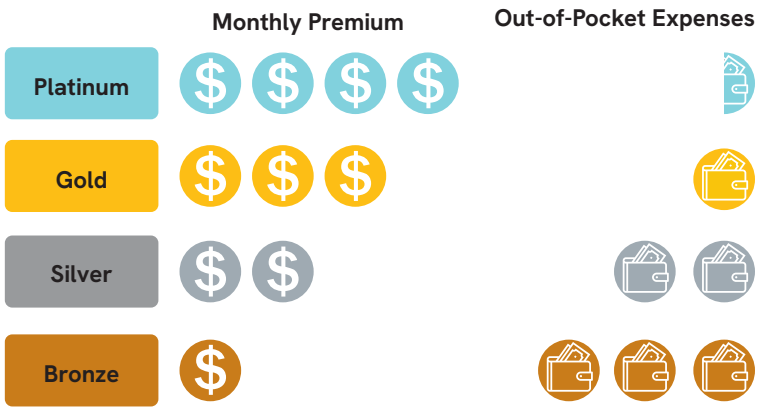
2026 HMO Plans

GHC-SCW Small Group Plans

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

Small Groups must be headquartered in Columbia, Dane, Jefferson and Sauk counties.



Terms to Know

HMO Plans – Emphasize high-quality, preventive health care with a strong relationship with a Primary Care Provider and access to area Specialists. *This plan is available for members that live or work for a company headquartered in Dane, Columbia, Jefferson and Sauk Counties.*

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.

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

Better Together HMO Product – The GHC Better Together HMO Product gives individuals access to their choice of our five 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 East Clinic, GHC-SCW Hatchery Hill Clinic, GHC-SCW Madison College Community Clinic and GHC-SCW Sauk Trails Clinic.

Partners HMO Product – GHC-SCW members have the largest primary care provider network in Dane County. Our regional counties include Columbia, Jefferson and Sauk counties.

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, “Find A 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 2026 stipulate that an individual cannot pay more than $10,600 in out-of-pocket expenses in a plan year.

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

Maximum Out-of-Pocket (MOOP) – This is the limit to the amount you will pay out-of-pocket during a policy period (typically one year long) for Covered Health Services. Once you’ve paid this maximum amount, your health insurance plan will pay 100% of the allowed amount for Covered Health Services. This limit never includes your premium, balance-billed charges or heath care your health insurance does not cover.

GHC Primary Care Preferred (PCP) Plan – No Out-of-Pocket costs for In-Network Primary Care Office Visits, Labs, X-rays, Urgent Care, Outpatient Behavioral Health and Outpatient Rehabilitation and Habilitation Therapies.

