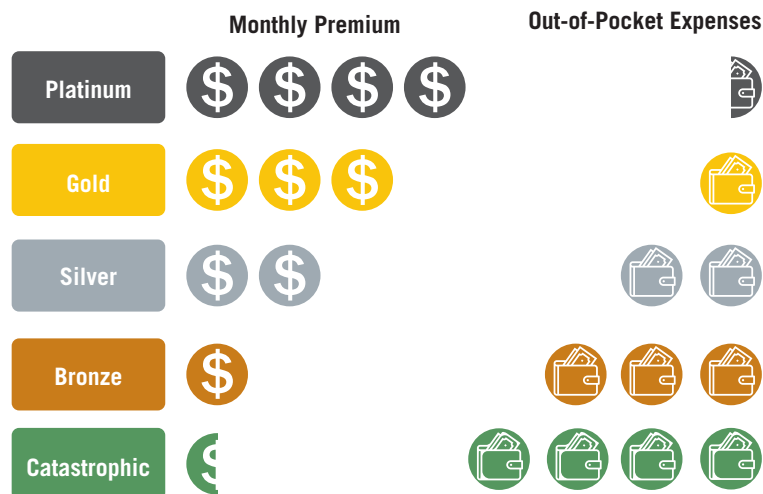


GHC-SCW 2023 Individual Plans Dane County

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 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.

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 2023 stipulate that an individual cannot pay more than \$9,100 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.

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

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 – 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 & Family Plan Options 2023:

