visits	$20	No Charge	No Charge
Emergency Ambulance Service (air/ground)	No Charge	No Charge	No Charge
Emergency Room Visits	$100	$150	$150
PRESCRIPTION DRUGS			
Tier 1	$10	$10	$10
Tier 2	$30	$30	$30
Tier 3	$60	$60	$60
Tier 4	30% after Pharmacy Deductible up to $300 maximum	30% after Pharmacy Deductible up to $300 maximum	30% after Pharmacy Deductible up to $300 maximum
The Prescription Drugs Benefit is administered by GHC-SCW Clinic pharmacies and Navitus. Prescription Drugs are NOT COVERED outside of the GHC-SCW network of providers. For a list of formulary drugs, tier ($) placement, prior authorization requirements and other limitations that may apply, see ghcscw.com.			
COMPLEMENTARY MEDICINE	$79 initial visit of Acupuncture, $75 initial visit of Naturopathy, $49 one-hour personal sessions for Acupuncture, Massage Therapy and Reiki. For HSA Plans, Copayment applies after Deductible.		
HOSPITAL SERVICES			
Inpatient Hospital Services: Physician Services, Surgery, Facility Fees	20% after Deductible	20% after Deductible	20% after Deductible
Outpatient Hospital Surgical/Non-Surgical Services, Facility Fees	20% after Deductible	20% after Deductible	20% after Deductible
Skilled Nursing Facility Services	20% after Deductible	20% after Deductible	20% after Deductible
VISION SERVICES			
Vision Examinations	No Charge	No Charge	No Charge
MENTAL HEALTH & SUBSTANCE USE DISORDER			
Outpatient Services	$20	No Charge	No Charge
Inpatient Services	20% after Deductible	20% after Deductible	20% after Deductible
Transitional Services	20% after Deductible	20% after Deductible	20% after Deductible

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INDIVIDUAL ACA PLANS (2018)