Group Health Cooperative
of South Central Wisconsin

ghcscw.com

MK21-75-4(9.25)0

HMO SMALL GROUP PLANS 2026

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

CLICK ON THE PLAN NUMBER FOR DETAILED PLAN DESCRIPTIONS	Platinum 500 Ded / 1750 MOOP	Platinum No Ded / 3500 MOOP	Platinum No Ded / 2650 MOOP	Platinum 1000 Ded / 4000 MOOP Primary Care Preferred	Platinum 500 Ded / 2500 MOOP	Platinum 1000 Ded / 3000 MOOP	Platinum 1000 Ded / 1500 MOOP	Platinum 250 Ded / 1850 MOOP
Partners HMO / Better Together HMO Plan Number	2641120 / 2642120	2641135 / 2642135	2641121 / 2642121	2641125 / 2642125	2641122 / 2642122	2641123 / 2642123	2641133 / 2642133	2641132 / 2642132
Policy Deductible (Based on Plan Year)	$500/Individual or $1,000/Family	$0/Individual or $0/Family	$0/Individual or $0/Family	$1,000/Individual or $2,000/Family	$500/Individual or $1,000/Family	$1,000/Individual or $2,000/Family	$1,000/Individual or $2,000/Family	$250/Individual or $500/Family
Embedded/Non-Embedded	Embedded	Embedded	Embedded	Embedded	Embedded	Embedded	Embedded	Embedded
Policy Coinsurance	20%	0%	20%	20%	20%	20%	10%	10%
Maximum Out-of-Pocket Prescription & Medical Combined (MOOP)	$1,750/Individual or $3,500/Family	$3,500/Individual or $7,000/Family	$2,650/Individual or $5,300/Family	$4,000/Individual or $8,000/Family	$2,500/Individual or $5,000/Family	$3,000/Individual or $6,000/Family	$1,500/Individual or $3,000/Family	$1,850/Individual or $3,700/Family
Eligible Dependents	Dependents are covered until the end of the month in which they turn 26							
Clinic Services								
Primary Care Office Visits	$5	$40	$5	No Charge	$5	$5	$25	$30
Chiropractic Office Visits	$5	$40	$5	No Charge	$5	$5	$25	$30
Preventive Health Examinations	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge
Specialist Care Office Visits	$50	$80	$50	$50	$50	$20	$40	$60
Preventitive Immunizations	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge
Prenatal and Postnatal Maternity Care	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge
Diagnostic X-Ray and Laboratory Test	20% after Deductible	No Charge	20%	No Charge	20% after Deductible	20% after Deductible	10% after Deductible	10% after Deductible
Advanced Radiology	20% after Deductible	No Charge	20%	20% after Deductible	20% after Deductible	20% after Deductible	10% after Deductible	10% after Deductible
Emergency and Urgent Care								
Urgent Care Visits	$10	$80	$10	No Charge	$10	$10	$25	$30
Emergency Ambulance Service (air/ground)	20% after Deductible	No Charge	20%	20% after Deductible	20% after Deductible	20% after Deductible	10% after Deductible	10% after Deductible
Emergency Room Visits	$100	$600	$275	20% after Deductible	$325	$225	$150	$500
Prescription Drugs								
Tier 1	$5	$5	$10	$5	$5	$5	$10	$10
Tier 2	$40	$40	$40	$15	$40	$35	$40	$40
Tier 3	30%	50%	30%	30%	30%	30%	30%	30%
Tier 4	50%	50%	50%	50%	50%	50%	50%	50%
The Prescription Drugs Benefit is administered by GHC-SCW Clinic pharmacies and Navitus. Prescription Drugs are NOT COVERED outside of the GHC-SCW network of providers. For a list of formulary drugs, tier ($) placement, prior authorization requirements and other limitations that may apply, see **ghcscw.com**.								
Hospital Services								
Inpatient Hospital Services: Physician Services, Surgery, Facility Fees	20% after Deductible	No Charge	20%	20% after Deductible	20% after Deductible	20% after Deductible	10% after Deductible	10% after Deductible
Outpatient Hospital Surgical/Non-Surgical Services: Facility Fees	20% after Deductible	No Charge	20%	20% after Deductible	20% after Deductible	20% after Deductible	10% after Deductible	10% after Deductible
Skilled Nursing Facility Services	20% after Deductible	No Charge	20%	20% after Deductible	20% after Deductible	20% after Deductible	10% after Deductible	10% after Deductible
Vision Services								
Vision Examinations	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge
Mental Health & Substance Use Disorder								
Outpatient Services	$5	$40	$5	No Charge	$5	$5	$25	$30
Inpatient Services	20% after Deductible	No Charge	20%	20% after Deductible	20% after Deductible	20% after Deductible	10% after Deductible	10% after Deductible
Transitional Services	20% after Deductible	No Charge	20%	20% after Deductible	20% after Deductible	20% after Deductible	10% after Deductible	10% after Deductible

