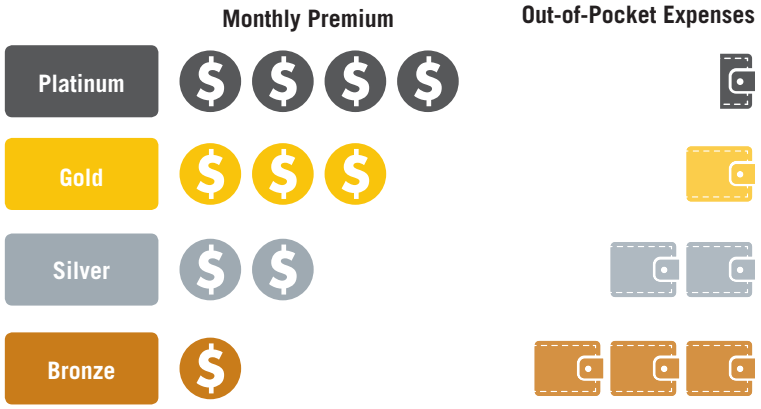
GHC-SCW Individual HMO ACA Plans 2020

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.

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 2020 stipulate that an individual cannot pay more than $8,150 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 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.

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 HMO ACA PLANS (2020)

CLICK ON THE PLAN NAME FOR DETAILED PLAN DESCRIPTIONS	Platinum No Ded/2000 MOOP	Platinum 500 Ded/1500 MOOP
Plan Number on Marketplace	2011116	2011110
Plan Number off Marketplace (Direct)	2031116	2031110
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 & 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	
Clinic Services		
Primary Care Office Visits	$10	$20
Chiropractic Office Visits	$10	$20
Preventive Health Examinations	No Charge	No Charge
Specialist Care Office Visits	$20	$40
Preventitive 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
Emergency and Urgent Care		
Urgent Care Visits	$10	$20
Emergency Ambulance Service (air/ground)	20% after Deductible	20% after Deductible
Emergency Room Visits	$400	$100
Prescription Drugs		
Tier 1	$10	$10
Tier 2	$30	$30
Tier 3	$60	$60
Tier 4	30% after Pharmacy Deductible	30% after Pharmacy Deductible
The Prescription Drugs Benefit is administered by GHC-SCW Clinic pharmacies and Navitus. Prescription Drugs are NOT COVERED outside of the GHC-SCW network of providers. For a list of formulary drugs, tier ($) placement, prior authorization requirements and other limitations that may apply, see **ghcscw.com**.		
Complementary Medicine	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.	
Hospital Services		
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
Vision Services		
Vision Examinations	No Charge	No Charge
Mental Health & Substance Use Disorder		
Outpatient Services	$10	$20
Inpatient Services	20% after Deductible	20% after Deductible
Transitional Services	20% after Deductible	20% after Deductible

INDIVIDUAL HMO ACA PLANS (2020)

