











# GHC-SCW Individual Select ACA Plans 2019

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

	Monthly Premium	Out-of-Pocket Expenses
Platinum		
Gold		
Silver		
Bronze		
Catastrophic		

## 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 that 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 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 that your health insurer or plan has contracted with to provide Covered Health Services. Visit [ghcscw.com](http://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 2019 stipulate that an individual cannot pay more than \$7,900 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 health care that your health insurance does not cover. Some health insurance or plans don’t count all of your Copayments, Deductibles, Coinsurance payments, Out-of-Network payments or other expenses toward this limit.

### Where to find Complete Description of Covered Health Services

To see a complete description of Covered Health Services, please see your Member Certificate, Benefit Summary and any Amendments to your Benefit Plan at <http://planfinder.ghcscw.com/>. You can also see the Glossary of Health Coverage, Medical Terms and Summary of Benefits and Coverage (SBC). If you have questions regarding GHC-SCW benefits, please call Member Services at (608) 828-4853 or (800) 605-4327.

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.

## INDIVIDUAL SELECT ACA PLANS (2019)

<b>CLICK ON THE PLAN NAME FOR DETAILED PLAN DESCRIPTIONS.</b>	<b>Select Platinum No Ded/2000 MOOP</b>	<b>Select Platinum 500 Ded/1500 MOOP</b>
Plan Number on Marketplace	1912116	1912110
Plan Number off Marketplace (Direct)	1932116	1932110
Plan Offered Direct and/or on the Marketplace	Direct & Marketplace	Direct & Marketplace
Deductible - Medical (Based on Calendar Year)	\$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
Deductible - Medical & Prescription Combined (Based on Calendar Year)	N/A	N/A
Embedded/Non-Embedded	Embedded	Embedded
Policy Coinsurance	20%	20%
Maximum Out-of-Pocket Prescription Drug & Medical Combined (MOOP)	\$2,000/Individual or \$4,000/ Family	\$1,500/Individual or \$3,000/ Family
Eligible Dependents	Dependents are covered until the end of the month in which they turn 26.	
<b>Clinic Services</b>		
Primary Care Office Visits	\$10	\$20
Chiropractic Office Visits	\$10	\$20
Preventive Health Examinations	No Charge	No Charge
Specialist Care Office Visits	\$20	\$40
Preventive Immunizations	No Charge	No Charge
Prenatal and Postnatal Maternity Care	No Charge	No Charge
Diagnostic X-Ray and Laboratory Test	20% after Deductible	20% after Deductible
Advanced Radiology	20% after Deductible	20% after Deductible
<b>Emergency and Urgent Care</b>		
Urgent Care Visits	\$10	\$20
Emergency Ambulance Service (air/ground)	No Charge	No Charge
Emergency Room Visits	\$150	\$100
<b>Prescription Drugs</b>		
Tier 1	\$10	\$10
Tier 2	\$30	\$30
Tier 3	\$60	\$60
Tier 4	30% after Pharmacy Deductible up to \$500 maximum	30% after Pharmacy Deductible up to \$500 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 <a href="http://ghcscw.com">ghcscw.com</a> .		
<b>Complementary Medicine</b>	Copayments: \$79 initial visit of Acupuncture, \$75 initial visit of Naturopathy, \$49 one-hour personal sessions for Acupuncture, Massage Therapy and Reiki. For HSA/HDHP plans, Member pays the full cost of service before the Deductible is met, then Copayment applies.	
<b>Hospital Services</b>		
Inpatient Hospital Services: Physician Services, Surgery, Facility Fees	20% after Deductible	20% after Deductible
Outpatient Hospital Surgical/Non-Surgical Services: Facility Fees	20% after Deductible	20% after Deductible
Skilled Nursing Facility Services	20% after Deductible	20% after Deductible
<b>Vision Services</b>		
Vision Examinations	No Charge	No Charge
<b>Mental Health &amp; Substance Use Disorder</b>		
Outpatient Services	\$10	\$20
Inpatient Services	20% after Deductible	20% after Deductible
Transitional Services	20% after Deductible	20% after Deductible

