GROUP HEALTH COOPERATIVE OF SOUTH CENTRAL WISCONSIN

http://www.ghcscw.com

Customer Service (800)605-4327

2015

A Health Maintenance Organization

This plan's health coverage qualifies as minimum essential coverage and meets the minimum value standard for the benefits it provides: See page 4 for details.

Serving: South Central Wisconsin

Enrollment in this Plan is limited. You must live or work in our geographic service area to enroll. See page 13 for requirements.

IMPORTANT
- Rates: Back Cover
- Changes for 2015: Page 14
- Summary of benefits: Page 70

Enrollment code for this Plan:
WJ1 High Option – Self Only
WJ2 High Option – Self and Family

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Authorized for distribution by the:

United States
Office of Personnel Management

Healthcare and Insurance
http://www.opm.gov/insure

Important Notice from Group Health Cooperative of South Central Wisconsin About Our Prescription Drug Coverage and Medicare

The Office of Personnel Management (OPM) has determined that the Group Health Cooperative of South Central Wisconsin's prescription drug coverage is, on average, expected to pay out as much as the standard Medicare prescription drug coverage will pay for all plan participants and is considered Creditable Coverage. This means you do not need to enroll in Medicare Part D and pay extra for prescription drug coverage. If you decide to enroll in Medicare Part D later, you will not have to pay a penalty for late enrollment as long as you keep your FEHB coverage.

However, if you choose to enroll in Medicare Part D, you can keep your FEHB coverage and your FEHB plan will coordinate benefits with Medicare.

Remember: If you are a former employee entitled to an annuity under a retirement system established for employees and you cancel your FEHB coverage, you may not re-enroll in the FEHB Program.

Please be advised

If you lose or drop your FEHB coverage and go 63 days or longer without prescription drug coverage that's at least as good as Medicare's prescription drug coverage, your monthly Medicare Part D premium will go up at least 1% per month for every month that you did not have that coverage. For example, if you go 19 months without Medicare Part D prescription drug coverage, your premium will always be at least 19 percent higher than what most other people pay. You will have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the next Annual Coordinated Election Period (October 15 through December 7) to enroll in Medicare Part D.

Medicare's Low Income Benefits

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information regarding this program is available through the Social Security Administration (SSA) online at www.socialsecurity.gov, or call the SSA at 1-800-772-1213. (TTY: 1-800-325-0778).

You can get more information about Medicare prescription drug plans and the coverage offered in your area from these places:

- Visit www.medicare.gov for personalized help.
- Call 1-800-MEDICARE (1-800-633-4227), (TTY: 1-877-486-2048)

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Introduction

This brochure describes the benefits of Group Health Cooperative of South Central Wisconsin under our contract (CS 1828) with the United States Office of Personnel Management, as authorized by the Federal Employees Health Benefits law. Member Services may be reached at (800) 605-4327 or through our website: www.ghcscw.com. The address for Group Health Cooperative of South Central Wisconsin (GHC-SCW) administration offices is:

Local Address: 1265 John Q Hammons Drive, Madison WI 53717-1941
Postal Address: PO Box 44971, Madison WI 53744-4971

This brochure is the official statement of benefits. No oral statement can modify or otherwise affect the benefits, limitations, and exclusions of this brochure. It is your responsibility to be informed about your health benefits.

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled in Self and Family coverage, each eligible family member is also entitled to these benefits. You do not have a right to benefits that were available before January 1, 2015, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2015, and changes are summarized on page 14. Rates are shown at the end of this brochure.

Coverage under this plan qualifies as minimum essential coverage (MEC) and satisfies the Patient Protection and Affordable Care Act's (ACA) individual and shared responsibility requirement. Please visit the the Internal Revenue Service (IRS) website at www.irs.gov/uac/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision for more information on the individual requirement for MEC.

The ACA establishes a minimum value for the standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). The health coverage of this plan does meet the minimum value standard for the benefits the plan provides.

Plain Language

All FEHB brochures are written in plain language to make them easy to understand. Here are some examples,

- Except for necessary technical terms, we use common words. For instance, “you” means the enrollee or family member, “we” means Group Health Cooperative of South Central Wisconsin (GHC-SCW).
- We limit acronyms to ones you know. FEHB is the Federal Employees Health Benefits Program. OPM is the United States Office of Personnel Management. If we use others, we tell you what they mean.
- Our brochure and other FEHB plans’ brochures have the same format and similar descriptions to help you compare plans.

Stop Health Care Fraud!

Fraud increases the cost of health care for everyone and increases your Federal Employees Health Benefits Program premium.

OPM’s Office of the Inspector General investigates all allegations of fraud, waste, and abuse in the FEHB Program regardless of the agency that employs you or from which you retired.

Protect Yourself From Fraud – Here are some things that you can do to prevent fraud:

- Do not give your plan identification (ID) number over the telephone or to people you do not know, except for your health care providers, authorized health benefits plan or OPM representative.
- Let only the appropriate medical professionals review your medical record or recommend services.
- Avoid using health care providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.
- Carefully review explanations of benefits (EOBs) statements that you receive from us.

- Periodically review your claim history for accuracy to ensure we have not been billed for services that you did not receive.
- Do not ask your doctor to make false entries on certificates, bills or records in order to get us to pay for an item or service.
- If you suspect that a provider has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:
  - Call the provider and ask for an explanation. There may be an error.
  - If the provider does not resolve the matter, call us at 608-828-4853 and explain the situation.

- If we do not resolve the issue:

CALL- THE HEALTH CARE FRAUD HOTLINE
877-499-7295
OR go to www.opm.gov/oig
You can also write to:
United States Office of Personnel Management
Office of the Inspector General Fraud Hotline
1900 E Street NW Room 6400
Washington, DC 20415-1100

- Do not maintain as a family member on your policy:
  - Your former spouse after a divorce decree or annulment is final (even if a court order stipulates otherwise)
  - Your child age 26 or over (unless he/she was disabled and incapable of self-support prior to age 26)
- If you have any questions about the eligibility of a dependent, check with your personnel office if you are employed, with your retirement office (such as OPM) if you are retired, or with the National Finance Center if you are enrolled under Temporary Continuation of Coverage.
- Fraud or intentional misrepresentation of material fact is prohibited under this Plan. You can be prosecuted for fraud and your agency may take action against you. Examples of fraud include, falsifying a claim to obtain FEHB benefits, trying to or obtaining service or coverage for yourself or someone else who is not eligible for coverage, or enrolling in the Plan when you are no longer eligible.
- If your enrollment continues after you are no longer eligible for coverage (i.e., you have separated from Federal service) and premiums are not paid, you will be responsible for all benefits paid during the period in which premiums were not paid. You may be billed by your provider for services received. You may be prosecuted for fraud for knowingly using health insurance benefits for which you have not paid premiums. It is your responsibility to know when you or a family member is no longer eligible to use your health insurance coverage.

Preventing Medical Mistakes

An influential report from the Institute of Medicine estimates that up to 98,000 Americans die every year from medical mistakes in hospitals alone. That's about 3,230 preventable deaths in the FEHB Program a year. While death is the most tragic outcome, medical mistakes cause other problems such as permanent disabilities, extended hospital stays, longer recoveries, and even additional treatments. By asking questions, learning more and understanding your risks, you can improve the safety of your own health care, and that of your family members. Take these simple steps:

1. Ask questions if you have doubts or concerns.

- Ask questions and make sure you understand the answers.
- Choose a doctor with whom you feel comfortable talking.
- Take a relative or friend with you to help you ask questions and understand answers.

2. Keep and bring a list of all the medicines you take.

- Bring the actual medicines or give your doctor and pharmacist a list of all the medicines and dosage that you take, including non-prescription (over-the-counter) medicines and nutritional supplements.
- Tell your doctor and pharmacist about any drug, food and other allergies you have, such as to latex.
- Ask about any risks or side effects of the medication and what to avoid while taking it. Be sure to write down what your doctor or pharmacist says.
- Make sure your medicine is what the doctor ordered. Ask the pharmacist about your medicine if it looks different than you expected.
- Read the label and patient package insert when you get your medicine, including all warnings and instructions.
- Know how to use your medicine. Especially note the times and conditions when your medicine should and should not be taken.
- Contact your doctor or pharmacist if you have any questions.

3. Get the results of any test or procedure.

- Ask when and how you will get the results of tests or procedures.
- Don't assume the results are fine if you do not get them when expected, be it in person, by phone, or by mail.
- Call your doctor and ask for your results.
- Ask what the results mean for your care.

4. Talk to your doctor about which hospital is best for your health needs.

- Ask your doctor about which hospital has the best care and results for your condition if you have more than one hospital to choose from to get the health care you need.
- Be sure you understand the instructions you get about follow-up care when you leave the hospital.

5. Make sure you understand what will happen if you need surgery.

- Make sure you, your doctor, and your surgeon all agree on exactly what will be done during the operation.
- Ask your doctor, "Who will manage my care when I am in the hospital?"
- Ask your surgeon:
  - "Exactly what will you be doing?"
  - "About how long will it take?"
  - "What will happen after surgery?"
  - "How can I expect to feel during recovery?"
- **Tell the surgeon, anesthesiologist, and nurses about any allergies, bad reactions to anesthesia and any medications or nutritional supplements you are taking**

Patient Safety Links

- www.ahrq.gov/consumer. The Agency for Healthcare Research and Quality makes available a wide-ranging list of topics not only to inform consumers about patient safety but to help choose quality health care providers and improve the quality of care you receive.
- www.npsf.org. The National Patient Safety Foundation has information on how to ensure safer health care for you and your family.
- www.talkaboutrx.org. The National Council on Patient Information and Education is dedicated to improving communication about the safe, appropriate use of medicines.
- www.leapfroggroup.org. The Leapfrog Group is active in promoting safe practices in hospital care.
- www.ahqa.org. The American Health Quality Association represents organizations and health care professionals working to improve patient safety.

Never Events

When you enter the hospital for treatment of one medical problem, you don't expect to leave with additional injuries, infections or other serious conditions that occur during the course of your stay. Although some of these complications may not be avoidable, too often patients suffer from injuries or illnesses that could have been prevented if the hospital had taken proper precautions.

We have a benefit payment policy that encourages hospitals to reduce the likelihood of hospital-acquired conditions such as certain infections, severe bedsores, and fractures; and to reduce medical errors that should never happen. These conditions and errors are called "Never Events." When a Never Event occurs, neither your FEHB plan nor you will incur costs to correct the medical error.

You will not be billed for inpatient services related to treatment of specific hospital-acquired conditions or for inpatient services needed to correct Never Events, if you use Group Health Cooperative preferred providers. This policy helps to protect you from the preventable medical errors and improve the quality of care you receive.

FEHB Facts

Coverage information

- **No pre-existing condition limitation**

  We will not refuse to cover the treatment of a condition you had before you enrolled in this Plan solely because you had the condition before you enrolled.

- **Minimum Essential Coverage (MEC)**

  Coverage under this plan qualifies as minimum essential coverage (MEC) and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at www.irs.gov/uac/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision for more information on the individual requirement for MEC.

- **Minimum value standard**

  Our health coverage meets the minimum value standard of 60% established by the ACA. This means we provide benefits to cover at least 60% of the total allowed costs of essential health benefits. The 60% standard is an actuarial value; your specific out-of-pocket costs are determined as explained in this brochure.

- **Where you can get information about enrolling in the FEHB Program**

  See www.opm.gov/healthcare-insurance for enrollment information as well as:

  - Information on the FEHB Program and plans available to you
  - A health plan comparison tool
  - A list of agencies that participate in Employee Express
  - A link to Employee Express
  - Information on and links to other electronic enrollment systems

  Also, your employing or retirement office can answer your questions, and give you a *Guide to Federal Benefits,* brochures for other plans, and other materials you need to make an informed decision about your FEHB coverage. These materials tell you:

  - When you may change your enrollment
  - How you can cover your family members
  - What happens when you transfer to another Federal agency, go on leave without pay, enter military service, or retire
  - What happens when your enrollment ends
  - When the next Open Season for enrollment begins

  We don't determine who is eligible for coverage and, in most cases, cannot change your enrollment status without information from your employing or retirement office. For information on your premium deductions, you must also contact your employing or retirement office.

- **Types of coverage available for you and your family**

  Self Only coverage is for you alone. Self and Family coverage is for you, your spouse, and your dependent children under age 26, including any foster children authorized for coverage by your employing agency or retirement office. Under certain circumstances, you may also continue coverage for a disabled child 26 years of age or older who is incapable of self-support.

  If you have a Self Only enrollment, you may change to a Self and Family enrollment if you marry, give birth, or add a child to your family. You may change your enrollment 31 days before to 60 days after that event.

  The Self and Family enrollment begins on the first day of the pay period in which the child is born or becomes an eligible family member. When you change to Self and Family because you marry, the change is effective on the first day of the pay period that begins after your employing office receives your enrollment form; benefits will not be available to your spouse until you marry.

Your employing or retirement office will **not** notify you when a family member is no longer eligible to receive benefits, nor will we. Please tell us immediately of changes in family member status, including your marriage, divorce, annulment, or when your child reaches age 26.

If you or one of your family members is enrolled in one FEHB plan, that person may not be enrolled in or covered as a family member by another FEHB plan.

If you have a qualifying life event (QLE) - such as marriage, divorce, or the birth of a child - outside of the Federal Benefits Open Season, you may be eligible to enroll to enroll in the FEHB Program, change your enrollment, or cancel coverage. For a complete list of QLEs, visit the FEHB website at www.opm.gov/healthcare-insurance/life-events. If you need assistance, please contact your employing agency, Tribal Benefits Officer, personnel/payroll office, or retirement office.

- **Family Member Coverage**

Family members covered under your Self and Family enrollment are your spouse (including a valid common law marriage and same sex domestic partners) and children as described in the chart below.

Children	Coverage
Natural children, adopted children, and stepchildren	Natural, adopted children and stepchildren (including children of same-sex domestic partners in certain states) are covered until their 26th birthday.
Foster children	Foster children are eligible for coverage until their 26th birthday if you provide documentation of your regular and substantial support of the child and sign a certification stating that your foster child meets all the requirements. Contact your human resources office or retirement system for additional information.
Children Incapable of self-support	Children who are incapable of self-support because of a mental or physical disability that began before age 26 are eligible to continue coverage. Contact your human resources office or retirement system for additional information.
Married children	Married children (but **NOT**their spouse or their own children) are covered until their 26th birthday.
Children with or eligible for employer-provided health insurance	Children who are eligible for or have their own employer-provided health insurance are covered until their 26th birthday.

You can find additional information at www.opm.gov/healthcare-insurance.

- **Children's Equity Act**

OPM has implemented the Federal Employees Health Benefits Children's Equity Act of 2000. This law mandates that you be enrolled for Self and Family coverage in the FEHB Program, if you are an employee subject to a court or administrative order requiring you to provide health benefits for your child(ren).

