

Group Health Cooperative of South Central Wisconsin

www.ghcscw.com

Customer Service 608-828-4853 or 800-605-4327

2026

A Health Maintenance Organization (High and Standard Option)

This plan's health coverage qualifies as minimum essential coverage and meets the minimum value standard for the benefits it provides: See page 8 for details. This plan is accredited. See page 13.

IMPORTANT

- Rates: Back Cover
- Changes for 2026: Page 15
- Summary of Benefits: Page 92

Serving: South Central Wisconsin

Enrollment in this Plan is limited. You must live or work in our geographic service area to enroll. See page 14 for requirements.

Postal Employees and Annuitants are no longer eligible for this plan. (unless currently under Temporary Continuation of Coverage)

Enrollment codes for this Plan:

- WJ1 High Option - Self Only
- WJ3 High Option - Self Plus One
- WJ2 High Option - Self and Family
- WJ4 Standard Option - Self Only
- WJ6 Standard Option - Self Plus One
- WJ5 Standard Option - Self and Family

Authorized for distribution by the:



United States
Office of Personnel Management

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

RI 73-061

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] 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 an annuitant 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 is 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 <http://www.socialsecurity.gov/>, or call the SSA at 800-772-1213 TTY 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 800-MEDICARE (1-800-633-4227), (TTY 1-877-486-2048)

Additional Premium for Medicare's High Income Members Income-Related Monthly Adjustment Amount (IRMAA)

The Medicare Income-Related Monthly Adjustment Amount (IRMAA) is an amount you may pay in addition to your FEHB premium to enroll in and maintain Medicare prescription drug coverage. This additional premium is assessed only to those with higher incomes and is adjusted based on the income reported on your IRS tax return. You do not make any IRMAA payments to your FEHB plan. Refer to the Part D-IRMAA section of the Medicare website: <https://www.medicare.gov/drug-coverage-part-d/costs-for-medicare-drug-coverage/monthly-premium-for-drug-plans> to see if you would be subject to this additional premium.

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 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 contract (CS 1828) between Group Health Cooperative of South Central Wisconsin and the United States Office of Personnel Management, as authorized by the Federal Employees Health Benefits law. Member Services may be reached at 608-828-4853 or 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 verbal 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 Plus One or 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, 2026, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates for each plan annually. Benefit changes are effective January 1, 2026, and changes are summarized on page 15. Rates are shown at the end of this brochure.

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 and each covered 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 healthcare 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 phone or to people you do not know, except for your healthcare 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 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 or 800-605-4327 and explain the situation.
- If we do not resolve the issue:

CALL- THE HEALTHCARE FRAUD HOTLINE
877-499-7295

OR go to www.opm.gov/our-inspector-general/hotline-to-report-fraud-waste-or-abuse/complaint-form/

The online reporting form is the desired method of reporting fraud in order to ensure accuracy , and a quicker response time.

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 they are disabled and incapable of self-support prior to age 26). A carrier may request that an enrollee verify the eligibility of any or all family members listed as covered under the enrollee's FEHB enrollment.
- If you have any questions about the eligibility of a family member, 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. (TCC)
- 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.

Discrimination is Against the Law

We comply with applicable Federal nondiscrimination laws and do not discriminate on the basis of race, color, national origin, age, disability, religion, sex (pregnancy, or genetic information). We do not exclude people or treat them differently because of race, color, national origin, age, disability, religion, sex (pregnancy, or genetic information).

The health benefits described in this brochure are consistent with applicable laws prohibiting discrimination. All coverage decisions will be based on nondiscriminatory standards and criteria. An individual's protected trait or traits, will not be used to deny health benefits for items, supplies, or services that are otherwise covered and determined to be medically necessary.

Preventing Medical Mistakes

Medical mistakes continue to be a significant cause of preventable deaths within the United States. 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. Medical mistakes and their consequences also add significantly to the overall cost of healthcare. Hospitals and healthcare providers are being held accountable for the quality of care and reduction in medical mistakes by their accrediting bodies. You can also improve the quality and safety of your own healthcare and that of your family members by learning more about and understanding your risks. 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 take notes, ask questions and understand answers.