**INDIVIDUAL SELECT ACA PLANS (2019)**

<b>CLICK ON THE PLAN NAME FOR DETAILED PLAN DESCRIPTIONS.</b>	<b>Select Gold 2000 Ded/2000 MOOP HSA</b>	<b>Select Gold Simple Choice 1400 Ded/5000 MOOP</b>	<b>Select Gold 2500 Ded/6500 MOOP</b>
Plan Number on Marketplace	1912210	1912213	1912216
Plan Number off Marketplace (Direct)	1932210	1932213	1932216
Plan Offered Direct and/or on the Marketplace	Direct & Marketplace	Direct & Marketplace	Direct & Marketplace
Deductible - Medical (Based on Calendar Year)	N/A	\$1,400/Individual or \$2,800/ Family	\$2,500/Individual or \$5,000/ Family
Deductible - Prescription (Based on Calendar Year)	N/A	\$0/Individual or \$0/Family	\$0/Individual or \$0/Family
Deductible - Medical & Prescription Combined (Based on Calendar Year)	\$2,000/Individual or \$4,000/ Family	N/A	N/A
Embedded/Non-Embedded	Non-Embedded	Embedded	Embedded
Policy Coinsurance	0%	20%	30%
Maximum Out-of-Pocket Prescription Drug & Medical Combined (MOOP)	\$2,000/Individual or \$4,000/ Family	\$5,000/Individual or \$10,000/ Family	\$6,500/Individual or \$13,000/ Family
Eligible Dependents	Dependents are covered until the end of the month in which they turn 26.		
<b>Clinic Services</b>			
Primary Care Office Visits	No Charge after Deductible	\$20	\$30
Chiropractic Office Visits	No Charge after Deductible	\$20	\$30
Preventive Health Examinations	No Charge	No Charge	No Charge
Specialist Care Office Visits	No Charge after Deductible	\$50	\$60
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	No Charge after Deductible	20% after Deductible	30% after Deductible
Advanced Radiology	No Charge after Deductible	20% after Deductible	30% after Deductible
<b>Emergency and Urgent Care</b>			
Urgent Care Visits	No Charge after Deductible	\$60	\$30
Emergency Ambulance Service (air/ground)	No Charge after Deductible	No Charge	No Charge
Emergency Room Visits	No Charge after Deductible	20% after Deductible	\$300
<b>Prescription Drugs</b>			
Tier 1	No Charge after Deductible	\$10	\$20
Tier 2	No Charge after Deductible	\$40	\$40
Tier 3	No Charge after Deductible	\$75	\$80
Tier 4	No Charge after Deductible	30% after Pharmacy Deductible	30% after Pharmacy Deductible up to \$750 maximum
<p>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 <a href="http://ghcscw.com">ghcscw.com</a>.</p>			
<b>Complementary Medicine</b>			
<p>Copayments: \$79 initial visit of Acupuncture, \$75 initial visit of Naturopathy, \$49 one-hour personal sessions for Acupuncture, Massage Therapy and Reiki. For HSA/HDHP plans, Member pays the full cost of service before the Deductible is met, then Copayment applies.</p>			
<b>Hospital Services</b>			
Inpatient Hospital Services: Physician Services, Surgery, Facility Fees	No Charge after Deductible	20% after Deductible	30% after Deductible
Outpatient Hospital Surgical/Non-Surgical Services: Facility Fees	No Charge after Deductible	20% after Deductible	30% after Deductible
Skilled Nursing Facility Services	No Charge after Deductible	20% after Deductible	30% after Deductible
<b>Vision Services</b>			
Vision Examinations	No Charge after Deductible	No Charge	No Charge
<b>Mental Health &amp; Substance Use Disorder</b>			
Outpatient Services	No Charge after Deductible	\$20	\$30
Inpatient Services	No Charge after Deductible	20% after Deductible	30% after Deductible
Transitional Services	No Charge after Deductible	20% after Deductible	30% after Deductible