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CLICK ON THE PLAN NAME FOR DETAILED PLAN DESCRIPTIONS.	Gold $1,500 Ded/ $5,200X MOOP	Gold $1,000 Ded/ $4,000 MOOP	Gold $2,500 Ded/ $7,000X MOOP	Gold $2,000 Ded/ $2,000 MOOP HSA
Plan Offered Direct and/or on the Marketplace	Direct & Marketplace	Direct & Marketplace	Direct & Marketplace	Direct & Marketplace
Deductible - Medical (Based on Calendar Year)	$1,500/Individual or $3,000/Family	$1,000/Individual or $2,000/Family	$2,500/Individual or $5,000/Family	N/A
Deductible - Prescription (Based on Calendar Year)	$0/Individual or $0/Family	$0/Individual or $0/Family	$0/Individual or $0/Family	N/A
Deductible - Medical & Prescription Combined (Based on Calendar Year)	N/A	N/A	N/A	$2,000/Individual or $4,000/Family
Embedded/Non-Embedded	Embedded	Embedded	Embedded	Non-Embedded
Policy Coinsurance	20%	30%	20%	0%
Maximum Out-of-Pocket - Medical (MOOP)	$2,200/Individual or $4,400/Family	N/A	$3,000/Individual or $6,000/Family	N/A
Maximum Out-of-Pocket - Prescription Drug (MOOP)	$3,000/Individual or $6,000/Family	N/A	$4,000/Individual or $8,000/Family	N/A
Maximum Out-of-Pocket Prescription Drug & Medical Combined (MOOP)	N/A	$4,000/Individual or $8,000/Family	N/A	$2,000/Individual or $4,000/Family
Eligible Dependents	Dependents are covered until the end of the month at age 26.			
CLINIC SERVICES				
Primary Care Office Visits	No Charge	$30	No Charge	No Charge after Deductible
Chiropractic Office Visits	No Charge	$30	No Charge	No Charge after Deductible
Preventive Health Examinations	No Charge	No Charge	No Charge	No Charge
Specialist Care Office Visits	$60	$60	$50	No Charge after Deductible
Preventive Immunizations	No Charge	No Charge	No Charge	No Charge
Prenatal and Postnatal Maternity Care	No Charge	No Charge	No Charge	No Charge
Diagnostic X-Ray and Laboratory Test	20% after Deductible	30% after Deductible	20% after Deductible	No Charge after Deductible
Advanced Radiology	20% after Deductible	30% after Deductible	20% after Deductible	No Charge after Deductible
EMERGENCY AND URGENT CARE				
Urgent Care Visits	No Charge	$30	No Charge	No Charge after Deductible
Emergency Ambulance Service (air/ground)	No Charge	No Charge	No Charge	No Charge after Deductible
Emergency Room Visits	$200	$250	$200	No Charge after Deductible
PRESCRIPTION DRUGS				
Tier 1	$20	$20	$20	No Charge after Deductible
Tier 2	$40	$40	$40	No Charge after Deductible
Tier 3	$80	$80	$80	No Charge after Deductible
Tier 4	30% after Pharmacy Deductible up to $300 maximum	30% after Pharmacy Deductible up to $300 maximum	30% after Pharmacy Deductible up to $300 maximum	No Charge after Deductible
The Prescription Drugs Benefit is administered by GHC-SCW Clinic pharmacies and Navitus. Prescription Drugs are NOT COVERED outside of the GHC-SCW network of providers. For a list of formulary drugs, tier ($) placement, prior authorization requirements and other limitations that may apply, see ghcscw.com.				
COMPLEMENTARY MEDICINE	$79 initial visit of Acupuncture, $75 initial visit of Naturopathy, $49 one-hour personal sessions for Acupuncture, Massage Therapy and Reiki. For HSA Plans, Copayment applies after Deductible.			
HOSPITAL SERVICES				
Inpatient Hospital Services: Physician Services, Surgery, Facility Fees	20% after Deductible	30% after Deductible	20% after Deductible	No Charge after Deductible
Outpatient Hospital Surgical/Non-Surgical Services, Facility Fees	20% after Deductible	30% after Deductible	20% after Deductible	No Charge after Deductible
Skilled Nursing Facility Services	20% after Deductible	30% after Deductible	20% after Deductible	No Charge after Deductible
VISION SERVICES				
Vision Examinations	No Charge	No Charge	No Charge	No Charge after Deductible
MENTAL HEALTH & SUBSTANCE USE DISORDER				
Outpatient Services	No Charge	$30	No Charge	No Charge after Deductible
Inpatient Services	20% after Deductible	30% after Deductible	20% after Deductible	No Charge after Deductible
Transitional Services	20% after Deductible	30% after Deductible	20% after Deductible	No Charge after Deductible