Dane County

Platinum	Deductible Single / Family	Coinsurance	Maximum Out of Pocket Single / Family	Office Visit Primary / Specialist	Diagnostic X-Ray & Laboratory Test / Advanced Radiology (MRI/PET/CAT)	Hospital (Inpatient / Outpatient)	Urgent Care	Emergency Room	Prescription Drugs				Mental Health Outpatient	Adult Vision Exam Age 19 and Older	Pediatric Vision Exam Age 18 and Under	HSA Eligible	Plan Number Marketplace Select / HMO	Plan Number Direct Select / HMO	Embedded / NonEmbedded
									Tier 1	Tier 2	Tier 3	Tier 4							
Platinum No Ded/3000 MOOP	\$0/Individual or \$0/Family	0%	\$3,000/Individual or \$6,000/Family	\$10 / \$20	\$30 / \$100	\$350 / \$150	\$15	\$100	\$5	\$10	\$50	\$150	\$10	Not Covered	No Charge	No	2312129 / 2311129	2332129 / 2331129	Embedded
Platinum 500 Ded/1500 MOOP	\$500/Individual or \$1,000/Family	20%	\$1,500/Individual or \$3,000/Family	\$20 / \$40	20% after Deductible / 20% after Deductible	20% after Deductible / 20% after Deductible	\$20	\$100	\$10	\$30	\$60	30% after Pharmacy Deductible	\$20	Not Covered	No Charge	No	2312110 / 2311110	2332110 / 2331110	Embedded
Platinum No Ded/2200 MOOP	\$0/Individual or \$0/Family	20%	\$2,200/Individual or \$4,400/Family	\$10 / \$20	20% after Deductible / 20% after Deductible	20% after Deductible / 20% after Deductible	\$10	\$450	\$10	\$30	\$60	30% after Pharmacy Deductible	\$10	Not Covered	No Charge	No	2312116 / 2311116	2332116 / 2331116	Embedded
Platinum 1000 Ded/4000 MOOP PCP	\$1,000/Individual or \$2,000/Family	20%	\$4,000/Individual or \$8,000/Family	No Charge / \$30	No Charge / No Charge	20% after Deductible / 20% after Deductible	No Charge	20% after Deductible	\$10	\$25	\$150	\$300	No Charge	Not Covered	No Charge	No	2312126 / 2311126	2332126 / 2331126	Embedded
Gold	Deductible Single / Family	Coinsurance	Maximum Out of Pocket Single / Family	Office Visit Primary / Specialist	Diagnostic X-Ray & Laboratory Test / Advanced Radiology (MRI/PET/CAT)	Hospital (Inpatient / Outpatient)	Urgent Care	Emergency Room	Prescription Drugs				Mental Health Outpatient	Adult Vision Exam Age 19 and Older	Pediatric Vision Exam Age 18 and Under	HSA Eligible	Plan Number Marketplace Select / HMO	Plan Number Direct Select / HMO	Embedded / NonEmbedded
Gold 1800 Ded/5600 MOOP	\$1,800/Individual or \$3,600/Family	20%	\$5,600/Individual or \$11,200/Family	\$25 / \$65	20% after Deductible / 20% after Deductible	20% after Deductible / 20% after Deductible	\$65	20% after Deductible	\$15	\$55	\$75	30% after Pharmacy Deductible	\$25	Not Covered	No Charge	No	2312213 / 2311213	2332213 / 2331213	Embedded
Gold 2500 Ded/6500 MOOP	\$2,500/Individual or \$5,000/Family	30%	\$6,500/Individual or \$13,000/Family	\$30 / \$60	30% after Deductible / 30% after Deductible	30% after Deductible / 30% after Deductible	\$30	\$300	\$20	\$40	\$80	30% after Pharmacy Deductible	\$30	Not Covered	No Charge	No	2312216 / 2311216	2332216 / 2331216	Embedded
Gold 2600 Ded/2600 MOOP HSA	\$2,600/Individual or \$5,200/Family	0%	\$2,600/Individual or \$5,200/Family	No Charge after Deductible / No Charge after Deductible	No Charge after Deductible / No Charge after Deductible	No Charge after Deductible / No Charge after Deductible	No Charge after Deductible	No Charge after Deductible	No Charge after Deductible	No Charge after Deductible	No Charge after Deductible	No Charge after Deductible	No Charge after Deductible	Not Covered	No Charge after Deductible	Yes	2312210 / 2311210	2332210 / 2331210	Non-Embedded
Gold 2000 Ded/8700 MOOP	\$2,000/Individual or \$4,000/Family	25%	\$8,700/Individual or \$17,400/Family	\$30 / \$60	25% after Deductible / 25% after Deductible	25% after Deductible / 25% after Deductible	\$45	25% after Deductible	\$15	\$30	\$60	\$250	\$30	Not Covered	No Charge	No	2312231 / 2311231	2332231 / 2331231	Embedded
Gold 1500 Ded/8550 MOOP	\$1,500/Individual or \$3,000/Family	30%	\$8,550/Individual or \$17,100/Family	\$10 / \$120	30% after Deductible / 30% after Deductible	30% after Deductible / 30% after Deductible	\$10	\$750	\$5	\$80	\$150	\$450	\$10	Not Covered	No Charge	No	2312220 / 2311220	2332220 / 2331220	Embedded
Gold 4450 Ded/7450 MOOP PCP	\$4,450/Individual or \$8,900/Family	40%	\$7,450/Individual or \$14,900/Family	No Charge / \$150	No Charge / No Charge	40% after Deductible / 40% after Deductible	No Charge	40% after Deductible	\$20	\$50	\$150	\$300	No Charge	Not Covered	No Charge	No	2312228 / 2311228	2332228 / 2331228	Embedded
Silver	Deductible Single / Family	Coinsurance	Maximum Out of Pocket Single / Family	Office Visit Primary / Specialist	Diagnostic X-Ray & Laboratory Test / Advanced Radiology (MRI/PET/CAT)	Hospital (Inpatient / Outpatient)	Urgent Care	Emergency Room	Prescription Drugs				Mental Health Outpatient	Adult Vision Exam Age 19 and Older	Pediatric Vision Exam Age 18 and Under	HSA Eligible	Plan Number Marketplace Select / HMO	Plan Number Direct Select / HMO	Embedded / NonEmbedded
Silver 4900 Ded/7900 MOOP	\$4,900/Individual or \$9,800/Family	30%	\$7,900/Individual or \$15,800/Family	\$35 / \$80	30% after Deductible / 30% after Deductible	30% after Deductible / 30% after Deductible	\$35	30% after Deductible	\$30	\$70	\$200	50%	\$35	Not Covered	No Charge	No	2312355 / 2311355	2332355 / 2331355	Embedded