## INDIVIDUAL SELECT ACA PLANS (2019)

<b>CLICK ON THE PLAN NAME FOR DETAILED PLAN DESCRIPTIONS.</b>	<b>Select Silver 2000 Ded/6000 MOOP</b>	<b>Select Silver 4900 Ded/7900 MOOP</b>	<b>Select Silver 5250 Ded/5250 MOOP HSA</b>
Plan Number on Marketplace	1912325	1912355	1912361
Plan Number off Marketplace (Direct)	1932325	1932355	1932361
Plan Offered Direct and/or on the Marketplace	Direct & Marketplace	Direct & Marketplace	Direct & Marketplace
Deductible - Medical (Based on Calendar Year)	\$2,000/Individual or \$4,000/ Family	N/A	N/A
Deductible - Prescription (Based on Calendar Year)	\$0/Individual or \$0/Family	N/A	N/A
Deductible - Medical & Prescription Combined (Based on Calendar Year)	N/A	\$4,900/Individual or \$9,800/ Family	\$5,250/Individual or \$10,500/ Family
Embedded/Non-Embedded	Embedded	Embedded	Embedded
Policy Coinsurance	30%	30%	0%
Maximum Out-of-Pocket Prescription Drug & Medical Combined (MOOP)	\$6,000/Individual or \$12,000/ Family	\$7,900/Individual or \$15,800/ Family	\$5,250/Individual or \$10,500/ Family
Eligible Dependents	Dependents are covered until the end of the month in which they turn 26.		
<b>Clinic Services</b>			
Primary Care Office Visits	30% after Deductible	\$30	No Charge after Deductible
Chiropractic Office Visits	30% after Deductible	\$30	No Charge after Deductible
Preventive Health Examinations	No Charge	No Charge	No Charge
Specialist Care Office Visits	30% after Deductible	\$75	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	30% after Deductible	30% after Deductible	No Charge after Deductible
Advanced Radiology	30% after Deductible	30% after Deductible	No Charge after Deductible
<b>Emergency and Urgent Care</b>			
Urgent Care Visits	30% after Deductible	\$30	No Charge after Deductible
Emergency Ambulance Service (air/ground)	No Charge	No Charge	No Charge after Deductible
Emergency Room Visits	30% after Deductible	30% after Deductible	No Charge after Deductible
<b>Prescription Drugs</b>			
Tier 1	\$30	\$40	No Charge after Deductible
Tier 2	\$60	\$80	No Charge after Deductible
Tier 3	50% after Pharmacy Deductible	30% after Deductible	No Charge after Deductible
Tier 4	50% after Pharmacy Deductible up to \$1,000 maximum	30% 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 <a href="http://ghcscw.com">ghcscw.com</a> .			
<b>Complementary Medicine</b>	Copayments: \$79 initial visit of Acupuncture, \$75 initial visit of Naturopathy, \$49 one-hour personal sessions for Acupuncture, Massage Therapy and Reiki. For HSA/HDHP plans, Member pays the full cost of service before the Deductible is met, then Copayment applies.		
<b>Hospital Services</b>			
Inpatient Hospital Services: Physician Services, Surgery, Facility Fees	30% after Deductible	30% after Deductible	No Charge after Deductible
Outpatient Hospital Surgical/Non-Surgical Services: Facility Fees	30% after Deductible	30% after Deductible	No Charge after Deductible
Skilled Nursing Facility Services	30% after Deductible	30% after Deductible	No Charge after Deductible
<b>Vision Services</b>			
Vision Examinations	No Charge	No Charge	No Charge after Deductible
<b>Mental Health &amp; Substance Use Disorder</b>			
Outpatient Services	30% after Deductible	\$30	No Charge after Deductible
Inpatient Services	30% after Deductible	30% after Deductible	No Charge after Deductible
Transitional Services	30% after Deductible	30% after Deductible	No Charge after Deductible