If this law applies to you, you must enroll for Self and Family coverage in a health plan that provides full benefits in the area where your children live or provide documentation to your employing office that you have obtained other health benefits coverage for your children. If you do not do so, your employing office will enroll you involuntarily as follows:

- If you have no FEHB coverage, your employing office will enroll you for Self and Family coverage in the Blue Cross and Blue Shield Service Benefit Plan's Basic Option;

- If you have a Self Only enrollment in a fee-for-service plan or in an HMO that serves the area where your children live, your employing office will change your enrollment to Self and Family in the same option of the same plan; or
- If you are enrolled in an HMO that does not serve the area where the children live, your employing office will change your enrollment to Self and Family in the Blue Cross and Blue Shield Service Benefit Plan's Basic Option.

As long as the court/administrative order is in effect, and you have at least one child identified in the order who is still eligible under the FEHB Program, you cannot cancel your enrollment, change to Self Only, or change to a plan that doesn't serve the area in which your children live, unless you provide documentation that you have other coverage for the children. If the court/administrative order is still in effect when you retire, and you have at least one child still eligible for FEHB coverage, you must continue your FEHB coverage into retirement (if eligible) and cannot cancel your coverage, change to Self Only, or change to a plan that doesn't serve the area in which your children live as long as the court/administrative order is in effect. Contact your employing office for further information.

- **When benefits and premiums start**

The benefits in this brochure are effective January 1. If you joined this Plan during Open Season, your coverage begins on the first day of your first pay period that starts on or after January 1. **If you changed plans or plan options during Open Season and you receive care between January 1 and the effective date of coverage under your new plan or option, your claims will be paid according to the 2015 benefits of your old plan or option.** However, if your old plan left the FEHB Program at the end of the year, you are covered under that plan's 2014 benefits until the effective date of your coverage with your new plan. Annuitants' coverage and premiums begin on January 1. If you joined at any other time during the year, your employing office will tell you the effective date of coverage.

If your enrollment continues after you are no longer eligible for coverage, (i.e., you have separate from Federal service) and premiums are not paid, you will be responsible for all benefits paid during the period in which premiums were not paid. You may be billed for services received directly from your provider. You may be prosecuted for fraud for knowingly using health insurance benefits for which you have not paid premiums. It is your responsibility to know when you or a family member are no longer eligible to use your health insurance coverage.

- **When you retire**

When you retire, you can usually stay in the FEHB Program. Generally, you must have been enrolled in the FEHB Program for the last five years of your Federal service. If you do not meet this requirement, you may be eligible for other forms of coverage, such as Temporary Continuation of Coverage (TCC).

When you lose benefits

- **When FEHB coverage ends**

You will receive an additional 31 days of coverage, for no additional premium, when:

- Your enrollment ends, unless you cancel your enrollment or
- You are a family member no longer eligible for coverage.

Any person covered under the 31 day extension of coverage who is confined in a hospital or other institution for care or treatment on the 31st day of the temporary extension is entitled to continuation of the benefits of the Plan during the continuance of the confinement but not beyond the 60th day after the end of the 31 day temporary extension.

You may be eligible for spouse equity coverage or Temporary Continuation of Coverage (TCC).

- **Upon divorce** — If you are divorced from a Federal employee, or annuitant, you may not continue to get benefits under your former spouse's enrollment. This is the case even when the court has ordered your former spouse to provide health coverage for you. However, you may be eligible for your own FEHB coverage under either the spouse equity law or Temporary Continuation of Coverage (TCC). If you are recently divorced or are anticipating a divorce, contact your ex-spouse's employing or retirement office to get RI 70-5, the *Guide to Federal Benefits for Temporary Continuation of Coverage and Former Spouse Enrollees,* or other information about your coverage choices. You can also download the guide from OPM's website, www.opm.gov/healthcare-insurance/healthcare/plan-information/guides.

- **Temporary Continuation of Coverage (TCC)** — If you leave Federal service, Tribal employment, or if you lose coverage because you no longer qualify as a family member, you may be eligible for Temporary Continuation of Coverage (TCC). The Affordale Care Act (ACA) did not eliminate TCC or change the TCC rules. For example, you can receive TCC if you are not able to continue your FEHB enrollment after you retire, if you lose your Federal or Tribal job, if you are a covered dependent child and you turn 26, etc.

  You may not elect TCC if you are fired from your Federal or Tribal job due to gross misconduct.

  Enrolling in TCC. Get the RI 79-27, which describes TCC, and the RI 70-5, the *Guide to Federal Benefits for Temporary Continuation of Coverage and Former Spouse Enrollees,* from your employing or retirement office or from www.opm.gov/healthcare-insurance. It explains what you have to do to enroll.

  Alternatively, you can buy coverage through the Health Insurance Marketplace where, depending on your income, you could be eligible for a new kind of tax credit that lowers your monthly premiums. Visit www.HealthCare.gov to compare plans and see what your premium, deductible, and out-of-pocket costs would be before you make a decision to enroll. Finally, if you qualify for coverage under another group health plan (such as your spouse's plan), you may be able to enroll in that plan, as long as you apply within 30 days of losing FEHB Program coverage.

Converting to individual coverage

You may convert to a non-FEHB individual policy if:

- Your coverage under TCC or the spouse equity law ends (If you canceled your coverage or did not pay your premium you cannot convert):
- You decided not to receive co verage under TCC or the spouse equity law; or
- You are not eligible for coverage under TCC or the spouse equity law.

If you leave Federal or Tribal service, your employing office will notify you of your right to covert. You must apply in wirting to us within 31 days after you receive this notice. however, if you are a family member who is losing coverage, the employing or retirement office will **not** notify you. You must apply in writing to us within 31 days after you are no longer eligible for coverage.

Your benefits and rates will differ from those under the FEHB Program; however, you will not have to answer questions about your health, and we will not impose a waiting period or limit your coveage due to pre-**exisiting conditions.**

- Health Insurance Marketplace — If you would like to purchase health insurance through the Affordable Care Act's Health Insurance Marketplace, please visit www.HealthCare.gov. This is a website provided by the U. S. Department of Health and Human Services that provides up-to-date information on the Marketplace.

Section 1. How this plan works

This Plan is a health maintenance organization (HMO). We require you to see specific physicians, hospitals, and other providers that contract with us. These Plan providers coordinate your health care services. The Plan is solely responsible for the selection of these providers in your area. Contact the Plan for a copy of their most recent provider directory.

HMOs emphasize preventive care such as routine office visits, physical exams, well-baby care, and immunizations, in addition to treatment for illness and injury. Our providers follow generally accepted medical practice when prescribing any course of treatment.

When you receive services from Plan providers, you will not have to submit claim forms or pay bills. You pay only the copayments, coinsurance, and deductibles described in this brochure. When you receive emergency services from non-Plan providers, you may have to submit claim forms.

We protect you against catastrophic out-of-pocket expenses for covered services. Your annual out-of-pocket expenses for covered services, including deductibles and copayments, cannot exceed $6450 for Self Only enrollment or $12,900 Self and Family coverage.

You should join an HMO because you prefer the plan's benefits, not because a particular provider is available. You cannot change plans because a provider leaves our Plan. We cannot guarantee that any one physician, hospital, or other provider will be available and/or remain under contract with us.

General features of our High Option

Our HMO offers benefits for covered services in a primary care setting and requires a referral to see specialty providers. There are no out-of-network benefits.

How we pay providers

We contract with individual physicians, medical groups, and hospitals to provide the benefits in this brochure. These Plan providers accept a negotiated payment from us, and you will only be responsible for your copayments or coinsurance.

Your Rights

OPM requires that all FEHB plans provide certain information to their FEHB members. You may request information about us, our networks, and our providers. OPM's FEHB website (www.opm.gov/healthcare-insurance) lists the specific types of information that we must make available to you. Some of the required information is listed below.

- **Years in existence** **36 (first clinic opened in 1976)**
- **Profit status** **Not-for-profit**

If you want more information about us, call 608-828-4827, or write to GHC-SCW Marketing Department, PO Box 44971, Madison WI 53744-4971. You may also contact us by fax at 608-828-9333 or visit our website at www.ghcscw.com.

Your medical and claims records are confidential

We will keep your medical and claims records confidential. Please note that we may disclose your medical and claims information (including your prescription drug utilization) to any of your treating physicians or dispensing pharmacies.

Service Area

To enroll in this Plan, you must live in or work in our service area. This is where our providers practice. Service area means Dane County, Wisconsin. A member who resides outside of the Service Area is eligible for coverage provided his or her residence is located in contiguous counties to Dane County, Wisconsin:

Columbia County Dodge County Green County Iowa County

Jefferson County Lafayette County Rock County Sauk County

Ordinarily, you must get your care from providers who contract with us. If you receive care outside our service area, we will pay only for emergency care benefits. We will not pay for any other health care services out of our service area unless the services have prior Plan approval.

If you or a covered family member move outside of our service area, you can enroll in another plan. If your dependents live out of the area (for example, if your child goes to college in another state), you should consider enrolling in a fee-for-service plan or an HMO that has agreements with affiliates in other areas. If you or a family member move, you do not have to wait until Open Season to change plans. Contact your employing or retirement office.

Section 2. Changes for 2015

Do not rely only on these change descriptions; this Section is not an official statement of benefits. For that, go to Section 5 Benefits. Also, we edited and clarified language throughout the brochure; any language change not shown here is a clarification that does not change benefits.

Changes to this Plan

- Wellness Reimbursement Program. GHC-SCW will offer an annual reimbursement (up to $100 for each family member over the age of 18) for specific weight loss programs, fitness programs, membership in participating Community Supported Agriculture (CSA) farms/gardens, athletic shoe reimbursement, and Doula Services.
- Removal of Expanded Complementary Medicine benefit.
- Your share of the non-Postal premium will increase for Self Only and Family. See page 71.

Section 3. How you get care

Identification cards

We will send you an identification (ID) card when you enroll. You should carry your ID card with you at all times. You must show it whenever you receive services from a Plan provider, or fill a prescription at a Plan pharmacy. Until you receive your ID card, use your copy of the Health Benefits Election Form, SF-2809, your health benefits enrollment confirmation (for annuitants), or your electronic enrollment system (such as Employee Express) confirmation letter.

If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call us at 608-260-3170, or fax us at 608-662-4837, or write to us at PO Box 44971, Madison WI 53744-4971. You may also request replacement cards through our website: www.ghcscw.com.

Where you get covered care

You get care from "Plan providers" and "Plan facilities." You will only pay copayments and/or coinsurance.

- **Plan providers**

Plan providers are physicians and other health care professionals in our service area that we contract with to provide covered services to our members. We credential Plan providers according to national standards.

Members must receive care through GHC-SCW In-Plan Providers for services to be covered. Use of Out-Of-Plan Providers will result in the member being financially responsible for full payment of services, unless written approval (Prior Authorization) for such out-of-plan services has been obtained from GHC-SCW's Care Management Department.

We list Plan providers in the provider directory, which we update periodically. The list is also on our website.

- **Plan facilities**

Plan facilities are hospitals and other facilities in our service area that we contract with to provide covered services to our members. We list these in the provider directory, which we update periodically. The list is also on our website.

What you must do to get covered care

It depends on the type of care you need. First, you and each family member must choose a primary care physician. This decision is important since your primary care physician provides or arranges for most of your health care. If you need assistance, please call the GHC-SCW Member Services Department at 608-828-4853.

- **Primary care**

Your primary care physician can be a family practitioner, internist or pediatrician. (You may also select physician assistants or nurse practitioners). Your primary care practitioner will provide most of your health care or give you a referral to see a specialist.

If you want to change primary care physicians or if your primary care physician leaves the Plan, call us. We will help you select a new one

- **Specialty care**

Your primary care physician will refer you to a specialist for needed care. When you receive a referral from your primary care physician, you must return to the primary care physician after the consultation, unless your primary care physician authorized a certain number of visits without additional referrals. The primary care physician must provide or authorize all follow-up care. Do not go to the specialist for return visits unless your primary care physician gives you a referral. However, you may see the following in-plan providers without a referral: mental health, substance abuse, vision, dental, chiropractic, and complementary medicine.

Here are some other things you should know about specialty care:

- If you need to see a specialist frequently because of a chronic, complex, or serious medical condition, your primary care physician will develop a treatment plan that allows you to see your specialist for a certain number of visits without additional referrals.

Your primary care physician will create your treatment plan. The physician may have to get an authorization or approval from us beforehand. If you are seeing a specialist when you enroll in our Plan, talk to your primary care physician. If he or she decides to refer you to a specialist, ask if you can see your current specialist.

If your current specialist does not participate with us, you must receive treatment from a specialist who does. Generally, we will not pay for you to see a specialist who does not participate with our Plan.

- If you are seeing a specialist and your specialist leaves the Plan, call your primary care physician, who will arrange for you to see another specialist. You may receive services from your current specialist until we can make arrangements for you to see someone else.
- If you have a chronic and disabling condition and lose access to your specialist because we:
  - terminate our contract with your specialist for other than cause;
  - drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB program plan; or
  - reduce our Service Area and you enroll in another FEHB plan,

you may be able to continue seeing your specialist for up to 90 days after you receive notice of the change. Contact us, or if we drop out of the Program, contact your new plan.

If you are in the second or third trimester of pregnancy and you lose access to your specialist based on the above circumstances, you can continue to see your specialist until the end of your postpartum care, even if it is beyond the 90 days.

- **Hospital care**

Your Plan primary care physician or specialist will make necessary hospital arrangements and supervise your care. This includes admission to a skilled nursing or other type of facility.

- **If you are hospitalized when your enrollment begins**

We pay for covered services from the effective date of your enrollment. However, if you are in the hospital when your enrollment in our Plan begins, call our Care Management Department immediately at 608-257-5294. If you are new to the FEHB Program, we will arrange for you to receive care and provide benefits for your covered services while you are in the hospital beginning on the effective date of your coverage.

If you changed from another FEHB plan to us, your former plan will pay for the hospital stay until:

- you are discharged, not merely moved to an alternative care center;
- the day your benefits from your former plan run out; or
- the 92nd day after you become a member of this Plan, whichever happens first.

These provisions apply only to the benefits of the hospitalized person. If your plan terminates participation in the FEHB Program in whole or in part, or if OPM orders an enrollment change, this continuation of coverage provision does not apply. In such cases, the hospitalized family member's benefits under the new plan begin on the effective date of enrollment.

You need prior Plan approval for certain serivces

Since your primary care physician arranges most referrals to specialists and inpatient hospitalization, the pre-service claim approval process only applies to care shown under *Other services.*

- **Inpatient hospital admission**

Precertification is the process by which - prior to your inpatient hospital admission - we evaluate the medical necessity of your proposed stay and the number of days required to treat your condition.

- **Other services**

Your primary care physician has authority to refer you for most services. For certain services, however, your physician must obtain prior approval from us. Before giving approval, we consider if the service is covered, medically necessary, and follows generally accepted medical practice. You must obtain authorization for services such as, but not limited to:

- Transplants
- Inpatient hospital services
- Outpatient surgical/non-surgical services
- The following outpatient diagnostic and therapeutic services: MRI, MRA, CT/CAT and PET
- Inpatient maternity care
- Home Health Agency services
- Skilled Nursing Facility services
- Orthopedic and Prosthetic devices
- Durable Medical Equipment
- End of Life (Hospice) services
- Outpatient Rehabilitative Therapy (physical therapy, occupational therapy, speech therapy, vision therapy)
- All inpatient Mental Health and AODA services
- Surgical Infertility services
- Surgical and/or Non-Surgical treatment of Temporomandibular Joint (TMJ) syndrome. A written prior authorization is required for the initial acquisition of an intraoral splint.
- All Accidental Injury dental procedures
- Oral surgery services
- Specialist care
- Breast reduction mammoplasty
- Plastic surgery
- Bariatric surgery for morbid obesity
- Growth Hormone Therapy (GHT)
- Prescription drugs not included in the GHC-SCW formulary
- Experimental, Investigational or unproven services
- Injectable medications
- Enteral or specialized nutional support

GHC-SCW will not guarantee payment for services and/or drugs that require prior authorization which were not prior authorized unless emergent in nature.