CLICK ON THE PLAN NAME FOR DETAILED PLAN DESCRIPTIONS	Gold 2500 Ded/2500 MOOP HSA	Gold Simple Choice 1600 Ded/5200 MOOP	Gold 2500 Ded/6500 MOOP	Gold 1500 Ded/8150 MOOP
Plan Number on Marketplace	2011210	2011213	2011216	2011220
Plan Number off Marketplace (Direct)	2031210	2031213	2031216	2031220
Plan Offered Direct and/or on the Marketplace	Direct & Marketplace	Direct & Marketplace	Direct & Marketplace	Direct & Marketplace
Deductible - Medical (Based on Calendar Year)	N/A	$1,600/Individual or $3,200/Family	$2,500/Individual or $5,000/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)	$2,500/Individual or $5,000/Family	N/A	N/A	$1,500/Individual or $3,000/Family
Embedded/Non-Embedded	Non-Embedded	Embedded	Embedded	Embedded
Policy Coinsurance	0%	20%	30%	30%
Maximum Out-of-Pocket Prescription & Medical Combined (MOOP)	$2,500/Individual or $5,000/Family	$5,200/Individual or $10,400/Family	$6,500/Individual or $13,000/Family	$8,150/Individual or $16,300/Family
Eligible Dependents	Dependents are covered until the end of the month in which they turn 26			
Clinic Services				
Primary Care Office Visits	No Charge after Deductible	$20	$30	$10
Chiropractic Office Visits	No Charge after Deductible	$20	$30	$10
Preventive Health Examinations	No Charge	No Charge	No Charge	No Charge
Specialist Care Office Visits	No Charge after Deductible	$60	$60	$120
Preventitive 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	20% after Deductible	30% after Deductible	30% after Deductible
Advanced Radiology	No Charge after Deductible	20% after Deductible	30% after Deductible	30% after Deductible
Emergency and Urgent Care				
Urgent Care Visits	No Charge after Deductible	$60	$30	$10
Emergency Ambulance Service (air/ground)	No Charge after Deductible	20% after Deductible	30% after Deductible	30% after Deductible
Emergency Room Visits	No Charge after Deductible	20% after Deductible	$300	$750
Prescription Drugs				
Tier 1	No Charge after Deductible	$10	$20	$5
Tier 2	No Charge after Deductible	$50	$40	$80
Tier 3	No Charge after Deductible	$75	$80	$150
Tier 4	No Charge after Deductible	30% after Pharmacy Deductible	30% after Pharmacy Deductible	$450
The Prescription Drugs Benefit is administered by GHC-SCW Clinic pharmacies and Navitus. Prescription Drugs are NOT COVERED outside of the GHC-SCW network of providers. For a list of formulary drugs, tier ($) placement, prior authorization requirements and other limitations that may apply, see **ghcscw.com**.				
Complementary Medicine	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.			
Hospital Services				
Inpatient Hospital Services: Physician Services, Surgery, Facility Fees	No Charge after Deductible	20% after Deductible	30% after Deductible	30% after Deductible
Outpatient Hospital Surgical/Non-Surgical Services: Facility Fees	No Charge after Deductible	20% after Deductible	30% after Deductible	30% after Deductible
Skilled Nursing Facility Services	No Charge after Deductible	20% after Deductible	30% after Deductible	30% after Deductible
Vision Services				
Vision Examinations	No Charge after Deductible	No Charge	No Charge	No Charge
Mental Health & Substance Use Disorder				
Outpatient Services	No Charge after Deductible	$20	$30	$10
Inpatient Services	No Charge after Deductible	20% after Deductible	30% after Deductible	30% after Deductible
Transitional Services	No Charge after Deductible	20% after Deductible	30% after Deductible	30% after Deductible

INDIVIDUAL HMO ACA PLANS (2020)

CLICK ON THE PLAN NAME FOR DETAILED PLAN DESCRIPTIONS	Silver Simple Choice 4550X Ded/7900 MOOP	Silver 4900 Ded/7900 MOOP	Silver 8100X Ded/8150 MOOP	Silver 4200 Ded/4200 MOOP HSA
Plan Number on Marketplace	2011343	2011355	2011367	N/A
Plan Number off Marketplace (Direct)	2031343	2031355	2031367	2031331
Plan Offered Direct and/or on the Marketplace	Direct & Marketplace	Direct & Marketplace	Direct & Marketplace	Direct Only
Deductible - Medical (Based on Calendar Year)	$4,000/Individual or $8,000/Family	N/A	$7,500/Individual or $15,000/Family	N/A
Deductible - Prescription (Based on Calendar Year)	$550/Individual or $1,100/Family	N/A	$600/Individual or $1,200/Family	N/A
Deductible - Medical & Prescription Combined (Based on Calendar Year)	N/A	$4,900/Individual or $9,800/Family	N/A	$4,200/Individual or $8,400/Family
Embedded/Non-Embedded	Embedded	Embedded	Embedded	Embedded
Policy Coinsurance	20%	30%	30%	0%
Maximum Out-of-Pocket Prescription & Medical Combined (MOOP)	$7,900/Individual or $15,800/Family	$7,900/Individual or $15,800/Family	$8,150/Individual or $16,300/Family	$4,200/Individual or $8,400/Family
Eligible Dependents	Dependents are covered until the end of the month in which they turn 26			
Clinic Services				
Primary Care Office Visits	$40	$30	$35	No Charge after Deductible
Chiropractic Office Visits	$40	$30	$35	No Charge after Deductible
Preventive Health Examinations	No Charge	No Charge	No Charge	No Charge
Specialist Care Office Visits	$90	$75	$125	No Charge after Deductible
Preventitive 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	No Charge after Deductible
Advanced Radiology	20% after Deductible	30% after Deductible	30% after Deductible	No Charge after Deductible
Emergency and Urgent Care				
Urgent Care Visits	$90	$30	$35	No Charge after Deductible
Emergency Ambulance Service (air/ground)	20% after Deductible	30% after Deductible	30% after Deductible	No Charge after Deductible
Emergency Room Visits	20% after Deductible	30% after Deductible	30% after Deductible	No Charge after Deductible
Prescription Drugs				
Tier 1	$25	$40	$25	No Charge after Deductible
Tier 2	$65	$80	$65	No Charge after Deductible
Tier 3	$200	30% after Deductible	$200	No Charge after Deductible
Tier 4	50% after Pharmacy Deductible	30% after Deductible	50% after Pharmacy Deductible	No Charge after Deductible
The Prescription Drugs Benefit is administered by GHC-SCW Clinic pharmacies and Navitus. Prescription Drugs are NOT COVERED outside of the GHC-SCW network of providers. For a list of formulary drugs, tier ($) placement, prior authorization requirements and other limitations that may apply, see **ghcscw.com**.				
Complementary Medicine	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.			
Hospital Services				
Inpatient Hospital Services: Physician Services, Surgery, Facility Fees	20% after Deductible	30% after Deductible	30% after Deductible	No Charge after Deductible
Outpatient Hospital Surgical/Non-Surgical Services: Facility Fees	20% after Deductible	30% after Deductible	30% after Deductible	No Charge after Deductible
Skilled Nursing Facility Services	20% after Deductible	30% after Deductible	30% 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	$40	$30	$35	No Charge after Deductible
Inpatient Services	20% after Deductible	30% after Deductible	30% after Deductible	No Charge after Deductible
Transitional Services	20% after Deductible	30% after Deductible	30% after Deductible	No Charge after Deductible