**INDIVIDUAL SELECT ACA PLANS (2019)**

<b>CLICK ON THE PLAN NAME FOR DETAILED PLAN DESCRIPTIONS.</b>	<b>Select Silver Simple Choice 4000X Ded/7350 MOOP</b>	<b>Select Silver 3000 Ded/7350 MOOP</b>	<b>Select Silver 4000 Ded/4000 MOOP HSA</b>
Plan Number on Marketplace	1912343	N/A	N/A
Plan Number off Marketplace (Direct)	1932343	1932319	1932331
Plan Offered Direct and/or on the Marketplace	Direct & Marketplace	Direct Only	Direct Only
Deductible - Medical (Based on Calendar Year)	\$3,500/Individual or \$7,000/Family	\$3,000/Individual or \$6,000/Family	N/A
Deductible - Prescription (Based on Calendar Year)	\$500/Individual or \$1,000/Family	\$0/Individual or \$0/Family	N/A
Deductible - Medical & Prescription Combined (Based on Calendar Year)	N/A	N/A	\$4,000/Individual or \$8,000/Family
Embedded/Non-Embedded	Embedded	Embedded	Embedded
Policy Coinsurance	20%	30%	0%
Maximum Out-of-Pocket Prescription Drug & Medical Combined (MOOP)	\$7,350/Individual or \$14,700/Family	\$7,350/Individual or \$14,700/Family	\$4,000/Individual or \$8,000/Family
Eligible Dependents	Dependents are covered until the end of the month in which they turn 26.		
<b>Clinic Services</b>			
Primary Care Office Visits	\$30	\$50	No Charge after Deductible
Chiropractic Office Visits	\$30	\$50	No Charge after Deductible
Preventive Health Examinations	No Charge	No Charge	No Charge
Specialist Care Office Visits	\$65	\$100	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	20% after Deductible	30% after Deductible	No Charge after Deductible
Advanced Radiology	20% after Deductible	30% after Deductible	No Charge after Deductible
<b>Emergency and Urgent Care</b>			
Urgent Care Visits	\$75	\$50	No Charge after Deductible
Emergency Ambulance Service (air/ground)	No Charge	No Charge	No Charge after Deductible
Emergency Room Visits	20% after Deductible	30% after Deductible	No Charge after Deductible
<b>Prescription Drugs</b>			
Tier 1	\$20	\$30	No Charge after Deductible
Tier 2	\$50	\$60	No Charge after Deductible
Tier 3	\$100	\$120	No Charge after Deductible
Tier 4	40% after Pharmacy Deductible	30% after Pharmacy Deductible up to \$1,000 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 <a href="http://ghcscw.com">ghcscw.com</a> .			
<b>Complementary Medicine</b>	Copayments: \$79 initial visit of Acupuncture, \$75 initial visit of Naturopathy, \$49 one-hour personal sessions for Acupuncture, Massage Therapy and Reiki. For HSA/HDHP plans, Member pays the full cost of service before the Deductible is met, then Copayment applies.		
<b>Hospital Services</b>			
Inpatient Hospital Services: Physician Services, Surgery, Facility Fees	20% after Deductible	30% after Deductible	No Charge after Deductible
Outpatient Hospital Surgical/Non-Surgical Services: Facility Fees	20% after Deductible	30% after Deductible	No Charge after Deductible
Skilled Nursing Facility Services	20% after Deductible	30% after Deductible	No Charge after Deductible
<b>Vision Services</b>			
Vision Examinations	No Charge	No Charge	No Charge after Deductible
<b>Mental Health &amp; Substance Use Disorder</b>			
Outpatient Services	\$30	\$50	No Charge after Deductible
Inpatient Services	20% after Deductible	30% after Deductible	No Charge after Deductible
Transitional Services	20% after Deductible	30% after Deductible	No Charge after Deductible