How to request precertification for an admission or get prior authorization for Other services

First, your physician, your hospital, you, or your representative, must call us at 608-257-5294 before admission or services requiring prior authorization are rendered.

Next, provide the following information:

- enrollee's name and Plan identification number;
- patient's name, birth date, identification number and phone number;
- reason for hospitalization, proposed treatment, or surgery;
- name and phone number of admitting physician;
- name of hospital or facility; and
- number of days requested for hospital stay

- **Non-urgent care claims**

  For non-urgent care claims, we will then tell the physician and/or hospital the number of approved inpatient days, or the care that we approve for other services that must have prior authorization. We will make our decision within 15 days of receipt of the pre-service claim. If matters beyond our control require an extension of time, we may take up to an additional 15 days for review and we will notify you of the need for an extension of time before the end of the original 15 day period. Our notice will include the circumstances underlying the request for the extension and the date when a decision is expected.

  If we need an extension because we have not received necessary information from you, our notice will describe the specific information required and we will allow you up to 60 days from the receipt of the notice to provide the information.

- **Urgent care claims**

  If you have an urgent care claim (i.e., when waiting for the regular time limit for your medical care or treatment could seriously jeopardize your life, health, or ability to regain maximum function, or in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without this care or treatment), we will expedite our review and notify you of our decision within 72 hours. If you request that we review your claim as an urgent care claim, we will review the documentation you provide and decide whether it is an urgent care claim by applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine.

  If you fail to provide sufficient information, we will contact you within 24 hours after we receive the claim to provide notice of the specific information we need to complete our review of the claim. We will allow you up to 48 hours after the receipt of this notice to provide the necessary information. We will make our decision on the claim within 48 hours of (1) the time we received the additional information or (2) to end of the time frame, whichever is earlier.

  We may provide our decision orally within these time frames, but we will follow up with written or electronic notification within three days of oral notification.

  You may request that your urgent care claim on appeal be reviewed simultaneously by us and OPM. Please let us know that you would like a simultaneous review of your urgent care claim by OPM either in writing at the time you appeal our initial decision, or by calling us at 800-605-4327. You may also call OPM's Health Insurance 3 at (202) 606-0737 between 8 a.m. and 5 p.m. Eastern Time to ask for the simultaneous review. We will cooperate with OPM so they can quickly review your claim on appeal. In addition, if you did not indicate that your claim was a claim for urgent care, call us at 800-605-4327. If it is determined that your claim is an urgent care claim, we will expedite our review (if we have not yet responded to your claim).

- **Concurrent care claims**

  A concurrent care claim involves care provided over a period of time or over a number of treatments. We will treat any reduction or trermination of our pre-approved course of treatment before the end of the approved period of time or number of treatmjents as an appealable decision. This does not inlcude redution or termination due to benefit changes or if your enrollment ends. If we believe a reduction or termination is warranted we will allow you sufficient time to appeal and obtain a decision from us before the reduction or termiantion takes effect.

  if you request an extension of an ongoing course of treamtent at least 24 hours pior to expriation of the approved time period and this is also an urgent care claim, then we will make a decision within 24 hours after we receive the claim.

- **Maternity Care**

  You do not need to precertify a maternity admission for a routine delivery with an in-plan facility. However, if your medical condition requires you to stay more than 48 hours after a vaginal delivery or 96 hours after a cesarean section, your practitioner or hospital must contact us for prior authorization of the additional days. Further, if your baby stays after you are discharged, your practitioner or hospital must contact us for prior authorization of additional days for your baby.

- **If your treatment needs to be extended**

If you request an extension of an ongoing course of treatment at least 24 hours prior to the expiration of the approved time period and this is also an urgent care claim, then we will make a decision within 24 hours after we receive the claim.

What happens when you do not follow the precertification rules when using non-network facilities

Use of Out-of-Plan Providers will result in the Member being financially responsible for full payment of services unless written approval (Prior authorization) for such Out-of-Plan services has been obtained from GHC-SCW's Care Management Department.

Circumstances beyond our control

Under certain extraordinary circumstances, such as natural disasters, we may have to delay your services or we may be unable to provide them. In that case, we will make all reasonable efforts to provide you with the necessary care.

If you disagree with our pre-service claim decision

If you have a **pre-service claim** and you do not agree with our decision regarding precertification of an inpatient admission or prior approval of other services, you may request a review in accord with the procedures detailed below.

If you have already received the service, supply or treatment, then you have a **post-service claim** and must follow the entire disputed claims process detailed in Section 8.

- **To reconsider a non-urgent care claim**

Within 6 months of our initial decision, you may ask us in writing to reconsider our initial decision. Follow Step 1 of the disputed claims process detailed in Section 8 of this brochure.

In the case of a pre-service claim and unless we request additional information, we will notify you of our descision within 72 hours after receipt of your reconsideration request.

1. Precertify your hospital stay or, if applicable, arrange for the health care provider to give you the care or grant your request for prior approval for a service, drug, or supply; or
2. Ask you or your provider for more information.

You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days.

If we do not receive the information within 60 days, we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.

3. Write to you and maintain our denial.

- **To reconsider an urgent care claim**

In the case of an appeal of a pre-service urgent care claim, within 6 months of our initial decision, you may ask us in writing to reconsider our initial decision. Follow Step 1 of the disputed claims process detailed in Section 8 of this brochure.

Unless we request additional information, we will notify you of our decision within 72 hours after receipt of your reconsideration request. We will expedite the review process, which allows oral or written requests for appeals and the exchange of information by telephone, electronic mail, facsimile, or other expeditious methods.

- **To file an appeal with OPM**

After we reconsider your **pre-service claim**, if you do not agree with our decision, you may ask OPM to review it by following Step 3 of the disputed claims process detailed in Section 8 of this brochure.

Section 4. Your costs for covered services

This is what you will pay out-of-pocket for covered care:

Cost-sharing	Cost-sharing is the general term used to refer to your out-of-pocket costs (e.g., deductible, coinsurance, and copayments) for the covered care you receive.
Copayments	A copayment is a fixed amount of money you pay to the provider, facility, pharmacy, etc., when you receive certain services. Example: when you see your primary care physician, you pay a copayment of $10 per office visit, and when you go in the hospital, you pay $100 per admission.
Deductible	We do not have a deductible.
Coinsurance	Coinsurance is the percentage of our allowance that you must pay for your care. Coinsurance does not begin until you have met your calendar year deductible. Example: In our Plan, you pay 20% of our allowance for Durable Medical Equipment, disposable medical supplies, and Orthopedic and Prosthetic devices, and 50% of our allowances for sexual dysfunction drugs and preventive dental care services if a non-participating dentist is used.
Differences between our Plan allowance and the bill	
Your catastrophic protection out-of-pocket maximum	After your (copayments and coinsurances) total $6,350 for self only or $12,700 per family enrollment in any calendar year, you do not have to pay any more for covered services. However, copayments and coinsurances for non Essential Health Benefits do not count toward your catastrophic protection out-of-pocket maximum, and you must continue to pay copayments and coinsurances for these services. Be sure to keep accurate records of your copayments since you are responsible for informing us when you reach the maximum.
Carryover	Does not apply.
When Government facilities bill us	Facilities of the Department of Veterans Affairs, the Department of Defense and the Indian Health Services are entitled to seek reimbursement from us for certain services and supplies they provide to you or a family member. They may not seek more than their governing laws allow. You may be responsible to pay for certain services and charges. Contact the government facility directly for more information.

Section 5. HMO Benefits

See page 14 for how our benefits changed this year. Page 71 is a benefits summary of this option.

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Section 5. High Option Benefit Overview

This Plan offers a High Option. The benefit package is described in Section 5. Make sure that you review the benefits that are available.

The High Option Section 5 is divided into subsections. Please read *Important things you should keep in mind* at the beginning of the subsections. Also read the general exclusions in Section 6; they apply to the benefits in the following subsections. To obtain claim forms, claims filing advice, or more information about High Option benefits, contact GHC-SCW Member Services at 608-828-4853 or on our website at www.ghcscw.com.

Section 5(a). Medical services and supplies provided by physicians and other health care professionals

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also, read Section 9 about coordinating benefits with other coverage, including with Medicare.

Benefit Description	You pay
Diagnostic and treatment services	**High Option**
Professional services of physicians • In physician's office • In an urgent care center • Office medical consultations • Second surgical opinion • At home Note: Speciality medical care provided by a non GHC-SCW Practitioner, whether or not under contract, is not a covered benefit if the service requested can be provided by a GHC-SCW Specialty Practitioner.	$10 per office visit
Professional services of physicians • During a hospital stay • In a skilled nursing facility	Nothing
Out of Area Care • Medically necessary, non-urgent, non-emergent follow-up medical care will be covered at 50% of eligible charges with Prior Authorization from GHC-SCW	50% of eligible charges with Prior Authorization
Lab, X-ray and other diagnostic tests	**High Option**
Tests, such as: • Blood tests • Urinalysis • Non-routine pap tests • Pathology • X-rays • Non-routine mammograms • CAT Scans/MRI • Ultrasound • Electrocardiogram and EEG	Nothing

Benefit Description	You pay
Preventive care, adult	**High Option**
Routine Physical every year which includes: Routine screenings, such as: • Total Blood Cholesterol • Colorectal Cancer Screening, including - Fecal occult blood test - Sigmoidoscopy screening – every five years starting at age 50 - Colonoscopy screening – every ten years starting at age 50 Routine Prostate Specific Antigen (PSA) test - one annually for men age 40 and older Well woman care - including, but not limited to: • Routine Pap test • Human papillomavirus testing for women age 30 and up once every three years • Annual counseling for sexually transmitted infections. • Annual counseling and screening for human immune-deficiency virus. • Contraceptive methods (including tubal ligation) and counseling • Screening and counseling for interpersonal and domestic violence. Routine Mammogram - covered for women age 35 and older,as follows: • From age 35 through age 39, one during this five year period • From age 40 and older, one every calendar year • At age 65 and older, one every two consecutive calendar year **Note**: Mammograms require a Prior Authorization from the GHC-SCW Care Management Department if they are performed outside of a GHC-SCW owned and operated facility. • Adult routine immunizations endorsed by the Centers for Disease Control and Prevention (CDC) • Physical exams required for travel or for attending school or camp **Note**: Travel related immunizations may be provided in accordance with CDC recommendations and GHC-SCW protocols. **Note:** A complete list of preventive care services recommended under the U.S. Preventive Services Task Force is available (USPTF) is available online at http://www.uspreventiveservicestaskforgce.org/uspstf/uspabrecs.htm and HHS at www.healthcare.gov/prevention.	Nothing
Not covered: *Physical examinations for services and/or treatments including, but not limited to:* • *Supplies requested by a third party for any reason.* • *Any testing or procedures such as, but not limited to, echocardiograms, blood tests, ultrasounds, etc. requested by a third party for any reason* • Any routine physical exam requested by a third party for any purpose except those exams provided to an eligible Dependent child for camp, school or non-professional sports	*All charges*

Benefit Description	You pay
Preventive care, children	**High Option**
• Childhood immunizations recommended by the American Academy of Pediatrics • Well-child care charges for routine examinations, immunizations and care (up to age 22) • Examinations, such as: - Eye exams through age 17 to determine the need for vision correction - Hearing exams through age 17 to determine the need for hearing correction - Examinations done on the day of immunizations (up to age 22) • Physical examinations required for travel or for attending school or camp **Note**: travel related immunizations may be provided in accordance with CDC recommendations and GHC-SCW protocols. **Note:** A complete list of preventive care services recommended under the U.S. Preventive Services Task Force is available (USPTF) is available online at http://www.uspreventiveservicestaskforgce.org/uspstf/uspabrecs.htm and HHS at www.healthcare.gov/prevention.	Nothing
Maternity care	**High Option**
Complete maternity (obstetrical) care, such as: • Prenatal care • Screening for gestational diabetes for pregnant women between 24-28 weeks gestation or first prenatal visit for women at a high risk. • Delivery • Postnatal care	Nothing for prenatal care or the first postpartum care visit; $10 per office visit for all postparatum care visits thereafter. Nothing for Inpatient professional delievery services.
Breastfeeding support, supplies and counseling for each birth	Nothing
Note: Here are some things to keep in mind: • You do not need to precertify your normal delivery; see page 19 for other circumstances, such as extended stays for you or your baby. • You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will extend your inpatient stay if medically necessary. • We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self and Family enrollment. Surgical benefits, not maternity benefits, apply to circumcision. • We pay hospitalization and surgeon services for non-maternity care the same as for illness and injury. • We offer Doula services through the Wellness Reimbursement Program (see page 35).	
Not covered: • *Midwives*	*All charges*

Benefit Description	You pay
Family planning	**High Option**
Contraceptive counseling on an annual basis	Nothing
A range of voluntary family planning services, limited to: • Voluntary sterilization (See Surgical procedures Section 5 (b)) • Surgically implanted contraceptives • Intrauterine devices (IUDs) • Diaphragms Note: We cover oral contraceptives under the prescription drug benefit at no charge.	Nothing
• Genetic testing is covered when it is medically necessary for treating an illness or when medically necessary to develop a member's individual health maintenance or screening program.	Nothing
Not covered: • *Reversal of voluntary surgical sterilization* • *Genetic Couseling*	*All charges*
Infertility services	**High Option**
Diagnosis and treatment of infertility such as: • Artificial Insemination: - Intravaginal insemination (IVI) - Intracervical insemination (ICI) - Intrauterine Insemination (IUI) Note: Drugs for fertility and for embryo support after assisted reprodcutive technology (ART) procedures, are excluded unless the drug is included in the Formulary.	50% coinsurance
Not covered: • *Assisted reproductive technology (ART) procedures, such as:* - *in vitro fertilization* - *embryo transfer, gamete intra-fallopian transfer (GIFT) and zygote intra-fallopian transfer (ZIFT)* • *Services and supplies related to ART procedures* • *Cost of donor sperm* • *Cost of donor egg* • *Injectable and oral fertiity drugs, except for Clomiphene Citrate and Progesterone*	*All charges*

