

GHC-SCW Individual Select ACA Plans 2021

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	\$\$\$	1
Gold	\$\$\$	2
Silver	\$\$	3
Bronze	\$	4
Catastrophic	\$	4

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 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 2021 stipulate that an individual cannot pay more than \$8,550 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.



of South Central Wisconsin

ghcscw.com

MK20-63-0(7.20)0

INDIVIDUAL SELECT ACA PLANS 2021

CLICK ON THE PLAN NAME FOR DETAILED PLAN DESCRIPTIONS	Select Platinum No Ded/2000 MOOP	Select Platinum 500 Ded/1500 MOOP
Plan Number on Marketplace	2112116	2112110
Plan Number off Marketplace (Direct)	2132116	2132110
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
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
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 SELECT ACA PLANS 2021

CLICK ON THE PLAN NAME FOR DETAILED PLAN DESCRIPTIONS	Select Gold Simple Choice 1600 Ded/5400 MOOP	Select Gold 2500 Ded/2500 MOOP HSA	Select Gold 2500 Ded/6500 MOOP	Select Gold 1500 Ded/8550 MOOP
Plan Number on Marketplace	2112213	2112210	2112216	2112220
Plan Number off Marketplace (Direct)	2132213	2132210	2132216	2132220
Plan Offered Direct and/or on the Marketplace	Direct & Marketplace	Direct & Marketplace	Direct & Marketplace	Direct & Marketplace
Deductible - Medical (Based on Calendar Year)	\$1,600/Individual or \$3,200/Family	N/A	\$2,500/Individual or \$5,000/Family	N/A
Deductible - Prescription (Based on Calendar Year)	\$0/Individual or \$0/Family	N/A	\$0/Individual or \$0/Family	N/A
Deductible - Medical & Prescription Combined (Based on Calendar Year)	N/A	\$2,500/Individual or \$5,000/Family	N/A	\$1,500/Individual or \$3,000/Family
Embedded/Non-Embedded	Embedded	Non-Embedded	Embedded	Embedded
Policy Coinsurance	20%	0%	30%	30%
Maximum Out-of-Pocket Prescription & Medical Combined (MOOP)	\$5,400/Individual or \$10,800/Family	\$2,500/Individual or \$5,000/Family	\$6,500/Individual or \$13,000/Family	\$8,550/Individual or \$17,100/Family
Eligible Dependents	Dependents are covered until the end of the month in which they turn 26			
Clinic Services				
Primary Care Office Visits	\$25	No Charge after Deductible	\$30	\$10
Chiropractic Office Visits	\$25	No Charge after Deductible	\$30	\$10
Preventive Health Examinations	No Charge	No Charge	No Charge	No Charge
Specialist Care Office Visits	\$65	No Charge after Deductible	\$60	\$120
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	No Charge after Deductible	30% after Deductible	30% after Deductible
Advanced Radiology	20% after Deductible	No Charge after Deductible	30% after Deductible	30% after Deductible
Emergency and Urgent Care				
Urgent Care Visits	\$65	No Charge after Deductible	\$30	\$10
Emergency Ambulance Service (air/ground)	20% after Deductible	No Charge after Deductible	30% after Deductible	30% after Deductible
Emergency Room Visits	20% after Deductible	No Charge after Deductible	\$300	\$750
Prescription Drugs				
Tier 1	\$15	No Charge after Deductible	\$20	\$5
Tier 2	\$55	No Charge after Deductible	\$40	\$80
Tier 3	\$75	No Charge after Deductible	\$80	\$150
Tier 4	30% after Pharmacy Deductible	No Charge after 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	20% after Deductible	No Charge after Deductible	30% after Deductible	30% after Deductible
Outpatient Hospital Surgical/Non-Surgical Services: Facility Fees	20% after Deductible	No Charge after Deductible	30% after Deductible	30% after Deductible
Skilled Nursing Facility Services	20% after Deductible	No Charge after Deductible	30% after Deductible	30% after Deductible
Vision Services				
Vision Examinations	No Charge	No Charge after Deductible	No Charge	No Charge
Mental Health & Substance Use Disorder				
Outpatient Services	\$25	No Charge after Deductible	\$30	\$10
Inpatient Services	20% after Deductible	No Charge after Deductible	30% after Deductible	30% after Deductible
Transitional Services	20% after Deductible	No Charge after Deductible	30% after Deductible	30% after Deductible