**INDIVIDUAL SELECT ACA PLANS (2019)**

<b>CLICK ON THE PLAN NAME FOR DETAILED PLAN DESCRIPTIONS.</b>	<b>Select Bronze 4000 Ded/7350 MOOP</b>	<b>Select Bronze Simple Choice 6650 Ded/7350 MOOP</b>	<b>Select Bronze 6550 Ded/6550 MOOP HSA</b>	<b>Select Bronze 7900 Ded/7900 MOOP</b>
Plan Number on Marketplace	1912401	1912407	1912404	1912416
Plan Number off Marketplace (Direct)	1932401	1932407	1932404	1932416
Plan Offered Direct and/or on the Marketplace	Direct & Marketplace	Direct & Marketplace	Direct & Marketplace	Direct & Marketplace
Deductible - Medical (Based on Calendar Year)	\$4,000/Individual or \$8,000/ Family	N/A	N/A	N/A
Deductible - Prescription (Based on Calendar Year)	\$0/Individual or \$0/Family	N/A	N/A	N/A
Deductible - Medical & Prescription Combined (Based on Calendar Year)	N/A	\$6,650/Individual or \$13,300/ Family	\$6,550/Individual or \$13,100/ Family	\$7,900/Individual or \$15,800/ Family
Embedded/Non-Embedded	Embedded	Embedded	Embedded	Embedded
Policy Coinsurance	40%	40%	0%	0%
Maximum Out-of-Pocket Prescription Drug & Medical Combined (MOOP)	\$7,350/Individual or \$14,700/ Family	\$7,350/Individual or \$14,700/ Family	\$6,550/Individual or \$13,100/ Family	\$7,900/Individual or \$15,800/ Family
Eligible Dependents	Dependents are covered until the end of the month in which they turn 26.			
<b>Clinic Services</b>				
Primary Care Office Visits	\$125	\$35	No Charge after Deductible	\$100
Chiropractic Office Visits	\$125	\$35	No Charge after Deductible	\$100
Preventive Health Examinations	No Charge	No Charge	No Charge	No Charge
Specialist Care Office Visits	\$250	\$75	No Charge after Deductible	\$175
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	40% after Deductible	40% after Deductible	No Charge after Deductible	No Charge after Deductible
Advanced Radiology	40% after Deductible	40% after Deductible	No Charge after Deductible	No Charge after Deductible
<b>Emergency and Urgent Care</b>				
Urgent Care Visits	\$125	\$75	No Charge after Deductible	\$100
Emergency Ambulance Service (air/ground)	No Charge	No Charge	No Charge after Deductible	No Charge
Emergency Room Visits	40% after Deductible	40% after Deductible	No Charge after Deductible	No Charge after Deductible
<b>Prescription Drugs</b>				
Tier 1	\$50	\$35	No Charge after Deductible	No Charge after Deductible
Tier 2	\$150	35% after Deductible	No Charge after Deductible	No Charge after Deductible
Tier 3	\$250	40% after Deductible	No Charge after Deductible	No Charge after Deductible
Tier 4	50% after Pharmacy Deductible	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 <a href="http://ghcscw.com">ghcscw.com</a> .				
<b>Complementary Medicine</b>	Copayments: \$79 initial visit of Acupuncture, \$75 initial visit of Naturopathy, \$49 one-hour personal sessions for Acupuncture, Massage Therapy and Reiki. For HSA/HDHP plans, Member pays the full cost of service before the Deductible is met, then Copayment applies.			
<b>Hospital Services</b>				
Inpatient Hospital Services: Physician Services, Surgery, Facility Fees	40% after Deductible	40% after Deductible	No Charge after Deductible	No Charge after Deductible
Outpatient Hospital Surgical/Non-Surgical Services: Facility Fees	40% after Deductible	40% after Deductible	No Charge after Deductible	No Charge after Deductible
Skilled Nursing Facility Services	40% after Deductible	40% after Deductible	No Charge after Deductible	No Charge after Deductible
<b>Vision Services</b>				
Vision Examinations	No Charge	No Charge	No Charge after Deductible	No Charge
<b>Mental Health &amp; Substance Use Disorder</b>				
Outpatient Services	\$125	\$35	No Charge after Deductible	\$100
Inpatient Services	40% after Deductible	40% after Deductible	No Charge after Deductible	No Charge after Deductible
Transitional Services	40% after Deductible	40% after Deductible	No Charge after Deductible	No Charge after Deductible