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CLICK ON THE PLAN NAME FOR DETAILED PLAN DESCRIPTIONS.	Gold Simple Choice Plan	Gold $2,500 Ded/ $6,500 MOOP	Silver $4,000 Ded/ $7,350X MOOP	Silver $2,000 Ded/ $6,000 MOOP
Plan Offered Direct and/or on the Marketplace	Direct & Marketplace	Direct & Marketplace	Direct & Marketplace	Direct & Marketplace
Deductible - Medical (Based on Calendar Year)	$1,400/Individual or $2,800/Family	$2,500/Individual or $5,000/Family	$4,000/Individual or $8,000/Family	$2,000/Individual or $4,000/Family
Deductible - Prescription (Based on Calendar Year)	$0/Individual or $0/Family	$0/Individual or $0/Family	$0/Individual or $0/Family	$0/Individual or $0/Family
Deductible - Medical & Prescription Combined (Based on Calendar Year)	N/A	N/A	N/A	N/A
Embedded/Non-Embedded	Embedded	Embedded	Embedded	Embedded
Policy Coinsurance	20%	30%	30%	30%
Maximum Out-of-Pocket - Medical (MOOP)	N/A	N/A	$5,000/Individual or $10,000/Family	N/A
Maximum Out-of-Pocket - Prescription Drug (MOOP)	N/A	N/A	$2,350/Individual or $4,700/Family	N/A
Maximum Out-of-Pocket Prescription Drug & Medical Combined (MOOP)	$5,000/Individual or $10,000/Family	$6,500/Individual or $13,000/Family	N/A	$6,000/Individual or $12,000/Family
Eligible Dependents	Dependents are covered until the end of the month at age 26.			
CLINIC SERVICES				
Primary Care Office Visits	$20	$30	No Charge	30% after Deductible
Chiropractic Office Visits	$20	$30	No Charge	30% after Deductible
Preventive Health Examinations	No Charge	No Charge	No Charge	No Charge
Specialist Care Office Visits	$50	$60	$150	30% after Deductible
Preventive Immunizations	No Charge	No Charge	No Charge	No Charge
Prenatal and Postnatal Maternity Care	No Charge	No Charge	No Charge	No Charge
Diagnostic X-Ray and Laboratory Test	20% after Deductible	30% after Deductible	30% after Deductible	30% after Deductible
Advanced Radiology	20% after Deductible	30% after Deductible	30% after Deductible	30% after Deductible
EMERGENCY AND URGENT CARE				
Urgent Care Visits	$60	$30	No Charge	30% after Deductible
Emergency Ambulance Service (air/ground)	No Charge	No Charge	No Charge	No Charge
Emergency Room Visits	20% after Deductible	$300	$300	30% after Deductible
PRESCRIPTION DRUGS				
Tier 1	$10	$20	$50	$30
Tier 2	$40	$40	$150	$60
Tier 3	$75	$80	$250	$120
Tier 4	30% after Pharmacy Deductible	30% after Pharmacy Deductible up to $300 Maximum	50% after Pharmacy Deductible	30% after Pharmacy Deductible up to $300 Maximum
The Prescription Drugs Benefit is administered by GHC-SCW Clinic pharmacies and Navitus. Prescription Drugs are NOT COVERED outside of the GHC-SCW network of providers. For a list of formulary drugs, tier ($) placement, prior authorization requirements and other limitations that may apply, see ghcscw.com.				
COMPLEMENTARY MEDICINE	$79 initial visit of Acupuncture, $75 initial visit of Naturopathy, $49 one-hour personal sessions for Acupuncture, Massage Therapy and Reiki. For HSA Plans, Copayment applies after Deductible.			
HOSPITAL SERVICES				
Inpatient Hospital Services: Physician Services, Surgery, Facility Fees	20% after Deductible	30% after Deductible	30% after Deductible	30% after Deductible
Outpatient Hospital Surgical/Non-Surgical Services, Facility Fees	20% after Deductible	30% after Deductible	30% after Deductible	30% after Deductible
Skilled Nursing Facility Services	20% after Deductible	30% after Deductible	30% after Deductible	30% after Deductible
VISION SERVICES				
Vision Examinations	No Charge	No Charge	No Charge	No Charge
MENTAL HEALTH & SUBSTANCE USE DISORDER				
Outpatient Services	$20	$30	No Charge	30% after Deductible
Inpatient Services	20% after Deductible	30% after Deductible	30% after Deductible	30% after Deductible
Transitional Services	20% after Deductible	30% after Deductible	30% after Deductible	30% after Deductible