INDIVIDUAL SELECT ACA PLANS 2021

CLICK ON THE PLAN NAME FOR DETAILED PLAN DESCRIPTIONS	Select Silver 8000X Ded/8550 MOOP	Select Silver 4900 Ded/7900 MOOP	Select Silver Simple Choice 4550X Ded/7900 MOOP	Select Silver 4300 Ded/4300 MOOP HSA
Plan Number on Marketplace	2112367	2112355	2112343	N/A
Plan Number off Marketplace (Direct)	2132367	2132355	2132343	2132331
Plan Offered Direct and/or on the Marketplace	Direct & Marketplace	Direct & Marketplace	Direct & Marketplace	Direct Only
Deductible - Medical (Based on Calendar Year)	\$7,400/Individual or \$14,800/Family	N/A	\$4,000/Individual or \$8,000/Family	N/A
Deductible - Prescription (Based on Calendar Year)	\$600/Individual or \$1,200/Family	N/A	\$550/Individual or \$1,100/Family	N/A
Deductible - Medical & Prescription Combined (Based on Calendar Year)	N/A	\$4,900/Individual or \$9,800/Family	N/A	\$4,300/Individual or \$8,600/Family
Embedded/Non-Embedded	Embedded	Embedded	Embedded	Embedded
Policy Coinsurance	30%	30%	20%	0%
Maximum Out-of-Pocket Prescription & Medical Combined (MOOP)	\$8,550/Individual or \$17,100/Family	\$7,900/Individual or \$15,800/Family	\$7,900/Individual or \$15,800/Family	\$4,300/Individual or \$8,600/Family
Eligible Dependents	Dependents are covered until the end of the month in which they turn 26			
Clinic Services				
Primary Care Office Visits	\$35	\$30	\$40	No Charge after Deductible
Chiropractic Office Visits	\$35	\$30	\$40	No Charge after Deductible
Preventive Health Examinations	No Charge	No Charge	No Charge	No Charge
Specialist Care Office Visits	\$125	\$75	\$90	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	30% after Deductible	30% after Deductible	20% after Deductible	No Charge after Deductible
Advanced Radiology	30% after Deductible	30% after Deductible	20% after Deductible	No Charge after Deductible
Emergency and Urgent Care				
Urgent Care Visits	\$35	\$30	\$90	No Charge after Deductible
Emergency Ambulance Service (air/ground)	30% after Deductible	30% after Deductible	20% after Deductible	No Charge after Deductible
Emergency Room Visits	30% after Deductible	30% after Deductible	20% 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	30% after Deductible	30% after Deductible	20% after Deductible	No Charge after Deductible
Outpatient Hospital Surgical/Non-Surgical Services: Facility Fees	30% after Deductible	30% after Deductible	20% after Deductible	No Charge after Deductible
Skilled Nursing Facility Services	30% 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	\$35	\$30	\$40	No Charge after Deductible
Inpatient Services	30% after Deductible	30% after Deductible	20% after Deductible	No Charge after Deductible
Transitional Services	30% after Deductible	30% after Deductible	20% after Deductible	No Charge after Deductible

INDIVIDUAL SELECT ACA PLANS 2021

CLICK ON THE PLAN NAME FOR DETAILED PLAN DESCRIPTIONS	Select Bronze Simple Choice 6850 Ded/8200 MOOP	Select Bronze 7000 Ded/7000 MOOP HSA	Select Bronze 4000 Ded/8500 MOOP	Select Bronze 8550 Ded/8550 MOOP
Plan Number on Marketplace	2112407	2112404	2112401	2112416
Plan Number off Marketplace (Direct)	2132407	2132404	2132401	2132416
Plan Offered Direct and/or on the Marketplace	Direct & Marketplace	Direct & Marketplace	Direct & Marketplace	Direct & Marketplace
Deductible - Medical (Based on Calendar Year)	N/A	N/A	\$4,000/Individual or \$8,000/Family	N/A
Deductible - Prescription (Based on Calendar Year)	N/A	N/A	\$0/Individual or \$0/Family	N/A
Deductible - Medical & Prescription Combined (Based on Calendar Year)	\$6,850/Individual or \$13,700/Family	\$7,000/Individual or \$14,000/Family	N/A	\$8,550/Individual or \$17,100/Family
Embedded/Non-Embedded	Embedded	Embedded	Embedded	Embedded
Policy Coinsurance	40%	0%	40%	0%
Maximum Out-of-Pocket Prescription & Medical Combined (MOOP)	\$8,200/Individual or \$16,400/Family	\$7,000/Individual or \$14,000/Family	\$8,500/Individual or \$17,000/Family	\$8,550/Individual or \$17,100/Family
Eligible Dependents	Dependents are covered until the end of the month in which they turn 26			
Clinic Services				
Primary Care Office Visits	\$35	No Charge after Deductible	\$125	\$125
Chiropractic Office Visits	\$35	No Charge after Deductible	\$125	\$125
Preventive Health Examinations	No Charge	No Charge	No Charge	No Charge
Specialist Care Office Visits	\$150	No Charge after Deductible	\$250	\$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	No Charge after Deductible	40% after Deductible	No Charge after Deductible
Advanced Radiology	40% after Deductible	No Charge after Deductible	40% after Deductible	No Charge after Deductible
Emergency and Urgent Care				
Urgent Care Visits	\$75	No Charge after Deductible	\$125	\$125
Emergency Ambulance Service (air/ground)	40% after Deductible	No Charge after Deductible	40% after Deductible	No Charge after Deductible
Emergency Room Visits	40% after Deductible	No Charge after Deductible	40% after Deductible	No Charge after Deductible
Prescription Drugs				
Tier 1	\$35	No Charge after Deductible	\$50	\$35
Tier 2	35% after Deductible	No Charge after Deductible	\$200	No Charge after Deductible
Tier 3	40% after Deductible	No Charge after Deductible	\$300	No Charge after Deductible
Tier 4	45% after Deductible	No Charge 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	40% after Deductible	No Charge after Deductible	40% after Deductible	No Charge after Deductible
Outpatient Hospital Surgical/Non-Surgical Services: Facility Fees	40% after Deductible	No Charge after Deductible	40% after Deductible	No Charge after Deductible
Skilled Nursing Facility Services	40% after Deductible	No Charge after Deductible	40% after Deductible	No Charge after Deductible
Vision Services				
Vision Examinations	No Charge	No Charge after Deductible	No Charge	No Charge
Mental Health & Substance Use Disorder				
Outpatient Services	\$35	No Charge after Deductible	\$125	\$125
Inpatient Services	40% after Deductible	No Charge after Deductible	40% after Deductible	No Charge after Deductible
Transitional Services	40% after Deductible	No Charge after Deductible	40% after Deductible	No Charge after Deductible