## INDIVIDUAL SELECT ACA PLANS (2019)

CLICK ON THE PLAN NAME FOR DETAILED PLAN DESCRIPTIONS.	Select Catastrophic 7900 Ded/7900 MOOP
Plan Number on Marketplace	1912001
Plan Number off Marketplace (Direct)	1932001
Plan Offered Direct and/or on the Marketplace	Direct & Marketplace
Deductible - Medical (Based on Calendar Year)	N/A
Deductible - Prescription (Based on Calendar Year)	N/A
Deductible - Medical & Prescription Combined (Based on Calendar Year)	\$7,900/Individual or \$15,800/Family
Embedded/Non-Embedded	Embedded
Policy Coinsurance	0%
Maximum Out-of-Pocket Prescription Drug & Medical Combined (MOOP)	\$7,900/Individual or \$15,800/Family
Eligible Dependents	Dependents are covered until the end of the month in which they turn 26.
<b>Clinic Services</b>	
Primary Care Office Visits	No Charge after Deductible; First three (3) visits free
Chiropractic Office Visits	No Charge after Deductible
Preventive Health Examinations	No Charge
Specialist Care Office Visits	No Charge after Deductible
Preventive Immunizations	No Charge
Prenatal and Postnatal Maternity Care	No Charge
Diagnostic X-Ray and Laboratory Test	No Charge after Deductible
Advanced Radiology	No Charge after Deductible
<b>Emergency and Urgent Care</b>	
Urgent Care Visits	No Charge after Deductible
Emergency Ambulance Service (air/ground)	No Charge after Deductible
Emergency Room Visits	No Charge after Deductible
<b>Prescription Drugs</b>	
Tier 1	No Charge after Deductible
Tier 2	No Charge after Deductible
Tier 3	No Charge after Deductible
Tier 4	No Charge after Deductible
<p>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 <a href="http://ghcscw.com">ghcscw.com</a>.</p>	
<b>Complementary Medicine</b>	
	Copayments: \$79 initial visit of Acupuncture, \$75 initial visit of Naturopathy, \$49 one-hour personal sessions for Acupuncture, Massage Therapy and Reiki. For HSA/HDHP plans, Member pays the full cost of service before the Deductible is met, then Copayment applies.
<b>Hospital Services</b>	
Inpatient Hospital Services: Physician Services, Surgery, Facility Fees	No Charge after Deductible
Outpatient Hospital Surgical/Non-Surgical Services: Facility Fees	No Charge after Deductible
Skilled Nursing Facility Services	No Charge after Deductible
<b>Vision Services</b>	
Vision Examinations	No Charge after Deductible
<b>Mental Health &amp; Substance Use Disorder</b>	
Outpatient Services	No Charge after Deductible
Inpatient Services	No Charge after Deductible
Transitional Services	No Charge after Deductible

## PLAN LIMITATIONS & EXCLUSIONS

This is an outline of the Limitations and Exclusions for the Group Health Cooperative of South Central Wisconsin (GHC-SCW) group and individual health plans. It is designed for reference only. Consult the Policy, Policy Amendments, Certificate of Coverage and Benefits Summary for a complete list of Limitations and Exclusions.

The following services and expenses are not covered, and no benefits will be payable unless stated otherwise for expenses arising from:

Medical care or services provided by a non-GHC-SCW Provider, whether or not under contract with GHC-SCW. Using a non-GHC-SCW Provider or an Out-of-Plan Provider is not covered and the member will be financially responsible for full payment of care and services unless: written approval for Out-of-Plan care and services has been obtained from GHC-SCW's Care Management Department prior to obtaining the medical care; or, service is for an Emergency Condition or an Urgent Condition when the member is outside of the GHC-SCW Service Area; or, the plan provides for the use of non-GHC-SCW Providers

Services that are not medically necessary, are experimental, investigative or for research purposes

Billed amounts that are over and above the GHC-SCW reasonable and customary fees and charges for covered benefits

Items or services required as a result of war or any act of war, insurrection, riot, terrorism, or sustained while performing military services

Services provided before the effective date or after the termination date of the Policy or Certificate of coverage

Services related to an admission or confinement which occurs prior to and continues on or after the member's effective date when GHC-SCW coverage replaces other group coverage.