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CLICK ON THE PLAN NAME FOR DETAILED PLAN DESCRIPTIONS.	Silver Simple Choice Plan	Silver $5,000 Ded/ $7,350X MOOP	Silver $3,000 Ded/ $7,350 MOOP	Silver $4,500 Ded/ $7,350 MOOP
Plan Offered Direct and/or on the Marketplace	Direct & Marketplace	Direct Only	Direct Only	Direct Only
Deductible - Medical (Based on Calendar Year)	$3,500/Individual or $7,000/Family	$5,000/Individual or $10,000/Family	$3,000/Individual or $6,000/Family	$4,500/Individual or $9,000/Family
Deductible - Prescription (Based on Calendar Year)	$500/Individual or $1,000/Family	$0/Individual or $0/Family	$0/Individual or $0/Family	$0/Individual or $0/Family
Deductible - Medical & Prescription Combined (Based on Calendar Year)	N/A	N/A	N/A	N/A
Embedded/Non-Embedded	Embedded	Embedded	Embedded	Embedded
Policy Coinsurance	20%	30%	30%	40%
Maximum Out-of-Pocket - Medical (MOOP)	N/A	$6,000/Individual or $12,000/Family	N/A	N/A
Maximum Out-of-Pocket - Prescription Drug (MOOP)	N/A	$1,350/Individual or $2,700/Family	N/A	N/A
Maximum Out-of-Pocket Prescription Drug & Medical Combined (MOOP)	$7,350/Individual or $14,700/Family	N/A	$7,350/Individual or $14,700/Family	$7,350/Individual or $14,700/Family
Eligible Dependents	Dependents are covered until the end of the month at age 26.			
CLINIC SERVICES				
Primary Care Office Visits	$30	No Charge	$50	$30
Chiropractic Office Visits	$30	No Charge	$50	$30
Preventive Health Examinations	No Charge	No Charge	No Charge	No Charge
Specialist Care Office Visits	$65	$150	$100	$60
Preventive Immunizations	No Charge	No Charge	No Charge	No Charge
Prenatal and Postnatal Maternity Care	No Charge	No Charge	No Charge	No Charge
Diagnostic X-Ray and Laboratory Test	20% after Deductible	30% after Deductible	30% after Deductible	40% after Deductible
Advanced Radiology	20% after Deductible	30% after Deductible	30% after Deductible	40% after Deductible
EMERGENCY AND URGENT CARE				
Urgent Care Visits	$75	No Charge	$50	$30
Emergency Ambulance Service (air/ground)	No Charge	No Charge	No Charge	No Charge
Emergency Room Visits	20% after Deductible	$400	$350	$350
PRESCRIPTION DRUGS				
Tier 1	$15	$40	$30	$30
Tier 2	$50	$80	$60	$60
Tier 3	$100	$120	$120	$120
Tier 4	40% after Pharmacy Deductible	30% after Pharmacy Deductible up to $300 Maximum	30% after Pharmacy Deductible up to $300 Maximum	30% after Pharmacy Deductible up to $300 Maximum
The Prescription Drugs Benefit is administered by GHC-SCW Clinic pharmacies and Navitus. Prescription Drugs are NOT COVERED outside of the GHC-SCW network of providers. For a list of formulary drugs, tier ($) placement, prior authorization requirements and other limitations that may apply, see ghcscw.com.				
COMPLEMENTARY MEDICINE	$79 initial visit of Acupuncture, $75 initial visit of Naturopathy, $49 one-hour personal sessions for Acupuncture, Massage Therapy and Reiki. For HSA Plans, Copayment applies after Deductible.			
HOSPITAL SERVICES				
Inpatient Hospital Services: Physician Services, Surgery, Facility Fees	20% after Deductible	30% after Deductible	30% after Deductible	40% after Deductible
Outpatient Hospital Surgical/Non-Surgical Services, Facility Fees	20% after Deductible	30% after Deductible	30% after Deductible	40% after Deductible
Skilled Nursing Facility Services	20% after Deductible	30% after Deductible	30% after Deductible	40% after Deductible
VISION SERVICES				
Vision Examinations	No Charge	No Charge	No Charge	No Charge
MENTAL HEALTH & SUBSTANCE USE DISORDER				
Outpatient Services	$30	No Charge	$50	$30
Inpatient Services	20% after Deductible	30% after Deductible	30% after Deductible	40% after Deductible
Transitional Services	20% after Deductible	30% after Deductible	30% after Deductible	40% after Deductible