INDIVIDUAL HMO ACA PLANS (2020)

CLICK ON THE PLAN NAME FOR DETAILED PLAN DESCRIPTIONS	Bronze Simple Choice 6750 Ded/7650 MOOP	Bronze 4000 Ded/7350 MOOP	Bronze 6900 Ded/6900 MOOP HSA	Bronze 8150 Ded/8150 MOOP
Plan Number on Marketplace	2011407	2011401	2011404	2011416
Plan Number off Marketplace (Direct)	2031407	2031401	2031404	2031416
Plan Offered Direct and/or on the Marketplace	Direct & Marketplace	Direct & Marketplace	Direct & Marketplace	Direct & Marketplace
Deductible - Medical (Based on Calendar Year)	N/A	$4,000/Individual or $8,000/Family	N/A	N/A
Deductible - Prescription (Based on Calendar Year)	N/A	$0/Individual or $0/Family	N/A	N/A
Deductible - Medical & Prescription Combined (Based on Calendar Year)	$6,750/Individual or $13,500/Family	N/A	$6,900/Individual or $13,800/Family	$8,150/Individual or $16,300/Family
Embedded/Non-Embedded	Embedded	Embedded	Embedded	Embedded
Policy Coinsurance	40%	40%	0%	0%
Maximum Out-of-Pocket Prescription & Medical Combined (MOOP)	$7,650/Individual or $15,300/Family	$7,350/Individual or $14,700/Family	$6,900/Individual or $13,800/Family	$8,150/Individual or $16,300/Family
Eligible Dependents	Dependents are covered until the end of the month in which they turn 26			
Clinic Services				
Primary Care Office Visits	$35	$125	No Charge after Deductible	$125
Chiropractic Office Visits	$35	$125	No Charge after Deductible	$125
Preventive Health Examinations	No Charge	No Charge	No Charge	No Charge
Specialist Care Office Visits	$95	$250	No Charge after Deductible	$175
Preventitive 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
Emergency and Urgent Care				
Urgent Care Visits	$75	$125	No Charge after Deductible	$125
Emergency Ambulance Service (air/ground)	40% after Deductible	40% after Deductible	No Charge after Deductible	No Charge after Deductible
Emergency Room Visits	40% after Deductible	40% after Deductible	No Charge after Deductible	No Charge after Deductible
Prescription Drugs				
Tier 1	$35	$50	No Charge after Deductible	$35
Tier 2	35% after Deductible	$200	No Charge after Deductible	No Charge after Deductible
Tier 3	40% after Deductible	$300	No Charge after Deductible	No Charge after Deductible
Tier 4	45% after Deductible	50% after Pharmacy Deductible	No Charge after Deductible	No Charge after Deductible
The Prescription Drugs Benefit is administered by GHC-SCW Clinic pharmacies and Navitus. Prescription Drugs are NOT COVERED outside of the GHC-SCW network of providers. For a list of formulary drugs, tier ($) placement, prior authorization requirements and other limitations that may apply, see **ghcscw.com**.				
Complementary Medicine	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.			
Hospital Services				
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
Vision Services				
Vision Examinations	No Charge	No Charge	No Charge after Deductible	No Charge
Mental Health & Substance Use Disorder				
Outpatient Services	$35	$125	No Charge after Deductible	$125
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

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

Gene Therapy

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-SCW 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

New-to-Market Drugs and Treatments are subject to an exclusion period of six (6) months

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.