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

- Bring the actual medication or give your doctor and pharmacist a list of all the medications and dosage that you take, including non-prescription (over-the-counter) medications 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 medication is what the doctor ordered. Ask the pharmacist about your medication if it looks different than you expected.
- Read the label and patient package insert when you get your medication, including all warnings and instructions.
- Know how to use your medication. Especially note the times and conditions when your medication should and should not be taken.
- Contact your doctor or pharmacist if you have any questions.
- Understanding both the generic and brand names for all of your medication(s) is important. This helps ensure you do not receive double dosing from taking both a generic and a brand of the same medication. It also helps you avoid taking a medication to which you are allergic.

3. Get the results of any test or procedure.

- Ask when and how you will get the results of tests or procedures. Will it be in person, by phone, mail, through the Plan or Provider's portal?
- Don't assume the results are fine if you do not get them when expected. Contact your healthcare provider and ask for your results.
- Ask what the results mean for your care.

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

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

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

For more information on patient safety, please visit

- www.jointcommission.org/speakup.aspx
The Joint Commission's Speak Up™ patient safety program.
- www.jointcommission.org/topics/patient_safety.aspx. The Joint Commission helps healthcare organizations to improve the quality and safety of the care they deliver.
- www.ahrq.gov/patients-consumers/. 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 healthcare providers and improve the quality of care you receive.
- <https://psnet.ahrq.gov/issue/national-patient-safety-foundation>. The National Patient Safety Foundation has information on how to ensure safer health care for you and your family.
- www.bemedwise.org. The National Council on Patient Information and Education is dedicated to improving communication about the safe, appropriate use of medications.
- 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 healthcare professionals working to improve patient safety.

Preventable Healthcare Acquired Conditions ("Never Events")

When you enter the hospital for treatment of one medical problem, you do not 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, patients do suffer from injuries or illnesses that could have been prevented if doctors or the hospital had taken proper precautions. Errors in medical care that are clearly identifiable, preventable and serious in their consequences for patients, can indicate a significant problem in the safety and credibility of a healthcare facility. These conditions and errors are sometimes called "Never Events" or "Serious Reportable Events."

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. When such an event occurs, neither you nor your FEHB plan will incur costs to correct the medical error. Plan Providers agree to notify all applicable reporting agencies of any Serious Reportable Adverse Events, including but not limited to, root cause analysis and corrective action taken. Plan Providers further agree that when a Serious Reportable Adverse Event occurs, GHC-SCW and Members shall not be required to pay for the cost of medical care related to the event.

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. 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, give you other plans' brochures, 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 do not 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, disability leave, pensions, etc you must also contact your employing or retirement office.

Once enrolled in your FEHB Program Plan, you should contact your carrier directly for updates and questions about your benefit coverage.

- **Enrollment types available for you and your family**

Self Only coverage is only for the enrollee. Self Plus One coverage is for the enrollee and one eligible family member. Self and Family coverage is for the enrollee, and one or more eligible family members. Family members include your spouse and your 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 Plus One or 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 Plus One or 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 Plus One or 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 are married. A carrier may request that an enrollee verify the eligibility of any or all family members listed as covered under the enrollee's FEHB enrollment.

Contact your employing or retirement office if you want to change from Self Only to Self Plus One or Self and Family. If you have a Self and Family enrollment, you may contact us to add a family member.

Your employing or retirement office will not notify you when a family member is no longer eligible to receive benefits. Please tell us immediately of changes in family member status, including your marriage, divorce, annulment, or when your child reaches age 26. We will send written notice to you 60 days before we proactively disenroll your child 31 days after their 26th birthday unless your child is eligible for continued coverage because they are incapable of self-support due to a physical or mental disability that began before age 26.