Silver 5400 Ded/5400 MOOP HSA	\$5,400/Individual or \$10,800/Family	0%	\$5,400/Individual or \$10,800/Family	No Charge after Deductible / No Charge after Deductible	No Charge after Deductible / No Charge after Deductible	No Charge after Deductible / No Charge after Deductible	No Charge after Deductible	No Charge after Deductible	No Charge after Deductible	No Charge after Deductible	No Charge after Deductible	No Charge after Deductible	No Charge after Deductible	Not Covered	No Charge after Deductible	Yes	2312331 / 2311331	2332331 / 2331331	Embedded
Silver 9050 Ded/9050 MOOP PCP	\$9,050/Individual or \$18,100/Family	0%	\$9,050/Individual or \$18,100/Family	No Charge / \$175	No Charge / No Charge	No Charge after Deductible / No Charge after Deductible	No Charge	No Charge after Deductible	\$30	\$140	\$300	\$500	No Charge	Not Covered	No Charge	No	2312377 / 2311377	2332377 / 2331377	Embedded
Silver 5800 Ded/8900 MOOP	\$5,800/Individual or \$11,600/Family	40%	\$8,900/Individual or \$17,800/Family	\$40 / \$80	40% after Deductible / 40% after Deductible	40% after Deductible / 40% after Deductible	\$60	40% after Deductible	\$20	\$40	\$80 after Deductible	\$350 after Deductible	\$40	Not Covered	No Charge	No	2312383 / 2311383	2332383 / 2331383	Embedded
Bronze	Deductible Single / Family	Coinsurance	Maximum Out of Pocket Single / Family	Office Visit Primary / Specialist	Diagnostic X-Ray & Laboratory Test / Advanced Radiology (MRI/PET/CAT)	Hospital (Inpatient / Outpatient)	Urgent Care	Emergency Room	Prescription Drugs				Mental Health Outpatient	Adult Vision Exam Age 19 and Older	Pediatric Vision Exam Age 18 and Under	HSA Eligible	Plan Number Marketplace Select / HMO	Plan Number Direct Select / HMO	Embedded / NonEmbedded
Bronze 6850 Ded/8200 MOOP	\$6,850/Individual or \$13,700/Family	40%	\$8,200/Individual or \$16,400/Family	\$35 / \$150	40% after Deductible / 40% after Deductible	40% after Deductible / 40% after Deductible	\$75	40% after Deductible	\$35	35% after Deductible	40% after Deductible	45% after Deductible	\$35	Not Covered	No Charge	No	2312407 / 2311407	2332407 / 2331407	Embedded
Bronze 7500 Ded/9000 MOOP	\$7,500/Individual or \$15,000/Family	50%	\$9,000/Individual or \$18,000/Family	\$50 / \$100	50% after Deductible / 50% after Deductible	50% after Deductible / 50% after Deductible	\$75	50% after Deductible	\$25	\$50 after Deductible	\$100 after Deductible	\$500 after Deductible	\$50	Not Covered	No Charge	No	2312420 / 2311420	2332420 / 2331420	Embedded
Bronze 4000 Ded/8500 MOOP	\$4,000/Individual or \$8,000/Family	40%	\$8,500/Individual or \$17,000/Family	\$125 / \$250	40% after Deductible / 40% after Deductible	40% after Deductible / 40% after Deductible	\$125	40% after Deductible	\$50	\$200	\$300	50% after Pharmacy Deductible	\$125	Not Covered	No Charge	No	2312401 / 2311401	2332401 / 2331401	Embedded
Bronze 7500 Ded/7500 MOOP HSA	\$7,500/Individual or \$15,000/Family	0%	\$7,500/Individual or \$15,000/Family	No Charge after Deductible / No Charge after Deductible	No Charge after Deductible / No Charge after Deductible	No Charge after Deductible / No Charge after Deductible	No Charge after Deductible	No Charge after Deductible	No Charge after Deductible	No Charge after Deductible	No Charge after Deductible	No Charge after Deductible	No Charge after Deductible	Not Covered	No Charge after Deductible	Yes	2312404 / 2311404	2332404 / 2331404	Embedded
Bronze 9050 Ded/9050 MOOP	\$9,050/Individual or \$18,100/Family	0%	\$9,050/Individual or \$18,100/Family	\$125 / \$175	No Charge after Deductible / No Charge after Deductible	No Charge after Deductible / No Charge after Deductible	\$125	No Charge after Deductible	\$35	No Charge after Deductible	No Charge after Deductible	No Charge after Deductible	\$125	Not Covered	No Charge	No	2312416 / 2311416	2332416 / 2331416	Embedded
Bronze 9100 Ded/9100 MOOP	\$9,100/Individual or \$18,200/Family	0%	\$9,100/Individual or \$18,200/Family	No Charge after Deductible / No Charge after Deductible	No Charge after Deductible / No Charge after Deductible	No Charge after Deductible / No Charge after Deductible	No Charge after Deductible	No Charge after Deductible	No Charge after Deductible	No Charge after Deductible	No Charge after Deductible	No Charge after Deductible	No Charge after Deductible	Not Covered	No Charge	No	2312423 / 2311423	2332423 / 2331423	Embedded
Catastrophic	Deductible Single / Family	Coinsurance	Maximum Out of Pocket Single / Family	Office Visit Primary / Specialist	Diagnostic X-Ray & Laboratory Test / Advanced Radiology (MRI/PET/CAT)	Hospital (Inpatient / Outpatient)	Urgent Care	Emergency Room	Prescription Drugs				Mental Health Outpatient	Adult Vision Exam Age 19 and Older	Pediatric Vision Exam Age 18 and Under	HSA Eligible	Plan Number Marketplace Select / HMO	Plan Number Direct Select / HMO	Embedded / NonEmbedded
Catastrophic 9100 Ded/9100 MOOP	\$9,100/Individual or \$18,200/Family	0%	\$9,100/Individual or \$18,200/Family	No Charge after Deductible; First three (3) visits free / No Charge after Deductible	No Charge after Deductible / No Charge after Deductible	No Charge after Deductible / No Charge after Deductible	No Charge after Deductible	No Charge after Deductible	No Charge after Deductible	No Charge after Deductible	No Charge after Deductible	No Charge after Deductible	No Charge after Deductible	Not Covered	No Charge after Deductible	No	2312001 / 2311001	2332001 / 2331001	Embedded