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CLICK ON THE PLAN NAME FOR DETAILED PLAN DESCRIPTIONS.	Silver $4,000 Ded/ $4,000 MOOP HSA	Silver $5,500 Ded/ $7,350 MOOP	Bronze $4,000 Ded/ $7,350 MOOP	Bronze Simple Choice Plan HSA
Plan Offered Direct and/or on the Marketplace	Direct Only	Direct Only	Direct & Marketplace	Direct & Marketplace
Deductible - Medical (Based on Calendar Year)	N/A	$5,500/Individual or $11,000/Family	$4,000/Individual or $8,000/Family	N/A
Deductible - Prescription (Based on Calendar Year)	N/A	$0/Individual or $0/Family	$0/Individual or $0/Family	N/A
Deductible - Medical & Prescription Combined (Based on Calendar Year)	$4,000/Individual or $8,000/Family	N/A	N/A	$6,000/Individual or $12,000/Family
Embedded/Non-Embedded	Embedded	Embedded	Embedded	Embedded
Policy Coinsurance	0%	40%	40%	0%
Maximum Out-of-Pocket - Medical (MOOP)	N/A	N/A	N/A	N/A
Maximum Out-of-Pocket - Prescription Drug (MOOP)	N/A	N/A	N/A	N/A
Maximum Out-of-Pocket Prescription Drug & Medical Combined (MOOP)	$4,000/Individual or $8,000/Family	$7,350/Individual or $14,700/Family	$7,350/Individual or $14,700/Family	$6,000/Individual or $12,000/Family
Eligible Dependents	Dependents are covered until the end of the month at age 26.			
CLINIC SERVICES				
Primary Care Office Visits	No Charge after Deductible	$75	$125	No Charge after Deductible
Chiropractic Office Visits	No Charge after Deductible	$75	$125	No Charge after Deductible
Preventive Health Examinations	No Charge	No Charge	No Charge	No Charge
Specialist Care Office Visits	No Charge after Deductible	$150	$250	No Charge after Deductible
Preventive Immunizations	No Charge	No Charge	No Charge	No Charge
Prenatal and Postnatal Maternity Care	No Charge	No Charge	No Charge	No Charge
Diagnostic X-Ray and Laboratory Test	No Charge after Deductible	40% after Deductible	40% after Deductible	No Charge after Deductible
Advanced Radiology	No Charge after Deductible	40% after Deductible	40% after Deductible	No Charge after Deductible
EMERGENCY AND URGENT CARE				
Urgent Care Visits	No Charge after Deductible	$75	$125	No Charge after Deductible
Emergency Ambulance Service (air/ground)	No Charge after Deductible	No Charge	No Charge	No Charge after Deductible
Emergency Room Visits	No Charge after Deductible	$400	$400	No Charge after Deductible
PRESCRIPTION DRUGS				
Tier 1	No Charge after Deductible	$50	$50	No Charge after Deductible
Tier 2	No Charge after Deductible	$150	$150	No Charge after Deductible
Tier 3	No Charge after Deductible	$250	$250	No Charge after Deductible
Tier 4	No Charge after Deductible	50% after Pharmacy Deductible	50% after Pharmacy Deductible	No Charge after Deductible
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COMPLEMENTARY MEDICINE	$79 initial visit of Acupuncture, $75 initial visit of Naturopathy, $49 one-hour personal sessions for Acupuncture, Massage Therapy and Reiki. For HSA Plans, Copayment applies after Deductible.			
HOSPITAL SERVICES				
Inpatient Hospital Services: Physician Services, Surgery, Facility Fees	No Charge after Deductible	40% after Deductible	40% after Deductible	No Charge after Deductible
Outpatient Hospital Surgical/Non-Surgical Services, Facility Fees	No Charge after Deductible	40% after Deductible	40% after Deductible	No Charge after Deductible
Skilled Nursing Facility Services	No Charge after Deductible	40% after Deductible	40% after Deductible	No Charge after Deductible
VISION SERVICES				
Vision Examinations	No Charge after Deductible	No Charge	No Charge	No Charge after Deductible
MENTAL HEALTH & SUBSTANCE USE DISORDER				
Outpatient Services	No Charge after Deductible	$75	$125	No Charge after Deductible
Inpatient Services	No Charge after Deductible	40% after Deductible	40% after Deductible	No Charge after Deductible
Transitional Services	No Charge after Deductible	40% after Deductible	40% after Deductible	No Charge after Deductible

Please visit ghcscw.com to find the Summary of Benefits and Coverage (SBC) and Glossary of Health Coverage and Medical Terms for the plans being quoted. (P) Preventive Health Services: when provided in a primary care setting by GHC-SCW Contracted Providers. To include preventive health procedures as deemed appropriate by the United States Preventative Services Task Force (USPSTF) criteria with respect to the age, sex and health status of the member. Services and/or testing for ongoing diagnosis and treatment of a condition are not preventive services.