Benefit Description	You pay
Allergy care	**High Option**
• Testing and treatment	$10 per office visit
- Allergy antigen injections - Allergy serum injections	Nothing
Not covered: • *Provocative food testing* • *Sublingual allergy desensitization*	*All charges*
Treatment therapies	**High Option**
• Chemotherapy and radiation therapy Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under Organ/Tissue Transplants on page 38. • Respiratory and inhalation therapy • Dialysis – hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy • Growth hormone therapy (GHT) Note: Growth hormone is covered under the prescription drug benefit. Note: We only cover GHT when we preauthorized the treatment. We will ask you to submit information that establishes that the GHT is medically necessary. Ask us to authorize GHT before you begin treatment. We will only cover GHT services and related services and supplies that we determine are medically necessary. See Other Services under You need prior Plan approval for certain services on page 17. • Medical Nutrition Therapy Note: Medical Nutrition Therapy, Enteral or specialized nutritional support, is for those members with normal or abnormal gastrointestinal absorptive capacity who, due to non-function or disease of the gastrointestinal tract, require alternative formulas or routes of administration to provide sufficient nutrients. The formula must constitute 100% of the member's nutritional intake. The enteral and/ or other nutritional support supplies are covered as DME. See page 32.	Nothing
• Applied Behavior Analysis (ABA) Therapy for Autism Spectrum Disorder - Autism Spectrum Disorder Diagnostic Testing - Specialty Office Visit Note: Autism Spectrum Disorder medical care must first be provided by a GHC-SCW Practitioner. Prior Authorization is required to see a provider outside of GHC-SCW staff model. The coverage required shall provide at least $50,000 for intensive-level services per insured per year, for up to 35 hours of care per week for a maximum duration of 4 years, and at least $25,000 for non-intensive-level services per insured per year.	$10 per visit Nothing for Intensive-Level Services and Non-Intensive Services or Evidence Based Therapies
Not covered: *Food/infant formula and enteral nutrition products except when provided for the reasons stated above.*	*All charges*

Benefit Description	You pay
Physical and occupational therapies	**High Option**
Rehabilitative and Habilitative Services of each of the following 60 visits for the services of each of the following: • Qualified physical therapists • Occupational therapists Note: We only cover therapy when a provider orders the care. Phase II Cardiopulmonary Rehabilitation program consisting of up to 36 sessions in a calendar year when found Medically Necessary or following a hospital confinement for (a) myocardial infarction, (b) coronary bypass surgery, (c) unstable angina pectoris, (d) angioplasty, (e) acute coronary syndrome, (f) heart valve surgery, and (g) cardiac transplantation. We cover one follow-up visit six months after the date of your last physical or occupational therapy treatment	Nothing
Not covered: • *Long-term rehabilitative therapy* • *Exercise programs except for those named above*	*All charges*
Speech therapy	**High Option**
Rehabilitative and Habilitative Services of each of the following 60 consecutive days per condition for the services of qualified speech therapists	Nothing
Not covered: *Treatment for tongue thrust*	*All charges*
Hearing services (testing, treatment, and supplies)	**High Option**
• For treatment related to illness or injury, including evaluation and diagnostic hearing tests performed by an M.D., D.O.., or audiologist Note: For routine hearing screening performed during a child's preventive care visit, see Section 5(a) *Preventive Care, children on page 27.*	Nothing to age 18 $10 office visit age 18 and older
• External Hearing Aids • Implanted hearing related devices, such as bone anchored hearing aids (BAHA) and cochlear implants Note: For benefits for the devices, see Section 5(a) *Orthopedic and prosthetic devices on page 31.*	
Not covered *Hearing services that are not shown as covered.*	*All charges*

Benefit Description	You pay
Vision services (testing, treatment, and supplies)	**High Option**
• Annual vision examination • Annual eye refraction • Vision Therapy for treatment of Strabismus and other like Convergent disorders as medically necessary for the number of visits as determined by the health plan. Prior authorization is required. Note: See *Preventive care, children* for eye exams for children on page 27.	Nothing to age 18 $10 per office visit age 18 and older
• One eyeglass lens (frame not covered) or one contact lens to correct the affected eye for impairment directly caused by ocular injury or intraocular surgery (such as for cataracts).	All charges above cost of covered lens
Not covered: • *Eyewear: including lenses, frames, contact lenses, contact lens prescriptions and contact lens services except as shown above* • *Eye exercises and orthoptics* • *Radial keratotomy and other refractive surgery*	*All charges*
Foot care	**High Option**
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes.	$10 per office visit
Not covered: • *Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above* • *Treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery)*	*All charges*
Orthopedic and prosthetic devices	**High Option**
• Artificial limbs and eyes • Stump hose • Externally worn breast prostheses and surgical bras, including necessary replacements following a mastectomy • Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome • External hearing aids • Implanted hearing-related devices, such as bone anchored hearing aids (BAHA) and cochlear implants • Internal prosthetic devices, such as artificial joints, pacemakers, and surgically implanted breast implant following mastectomy Note: For information on the professional charges for the surgery to insert an implant, see Section 5(b) Surgical procedures. For information on the hospital and/or ambulatory surgery center benefits, see Section 5(c) Services provided by a hospital or other facility, and ambulance services. • Foot orthotics that are custom molded to the Member's foot are covered; limited to one pair of orthotics per calendar year. Prior authorization is required.	20% of the Plan allowance per item (per purchase or rental period) up to a maximum out-of-pocket amount of $2,500 per member per year, combined with Durable medical equipment. You pay nothing thereafter.

Orthopedic and prosthetic devices - continued on next page

Benefit Description	You pay
Orthopedic and prosthetic devices (cont.)	**High Option**
Note: GHC-SCW covers therapeutic shoes (depth or custom-molded) along with inserts for members with diabetes mellitus and any of the following complications involving the foot: - Peripheral neuropathy with evidence of callus formation - History of pre-ulcerative calluses - History of previous ulceration - Foot deformity - Previous amputation of the foot or part of the foot - Poor circulation These criteria are consistent with CMS guidelines. Coverage limited to one of the following per member per calendar year: - No more than one pair of custom-molded shoes (including inserts provided with the shoes) and two additional pairs of inserts; or - No more than one pair of depth shoes and three pairs of inserts (not including the non-customized removable insert provided with such shoes). Note: GHC-SCW will provide payment for the initial acquisition and medically necessary revision or replacement of prosthetic appliances, which are artificial devices used to replace all or part of an external body part.	20% of the Plan allowance per item (per purchase or rental period) up to a maximum out-of-pocket amount of $2,500 per member per year, combined with Durable medical equipment. You pay nothing thereafter.
• Hearing Aids for members under age 18. Limited to one aid every 36 months.	Nothing
• Hearing aids for members age 18 and older. Limited to one aid, per ear, every 36 months.	20% Coinsurance
Bone Anchored hearing Aid (BAHA) is limited to one BAHA device per member per lifetime. Member must have bilateral hearing loss, must meet the BAHA criteria and be prior authorized by the GHC-SCW Care Management Department.	20% Coinsurance and all charges above benefit maximum.
Not covered: • *Orthopedic and corrective shoes, arch supports, foot orthotics except as noted above, shoes or orthotics not custom made and purchased over the counter, heel pads and heel cups* • *Lumbosacral supports* • *Corsets, trusses, elastic stockings, support hose, and other supportive devices* • *Prosthetic replacements unless the item is no longer useful and has exceeded its reasonable lifetime under normal use; or the member's condition has changed so as to make the original equipment inappropriate.* • *Prosthetic replacements not meeting covered criteria.*	*All charges*

Benefit Description	You pay
Durable medical equipment (DME)	**High Option**
We cover rental or purchase of durable medical equipment, at our option, including repair and adjustment. Covered items include: • Oxygen • Dialysis equipment • Hospital beds • Wheelchairs (standard, motorized) (criteria must be met) • Scooters (criteria must be met) • Crutches • Walkers • Insulin infusion pumps and related supplies when coverage criteria are met and prior authorization is issued • TENS Unit • Compression Stockings (limited to 3 pair per calendar year); requires a prescription from a Plan provider • Disposable supplies, including Insulin Infusion Pump supplies • Disposable needles and syringes for the administration of covered medications • Enteral feeding supplies (see section 5(a) Treatment Therapies) • Light Boxes Note: We only cover Enteral feeding supplies when we preauthorize the treatment. If we determine Enteral feedings are not medically necessary, we will not cover the related services or treatments. Note: Call us at 608-257-5294 as soon as your Plan physician prescribes this equipment. We will arrange with a health care provider to rent or sell you the prescribed durable medical equipment at discounted rates. We will tell you more about this service when you call.	20% of the Plan allowance per item (per purchase or rental period) up to a maximum out of pocket expense of $2500 per member per year, combined with Orthopedic and prosthetic devices. You pay nothing thereafter.
• Diabetic disposable supplies (including insulin syringes, needles, injection pens, glucose test tablets and test tape, Benedict's solution or equivalent, and acetone test tablets) • Blood Glucose monitors	20% to a maximum of $250 per member per year
Not covered: • *Equipment, models or devices that have features over and above that which is Medically Necessary. Coverage will be limited to the standard model as determined by GHC-SCW. This includes the upgrade of equipment, models or devices to better or new technology when the existing equipment, models or devices are sufficient and there is no change in the Member's condition nor is the existing equipment, models or devices in need of repair or replacement.* • *Any requests for Insulin Infusion Pumps that do not meet criteria.*	*All charges*

Benefit Description	You pay
Home health services	**High Option**
• Home health care ordered by a Plan physician and provided by a registered nurse (R.N.), licensed practical nurse (L.P.N.), licensed vocational nurse (L.V.N.), or home health aide. • Services include oxygen therapy, intravenous therapy and medications.	Nothing
Not covered: • *Nursing care requested by, or for the convenience of, the patient or the patient's family* • *Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative.*	*All charges*
Chiropractic	**High Option**
• Manipulation of the spine and extremities	$10 per office visit
Not covered: • *Chiropractic services for chronic conditions or for maintenance* • *Adjunctive procedcures such as ultrasound, electrical muscle stimulation, vibratory therapy and cold pack application.*	*All Charges*
Alternative treatments	**High Option**
Complementary Medicine Services, when provided by a GHC-SCW Complementary Medicine practitioner at a GHC-SCW owned and operated facility, are limited to fifty percent (50%) of the first seven hundred fifty dollars ($750) for all combined Complementary Medicine services, with a maximum payment by GHC-SCW of three hundred and seventy-five dollars ($375) per member per calendar year. Complementary Medicine includes forms of therapy used alone or in combination with standard/conventional medicine (sometimes referred to as allopathic medicine). Services or treatments include but are not limited to: • acupuncture - anesthesia - pain relief • homeopathy • naturopathy • various types of manual therapy • various types of massage therapy and energy work • various types of stress reduction and mind/body medicine • various types of mindfulness therapy • various types of Eastern practices • yoga • Tai Chi • movement therapy • wellness classes • lifestyle change classes Contact GHC-SCW for a complete list of available Complementary Medicine services.	All charges above the $375 Plan maximum
Not covered:	*All charges*

Alternative treatments - continued on next page

Benefit Description	You pay
Alternative treatments (cont.)	**High Option**
• *Any Complementary Medicine services that are not within the scope of a practitioner's professional license, and services not provided at a GHC-SCW facility by a GHC-SCW practitioner. The Complementary Medicine services available do not represent the full spectrum of Complementary Medicine services that are available to the public.* • *Non-formulary medications and devices.*	*All charges*
Educational classes and programs	**High Option**
Coverage is provided for: • Tobacco Cessation programs, including individual group/telephone counseling, over-the-counter (OTC) and presciption drugs approved by the FDA to treat tobacco dependence.	Nothing, for counseling for up to two quit attempts per year. Nothing for OTC and prescription drugs approved by the FDA to treat tobacco dependence.
• Diabetes self-management	Nothing
• Childhood obesity education	Nothing
Coverage may include: • Nutrition Education • Weight Management • Stress Management • Prenatal Education • First Aid Training Note: Contact the GHC-SCW Health Promotion Department at 608-257-9705 for program and fee schedules.	Fees apply to some but not all classes and programs
GHC-SCW's "Wellness Reimbursement Program" offers an annual reimbursement (up to $100 for each family member over the age of 18) for specific weight loss programs, fitness programs, membership in participating Community Supported Agriculture (CSA) farms/gardens, athletic shoe reimbursement, and Doula services. Visit https://ghcscw.com/Wellness_Reimbursement_Program.asp for additional information.	All costs above reimbursement maximums

Section 5(b). Surgical and anesthesia services provided by physicians and other health care professionals

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also, read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The services listed below are for the charges billed by a physician or other health care professional for your surgical care. See in Section 5(c) for charges associated with the facility (i.e. hospital, surgical center, etc.).

YOUR PHYSICIAN MUST GET PRIOR AUTHORIZATION FOR SOME SURGICAL PROCEDURES. Please refer to the prior authorization information shown in Section 3 to be sure which services require prior authorization and identify which surgeries require prior authorization.

Benefit Description	You pay
Surgical procedures	**High Option**
A comprehensive range of services, such as: • Operative procedures • Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedures • Biopsy procedures • Removal of tumors and cysts • Correction of congenital anomalies (see *Reconstructive surgery*) • Surgical treatment of morbid obesity (bariatric surgery) - An individual must weigh 100 pounds or 100% over his or her normal weight according to the current underwriting standards. - An individual must be age 18 or over. - An individual's health must be endangered, that is, have a BMI of 40 or greater or a BMI between 35-39 with documented high-risk, comorbid medical conditions that have not responded to medical management and are a threat to life. - An individual must have tried conservative measures such as, but not limited to: psychological evaluation, behavior modification, diet restrictions/supplements, physician supervised weight loss plans, physical activity programs, prescription drugs such as appetite suppressants. - The following are excluded from coverage even if a physician prescribes or administers them: vitamins, nutrients and food supplements. - Note: Contact Plan for specific information regarding Covered and Not covered Bariatric Surgery procedures. • Insertion of internal prosthetic devices . See 5(a) – *Orthopedic and prosthetic devices* for device coverage information	$10 per office visit Nothing for in-patient hospital visits

Surgical procedures - continued on next page

Benefit Description	You pay
Surgical procedures (cont.)	**High Option**
- Note: Generally, we pay for internal prostheses (devices) according to where the procedure is done. For example, we pay Hospital benefits for a pacemaker and Surgery benefits for insertion of the pacemaker. • Voluntary sterilization (e.g. vasectomy) • Treatment of burns	$10 per office visit Nothing for in-patient hospital visits
• We cover Cochlear Implants for members under age 18. The member must have bilateral hearing loss and must meet the Cochlear Implant criteria and be prior authorized by the GHC-SCW Care Management Department.	Nothing
Not covered: • *Reversal of voluntary sterilization* • *Routine treatment of conditions of the foot; see Foot care* • *Bilateral cochlear implants*	*All Charges*
Reconstructive surgery	**High Option**
• Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: - the condition produced a major effect on the member's appearance and - the condition can reasonably be expected to be corrected by such surgery • Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities, cleft lip, cleft palate, birth marks, and webbed fingers and toes. • All stages of breast reconstruction surgery following a mastectomy/lumpectomy with radiation and chemotheraphy resulting in asymmetry , such as: - surgery to produce a symmetrical appearance of breasts - treatment of any physical complications, such as lymphedemas - breast prostheses and surgical bras and replacements (see *Prosthetic devices*) Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.	$10 per office visit Nothing for in-patient hospital visits
Not covered: • *Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury. This includes any cosmetic services or surgical procedures performed for psychological reasons.* • *Surgeries related to sex transformation*	*All Charges*