If you or one of your family members is enrolled in one FEHB plan, you or they cannot be enrolled in or covered as a family member by another enrollee in 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 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 your spouse by valid common-law marriage from a state that recognizes common-law marriages) and children as described in the chart below. A Self Plus One enrollment covers you and your spouse, or one other eligible family member as described below.

Natural children, adopted children, and stepchildren

Coverage: Natural children, adopted children, and stepchildren are covered until their 26th birthday.

Foster children

Coverage: 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

Coverage: 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

Coverage: 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

Coverage: Children who are eligible for or have their own employer-provided health insurance are covered until their 26th birthday.

Newborns of covered children are insured only for routine nursery care during the covered portion of the mother's maternity stay.

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

• Children's Equity Act

OPM implements the Federal Employees Health Benefits Children's Equity Act of 2000. This law mandates that you be enrolled for Self Plus One or 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 in Self Plus One or 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 Plus one or Self and Family coverage, as appropriate, in the lowest-cost nationwide plan option as determined by OPM.
- 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 Plus One or Self and Family, as appropriate, 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 Plus One or Self and Family, as appropriate, in the lowest-cost nationwide plan option as determined by OPM.

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 does not 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 does not serve the area in which your children live as long as the court/administrative order is in effect. Similarly, you cannot change to Self Plus One if the court/administrative order identifies more than one child. 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 processed according to the 2026 benefits of your prior plan or option.** If you have met (or pay cost-sharing that results in your meeting) the out-of-pocket maximum under the prior plan or option, you will not pay cost sharing for services covered between January 1 and the effective date of coverage under your new plan or option. However, if your prior plan left the FEHB Program at the end of 2025, you are covered under that plan's 2025 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 assistance with enrolling in a conversion policy (a non-FEHB individual policy).

- **Upon divorce** If you are an enrollee, and your divorce or annulment is final, your ex-spouse cannot remain covered as a family member under your Self Plus One or Self and Family enrollment. You must contact us to let us know the date of the divorce or annulment and have us remove your ex-spouse. We may ask for a copy of the divorce decree as proof. In order to change enrollment type, you must contact your employing or retirement office. A change will not automatically be made.

If you were married to an enrollee and your divorce or annulment is final, you may not remain covered as a family member 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 additional information about your coverage choices, <https://www.opm.gov/healthcare-insurance/life-events/memy-family/im-separated-or-im-getting-divorced/#url=Health>. We may request that you verify the eligibility of any or all family members listed as covered under the enrollee's FEHB enrollment.

- **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). 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 or if you are a covered child and you turn 26.

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, 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 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

If you leave Federal or Tribal service, your employing office will notify you of your right to convert. You must contact us in writing 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 contact us 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, a waiting period will not be imposed and your coverage will not be limited due to pre-existing conditions. When you contact us, we will assist you in obtaining information about health benefits coverage inside or outside the Affordable Care Act's Health Insurance Marketplace in your state. For assistance in finding coverage, please contact us at 608-251-3356 or visit our website at www.ghcscw.com

- Health Insurance Marketplace

If you would like to purchase health insurance through the ACA'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). OPM requires that FEHB plans be accredited to validate that plan operations and/or care management meet nationally recognized standards. Group Health Cooperative of South Central Wisconsin holds the following accreditations: Health Plan Accreditation for Commercial HMO, Marketplace HMO, the local plans and the vendor that supports Group Health Cooperative of South Central Wisconsin holds accreditation from NCQA. To learn more about this plan's accreditation(s), please visit the following websites: National Committee for Quality Assurance (www.ncqa.org).

We require you to see specific physicians, hospitals, and other providers that contract with us. These Plan providers coordinate your health care services. We are solely responsible for the selection of these providers in your area. Contact us for a copy of our most recent provider directory. We give you the choice of enrollment in a High Option or a Standard Option.

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.