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

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HMO SMALL GROUP PLANS 2026

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CLICK ON THE PLAN NUMBER FOR DETAILED PLAN DESCRIPTIONS	Gold 1500 Ded / 7500 MOOP	Gold 3250 Ded / 6350 MOOP Primary Care Preferred	Gold 3100 Ded / 3100 MOOP HSA	Gold 3300 Ded / 3300 MOOP	Gold 1200 Ded / 5600 MOOP	Gold 2250 Ded / 6250 MOOP
Partners HMO / Better Together HMO Plan Number	2641224 / 2642224	2641227 / 2642227	2641223 / 2642223	2641234 / 2642234	2641207 / 2642207	2641226 / 2642226
Policy Deductible (Based on Plan Year)	$1,500/Individual or $3,000/Family	$3,250/Individual or $6,500/Family	$3,100/Individual or $6,200/Family	$3,300/Individual or $6,600/Family	$1,200/Individual or $2,400/Family	$2,250/Individual or $4,500/Family
Embedded/Non-Embedded	Embedded	Embedded	Non-Embedded	Embedded	Embedded	Embedded
Policy Coinsurance	20%	30%	0%	0%	30%	20%
Maximum Out-of-Pocket Prescription & Medical Combined (MOOP)	$7,500/Individual or $15,000/Family	$6,350/Individual or $12,700/Family	$3,100/Individual or $6,200/Family	$3,300/Individual or $6,600/Family	$5,600/Individual or $11,200/Family	$6,250/Individual or $12,500/Family
Eligible Dependents	Dependents are covered until the end of the month in which they turn 26					
Clinic Services						
Primary Care Office Visits	$10	No Charge	No Charge after Deductible	No Charge after Deductible	$30	$30
Chiropractic Office Visits	$10	No Charge	No Charge after Deductible	No Charge after Deductible	$30	$30
Preventive Health Examinations	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge
Specialist Care Office Visits	$50	$100	No Charge after Deductible	No Charge after Deductible	$60	$60
Preventitive Immunizations	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge
Prenatal and Postnatal Maternity Care	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge
Diagnostic X-Ray and Laboratory Test	20% after Deductible	No Charge	No Charge after Deductible	No Charge after Deductible	30% after Deductible	20% after Deductible
Advanced Radiology	20% after Deductible	30% after Deductible	No Charge after Deductible	No Charge after Deductible	30% after Deductible	20% after Deductible
Emergency and Urgent Care						
Urgent Care Visits	$25	No Charge	No Charge after Deductible	No Charge after Deductible	$45	$45
Emergency Ambulance Service (air/ground)	20% after Deductible	30% after Deductible	No Charge after Deductible	No Charge after Deductible	30% after Deductible	20% after Deductible
Emergency Room Visits	$500	30% after Deductible	No Charge after Deductible	No Charge after Deductible	30% after Deductible	20% after Deductible
Prescription Drugs						
Tier 1	$15	$10	No Charge after Deductible	No Charge after Deductible	$10	$10
Tier 2	$35	$50	No Charge after Deductible	No Charge after Deductible	$40	$40
Tier 3	30%	30%	No Charge after Deductible	No Charge after Deductible	30%	30%
Tier 4	50%	50%	No Charge after Deductible	No Charge after Deductible	50%	50%
The Prescription Drugs Benefit is administered by GHC-SCW Clinic pharmacies and Navitus. Prescription Drugs are NOT COVERED outside of the GHC-SCW network of providers. For a list of formulary drugs, tier ($) placement, prior authorization requirements and other limitations that may apply, see **ghcscw.com**.						
Hospital Services						
Inpatient Hospital Services: Physician Services, Surgery, Facility Fees	20% after Deductible	30% after Deductible	No Charge after Deductible	No Charge after Deductible	30% after Deductible	20% after Deductible
Outpatient Hospital Surgical/Non-Surgical Services: Facility Fees	20% after Deductible	30% after Deductible	No Charge after Deductible	No Charge after Deductible	30% after Deductible	20% after Deductible
Skilled Nursing Facility Services	20% after Deductible	30% after Deductible	No Charge after Deductible	No Charge after Deductible	30% after Deductible	20% after Deductible
Vision Services						
Vision Examinations	No Charge	No Charge	No Charge after Deductible	No Charge after Deductible	No Charge	No Charge
Mental Health & Substance Use Disorder						
Outpatient Services	$10	No Charge	No Charge after Deductible	No Charge after Deductible	$30	$30
Inpatient Services	20% after Deductible	30% after Deductible	No Charge after Deductible	No Charge after Deductible	30% after Deductible	20% after Deductible
Transitional Services	20% after Deductible	30% after Deductible	No Charge after Deductible	No Charge after Deductible	30% after Deductible	20% after Deductible