Benefit Description	You pay
Oral and maxillofacial surgery	**High Option**
Oral surgical procedures (including anesthesia and related x-rays when received from a dentist or dental group designated by GHC-SCW), limited to: • Incision and drainage of cellulites • incision and removal of a foreign body • surgical procedures to correct accidental injuries to the lips and oral soft tissues • surgical correction of cleft lip, cleft palate and severe functional malocclusion • treatment of fractures and dislocations to facial bones • hard and soft tissue biopsies • excision of tumors, cysts, and lesions of the jaw, oral mucous membrane, and underlying soft tissue that require pathological examination • incision of maxillary sinus and salivary glands or ducts • extraction of impacted teeth • frenectomy • apioectomy • excision of exostoses • alveloctomy • removal of retained residual root • non-dental treatment of TMJ syndrome	$10 per office visit Nothing for in-patient hospital visits
• Dental treatment of temporomandibular (TMJ) syndrome Note: a physical therapy evaluation is required before an intraoral splint is considered as a treatment option.	$10 per visit
Not covered: • *Oral implants and transplants* • *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)*	*All charges*
Organ/tissue transplants	**High Option**
These **solid organ transplants** are subject to medical necessity and experimental/investigational review by the Plan. Refer to *Other Services* in Section 3 for prior authorization procedures. • Cornea • Heart • Heart/lung • Intestinal transplants - Isolated Small intestine - Small intestine with the liver - Small intestine with multiple organs, such as the liver, stomach and pancreas - Autologous pancreas islet cell transplant • Kidney • Liver • Lung: Single, bilateral/lobar	Nothing

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	**High Option**
• Pancreas • Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis	Nothing
These **tandem blood or marrow stem cell transplants for covered transplants** are subject to medical necessity review by the Plan. Refer to *Other services* in Section 3 for prior authorization procedures. • Autologous tandem transplants for - AL Amyloidosis - Multiple myeloma (de novo and treated) - Recurrent germ cell tumors (including testicular cancer)	
Blood or marrow stem cell transplants limited to the stages of the following diagnoses. For the diagnoses listed below, the medical necessity limitation is considered satisfied if the patient meets the staging description. Physicians consider many features to determine how diseases will respond to different types of treatment. Some of the features measured are the presence or absence of normal and abnormal chromosomes, the extension of the disease throughout the body, and how fast the tumor cells grow. By analyzing these and other characteristics, physicians can determine which diseases may respond to treatment without transplant and which diseases may respond to transplant. For the diagnoses listed below, the medical necessity limitation is considered satisfied in the patient meets the staging description. • Allogeneic transplants for - Acute lymphocytic or non-lymphocytic (i.e., myelogeneous) leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Acute myeloid leukemia - Advanced Myeloproliferative Disorders (MPDs) - Amyloidosis - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Hemoglobinopathy - Marrow Failure and Related Disorders (i.e.. Fanconi's, PNH, Pure Red Cell Aplasia) - Myelodysplasia/Myelodyplastic syndromes - Paroxysmal Nocturnal Hemoglobinuria - Phagocytic/Hemophagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome) - Severe combined immunodeficiency - Severe or very severe aplastic anemia • Autologous transplants for: - Acute lymphocytic or non-lymphocytic (i.e., myelogeneous) leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Amyloidosis - Breast Cancer	

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	**High Option**
- Epithelial ovarian cancer - Ewings Sarcoma - Multiple myeloma - Neuroblastoma - Testicular, Mediastinal, Retroperitoneal, and ovarian germ cell tumors **Mini-transplants performed in a clinical trial setting** (non-myeloablative, reduced intensity conditioning or RIC) for members with a diagnosis listed below are subject to medical necessity review by the Plan. Refer to *Other services* in Section 3 for prior authorization procedures. • Allogeneic transplants for - Acute lymphocytic or non-lymphocytic (i.e., myelogeneous) leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Acute myeloid leukemia - Advanced Myeloproliferative Disorders (MPDs) - Amyloidosis - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Hemoglobinopathy - Marrow Failure and Related Disorders (i.e.. Fanconi's, PNH, Pure Red Cell Aplasia) - Myelodysplasia/Myelodyplastic syndromes - Paroxysmal Nocturnal Hemoglobinuria - Severe combined immunodeficiency - Severe or very severe aplastic anemia • Autologous transplants for: - Acute lymphocytic or non-lymphocytic (i.e., myelogeneous) leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin's lymphona with recurrence (relapsed) - Amyloidosis - Neuroblastoma These blood or marrow stem cell transplants are covered only in a National Cancer Institute or National Institutes of health **approved clinical trial** or a Plan-designated center of excellence and if approved by the Plan's medical director in accordance with the Plan's protocols. If you are a participant in a clinical trial, the Plan will provide benefits for related routine care that is medically necessary (such as doctor visits, lab tests, x-rays and scans) and hospitalization related to treating the patient's condition) if it is not provided by the clinical trial. Section 9 has additional information on costs related to clinical trials. We encourage you to contact the Plan to discuss specific services if you participate in a clinical trial. • Autologous transplants for • Advanced Childhood kidney cancers • Advanced Ewing sarcoma	Nothing

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	**High Option**
• Aggressive non-Hodgkin's lumphomas (Mantel Cell lymphoma, adult T-cell leukemia/ lymphoma, peripheral T-cell lymphomas and aggressive Dendritic Cell neoplasms) • Breast Cancer • Childhood rhabdomyosarcoma • Epithelial Ovarian Cancer • Mantle Cell (Non-Hodgin lymphoma) National Transplant Program (NTP) Note: We cover related medical and hospital expenses of the donor when we cover the recipient. We cover donor testing for the actual solid organ donor or up to four bone marrow/stem cell transplant donors in addition to the testing of family members.	Nothing
Not covered: • *Donor screening tests and donor search expenses, except as shown above* • *Implants of artificial organs* • *Transplants not listed as covered*	*All Charges*
Anesthesia	**High Option**
Professional services provided in – • Hospital (inpatient) • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Office	Nothing

Section 5(c). Services provided by a hospital or other facility, and ambulance services

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care and you must be hospitalized in a Plan facility.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost-sharing works. Also, read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by the facility (i.e., hospital or surgical center) or ambulance service for your surgery or care. Any costs associated with the professional charge (i. e., physicians, etc.) are in Sections 5(a) or (b).

YOUR PHYSICIAN MUST GET PRIOR AUTHORIZATION FOR HOSPITAL STAYS. Please refer to Section 3 to be sure which services require prior authorization.

Benefit Description	You pay
Inpatient hospital	**High Option**
Room and board, such as • Ward, semiprivate, or intensive care accommodations • General nursing care • Meals and special diets Note: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate. Other hospital services and supplies, such as: • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and X-rays • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services • Take-home items • Medical supplies, appliances, medical equipment, and any other covered items billed by a hospital for use at home	Nothing
Not covered: • *Custodial care* • *Non-covered facilities, such as nursing homes, schools* • *Personal comfort items, such as telephone, television, barber services, guest meals and beds* • *Private nursing care*	*All Charges*

Benefit Description	You pay
Outpatient hospital or ambulatory surgical center	**High Option**
• Operating, recovery, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests, X-rays, and pathology services • Administration of blood, blood plasma, and other biologicals • Blood and blood plasma, if not donated or replaced • Pre-surgical testing • Dressings, casts, and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service Note: We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. We do not cover the dental procedures.	Nothing
Not covered: • *Blood and blood derivatives not replaced by the member*	*All charges*
Extended care benefits/Skilled nursing care facility benefits	**High Option**
Extended care benefit: We provide a comprehensive range of benefits for up to 100 days per calendar year when full-time skilled nursing care is necessary and confinement in a skilled nursing facility is medically appropriate as determined by a Plan doctor and approved by the Plan.	Nothing
Not covered: • *Custodial care*	*All charges*
Hospice care	**High Option**
GHC-SCW will provide supportive and palliative care for a terminally ill Member, whose life expectancy is six months or less if the illness runs its normal course, for in-home and inpatient care with Prior Authorization. Certification of the terminal illness must be given to GHC-SCW's Care Management Department by the Primary Care Practitioner upon request. End-of-life services are available if: • the terminally ill person is a GHC-SCW member, and • the care is ordered by a GHC-SCW Practitioner. Outpatient End-of-Life covered charges include: • Part-time or intermittent nursing care by an RN or LPN • Medical social services under the direction of a GHC-SCW Practitioner, including: - Assessment of the terminally ill person's social, emotional and medical needs, and home and family situation - Identification of community resources available to the terminally ill person - Assistance to the terminally ill person in obtaining the community resources needed to meet his or her assessed needs - Psychological and dietary counseling - Consultation or care management services by a GHC-SCW Practitioner - Physical and occupational therapy - Part-time or intermittent home health aid services consisting mainly of caring for the terminally ill person	Nothing

Hospice care - continued on next page

Benefit Description	You pay
Hospice care (cont.)	**High Option**
- Medical supplies, drugs, and medicines prescribed by a GHC-SCW practitioner - Charges made by any other covered health care practitioner for the services and supplies listed above only if the provider is not part of or employed by a hospice care agency, and the hospice care agency retains responsibility for the care of the terminally ill person - Bereavement counseling • Inpatient End-of-Life Services include: - Charges made by an end-of-life facility for room and board. If a private room is used, any part of the daily room and board charge that is more than the end-of-life facility's most common semi-private room charge is not covered; and - Other services and supplies furnished to the terminally ill person for uncontrolled, new onset acute symptom management when, in the determination of the GHC-SCW Medical Director, an inpatient stay is Medically Necessary.	Nothing
Members will be eligible for Complementary Medicine benefit.	
Not covered: • *Independent nursing, homemaker services*	*All Charges*
Ambulance	**High Option**
Local professional ambulance service when medically appropriate	Nothing
Not covered: • *ambulance services to home following an inpatient stay*	*All charges*

Section 5(d). Emergency services/accidents

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost-sharing works. Also, read Section 9 about coordinating benefits with other coverage, including with Medicare.

What is a medical emergency?

Emergency condition means a medical condition that, if a person did not seek medical attention for it, could result in death or serious injury. It means a medical condition that manifests itself by acute symptoms of sufficient severity, including severe pain, to lead a prudent layperson who possesses an average knowledge of health and medicine to reasonably conclude that a lack of immediate medical attention will likely result in any of the following: serious jeopardy to the person's health or, with respect to a pregnant women, serious jeopardy to the health of the woman or her unborn child; serious impairment to the person's bodily functions; or serious dysfunction of one or more of the person's body organs or parts.

In the absence of a finding by the GHC-SCW Medical Director of justifying circumstances, obstetrical delivery of a child or children outside of the Service Area during or after the ninth month of pregnancy will not constitute an Emergency Condition.

What to do in case of emergency:

Emergencies within our service area

If you are in an emergency, please call your primary care provider. In extreme emergencies, if you are unable to contact your provider, contact the nearest emergency system (e.g. the 911 telephone system) or go to the nearest hospital emergency room. Be sure to tell emergency room personnel that you are a GHC-SCW Plan member so that they can notify us.

If a GHC-SCW Plan doctor believes you will receive better care in a Plan hospital, we will transfer you when it is medically feasible and we will pay all ambulance charges for the transfer.

Benefits are available for care by non-Plan providers in a medical emergency only if delay in reaching a Plan provider would result in death, disability or significant jeopardy to your condition.

Any follow-up care recommended by non-Plan providers in such a medical emergency must be approved by GHC-SCW or provided by a GHC-SCW Plan provider.

Emergencies outside our service area

Benefits are available for any medically necessary health service that is immediately required because of injury or unforeseen illness.

If a GHC-SCW Plan provider believes you will receive better care in a Plan hospital, we will transfer you when it is medically feasible and we will pay all ambulance charges for the transfer.

Any follow up care recommended by non-Plan providers in such a medical emergency must be approved by GHC-SCW or provided by GHC-SCW Plan providers.

Benefit Description	You pay
Emergency within our service area	**High Option**
• Emergency care at a doctor's office • Emergency care at an urgent care center	$10 per office visit
• Emergency Outpatient Care at the emergency department of a Hospital for an Emergency Condition, inclusive of all necessary and related diagnostic and therapeutic services, is a covered benefit. GHC-SCW reserves the right to determine whether a specific medical situation actually constitutes an Emergency Condition. Prior authorization is not required. • Co-payments associated with this service are waived if the member is admitted as a hospital inpatient or is placed in observation status for a period of time more than 24 hours.	$75 per visit
Not covered: • *Elective care*	*All Charges*
Emergency outside our service area	**High Option**
• Emergency care at a doctor's office • Emergency care at an urgent care center	$10 per office visit
• Emergency Outpatient Care at the emergency department of a Hospital for an Emergency Condition, inclusive of all necessary and related diagnostic and therapeutic services, is a covered benefit. GHC-SCW reserves the right to determine whether a specific medical situation actually constitutes an Emergency Condition. Prior authorization is not required. • Co-payments associated with this service are waived if the member is admitted as a hospital inpatient or is placed in observation status for a period of time more than 24 hours.	$75 per visit
Not covered: • *Elective care or non-emergency care and follow-up care recommended by non-Plan providers that has not been approved by the Plan or provided by Plan providers* • *Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area* • *Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area*	*All Charges*
Ambulance	**High Option**
Professional ambulance service when medically appropriate. Note: See 5(c) for non-emergency service.	Nothing
Not covered: • *Ambulance services to home following an in-patient stay.*	*All Charges*

Section 5(e). Mental health and substance abuse benefits

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also, read Section 9 about coordinating benefits with other coverage, including with Medicare.
- **YOU MUST GET PREAUTHORIZATION FOR THESE SERVICES.** Benefits are payable only when we determine the care is clinically appropriate to treat your condition and only when you receive the care as part of a treatment plan that we approve. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure. To be eligible to receive full benefits, you must follow the preauthorization process and get Plan approval of your treatment plan. We may limit your benefits if you do not receive a treatment plan
- **Mental Health:** contact GHC-SW Mental health Department at 608-661-7227 (after hours 608-257-9700). If out of area, call 1-800-605-4327.
- **Substance Abuse:** contact Gateway Recovery services, Inc. 608-278-8200.
- We will provide medical review criteria or reasons for treatment plan denials to enrollees, members or providers upon request or as otherwise required.

OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.