DO NOT CANCEL YOUR INSURANCE. COVERAGE IS NOT IN EFFECT UNTIL WRITTEN APPROVAL IS ISSUED.

INDIVIDUAL ACA PLANS (2018)

For a complete description of Covered Health Services, please see your Member Certificate, Benefits Summary and any Amendments to your Benefits Plan. If you have questions regarding GHC-SCW benefits, please call Member Services at (608) 828-4853 or (800) 605-4327 and request Member Services.

CLICK ON THE PLAN NAME FOR DETAILED PLAN DESCRIPTIONS.	Bronze Simple Choice Plan	Bronze $6,550 Ded/ $6,550 MOOP HSA	Catastrophic $7,350 Ded/ $7,350 MOOP
Plan Offered Direct and/or on the Marketplace	Direct & Marketplace	Direct & Marketplace	Direct & Marketplace
Deductible - Medical (Based on Calendar Year)	N/A	N/A	N/A
Deductible - Prescription (Based on Calendar Year)	N/A	N/A	N/A
Deductible - Medical & Prescription Combined (Based on Calendar Year)	$6,650/Individual or $13,300/Family	$6,550/Individual or $13,100/Family	$7,350/Individual or $14,700/Family
Embedded/Non-Embedded	Embedded	Embedded	Embedded
Policy Coinsurance	40%	0%	0%
Maximum Out-of-Pocket - Medical (MOOP)	N/A	N/A	N/A
Maximum Out-of-Pocket - Prescription Drug (MOOP)	N/A	N/A	N/A
Maximum Out-of-Pocket Prescription Drug & Medical Combined (MOOP)	$7,350/Individual or $14,700/Family	$6,550/Individual or $13,100/Family	$7,350/Individual or $14,700/Family
Eligible Dependents	Dependents are covered until the end of the month at age 26.		
CLINIC SERVICES			
Primary Care Office Visits	$35	No Charge after Deductible	No Charge after Deductible/ First Three Free
Chiropractic Office Visits	$35	No Charge after Deductible	No Charge after Deductible
Preventive Health Examinations	No Charge	No Charge	No Charge
Specialist Care Office Visits	$75	No Charge after Deductible	No Charge after Deductible
Preventive Immunizations	No Charge	No Charge	No Charge
Prenatal and Postnatal Maternity Care	No Charge	No Charge	No Charge
Diagnostic X-Ray and Laboratory Test	40% after Deductible	No Charge after Deductible	No Charge after Deductible
Advanced Radiology	40% after Deductible	No Charge after Deductible	No Charge after Deductible
EMERGENCY AND URGENT CARE			
Urgent Care Visits	$75	No Charge after Deductible	No Charge after Deductible
Emergency Ambulance Service (air/ground)	No Charge	No Charge after Deductible	No Charge after Deductible
Emergency Room Visits	40% after Deductible	No Charge after Deductible	No Charge after Deductible
PRESCRIPTION DRUGS			
Tier 1	$35	No Charge after Deductible	No Charge after Deductible
Tier 2	35% after Deductible	No Charge after Deductible	No Charge after Deductible
Tier 3	40% after Deductible	No Charge after Deductible	No Charge after Deductible
Tier 4	45% after Deductible	No Charge after Deductible	No Charge after Deductible
The Prescription Drugs Benefit is administered by GHC-SCW Clinic pharmacies and Navitus. Prescription Drugs are NOT COVERED outside of the GHC-SCW network of providers. For a list of formulary drugs, tier ($) placement, prior authorization requirements and other limitations that may apply, see ghcscw.com.			
COMPLEMENTARY MEDICINE	$79 initial visit of Acupuncture, $75 initial visit of Naturopathy, $49 one-hour personal sessions for Acupuncture, Massage Therapy and Reiki. For HSA Plans, Copayment applies after Deductible.		
HOSPITAL SERVICES			
Inpatient Hospital Services: Physician Services, Surgery, Facility Fees	40% after Deductible	No Charge after Deductible	No Charge after Deductible
Outpatient Hospital Surgical/Non-Surgical Services, Facility Fees	40% after Deductible	No Charge after Deductible	No Charge after Deductible
Skilled Nursing Facility Services	40% after Deductible	No Charge after Deductible	No Charge after Deductible
VISION SERVICES			
Vision Examinations	No Charge	No Charge after Deductible	No Charge after Deductible
MENTAL HEALTH & SUBSTANCE USE DISORDER			
Outpatient Services	$35	No Charge after Deductible	No Charge after Deductible
Inpatient Services	40% after Deductible	No Charge after Deductible	No Charge after Deductible
Transitional Services	40% after Deductible	No Charge after Deductible	No Charge after Deductible