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CLICK ON THE PLAN NUMBER FOR DETAILED PLAN DESCRIPTIONS	Silver 5300 Ded / 5300 MOOP HSA	Silver 9650 Ded / 9650 MOOP Primary Care Preferred	Silver 3300 Ded / 9000 MOOP	Silver 7000 Ded / 8500 MOOP
Partners HMO / Better Together HMO Plan Number	2641373 / 2642373	2641376 / 2642376	2641319 / 2642319	2641374 / 2642374
Policy Deductible (Based on Plan Year)	$5,300/Individual or $10,600/Family	$9,650/Individual or $19,300/Family	$3,300/Individual or $6,600/Family	$7,000/Individual or $14,000/Family
Embedded/Non-Embedded	Embedded	Embedded	Embedded	Embedded
Policy Coinsurance	0%	0%	30%	50%
Maximum Out-of-Pocket Prescription & Medical Combined (MOOP)	$5,300/Individual or $10,600/Family	$9,650/Individual or $19,300/Family	$9,000/Individual or $18,000/Family	$8,500/Individual or $17,000/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	No Charge	$25	$55
Chiropractic Office Visits	No Charge after Deductible	No Charge	$25	$55
Preventive Health Examinations	No Charge	No Charge	No Charge	No Charge
Specialist Care Office Visits	No Charge after Deductible	$175	$80	$115
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	No Charge	30% after Deductible	50% after Deductible
Advanced Radiology	No Charge after Deductible	No Charge after Deductible	30% after Deductible	50% after Deductible
Emergency and Urgent Care				
Urgent Care Visits	No Charge after Deductible	No Charge	$40	$115
Emergency Ambulance Service (air/ground)	No Charge after Deductible	No Charge after Deductible	30% after Deductible	50% after Deductible
Emergency Room Visits	No Charge after Deductible	No Charge after Deductible	30% after Deductible	50% after Deductible
Prescription Drugs				
Tier 1	No Charge after Deductible	$30	$25	$10
Tier 2	No Charge after Deductible	$140	$80	$70
Tier 3	No Charge after Deductible	40%	40%	50%
Tier 4	No Charge after Deductible	50%	50%	60%
The Prescription Drugs Benefit is administered by GHC-SCW Clinic pharmacies and Navitus. Prescription Drugs are NOT COVERED outside of the GHC-SCW network of providers. For a list of formulary drugs, tier ($) placement, prior authorization requirements and other limitations that may apply, see **ghcscw.com**.				
Hospital Services				
Inpatient Hospital Services: Physician Services, Surgery, Facility Fees	No Charge after Deductible	No Charge after Deductible	30% after Deductible	50% after Deductible
Outpatient Hospital Surgical/Non-Surgical Services: Facility Fees	No Charge after Deductible	No Charge after Deductible	30% after Deductible	50% after Deductible
Skilled Nursing Facility Services	No Charge after Deductible	No Charge after Deductible	30% after Deductible	50% 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	No Charge	$25	$55
Inpatient Services	No Charge after Deductible	No Charge after Deductible	30% after Deductible	50% after Deductible
Transitional Services	No Charge after Deductible	No Charge after Deductible	30% after Deductible	50% after Deductible