Benefit Description	You pay
Professional Services	**High Option**
When part of a treatment plan we approve, we cover professional services by licensed professional mental health and substance abuse practitioners when acting within the scope of their license, such as psychiatrists, psychologists, clinical social workers, licensed professional counselors, or marriage and family therapists. **Diagnosis and treatment of psychiatric conditions, mental illness, or mental disorders. Services include:** • Diagnostic evaluation • Crisis intervention and stabilization for acute episodes • Medication evaluation and management (pharmacotherapy) • Psychological and neuropsychological testing necessary to determine the appropriate psychiatric treatment • Diagnosis and treatment of alcoholism and drug abuse, including detoxification, treatment and counseling • Professional charges for intensive outpatient treatment in a provider's office or other professional setting • Electroconvulsive therapy	Your cost-sharing responsibilities are no greater than for other illness or conditions.
• Treatment and counseling (including individual or group therapy visits) • Diagnosis and treatment of alcoholism and drug abuse, including detoxification, treatment and counseling	$10 per office visit for individual counseling sessions

Professional Services - continued on next page

Benefit Description	You pay
Professional Services (cont.)	**High Option**
• Professional charges for intensive outpatient treatment in a provider's office or other professional setting	$10 per office visit for individual counseling sessions Nothing for group counseling sessions
Diagnostics	**High Option**
• Outpatient diagnostic tests provided and billed by a licensed mental health and substance abuse practitioner • Outpatient diagnostic tests provided and billed by a laboratory, hospital or other covered facility • Inpatient diagnostic tests provided and billed by a hospital or other covered facility	Nothing
Inpatient hospital or other covered facility	**High Option**
Inpatient services provided and billed by a hospital or other covered facility • Room and board, such as semiprivate or intensive accommodations, general nursing care, meals and special diets, and other hospital services.	Nothing
Outpatient hospital or other covered facility	**High Option**
Outpatient services provided and billed by a hospital or other covered facility • Services in approved alternative care settings such as partial hospitalization, full-day hospitalization, facility based intensive outpatient treatment	Nothing
Not covered	**High Option**
• *Services that are not part of a preauthorized approved treatment plan*	*All charges*

Section 5(f). Prescription drug benefits

Important things you should keep in mind about these benefits:

- We cover prescribed drugs and medications, as described in the chart beginning on the next page.
- Please remember that all benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Members must make sure their physicians obtain prior approval/authorizations for certain prescription drugs and supplies before coverage applies. Pior approval/authorizations must be renewed periodically.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost-sharing works. Also, read Section 9 about coordinating benefits with other coverage, including with Medicare.

There are important features you should be aware of. These include:

- **Who can write your prescription.** A licensed physician or dentist, and in states allowing, licensed or certifited Physican Assitant, Nurse Practioner and Psychologist must prescribe your medication.
- **Where you can obtain them.** You must fill the prescription at a Plan pharmacy. Specialty Drugs must be obtain from a GHC-SCW Specialty network pharmacy. Prescription mail service is available; see our website for details.
- **We use a formulary.** A drug formulary is a list of prescription medications, representing the current judgment of medical practitioners, for the treatment of disease. Not all medications will be listed in the formulary, particularly when there are several similar medications available. The formulary will include the drugs covered by the Plan's benefit. Your physician/practitioner may request coverage for non-formulary drugs when clinically necessary.
- **Tiers.** Covered drugs are placed in various categories or Tiers. Tier 1 drugs include most preferred generics and selected preferred brands. Tier 2 contains most preferred brands, and selected generics. Specialty Drugs are listed on Formulary documents as Tier 4. Formulary documents will indicate those drugs that require prior authorization or step-therapy to be covered.
- **These are the dispensing limitations.** The quantity of drug dispensed is limited to the lesser of (a) The amount indicated on the prescription, or (b) 90 days' supply for drugs on Tier 1 or Tier 2, or (c) 30 days' supply for drugs other Tiers, or (c) Individual quantity limits identified for that specific drug, or (d) The quantity limit assigned to that drug by Prior Authorization, ore) The quantity that does not exceed the maximum approved prescription cost limit for the benefit plan.
- **Non-Formulary Drugs.** If coverage has been approved for a non-formulary drug, you pay the applicable generic or brand name copayment. For non-formulary drugs when coverage has not been approved, the copayment is equal to the Plan calculated total prescription cost, which is generally lower than the retail price, when service is obtained from GHC-SCW owned pharmacy.
- **A generic equivalent will be dispensed if it is available**, unless your physician specifically requires a name brand. If you receive a name brand drug when a Federally-approved generic drug is available, and your physician has not specified *Dispense as Written* for the name brand drug, you have to pay the difference in cost between the name brand drug and the generic drug in addition to the brand copay.
- **Why use generic drugs?** Generic drugs offer a safe and economic way to meet your prescription drug needs. The generic name of a drug is its chemical name; the brand name is the name under which the manufacturer advertises and sells a drug. Under federal law, generic and name brand drugs must meet the same standards for quality. A generic prescription costs you less and helps moderate the costs of providing healthcare. Generic drugs are defined as drugs that are designated as generic in the standard drug database used by GHC-SCW's pharmacy claims computer system and approved by GHC-SCW's Formulary committee.
- **When you do have to file a claim.** Generally you will not need to file a claim. An exception would be a drug prescribed in an emergency or urgent situation and a participatin pharmacy is not available. Forward such claims to the GHC-SCW Pharmacy Benefits, PO Box 44971, Madison WI 53744-4971. Be sure to include your member number and an explanation of why you are submitting the claim.

- **If you are a military reservist called to active duty or a member requiring a supply of medications during a national emergency, call us at 608-828-4811 for assistance obtaining your medication(s).**

Benefit Description	You pay
Covered medications and supplies	**High Option**
We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy or through our mail order program: • Drugs and medicines that by Federal law of the United States require a physician's prescription for their purchase, except those listed as *Not covered.* • Insulin • Oral fertility drugs - Clomiphene citrate and Progesterone - limited to one year, per lifetime. • Injectible Drugs: Coverage of prescription drugs administered by intravenous or intramuscular injection in a clinic or office setting are covered only when coverage criteria are met and when prior authorization is issued, unless required for immediate treatment of an acute medical problem. **Prescription drugs administered subcutaneously are considered outpatient prescription drugs, regardless if self-administered or administered by a health care provider.** • Vitamin D for adults age 65 and older NOTE: all prescription drugs must be obtained through a participating pharmacy except in an emergency situation out of the area. Note: Specialty drugs - see Section 10 for definition	$5 copay for generic drugs $20 copay for name brand drugs Note: If there is no generic equivalent available, you will still have to pay the brand name copay. Note: Patients wishing to use a formulary name brand medication instead of a covered generic equivalent may choose to do so but will pay the cost difference between the formulary brand and the formulary generic in addition to the brand copay.
• Drugs for sexual dysfunction are limited. Contact the Plan for dose limits.	50% copayment up to the doses limit and all charges after that
Women's contraceptive drugs and devices. The "morning after pill" is considred preventive service under contraceptives, with no cost to the member if prescribed by a physician and purchased at a network pharmacy. The "morning after pill" should be addressed under the pharmacy benefit as an over-the counter (OTC) embergency contracetptive drug.	Nothing
Not covered: • *Drugs not on the Formulary, unless prior authorized* • *Drugs and supplies for cosmetic purposes* • *Drugs to enhance athletic performance* • *Fertility drugs except Clomiphene Citrate and Progesterone* • *Drugs obtained at a non-Plan pharmacy; except for out-of-area emergencies. If a member uses a non-authorized pharmacy, reimbursement for that prescription will be limited to the amount the plan would be responsible for if the member had used an authorized pharmacy.* • *Vitamins (excluding vitamin D for adults 65 and older), nutrients and food supplements even if a physician prescribes or administers them* • *Nonprescription medicines*	*All Charges*

Covered medications and supplies - continued on next page

Benefit Description	You pay
Covered medications and supplies (cont.)	**High Option**
• *Drugs that are used for weight reduction* *Note: Over-the-counter and prescriptions drugs approved by the FDA to treat tobacco dependence are covered under the Tobacco cessation benefit. (See page 34)*	*All Charges*

Section 5(g). Dental benefits

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- If you are enrolled in a Federal Employees Dental/Vision Insurance Program (FEDVIP) Dental Plan, your FEHB Plan will be First/Primary payor of any Benefit payments and your FEDVIP Plan is secondary to your FEHB Plan. See Section 9 Coordinating benefits with other coverage.
- Plan dentists must provide or arrange your care.
- We cover hospitalization for dental procedures only when a non-dental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient. See Section 5(c) for inpatient hospital benefits. We do not cover the dental procedure unless it is described below.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost-sharing works. Also, read Section 9 about coordinating benefits with other coverage, including with Medicare.

Benefit Desription	You Pay
Accidental injury benefit	**High Option**
We cover restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth. The need for these services must result from an accidental injury. To be eligible for coverage, the accident and treatment must occur while the member is enrolled under the GHC-SCW Plan. Care must be initiated within 90 days of the accident. NOTE: Damage to teeth caused by chewing or biting does not constitute an accidental injury.	Nothing up to $1500 per accident All charges above $1500 per accident.
Dental related hospital and anesthetic services	**High Option**
Coverage for dependent children who are under age of 5 or those members with a chronic disability or a medical condition that requires hospitalization or general anesthesia for dental care. Prior authorization required.	Nothing if prior authorized and performed at a Plan participating hospital or facility

Dental Benefits	You Pay
Service	**High Option**
• Prophylaxis or cleaning (one in any six month period) • Topical applications of fluroide through age fifteen (15) - one every six months	Nothing if you use a GHC-SCW Plan dentist All charges for services provided by a non-plan dentist
Not covered: • *all other dental services, including but not limited to x-rays, fillings, extractions, crowns, orthodontics, etc.*	*All charges*

Section 5(h). Special features

Feature	Description
24 hour nurse line	For any of your health concerns, 24 hours a day, 7 days a week, you may call and talk with a registered nurse who will discuss treatment options and answer your health questions.
Services for deaf and hearing impaired	Hearing impaired interpreter for non-emergency services can be reached at this TDDY line: 608-257-7391.
Centers of Excellence	Our local Center of Excellence is associated with the University of Wisconsin Hospital and Clinics in Madison WI.
Travel benefits/ services overseas	Travel related immunizations may be provided in accordance with CDC recommendations and GHC-SCW protocols.
Online access to health and insurance information	Available 24/7 through GHCMyChart and KidsChart. Note: MyChart is a registered trademark of Epic Systems Corporation.

Section 6. General exclusions – services, drugs and supplies we do not cover

The exclusions in this section apply to all benefits. There may be other exclusions and limitations listed in Section 5 of this brochure. Although we may list a specific service as a benefit, we will not cover it unless it is medically necessary to prevent, diagnose, or treat your illness, disease, injury, or condition. For information on obtaining prior approval for specific services, such as transplants, see Section 3 *When you need prior Plan approval for certain services.*

We do not cover the following:

- Care by non-plan providers except for authorized referrals or emergencies (see *Emergency services/accidents*)
- Services, drugs, or supplies you receive while you are not enrolled in this Plan
- Services, drugs, or supplies not medically necessary
- Services, drugs, or supplies not required according to accepted standards of medical, dental, or psychiatric practice
- Experimental or investigational procedures, treatments, drugs or devices (see specifics regarding transplants)
- Services, drugs, or supplies related to abortions, except when the life of the mother would be endangered if the fetus were carried to term, or when the pregnancy is the result of an act of rape or incest
- Services, drugs, or supplies related to sex transformations
- Services, drugs, or supplies you receive from a provider or facility barred from the FEHB Program
- Services, drugs, or supplies you receive without charge while in active military service
- Extra care costs or research costs related to clinical trials
- Services or supplies furnished by yourself, immediate relatives or household members, such as a spouse, parents, children, brothers or sisters by blood, marriage or adoption.

Section 7. Filing a claim for covered services

This Section primarily deals with post-service claims (claims for services, drugs or supplies you have already received). See Section 3 for information on pre-service claims procedures (services, drugs or supplies requiring prior Plan approval), including urgent care claims procedures. When you see Plan physicians, receive services at Plan hospitals and facilities, or obtain your prescription drugs at Plan pharmacies, you will not have to file claims. Just present your identification card and pay your copayment or coinsurance.

You will only need to file a claim when you receive emergency services from non-plan providers. Sometimes these providers bill us directly. Check with the provider.

If you need to file the claim, here is the process:

Medical and hospital benefits

In most cases, providers and facilities file claims for you. Physicians must file on the form CMS-1500, Health Insurance Claim Form. Your facility will file on the UB-04 form. For claims questions and assistance, contact us at 608-828-4853 or at our website at www.ghcscw.com.

When you must file a claim – such as for services you received outside the Plan's service area – submit it on the CMS-1500 or a claim form that includes the information shown below. Bills and receipts should be itemized and show:

- Covered member's name, date of birth, address, phone number and ID number
- Name and address of the physician or facility that provided the service or supply
- Dates you received the services or supplies
- Diagnosis
- Type of each service or supply
- The charge for each service or supply
- A copy of the explanation of benefits, payments, or denial from any primary payor – such as the Medicare Summary Notice (MSN)
- Receipts, if you paid for your services

Note: Canceled checks, cash register receipts, or balance due statements are not acceptable substitutes for itemized bills.

Submit your claims to: GHC-SCW Claims Dept., PO Box 44971, Madison WI 53744-4971

Prescription drugs

Submit your claims to: GHC-SCW Claims Dept., PO Box 44971, Madison WI 53744-4971

Other supplies or services

Submit your claims to: GHC-SCW Claims Dept., PO Box 44971, Madison WI 53744-4971

Deadline for filing your claim

Send us all of the documents for your claim as soon as possible. You must submit the claim by December 31 of the year after the year you received the service, unless timely filing was prevented by administrative operations of Government or legal incapacity, provided the claim was submitted as soon as reasonably possible.

Post-service claims procedures

We will notify you of our decision within 30 days after we receive your post-service claim. If matters beyond our control require an extension of time, we may take up to an additional 15 days for review and we will notify you before the expiration of the original 30-day period. Our notice will include the circumstances underlying the request for the extension and the date when a decision is expected.

If we need an extension because we have not received necessary information from you, our notice will describe the specific information required and we will allow you up to 60 days from the receipt of the notice to provide the information.

If you do not agree with our initial decision, you may ask us to review it by following the disputed claims process detailed in Section 8 of this brochure.

Authorized Representative

You may designate an authorized representative to act on your behalf for filing a claim or to appeal claims decisions to us. For urgent care claims, we will permit a health care professional with knowledge of your medical condition to act as your authorized representative without your express consent. For the purposes of this section, we are also referring to your authorized representative when we refer to you.

Notice Requirements

If you live in a county where at least 10 percent of the population is literate only in a non-English language (as determined by the Secretary of Health and Human Services), we will provide language assistance in that non-English language. You can request a copy of your Explanation of Benefits (EOB) statement, related correspondence, oral language services (such as telephone customer assistance), and help with filing claims and appeals (including external reviews) in the applicable non-English language. The English versions of your EOBs and related correspondence will include information in the non-English language about how to access language services in that non-English language.

Any notice of an adverse benefit determination or correspondence from us confirming an adverse benefit determination will include information sufficient to identify the claim involved (including the date of service, the health care provider, and the claim amount, if applicable), and a statement describing the availability, upon request, of the diagnosis and procedure codes

Section 8. The disputed claims process

You may be able to appeal directly to the Office of Personnel Management (OPM) if we do not follow required claims processes. For more information about situations in which you are entitled to immediately appeal to OPM, including additional requirements not listed in Sections 3, 7 and 8 of this brochure, please visit https://ghcscw.com/Insurance_Individual_Main.asp.

Please follow this Federal Employees Health Benefits Program disputed claims process if you disagree with our decision on your post-service claim (a claim where services, drugs or supplies have already been provided). In Section 3 *If you disagree with our pre-service claim decision,* we describe the process you need to follow if you have a claim for services, referrals, drugs or supplies that must have prior Plan approval, such as inpatient hospital admissions.

To help you prepare your appeal, you may arrange with us to review and copy, free of charge, all relevant materials and Plan documents under our control relating to your claim, including those that involve any expert review(s) of your claim. To make your request, please contact our Customer Service Department by writing GHC-SCW Member Services Department, Attn: MS Appeals Representative, P.O. Box 44971 Madison, WI 53744-4971 or calling 1-800-605-4327, Ext. 4504.