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 and Standard Options

High Option Overview

- \$0 Deductible
- \$0 primary care provider office copayment
- \$10 specialist office copayment.
- \$10 urgent care copayment
- \$75 emergency room copayment
- Pharmacy: Tier 1 \$5; Tier 2 \$20; Tier 3 \$50; Tier 4 \$100

Maximum-out-of-pocket: \$7,150 Self only; \$14,300 Self Plus One and Self and Family

Standard Option Overview

- Deductible: \$1,000 Self Only; \$2,000 Self Plus One and Self Plus Family
- 20% Coinsurance after Deductible
- \$20 primary care provider office copayment.
- \$40 specialist office copayment.
- \$40 urgent care copayment
- \$100 emergency room copayment
- Pharmacy: Tier 1 \$5; Tier 2 \$20; Tier 3 \$50; Tier 4 \$100

Maximum-out-of-pocket: \$7,150 Self only; \$14,300 Self Plus One and Self and Family

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 except for urgent/emergent issues while traveling outside of the service area.

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 cost-sharing (copayments, coinsurance, deductibles, and non-covered services and supplies).

Your Rights and responsibilities

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/insure) lists the specific types of information that we must make available to you. Some of the required information is listed below.

- Years in existence 48 (first clinic opened in 1976)
- Profit status Non-profit

You are also entitled to a wide range of consumer protections and have specific responsibilities as a member of this Plan. You can view the complete list of these rights and responsibilities by visiting our website, Group Health Cooperative-SCW www.ghcscw.com. You can also contact us to request that we mail a copy to you.

If you want more information about us, call 608-828-4853 or 800 605-4327, or write to GHC-SCW Member Services Department, PO Box 44971, Madison WI 53744-4971. You may also visit our website at www.ghcscw.com.

By law, you have the right to access your protected health information (PHI). For more information regarding access to PHI, visit our website Group Health Cooperative-SCW at www.ghcscw.com to obtain our Notice of Privacy Practices. You can also contact us to request that we mail you a copy of that notice.

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:

Adams County Columbia County Dodge County Grant County Green County Iowa County Jefferson County
Juneau County Lafayette County Richland County Rock County Sauk County Vernon 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 urgent emergency care benefits. We will not pay for any other healthcare 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 covered family members 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 2026

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 both High and Standard Options

- Your share of the premium rate will **increase** for Self Only, Self Plus One and Self and Family. (please see page 94)
- **Allergy Care** - The Plan will now cover provocative food testing and sublingual allergy desensitization. Member cost shares for office visits remain the same: The High Option is a \$10 copay for PCP or Specialist, and the Standard Option has a \$20 copay for a PCP and a \$40 copay for a Specialist. (Please see page 37)
- **Genetic Testing** – The Plan will expand this benefit beyond family planning to all medically necessary, applicable diagnosis. There will be no member cost share for the High or Standard Option. Prior authorization is required. (Please see page 34)
- **Treatment for Gender Dysphoria, Prescription Drugs, and Surgery** – OPM has required the removal of gender dysphoria care medications and surgery for all ages from your Plan. Counseling services for possible or diagnosed gender dysphoria will continue to be covered. In addition, an exceptions process for coverage of excluded services is available for Members who have already initiated treatment within a surgical and/or hormonal regimen for diagnosed gender dysphoria. See Section 3, "How You get Care". (Please see page 48 for surgery changes and page 68 for medication changes)
- **Iatrogenic Infertility Benefit** - For persons facing the possibility of iatrogenic infertility, the Plan will now cover cryopreservation storage costs for one year. With this added benefit, covered standard fertility preservation services for persons facing the possibility of iatrogenic infertility now include: Members will pay 50% coinsurance under both the High and Standard Options. This benefit is not subject to the deductible. (please see page 36)
 - Procurement of sperm or eggs including medical, surgical, and pharmacy claims associated with retrieval
 - Cryopreservation of sperm and mature oocytes
 - Cryopreservation of testicular tissue
 - Cryopreservation of ovarian tissue
 - Cryopreservation storage costs for one year
- **Chimeric antigen receptor (CAR) T-cell Therapy** - The Plan will now cover Chimeric antigen receptor (CAR) T-cell therapy. Members pay Nothing under the High Option and 20% coinsurance after the deductible for the Standard Option. Other gene therapies will continue to be excluded benefits. (please see page 37)

