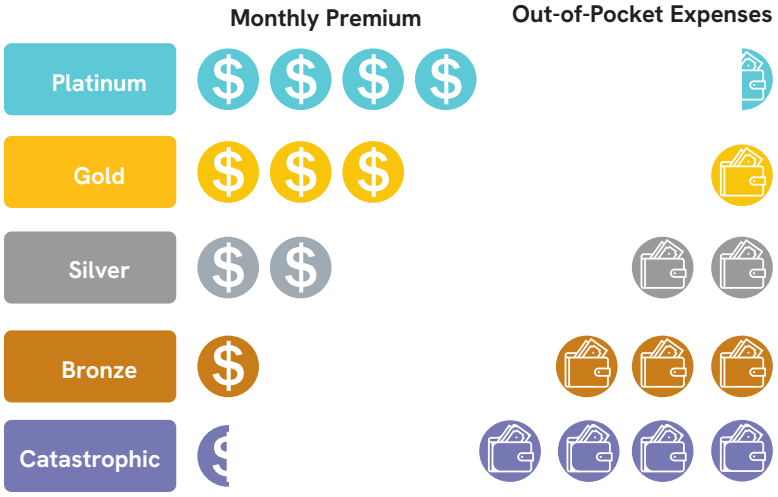
GHC-SCW 2024 Individual Plans

Adams, Columbia, Grant, Green, Iowa, Juneau, Lafayette, and Sauk Counties

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.

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, **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 2024 stipulate that an individual cannot pay more than $9,450 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 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.

Group Health Cooperative
of South Central Wisconsin

ghcscw.com

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Individual & Family Plan Options 2024: Adams, Columbia, Grant, Green, Iowa, Juneau, Lafayette, Sauk County

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 Tier 1	Prescription Drugs Tier 2	Prescription Drugs Tier 3	Prescription Drugs Tier 4	Mental Health Outpatient	Adult Vision Exam Age 19 and Older	Pediatric Vision Exam Age 18 and Under	HSA Eligible	Plan Number Marketplace / Direct	Embedded / NonEmbedded
Gold 2500 Ded/5000 MOOP Primary Care Preferred with Vision	$2,500/Individual or $5,000/Family	20%	$5,000/Individual or $10,000/Family	No Charge / $125	No Charge / 20% after Deductible	20% after Deductible / 20% after Deductible	No Charge	20% after Deductible	$20	$35	$150	$300	No Charge	No Charge	No Charge	No	2411228 / 2431228	Embedded
Gold 1000 Ded/6000 MOOP	$1,000/Individual or $2,000/Family	30%	$6,000/Individual or $12,000/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	2411220 / 2431220	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%	$30	Not Covered	No Charge	No	2411216 / 2431216	Embedded
Gold 1500 Ded/8700 MOOP	$1,500/Individual or $3,000/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	2411231 / 2431231	Embedded
Gold 2800 Ded/2800 MOOP HSA	$2,800/Individual or $5,600/Family	0%	$2,800/Individual or $5,600/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	2411210 / 2431210	Non-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 Tier 1**	**Prescription Drugs Tier 2**	**Prescription Drugs Tier 3**	**Prescription Drugs Tier 4**	**Mental Health Outpatient**	**Adult Vision Exam Age 19 and Older**	**Pediatric Vision Exam Age 18 and Under**	**HSA Eligible**	**Plan Number Marketplace / Direct**	**Embedded / NonEmbedded**
Silver 9400 Ded/9400 MOOP Primary Care Preferred with Vision	$9,400/Individual or $18,800/Family	0%	$9,400/Individual or $18,800/Family	No Charge / $175	No Charge / No Charge after Deductible	No Charge after Deductible / No Charge after Deductible	No Charge	No Charge after Deductible	$30	$140	$300	$500	No Charge	No Charge	No Charge	No	2411377 / 2431377	Embedded
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% after Deductible	$35	Not Covered	No Charge	No	2411355 / 2431355	Embedded
Silver 5900 Ded/9100 MOOP	$5,900/Individual or $11,800/Family	40%	$9,100/Individual or $18,200/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	2411383 / 2431383	Embedded
Silver 5700 Ded/5700 MOOP HSA	$5,700/Individual or $11,400/Family	0%	$5,700/Individual or $11,400/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	2411331 / 2431331	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 Tier 1**	**Prescription Drugs Tier 2**	**Prescription Drugs Tier 3**	**Prescription Drugs Tier 4**	**Mental Health Outpatient**	**Adult Vision Exam Age 19 and Older**	**Pediatric Vision Exam Age 18 and Under**	**HSA Eligible**	**Plan Number Marketplace / Direct**	**Embedded / NonEmbedded**
Bronze No Medical Ded/9450 MOOP	Medical Deductible: $0/Individual or $0/Family Pharmacy Deductible: $3,000/Individual or $6,000/Family	50%	$9,450/Individual or $18,900/Family	$45 / $160	$55 / $1,000	50%/$1,500 and 50%	$45	$1,500	$35	$175	50% after Pharmacy Deductible	50% after Pharmacy Deductible	$45	Not Covered	No Charge	No	2411427 / 2431427	Embedded
Bronze 7000 Ded/8500 MOOP	$7,000/Individual or $14,000/Family	40%	$8,500/Individual or $17,000/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	2411407 / 2431407	Embedded
Bronze 7500 Ded/9400 MOOP	$7,500/Individual or $15,000/Family	50%	$9,400/Individual or $18,800/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	2411420 / 2431420	Embedded
Bronze 4000 Ded/9450 MOOP	$4,000/Individual or $8,000/Family	40%	$9,450/Individual or $18,900/Family	$125 / $250	40% after Deductible / 40% after Deductible	40% after Deductible / 40% after Deductible	$125	40% after Deductible	$50	$200	$300	50%	$125	Not Covered	No Charge	No	2411401 / 2431401	Embedded
Bronze 7900 Ded/7900 MOOP HSA	$7,900/Individual or $15,800/Family	0%	$7,900/Individual or $15,800/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	2411404 / 2431404	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 Tier 1**	**Prescription Drugs Tier 2**	**Prescription Drugs Tier 3**	**Prescription Drugs Tier 4**	**Mental Health Outpatient**	**Adult Vision Exam Age 19 and Older**	**Pediatric Vision Exam Age 18 and Under**	**HSA Eligible**	**Plan Number Marketplace / Direct**	**Embedded / NonEmbedded**
Catastrophic 9450 Ded/9450 MOOP	$9,450/Individual or $18,900/Family	0%	$9,450/Individual or $18,900/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	2411001 / 2431001	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

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

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

Allergy testing

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

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

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

Foot orthotics not attached to a medically necessary custom brace or prescribed as part as post-surgical or post-traumatic casting care

Functional capacity evaluations

Gastro-intestinal surgical procedures for purposes of weight loss

General nutrition counseling/education

Gene Therapy

Growth Hormone for the treatment of idiopathic short stature

Hair implants/transplants

General Health Plan Limitations and Exclusions

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

Vision therapy

Vocational Rehabilitation services

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

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.