Our reconsideration will take into account all comments, documents, records, and other information submitted by you relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

When our initial decision is based (in whole or in part) on a medical judgment (i.e., medical necessity, experimental/investigational), we will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment and who was not involved in making the initial decision.

Our reconsideration decision will not afford deference to the initial decision and will be conducted by a plan representative who is neither the individual who made the initial decision that is the subject of the reconsideration, nor the subordinate of that individual.

We will not make our decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) based upon the likelihood that the individual will support the denial of benefits.

Step	Description
1	Ask us in writing to reconsider our initial decision. You must: a) Write to us within 6 months from the date of our decision; and b) Send your request to us at: GHC-SCW Member Services Dept., PO Box 44971, Madison WI 53744-4971; and c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms. e) Include your email address (optional for member), if you would like to receive OPM's decision via e-mail. Please note that by providing your email address, you may receive OPM's decision more quickly. We will provide you, free of charge and in a timely manner, with any new or additional evidence considered, relied upon, or generated by us or at our direction in connection with our claim and any new rationale for our claim decision. We will provide you with this information sufficiently in advance of the date that we are required to provide you with our reconsideration decision to allow you a reasonable opportunity to respond to us before that date. However, our failure to provide you with new evidence or rationale in sufficient time to allow you to timely respond shall not invalidate our decision on reconsideration. You may respond to that new evidence or rationale at the OPM review stage described in step 4.
2	In the case of a post-service claim, we have 30 days from the date we receive your request to: a) Pay the claim or

b) Write to you and maintain our denial or

c) Ask you or your provider for more information.

You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days.

If we do not receive the information within 60 days we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.

3 If you do not agree with our decision, you may ask OPM to review it.

You must write to OPM within:

- 90 days after the date of our letter upholding our initial decision; or
- 120 days after you first wrote us -- if we did not answer that request in some way within 30 days; or
- 120 days after we asked for additional information.

Write to OPM at: United States Office of Personnel Management, Healthcare and Insurance, Federal Employee Insurance Operations, Health Insurance 3, 1900 E Street, NW, Washington DC 20415-3630.

Send OPM the following information:

- A statement about why you believe our decision was wrong, based on specific benefit provisions of this brochure;
- Copies of documents that support your cliam, such as physicians' letters, operative reports, bills, medical records, and explanatio of benefits (EOB) forms;
- Copies of all letters you sent to us about the claim;
- Copies of all letters we sent to you about the claim; and
- Your daytime phone number and the best time to call.
- Your email address, if you would like to receive OPM's decision via email. Please note that by providing your email address, you may receive OPM's decision more quickly.

Note: If you want OPM to review more than one claim, you must clearly identify which documents apply to which claim.

Note: You are the only person who has a right to file a disputed claim with OPM. Parties acting as your representative, such as medical providers, must inlcude a copy of your specific whitten consent with the review request. However, for urgent care claims, a health care professional with knowledge of your medical condition may act as your authorized representative without your express consent.

Note: The above deadlines may be extended if you show that you were unable to meet the deadline because of reasons beyond your control.

4 OPM will review your disputed claim request and will use the information it collects from you and us to decide whether our decision is correct. OPM will send you a final decision within 60 days. There are no other administrative appeals.

If you do not agree with OPM's decision, your only recourse is to file a lawsuit. If you decide to sue, you must file the suit against OPM in Federal court by December 31 of the third year after the year in which you received the disputed services, drugs, or supplies or from the year in which you were denied precertification or prior approval. This is the only deadline that may not be extended.

OPM may disclose the information it collects during the review process to support their disputed claim decision. This information will become part of the court record.

You may not file a lawsuit until you have completed the disputed claims process. Further, Federal law governs your lawsuit, benefits, and payment of benefits. The Federal court will base its review on the record that was before OPM when OPM decided to uphold or overturn our decision. You may recover only the amount of benefits in dispute.

Note: **If you have a serious or life threatening condition** (one that may cause permanent loss of bodily function or death if not treated as soon as possible), and you did not indicate that your claims was a claim for urgent care, then call us at (800) 605-4327. We will expedite our review (if we have not yet responded to your claim); or we will inform OPM so they can quickly review your claim on appeal. You may call OPM's Health Insurance 3 at 202-606-0737 between 8 a.m. and 5 p.m. Eastern Time.

Please remember that we do not make decisions about plan eligibility issues. For example, we do not determine whether you or a dependent are covered under this plan. You must raise eligibility issues with your Agency personnel/payroll office if you are an employee, your retirement system if you are an annuitant or the Office of Workers' Compensation Programs if you are receiving Workers' Compensation benefits.

Section 9. Coordinating benefits with Medicare and other coverage

When you have other health coverage

You must tell us if you or a covered family member has coverage under any other health plan or has automobile insurance that pays health care expenses without regard to fault. This is called "double coverage."

When you have double coverage, one plan normally pays its benefits in full as the primary payor and the other plan pays a reduced benefit as the secondary payor. We, like other insurers, determine which coverage is primary according to the National Association of Insurance Commissioners' (NAIC) guidelines. For more information on NAIC rules regarding the coordinating of benefits, visit the NAIC website at http://www.NAIC.org.

When we are the primary payor, we will pay the benefits described in this brochure.

When we are the secondary payor, we will determine our allowance. After the primary plan pays, we will pay what is left of our allowance, up to our regular benefit. We will not pay more than our allowance.

- **TRICARE and CHAMPVA**

TRICARE is the health care program for eligible dependents of military persons, and retirees of the military. TRICARE includes the CHAMPUS program. CHAMPVA provides health coverage to disabled Veterans and their eligible dependents. IF TRICARE or CHAMPVA and this Plan cover you, we pay first. See your TRICARE or CHAMPVA Health Benefits Advisor if you have questions about these programs.

Suspended FEHB coverage to enroll in TRICARE or CHAMPVA: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in one of these programs, eliminating your FEHB premium. (OPM does not contribute to any applicable plan premiums.) For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage under TRICARE or CHAMPVA.

- **Workers' Compensation**

We do not cover services that:

- You (or a covered family member) need because of a workplace-related illness or injury that the Office of Workers' Compensation Programs (OWCP) or a similar Federal or State agency determines they must provide; or
- OWCP or a similar agency pays for through a third-party injury settlement or other similar proceeding that is based on a claim you filed under OWCP or similar laws.

Once OWCP or similar agency pays its maximum benefits for your treatment, we will cover your care.

- **Medicaid**

When you have this Plan and Medicaid, we pay first.

Suspended FEHB coverage to enroll in Medicaid or a similar State-sponsored program of medical assistance: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in one of these State programs, eliminating your FEHB premium. For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage under the State program.

When other Government agencies are responsible for your care

We do not cover services and supplies when a local, State, or Federal government agency directly or indirectly pays for them.

When others are responsible for injuries

When you receive money to compensate you for injuries or illness for which another party may be responsible, you must reimburse us for any expenses we paid. However, we will cover the cost of treatment that exceeds the amount you received in the settlement.

If you do not seek damages, you must agree to let us try. This is called subrogation. If you need more information, contact us for our subrogation procedures.

When you have Federal Employees Dental and Vision Insurance Plan (FEDVIP) coverage

Some FEHB plans already cover some dental and vision services. When you are covered by more than one vision/dental plan, coverage provided under your FEHB plan remains as your primary coverage. FEDVIP coverage pays secondary to that coverage. When you enroll in a dental and/or vision plan on BENEFEDS.com, you will be asked to provide information on the FEHB plan so that your plans can coordinate benefits. Providing your FEHB information may reduce your out-of-pocket cost.

Clinical Trials

An approved clinical trial includes a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is either Federally funded; conducted under an investigational new drug application reviewed by the Food and Drug Administration; or is a drug trial that is exempt from teh requirement of an investigational new drug application.

If you are a participant in a clinical trial, this health plan will provide related care as follows, if it is not provided by the clinical trial:

- Routine care costs - costs for routine services such as doctor visits, lab tests, x-rays and scans, and hospitalizations related to treating the patient's condition, whether the patient is in a clinical trial or is receiing standard therapy.
- Extra care costs - costs related to taking part in a clinical trial such as additional teests that a patient may need as part of the trial but not as part of the patient's routine care
- Research costs - costs related to conduocting the clinical trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes. These costs are generally covered by the clinical trials. This plan does not cover these costs.

When you have Medicare

- **What is Medicare?**

Medicare is a health insurance program for:

- People 65 years of age or older
- Some people with disabilities under 65 years of age
- People with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant)

Medicare has four parts:

- Part A (Hospital Insurance). Most people do not have to pay for Part A. If you or your spouse worked for at least 10 years in Medicare-covered employment, you should be able to qualify for premium-free Part A insurance. (If you were a Federal employee at any time both before and during January 1983, you will receive credit for your Federal employment before January 1983.) Otherwise, if you are age 65 or older, you may be able to buy it. Contact 1-800-MEDICARE (1-800-633-4227), (TTY: 1-877-486-2048) for more information.
- Part B (Medical Insurance). Most people pay monthly for Part B. Generally, Part B premiums are withheld from your monthly Social Security check or your retirement check.
- Part C (Medicare Advantage). You can enroll in a Medicare Advantage plan to get your Medicare benefits. We do not offer a Medicare Advantage plan. Please review the information on coordinating benefits with Medicare Advantage plans on the next page.
- Part D (Medicare prescription drug coverage). There is a monthly premium for Part D coverage. Before enrolling in Medicare Part D, please review the important disclosure notice from us about the FEHB prescription drug coverage and Medicare. The notice is on the first inside page of this brochure. For people with limited income and resources , extra help in paying for a Medicare prescriptions drug plan is available. For more information about this extra help, visit the Social Security Administration online at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY: 1-800-325-0778)

- **Should I enroll in Medicare?**

The decision to enroll in Medicare is yours. We encourage you to apply for Medicare benefits 3 months before you turn age 65. It's easy. Just call the Social Security Administration toll-free number 1-800-772-1213 (TTY: 1-800-325-0778) to set up an appointment to apply. If you do not apply for one or more Parts of Medicare, you can still be covered under the FEHB Program.

If you can get premium-free Part A coverage, we advise you to enroll in it. Most Federal employees and annuitants are entitled to Medicare Part A at age 65 **without cost**. When you don't have to pay premiums for Medicare Part A, it makes good sense to obtain the coverage.

It can reduce your out-of-pocket expenses as well as costs to the FEHB, which can help keep FEHB premiums down.

Everyone is charged a premium for Medicare Part B coverage. The Social Security Administration can provide you with premium and benefit information. Review the information and decide if it makes sense for you to buy the Medicare Part B coverage. If you do not sign up for Medicare Part B when you are first eligible, you may be charged a Medicare Part B late enrollment penalty of a 10% increase in premium for every 12 months you are not enrolled. If you didn't take Part B at age 65 because you were covered under FEHB as an active employee (or you were covered under your spouse's group health insurance plan and he/she was an active employee), you may sign up for Part B (generally without an increased premium) within 8 months from the time you or your spouse stop working or are no longer covered by the group plan. You also can sign up at any time while you are covered by the group plan.

If you are eligible for Medicare, you may have choices in how you get your health care. Medicare Advantage is the term used to describe the various private health plan choices available to Medicare beneficiaries. The information in the next few pages shows how we coordinate benefits with Medicare, depending on whether you are in the Original Medicare Plan or a private Medicare Advantage plan.

- **The Original Medicare Plan (Part A or Part B)**

The Original Medicare Plan (Original Medicare) is available everywhere in the United States. It is the way everyone used to get Medicare benefits and is the way most people get their Medicare Part A and Part B benefits now. You may go to any doctor, specialist, or hospital that accepts Medicare. The Original Medicare Plan pays its share and you pay your share.

All physicians and other providers are required by law to file claims directly to Medicare for members with Medicare Part B, when Medicare is primary. This is true whether or not they accept Medicare.

When you are enrolled in Original Medicare along with this Plan, you still need to follow the rules in this brochure for us to cover your care.

Claims process when you have the Original Medicare Plan – You will probably not need to file a claim form when you have both our Plan and the Original Medicare Plan.

When we are the primary payor, we process the claim first.

When Original Medicare is the primary payor, Medicare processes your claim first. In most cases, your claim will be coordinated automatically and we will then provide secondary benefits for covered charges. To find out if you need to do something to file your claim, call us at 608-828-4853 or see our website at www.ghcscw.com.

We do not waive any costs if the Original Medicare Plan is your primary payor.

- **Tell us about your Medicare coverage**

You must tell us if you or a covered family member has Medicare coverage, and let us obtain information about services denied or paid under Medicare if we ask. You must also tell us about other coverage you or your covered family members may have, as this coverage may affect the primary/secondary status of this Plan and Medicare.

- **Medicare Advantage (Part C)**

  If you are eligible for Medicare, you may choose to enroll in and get your Medicare benefits from a Medicare Advantage plan. These are private health care choices (like HMOs and regional PPOs) in some areas of the country.

  To learn more about Medicare Advantage plans, contact Medicare at 1-800-MEDICARE (1-800-633-4227), (1-877-486-2048) or at www.medicare.gov.

  If you enroll in a Medicare Advantage plan, the following options are available to you:

  This Plan and our Medicare Advantage plan:

  This Plan and another plan's Medicare Advantage plan: You may enroll in another plan's Medicare Advantage plan and also remain enrolled in our FEHB plan. We will still provide benefits when your Medicare Advantage plan is primary, even out of the Medicare Advantage plan's network and/or service area (if you use our Plan providers). However, we will not waive any of our copayments, coinsurance, or deductibles. If you enroll in a Medicare Advantage plan, tell us. We will need to know whether you are in the Original Medicare Plan or in a Medicare Advantage plan so we can correctly coordinate benefits with Medicare.

  Suspended FEHB coverage to enroll in a Medicare Advantage plan: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in a Medicare Advantage plan, eliminating your FEHB premium. (OPM does not contribute to your Medicare Advantage plan premium.) For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage or move out of the Medicare Advantage plan's service area.

- **Medicare prescription drug coverage (Part D)**

  When we are the primary payor, we process the claim first. If you enroll in Medicare Part D and we are the secondary payor, we will review claims for your prescription drug costs that are not covered by Medicare Part D and consider them for payment under the FEHB plan.