INDIVIDUAL SELECT ACA PLANS 2021

CLICK ON THE PLAN NAME FOR DETAILED PLAN DESCRIPTIONS	Select Catastrophic 8550 Ded/8550 MOOP
Plan Number on Marketplace	2112001
Plan Number off Marketplace (Direct)	2132001
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)	\$8,550/Individual or \$17,100/Family
Embedded/Non-Embedded	Embedded
Policy Coinsurance	0%
Maximum Out-of-Pocket Prescription & Medical Combined (MOOP)	\$8,550/Individual or \$17,100/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; 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
Emergency and Urgent Care	
Urgent Care Visits	No Charge after Deductible
Emergency Ambulance Service (air/ground)	No Charge after Deductible
Emergency Room Visits	No Charge after Deductible
Prescription Drugs	
Tier 1	No Charge after Deductible
Tier 2	No Charge after Deductible
Tier 3	No Charge after Deductible
Tier 4	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	No Charge after Deductible
Outpatient Hospital Surgical/Non-Surgical Services: Facility Fees	No Charge after Deductible
Skilled Nursing Facility Services	No Charge after Deductible
Vision Services	
Vision Examinations	No Charge after Deductible
Mental Health & Substance Use Disorder	
Outpatient Services	No Charge after Deductible
Inpatient Services	No Charge after Deductible
Transitional Services	No Charge after Deductible

General Health Plan Limitations and 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

Couples Counseling

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.

GET CARE

Quick Care



Your Primary Care Clinic

Your primary care clinic is your first point of contact for all your health care needs. Anytime you need medical care (except for emergencies), call your primary care clinic for an appointment or to speak with your PCP's nursing staff. Find the clinic phone number listed next to your member number on your GHC-SCW Member ID card. **Call your primary care clinic.**



GHC NurseConnect

GHC-SCW nurses are here 24/7/365 to help you, guide you and get you on the path to better health fast. They can even access your medical record and get you scheduled for an appointment if you need one. **Call (608) 661-7350 or toll-free at (855) 661-7350.**



virtuwell

Get care anytime, anywhere with our 24/7 online clinic. Use virtuwell to get a diagnosis, treatment plan and prescription for over 60 common conditions without ever leaving home. Depending on your plan, GHC-SCW members get virtuwell visits for free.

Visit ghcscw.com/virtuwell.



GHC Care OnDemand

With GHC Care OnDemand, you can access a doctor from your home, office, or on-the-go, 24/7, 365. Board-certified doctors can visit with you either by phone or secure video to help treat any non-emergency medical conditions. Visits are free for most members. Members with HSA-eligible plans must reach their deductible before visits are free. **Go to ghccareondemand.com.**



Emergency Care

Emergency care is for life-threatening medical conditions (including severe symptoms) that can cause serious danger to your health.

Examples include:

- alcohol or drug overdose
- amputations or severe lacerations
- complex bone fractures (through skin)
- complications during pregnancy¹
- facial or eye trauma
- heart attack/chest pain
- knife/gunshot wounds
- loss of consciousness
- poisoning
- respiratory problems
- severe burns
- stroke

If it's not possible to go to your designated hospital, go to the nearest hospital emergency room or call 911.

¹ For complications during pregnancy, please go directly to UnityPoint Health – Meriter Hospital.



GHC-SCW Urgent Care Clinic

Urgent care is for non-life-threatening conditions that need to be treated that same day or after business hours. These conditions usually cause unusual discomfort.

Examples include:

- back pain
- ear pain
- colds and flu
- cuts, scrapes or bruises
- eye irritation
- fever
- migraine headaches
- sore throats
- simple bone fractures (not through skin)
- sprains
- skin rashes
- urinary burning

Physical therapy is available for some injuries at the GHC-SCW Urgent Care Clinic.

Call the GHC-SCW Urgent Care Clinic to schedule an appointment. Appointments are made to better serve your same-day access needs.



GHC-SCW Urgent Care Clinic at Capitol Clinic (608) 442-8100

675 W. Washington Ave.
Madison, WI 53703

Mon – Fri: 8 a.m. – 9 p.m.
Sat – Sun: 9 a.m. – 9 p.m.



of South Central Wisconsin

ghcscw.com