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CLICK ON THE PLAN NUMBER FOR DETAILED PLAN DESCRIPTIONS	Bronze 7100 Ded / 7100 MOOP HSA	Bronze No Medical Ded / 10400 MOOP	Bronze 8700 Ded / 8700 MOOP
Partners HMO / Better Together HMO Plan Number	2641404 / 2642404	2641430 / 2642430	2641419 / 2642419
Policy Deductible (Based on Plan Year)	$7,100/Individual or $14,200/Family	N/A	$8,700/Individual or $17,400/Family
Embedded/Non-Embedded	Embedded	Embedded	Embedded
Policy Coinsurance	0%	50%	0%
Maximum Out-of-Pocket Prescription & Medical Combined (MOOP)	$7,100/Individual or $14,200/Family	$10,400/Individual or $20,800/Family	$8,700/Individual or $17,400/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	$55	$50
Chiropractic Office Visits	No Charge after Deductible	$55	$50
Preventive Health Examinations	No Charge	No Charge	No Charge
Specialist Care Office Visits	No Charge after Deductible	$160	$150
Preventitive 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	$55	No Charge after Deductible
Advanced Radiology	No Charge after Deductible	$1,000	No Charge after Deductible
Emergency and Urgent Care			
Urgent Care Visits	No Charge after Deductible	$55	$150
Emergency Ambulance Service (air/ground)	No Charge after Deductible	50%	No Charge after Deductible
Emergency Room Visits	No Charge after Deductible	$1,500	No Charge after Deductible
Prescription Drugs			
Tier 1	No Charge after Deductible	$35	$35
Tier 2	No Charge after Deductible	$175	No Charge after Deductible
Tier 3	No Charge after Deductible	50% after Pharmacy Deductible	No Charge after Deductible
Tier 4	No Charge after Deductible	60% after Pharmacy Deductible	No Charge after Deductible
The Prescription Drugs Benefit is administered by GHC-SCW Clinic pharmacies and Navitus. Prescription Drugs are NOT COVERED outside of the GHC-SCW network of providers. For a list of formulary drugs, tier ($) placement, prior authorization requirements and other limitations that may apply, see **ghcscw.com**.			
Hospital Services			
Inpatient Hospital Services: Physician Services, Surgery, Facility Fees	No Charge after Deductible	50%	No Charge after Deductible
Outpatient Hospital Surgical/Non-Surgical Services: Facility Fees	No Charge after Deductible	50%	No Charge after Deductible
Skilled Nursing Facility Services	No Charge after Deductible	50%	No Charge after Deductible
Vision Services			
Vision Examinations	No Charge after Deductible	No Charge	No Charge
Mental Health & Substance Use Disorder			
Outpatient Services	No Charge after Deductible	$55	$50
Inpatient Services	No Charge after Deductible	50%	No Charge after Deductible
Transitional Services	No Charge after Deductible	50%	No Charge after Deductible

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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) Small Group 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:

For HMO plans, services received from an Out-of-Plan Provider, unless for an Emergency Condition or Urgent Condition, or unless prior authorized by GHC-SCW. Services must be received from an In-Network Provider

For HMO plans, if services can be provided by a GHC-SCW Provider (for example, Dermatology, Physical Therapy, etc.), services received from a Non-GHC-SCW Provider or Out-of-Plan Provider, unless prior authorized

For POS plans, if a GHC-SCW Provider or GHC-SCW Clinic offers specialty medical care required by a Member, and Member chooses to not utilize the GHC-SCW Provider or GHC-SCW Clinic, payment for these services will be made under the Out-of-Network benefit

Services that are not Medically Necessary, are experimental, investigative or for research purposes

Billed amounts that are over and above the GHC-SCW Usual, Customary 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

Services and supplies obtained while outside the United States, except for Urgent Conditions and Emergency Conditions

Charges for missed appointment(s)

Services for injuries incurred during the commission of a crime

Blood donor services

Common use supplies

Complementary Medicine services

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

Conception services

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. This exclusion does not apply to chimeric antigen receptor (CAR) T-cell therapy.

Growth Hormone for the treatment of idiopathic short stature

Hair implants/transplants

Hearing Aid 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

Insulin injection pens not included in the GHC formulary

Keratorefractive surgery

Maintenance and Supportive care and/or therapy

Maternity Services for third party or non-Member Traditional Surrogates or Gestational Carriers

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 contraceptive drugs or devices that do not meet all necessary requirements under the Policy or Certificate of coverage

Over-the-counter supplies

Personal comfort items

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

Private duty nursing services

Prolotherapy

Recreational and Educational therapy, financial and occupational counseling, and therapies beyond the services specified in the Policy or Certificate of coverage

Services performed by a family member

Scar revisions

Sensory integration therapy, except for when medically necessary to treat Autism Spectrum Disorder

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

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

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

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

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

Vocational Rehabilitation services

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

CSC25-21-02-1(7/25)F

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.