Services while incarcerated, except as specifically required by state or federal law

Charges for missed appointment(s)

Services for injuries incurred during the commission of a crime

Blood donor services

Common use supplies

Complementary Medicine services not specifically covered under the Policy or Certificate of coverage

Complications, consultations, services and procedures related to a non-covered procedure

Cosmetic services

Custodial care

Dental services not specifically covered under the Policy or Certificate of coverage

Drug screening, except as specifically covered under the Policy or Certificate of coverage

Duplicate services

Durable medical equipment and medical supplies not specifically covered under the Policy or Certificate of coverage

Elective abortions

Electrolysis services

Emergency outpatient services when a member leaves the emergency room prior to seeing a physician

End of life services not specifically included under the Policy or Certificate of coverage

Food or nutrition that is not medical food that is specifically covered under the Policy or Certificate

Functional capacity evaluations

Gastro-intestinal surgical procedures for purposes of weight loss

Growth hormone for the treatment of idiopathic short stature

Hair implants/transplants

Hearing aid repair costs, batteries, and ancillary equipment

Home health visits beyond the amount specified in the Policy or Certificate of coverage

Home modifications

Hospital services for a Skilled Nursing Facility beyond the amount specified in the Policy or Certificate of coverage

Housecleaning

Hypnotherapy services

Infertility services not specifically covered under the Policy or Certificate of coverage, and services beyond the Benefit Maximum specified in the Benefits Summary

Insulin injection pens not included in the GHC formulary.

Keratorefractive surgery

Maintenance care and/or therapy

Mental health and substance use disorder services beyond the services specified in the Policy or Certificate of coverage

Obesity-related services

Outpatient rehabilitation therapies and habilitation services beyond the services specified in the Policy or Certificate of coverage

Over the counter supplies

Personal comfort items

Prescription drugs or contraceptive devices unless specifically included under the Policy or Certificate of coverage

Private duty nursing services

Prolotherapy

Services performed by a family member

Scar revisions

Sensory integration therapy

Specialty medical care provided by a non-GHC-SCW Provider, whether or not under contract with GHC-SCW, when the service requested may be provided by a GHC-SCW Specialty Provider

Sperm banking or egg harvesting

Supportive care and/or therapy

Surgical services and treatment to correct or reverse complications and/or dissatisfaction resulting from surgery, cosmetic treatment, or reconstruction when no functional impairment exists, as determined by GHC-SCW

Surrogate maternity services

Tattoos: services for the removal of tattoos or complications related to tattoos

Transplant donor services when the recipient is not a current member under this certificate.

Recreational and educational therapy, therapy for congenital conditions (unless specifically included under the Policy or Certificate of coverage), telephonic mental health care therapy session, sexual dysfunction therapy, financial and occupational counseling, and therapies beyond the services specified in the Policy or Certificate of coverage

Therapies (including, but not limited to physical therapy, occupational therapy, vision therapy, speech therapy, and hearing treatments) for the treatment of non-acute medical conditions, which may include but are not limited to: chronic brain injuries, developmental delay, intellectual disability, and cerebral palsy

Third-party examinations

Tongue thrust services or treatment

Transplants, except for those specified in the Policy or Certificate of coverage and services, any organ or tissue which is sold rather than donated, involving non-human or artificial organs and tissues, and human to human organ or tissue transplant other than those specifically listed and specified within the Policy or Certificate of coverage

Transportation services and costs, except medically necessary ambulance services

Travel immunizations, unless specifically included under the Policy or Certificate of Coverage

Vocational rehabilitation services

Vision services, and eyewear for all members (to include lenses, frames, contact lenses, contact lens prescriptions or contact lens fitting), unless specifically included under the Policy or Certificate of coverage

Workers' compensation items and services incidental to an injury or conditions covered by any workers' compensation law or occupational disease law

For HMO plans, out-of-area dependents (who do not reside in the service area) are only eligible for out-of-area care as specified in the Policy or Certificate of coverage, unless the plan provides for the use of non-GHC-SCW Providers

## COVERAGE INFORMATION

**Important:** This plan summary provides only a general description of benefits and limitations. You can find a detailed description of coverage in the Individual 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 Individual Certificate, the Individual Certificate has final authority.

### Benefit and Provider Information

The GHC-SCW Individual Certificate requires the use of In-Network Providers. Benefits payments will be subject to the applicable Deductible, Co-insurance, annual Out-Of-Pocket Maximums, Copayments, 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** means 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 a number of 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 as long as 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 policyholders. We will renew this Policy unless we discontinue offering this type of Individual Policy in Wisconsin. The Policy is guaranteed renewable except for the reasons stated in the Individual Certificate, Article II.

**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** The GHC-SCW Individual 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.