Federal funding of Cost Sharing Reductions (CSRs) may no longer exist in 2018. This uncertainty is contributing significantly to the premium increases for Silver Plans.

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PLAN LIMITATIONS & EXCLUSIONS

Consult the Summary of Benefits and Coverage (SBC) for a complete list of Limitations and Exclusions.

Important: This plan summary provides only a general description of benefits and limitations. You can find a detailed description of coverage in the Plan Certificate. Coverage is subject to all the terms and conditions of the Certificate and any amendments. If there is ever a discrepancy between this plan summary and the Certificate, the Certificate has final authority.

Benefit and Provider Information: HMO plans require the use of In-Network Providers. Benefits payments will be subject to the applicable Deductible, Coinsurance, Copayments, annual Maximum Out-of-Pocket, Lifetime Maximum Benefits, exclusions and limitations and other policy terms and conditions. A member's coverage depends on his or her eligibility under the terms and conditions of the GHC-SCW certificate.

Prior Authorization: Advance authorization for specific medical services or treatment. Services requiring prior authorization are specified in the Covered Health Services section of the Certificate and in the Benefits Summary. Failure to obtain prior authorization may result in a reduction or declination of coverage.

Premium Rates and Renewal Terms: Your premium is based on several factors, including your age and the benefit option you select. Premium rates may change from time to time. You must submit the initial monthly premium, along with your completed application materials to us. All subsequent premium payments should be sent to us along with a copy of the premium invoice. This Policy will remain in force and will renew for future periods of coverage if you pay your premiums on time. We will notify you of a premium change at least 30 days prior to your renewal date. We will provide a 60-day notice of any premium increase of 25% or more.

This Policy will become effective as of the date stated in your letter of acceptance. Renewal periods of coverage for this Policy are annually, and occur on January 1 for all individual policyholders. We will renew this Policy unless we discontinue offering this type of Policy in Wisconsin. The Policy is guaranteed renewable except for the reasons stated in Article II of the Certificate.

Emergency Outpatient Care: occurring at an Out-of-Network provider or facility may be subject to applicable limitations to include reasonable and customary charges, medical necessity determination or other provisions, exclusions or limitation of the policy.

Grievance Procedure: If a member has a question or concern that can't be resolved by our Member Services Department, he or she can file a written grievance detailing the reason(s) for disagreeing with our benefit or claim payment decision.

We define a "grievance" as meaning dissatisfaction with the provision of services or claims practices or administration of a health plan. This grievance is generally expressed to us in writing by a member or by a member's representative. A member may file a grievance with us by sending their written grievance to:

ATTN: Member Appeals
GHC-SCW Member Services Department
P.O. Box 44971
Madison, WI 53744-4971

Dependent Children: This Policy includes coverage for eligible dependent children through the end of the month they turn age 26. There may be tax consequences to individuals who enroll dependents who do not meet the IRS definitions of dependents/spouses. Individuals may want to consult with a tax advisor prior to enrolling dependents for this coverage.

HOW TO APPLY?

1) Go to **ghcscw.com**
2) Click on **"Get a Quote"**
3) Click on **"Get a Quote Individual/Family"**

You will be asked to complete a series of questions to receive your monthly premium rate.

Once you choose the plan that's right for you, you can apply:

- By visiting our website and selecting "Get a Quote."
- By visiting the Marketplace at healthcare.gov or by calling 1-800-318-2596.

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