Dependents are covered until the end of the month in which they turn 26. **Prescription Drugs** - Covers up to a 30-day supply; 31-90 day supply available from January to September for multiple copays - subject to maximum cost limit. All Plans renew January 1st and are on a Calendar Year Plan. For more details of each plan, go to planfinder.ghcscw.com. Group Health Cooperative does not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, sexual orientation, or health status in the administration of the plan, including enrollment and benefit determination.

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) 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:

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	Drug screening, except as specifically covered under the Policy or Certificate of coverage	Hospital services for a Skilled Nursing Facility beyond the amount specified in the Policy or Certificate of coverage	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
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	Drugs dispensed in quantities equal to a supply of more than 30 days, if dispensed during the final 3 months of the plan year for the Policy or Certificate. During the first 9 months of a plan year, supplies of up to 90 days may be dispensed at participating pharmacies, so long as the cost of the resulting quantity does not exceed the current maximum cost limit established by GHC-SCW	Housecleaning	Sperm banking or egg harvesting
Services that are not Medically Necessary, are experimental, investigative or for research purposes	Duplicate services	Hypnotherapy services	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
Billed amounts that are over and above the GHC-SCW Usual, Customary and Charges for covered benefits	Durable Medical Equipment and Medical Supplies not specifically covered under the Policy or Certificate of Coverage	Infertility services	Tattoos: services for the removal of tattoos or complications related to tattoos
Items or services required as a result of war or any act of war, insurrection, riot, terrorism, or sustained while performing military services	Elective Abortions	Insulin injection pens not included in the GHC formulary.	Transplant donor services when the recipient is not a current Member under this Certificate
Services provided before the effective date or after the termination date of the Policy or Certificate of coverage	Electrolysis services	Keratorefractive surgery	Third-party examinations
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	Emergency Outpatient Services when a Member leaves the emergency room prior to seeing a physician	Maintenance and Supportive care and/or therapy	Tongue thrust services or treatment
Services while incarcerated, except as specifically required by state or federal law	End of Life Services not specifically included under the Policy or Certificate of coverage	Maternity Services for third party or non-Member Traditional Surrogates or Gestational Carriers	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
Services and supplies obtained while outside the United States, except for Urgent Conditions and Emergency Conditions	Food or nutrition that is not Medical Food that is specifically covered under the Policy or Certificate	Mental Health and Substance Use Disorder services beyond the services specified in the Policy or Certificate of coverage	Transportation services and costs, except Medically Necessary ambulance services
Charges for missed appointment(s)	Foot orthotics not attached to a medically necessary custom brace or prescribed as part as post-surgical or post-traumatic casting care	New-to-Market Drugs and Treatments are subject to an exclusion period of six (6) months	Travel Immunizations
Services for injuries incurred during the commission of a crime	Functional capacity evaluations	Obesity-related 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
Allergy testing	Gastro-intestinal surgical procedures for purposes of weight loss	Outpatient Rehabilitation Therapies and Habilitation Services beyond the services specified in the Policy or Certificate of coverage	Vision therapy
Blood donor services	General nutrition counseling/education	Over-the-counter contraceptive drugs or devices that do not meet all necessary requirements under the Policy or Certificate of coverage	Vocational Rehabilitation services
Common use supplies	Gene Therapy	Over-the-counter supplies	Workers' Compensation items and services incidental to an injury or conditions covered by any Workers' Compensation law or occupational disease law
Complementary Medicine services	Growth Hormone for the treatment of idiopathic short stature	Personal comfort items	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
Complications, consultations, services and procedures related to a non-covered procedure	Hair implants/transplants	Prescription drugs unless specifically included under the Policy or Certificate of coverage	
Conception services	General Health Plan Limitations and Exclusions	Private duty nursing services	
Cosmetic services	Hearing Aid batteries and ancillary equipment	Prolotherapy	
Custodial care	Home health visits beyond the amount specified in the Policy or Certificate of coverage	Recreational and Educational therapy, financial and occupational counseling, and therapies beyond the services specified in the Policy or Certificate of coverage	
Dental services not specifically covered under the Policy or Certificate of coverage	Home modifications	Services performed by a family member	
		Scar revisions	
		Sensory integration therapy, except for when medically necessary to treat Autism Spectrum Disorder	

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 decline 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.