Medicare always makes the final determination as to whether they are the primary payor. The following chart illustrates whether Medicare or this Plan should be the primary payor for you according to your employment status and other factors determined by Medicare. It is critical that you tell us if you or a covered family member has Medicare coverage so we can administer these requirements correctly. **(Having coverage under more than two health plans may change the order of benefits determined on this chart.)**

Primary Payor Chart		
A. When you - or your covered spouse - are age 65 or over and have Medicare and you...	**The primary payor for the individual with Medicare is...**	
	Medicare	**This Plan**
1) Have FEHB coverage on your own as an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through your spouse who is an annuitant	✓	
3) Have FEHB through your spouse who is an active employee		✓
4) Are a reemployed annuitant with the Federal government and your position is excluded from the FEHB (your employing office will know if this is the case) and you are not covered under FEHB through your spouse under #3 above	✓	
5) Are a reemployed annuitant with the Federal government and your position is not excluded from the FEHB (your employing office will know if this is the case) and...		
• You have FEHB coverage on your own or through your spouse who is also an active employee		✓
• You have FEHB coverage through your spouse who is an annuitant	✓	
6) Are a Federal judge who retired under title 28, U.S.C., or a Tax Court judge who retired under Section 7447 of title 26, U.S.C. (or if your covered spouse is this type of judge) and you are not covered under FEHB through your spouse under #3 above	✓	
7) Are enrolled in Part B only, regardless of your employment status	✓ for Part B services	✓ for other services
8) Are a Federal employee receiving Workers' Compensation disability benefits for six months or more	✓*	
B. When you or a covered family member...		
1) Have Medicare solely based on end stage renal disease (ESRD) and...		
• It is within the first 30 months of eligibility for or entitlement to Medicare due to ESRD **(30-month coordination period)**		✓
• It is beyond the 30-month coordination period and you or a family member are still entitled to Medicare due to ESRD	✓	
2) Become eligible for Medicare due to ESRD while already a Medicare beneficiary and...		
• This Plan was the primary payor before eligibility due to ESRD **(for 30 month coordination period)**		✓
• Medicare was the primary payor before eligibility due to ESRD	✓	
3) Have Temporary Continuation of Coverage (TCC) and...		
• Medicare based on age and disability	✓	
• Medicare based on ESRD **(for the 30 month coordination period)**		✓
• Medicare based on ESRD **(after the 30 month coordination period)**	✓	
C. When either you or a covered family member are eligible for Medicare solely due to disability and you...		
1) Have FEHB coverage on your own as an active employee or through a family member who is an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through a family member who is an annuitant	✓	
D. When you are covered under the FEHB Spouse Equity provision as a former spouse	✓	

*Workers' Compensation is primary for claims related to your condition under Workers' Compensation.

Section 10. Definitions of terms we use in this brochure

Calendar year — January 1 through December 31 of the same year. For new enrollees, the calendar year begins on the effective date of their enrollment and ends on December 31 of the same year.

Clinical Trials Cost Categories — An approved clinical trial includes a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition, and is either Federally-funded; conducted under an investigational new drug application reviewed by the Food and Drug Administration (FDA); or is a drug trial that is exempt from the requirement of an investigational new drug application.

- Routine care costs - costs for routine services such as doctor visits, lab tests, x-rays and scans, and hospitalizations related to treating the patient's condition, whether the patient is in a clinical trial or is receiving standard therapy
- Extra care costs - costs related to taking part in a clinical trial such as additional tests that a patient may need as part of the trial, but not as part of the patient's routine care
- Research costs - costs related to conducting the clinical trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes. These costs are generally covered by the clinical trials. This plan does not cover these costs.

Coinsurance — Coinsurance is the percentage of our allowance that you must pay for your care. You may also be responsible for additional amounts.

Confinement — Confinement/Confined means (a) the period of time between admission as an inpatient or outpatient to a Hospital, AODA residential center, Skilled Nursing Facility or licensed ambulatory surgical center on the advice of your physician; and discharge there from, or (b) the time spent receiving Emergency Care for illness or injury in a Hospital. Hospital swing bed confinement is considered the same as Confinement in a Skilled Nursing Facility. If the member is transferred or discharged to another facility for continued treatment of the same or related condition, it is one Confinement.

Copayment — A copayment is a fixed amount of money you pay when you receive covered services.

Cost-sharing — Cost-sharing is the general term used to refer to your out-of-pocket costs (e.g., deductible, coinsurance, and/or copayments) for the covered care you receive.

Covered services — Care we provide benefits for, as described in this brochure.

Custodial care — Custodial care means care that is primarily for the purpose of meeting personal needs and which could be provided by persons without professional skill or training. For example, custodial care includes help in walking, getting in or out of bed, bathing, dressing, eating, preparing special diets, and taking medicine. Custodial care that lasts 90 days or more is known as Long Term Care.

Deductible — A deductible is a fixed amount of covered expenses you must incur for certain covered services and supplies before we start paying benefits for those services.

Experimental, Investigational or Unproven services — Means a health service, treatment, or supply used for an illness or injury which, at the time it is used, meets one or more of the following criteria:

(a) is subject to final approval by an appropriate governmental agency for the purpose it is being used for, such as, but not limited to the Food and Drug Administration (FDA),

(b) is not commonly accepted medical practice in the American medical community

(c) is the subject of a written investigational or research protocol,

(d) requires a written investigational or research protocol,

(e) requires a written informed consent by a treating facility that makes reference to it being Experimental, Investigational, educational, for a research study, or posing an uncertain outcome, or having an unusual risk,

(f) is the subject of an ongoing FDA Phase I, II, III clinical trial.

Health care professional A physician or other health care professional licensed, accredited, or certified to perform specified health services consistent with state law.

Medical necessity Medical necessity means a service, treatment, procedure, equipment, drug, device or supply provided by a Hospital, Practitioner or other health care provider that is required to identify or treat a member's illness, disease or injury and which is, as determined by the GHC-SCW Medical Director:

1. consistent with the symptom(s) or diagnosis and treatment of the Member's illness, disease or injury;
2. appropriate under the standards of acceptable medical practice to treat that illness, disease or injury;
3. not solely for the convenience of the Member, Practitioner, Hospital or other health care provider; and
4. the most appropriate service, treatment, procedure, equipment, drug, device or supply which can be safely provided to the Member and accomplishes the desired end result in the most economical manner. This means if there is more than one medically established standard treatment approach available nationally, and these approaches are relatively equivalent in terms of proven medical outcomes, GHC-SCW will make the determination on the selected approach to be covered.

Plan allowance Plan allowance is the amount we use to determine our payment and your coinsurance for covered services.

Post-service claims Any claims that are not pre-service claims. In other words, post-service claims are those claims where treatment has been performed and the claims have been sent to us in order to apply for benefits.

Pre-service claims Those claims (1) that require precertification, prior approval, or a referral and (2) where failure to obtain precertification, prior approval, or a referral results in a reduction of benefits.

Specialty drugs Specialty drugs means drugs manufactured through advanced technologies including biotechnology methods involving live organisms or derived functional components (bioprocessing) approved and regulated by the FDA's Center for Drug Evaluation and Research (CDER) intended for the prevention, treatment or cure of disease/condition in human beings.

Specialty drugs are those drugs designated as 'Specialty' by the GHC-SCW Technology Assessment Committee (TAC). Please refer to www.ghcscw.com or contact GHC-SCW Member Services at 608-828-4853 or 800-650-4327, ext. 4504, for a current listing of Specialty Drugs.

Urgent Condition Urgent Condition means the rapid onset of symptoms of an illness or injury which requires medical care but is not life-threatening. Within the service area, treatment for an Urgent Condition must be obtained from a GHC-SCW practitioner. When outside the service area and care cannot be safely delayed until returning to the service area, treatment for an Urgent Condition should be obtained from the nearest medical facility.

Urgent care claims A claim for medical care or treatment is an urgent care claim if waiting for the regular time limit for non-urgent care claims could have one of the following impacts:

- Waiting could seriously jeopardize your life or health;
- Waiting could seriously jeopardize your ability to regain maximum function; or

- In the opinion of a physician with knowledge of your medical condition, waiting would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Urgent care claims usually involve Pre-service claims and not Post-service claims. We will judge whether a claim is an urgent care claim by applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine.

If you believe your claim qualifies as an urgent care claim, please contact our Customer Service Department at 608-828-4853. You may also prove that your claim is an urgent care claim by providing evidence that a physician with knowledge of your medical condition has determined that your claim involves urgent care.

Us/We Us and We refer to Group Health Cooperative of South Central Wisconsin (GHC-SCW).

You You refers to the enrollee and each covered family member.

Section 11. Other Federal Programs

Please note, the following programs are not part of your FEHB benefits. They are separate Federal programs that complement your FEHB benefits and can potentially reduce your annual out-of-pocket expenses. These programs are offered independent of the FEHB Program and require you to enroll separately with no government contribution.

Important information about three Federal programs that complement the FEHB Program

First, the **Federal Flexible Spending Account Program**, also known as FSAFEDS, lets you set aside pre-tax money from your salary to reimburse you for eligible dependent care and/or health care expenses. You pay less in taxes so you save money. Participating employees save an average of about 30% on products and services they routinely pay for out-of-pocket.

Second, the **Federal Employees Dental and Vision Insurance Program** (FEDVIP) provides comprehensive dental and vision insurance at competitive group rates. There are several plans from which to choose. Under FEDVIP you may choose self only, self plus one, or self and family coverage for yourself and any eligible dependents.

Third, the **Federal Long Term Care Insusrance Program** (FLTCIP) can help cover long term care costs, which are not covered under the FEHB Program.

The Federal Flexible Spending Account Program – *FSAFEDS*

What is an FSA?

It is an account where you contribute money from your salary **BEFORE** taxes are withheld, then incur eligible expenses and get reimbursed. You pay less in taxes so you save money. **Annuitants are not eligible to enroll.**

There are three types of FSAs offered by FSAFEDS. Each type has a minimum annual election of $100. The maximum annual election for a health care flexible spending account (HCFSA) or a limited expense health care spending account (LEX HCFSA) is $2,500 per person. The maximum annual election for a dependent care flexible spending account (DCFSA) is $5,000 per household.

- **Health Care FSA (HCFSA)** – Reimburses you for eligible out-of-pocket health care expenses (such as copayments, deductibles, prescriptions, **physician prescribed** over-the-counter drugs and medications, vision and dental expenses, and much more) for you and your tax dependents, including adult children (through the end of the calendar year in which they turn 26).
- FSAFEDS offers paperless reimbursement for your HCFSA through a number of FEHB and FEDVIP plans. This means that when you or your provider files claims with your FEHB or FEDVIP plan, FSAFEDS will automatically reimburse your eligible out-of-pocket expenses based on the claim information it receives from your plan.

- **Limited Expense Health Care FSA (LEX HCFSA)** – Designed for employees enrolled in or covered by a High Deductible Health Plan with a Health Savings Account. Eligible expenses are limited to out-of-pocket dental and vision care expenses for you and your tax dependents including adult children (through the end of the calendar year in which they turn 26).
- **Dependent Care FSA (DCFSA)** – Reimburses you for eligible **non-medical** day care expenses for your children under age 13 and/or for any person you claim as a dependent on your Federal Income Tax return who is mentally or physically incapable of self-care. You (and your spouse if married) must be working, looking for work (income must be earned during the year), or attending school full-time to be eligible for a DCFSA.
- **If you are a new or newly eligible employee you have 60 days from your hire date to enroll in an HCFSA or LEX HCFSA and/or DCFSA, but you must enroll before October 1. If you are hired or become eligible on or after October 1, you must wait and enroll during the Federal Benefits Open Season held each fall.**

Where can I get more information about FSAFEDS?	Visit www.FSAFEDS.com or call an FSAFEDS Benefits Counselor toll-free at 1-877-FSAFEDS (1-877-372-3337), Monday through Friday, 9 a.m. until 9 p.m., Eastern Time. TTY: 1-800-952-0450.

The Federal Empolyees Dental and Vision Insurance Program – *FEDVIP*

Important Information	The Federal Employees Dental and Vision Insurance Program (FEDVIP) is separate and different from the FEHB Programs. **This program provides comprehensive dental and vision insurace at competitive group rates with no pre-existing condition limitations for enrollment.** FEDVIP is available for eligible Federal and Postal Service employees, retirees, and their eligible family members on an enrollee-pay-all basis. Employee premiums are withheld from salary on a pre-tax basis.
Dental Insurance	All dental plans provide a comprehensive range of services, including: • Class A (Basic) services, which include oral examinations, prophylaxis, diagnostic evaluations, sealants and x-rays. • Class B (Intermediate) services, which include restorative procedures such as fillings, prefabricated stainless steel crowns, periodontal scaling, tooth extractions, and denture adjustments. • Class C (Major) services, which include endodontic services such as root canals, periodontal services such as gingivectomy, major restorative services such as crowns, oral surgery, bridges and prosthodontic services such as complete dentures. • Class D (Orthodontic) services with up to a 12-month waiting period. **Most FEDVIP dental plans cover adult orthodontia. Review your FEDVIP dental plan's brchoure for information on this benefit.**
Vision Insurance	All vision plans provide comprehensive eye examinations and coverage for your choice of either lenses, frames or for contact lenses. Other benefits such as discounts on LASIK surgery may also be available.
Additional Information	You can find a comparison of the plans available and their premiums on the OPM website at www.opm.gov/dental and www.opm.gov/vision. These sites also provide links to each plan's website, where you can view detailed information about benefits and preferred providers.
How do I enroll?	You enroll on the Internet at www.BENEFEDS.com. For those without access to a computer, call 1-877-888-3337 (TTY: 1-877-889-5680).

The Federal Long Term Care Insurance Program - *FLTCIP*

It's important protection	The Federal Long Term Care Insurance Program (FLTCIP) can help pay for the potentially high cost of long term care services, which are not covered by FEHB plans. Long term care is help you receive to perform activities of daily living - such as bathing or dressing yourself - or supervision you receive because of a severe cognitive impairment such as Alzheimer's disease. For example, long term care can be received in your home from a home health aide, in a nursing home, in an assisted living facility or in adult day care. To qualify for coverage under the FLTCIP, you must apply and pass a medical screening (called underwriting). Federal and U.S. Postal service employees and annuitants, active and retired members of the uniformed services, and qualified relatives are eligible to apply. Certain medical conditions, or combinations of conditions, will prevent some people from being approved for coverage. You must apply to know if you will be approved for enrollment. For more information, call 1-800-LTD-FEDS (1-800-582-3337), (TTY: 1-800-843-3557), or visit www.ltcfeds.com.

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Summary of Benefits for Group Health Cooperative of South Central Wisconsin -2015

- **Do not rely on this chart alone.** All benefits are provided in full unless indicated and are subject to the definitions, limitations, and exclusions in this brochure. On this page we summarize specific expenses we cover; for more detail, look inside.
- If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.
- We only cover services provided or arranged by Plan physicians, except in emergencies.

High Option Benefits	You pay	Page
Medical services provided by physicians:	$10 Primary Care, age 18 and older $10 Specialist Care, age 18 and older	25
• Diagnostic and treatment services provided in the office	Office visit copay: $10 primary care; $10 specialist	25
Services provided by a hospital:		
• Inpatient	Nothing	42
• Outpatient	Nothing	43
Emergency benefits:		
• In-area	$75 per visit, waived if admitted	45
• Out-of-area	$75 per visit, waived if admitted	45
Mental health and substance abuse treatment:	Regular cost-sharing	47
Prescription drugs:		
• Retail pharmacy	$5 generic; $20 brand	49
• Mail order	Certain prescriptions only	49
Dental care: • Prophylaxis or cleaning (one in any six month period) • Topical applications of fluoride through age fifteen (15) - one every six months	You pay nothing if you use a GHC-SCW paln dentist.	51
Vision care:	$10 office visit copay, age 18 and older	30
Protection against catastrophic costs (out-of-pocket maximum)**:**	$6,350 for Self Only; $12,700 for Family	20

2015 Rate Information

For 2015 health premium information, please see:
http://www.opm.gov/healthcare-insurance/indian-tribes/health-insurance/#url=Premiums or contact your tribe's Human Resources department.