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 healthcare professionals in our service area that we contract with to provide covered services to our members. Services by Plan Providers are covered when acting within the scope of their license or certification under applicable state law. We credential Plan providers according to national standards. Benefits are provided under this Plan for the services of covered providers, in accordance with Section 2706(a) of the Public Health Service Act. Coverage of practitioners is not determined by your state’s designation as a medically underserved area. 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. Benefits described in this brochure are available to all members meeting medical necessity guidelines regardless of race, color, national origin, age, disability, religion, sex, pregnancy or genetic information. This plan provides Care Coordinators for complex conditions and can be reached 608-257-5294 for assistance.
• 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.
• Balance Billing Protection	FEHB Carriers must have clauses in their in-network (participating) providers agreements. These clauses provide that, for a service that is a covered benefit in the plan brochure or for services determined not medically necessary, the in-network provider agrees to hold the covered individual harmless (and may not bill) for the difference between the billed charge and the in network contracted amount. If an in-network provider bills you for covered services over your normal cost share (deductible, copay, co-insurance) contact your Carrier to enforce the terms of its provider contract.
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 provider. This decision is important since your primary care provider 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 provider 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 healthcare or give you a referral to see a specialist.

If you want to change primary care providers or if your primary care provider leaves the Plan, call us at 608-828-4853 or 800-605-4327. We will help you select a new one

- **Specialty care** Your primary care provider will refer you to a specialist for needed care. When you receive a referral from your primary care provider, you must return to the primary care provider after the consultation, unless your primary care provider authorized a certain number of visits without additional referrals. The primary care provider must provide or authorize all follow-up care. Do not go to the specialist for return visits unless your primary care provider gives you a referral. However, you may see the following in-plan providers without a referral (Non-GHC-SCW providers may require Prior Authorization, contact GHC-SCW for additional information): mental health, substance abuse, vision, dental and chiropractic services.

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 provider will develop a treatment plan that allows you to see your specialist for a certain number of visits without additional referrals.

Your primary care provider 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 provider. If they decide 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 provider, 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.
- You may continue seeing your specialist for up to 90 days if you are undergoing treatment for a chronic or disabling condition and you lose access to your specialist because:
 - We terminate our contract with your specialist for other than cause.
 - We drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB Plan; or
 - We reduce our Service Area and you enroll in another FEHB plan.

Contact us at 800-605-4327, 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.

Note: If you lose access to your specialist because you changed your carrier or plan option enrollment, contact your new plan.

Sex-Trait Modification: If you are mid-treatment, within a surgical or chemical regimen for Sex-Trait Modification for diagnosed gender dysphoria, for services formerly covered under the 2025 Plan brochure, you may seek an exception to continue care. Our exception process is as follows: The GHC Medical Director will determine if a member qualifies as being in Gender Dysphoria Mid-Treatment Care, and therefore eligible for continued care, by reviewing relevant medical records. Gender Dysphoria Mid-Treatment Care refers to members who meet one or more of the following criteria at the time of enrollment:

- Are currently receiving gender-dysphoria chemical treatment. There is no period of treatment requirement.

- Have previously been approved by a qualified surgeon as meeting clinical criteria for gender-dysphoria sex-trait modification surgical care.
- Are currently scheduled for sex-trait modification surgery, and scheduling of the surgery (or initial surgery if multiple surgeries are medically necessary) has occurred prior to the effective date of coverage under this plan. The surgery (and any necessary subsequent surgeries) may be scheduled for a date after the effective date of coverage under this plan.

The exception process will be applied on a case-by-case basis. To initiate the review process, providers must submit a prior authorization request along with all pertinent medical documentation supporting the member's current treatment status. This includes, but is not limited to, hormone therapy records, surgical evaluations, and scheduled procedure documentation. All materials should be submitted through the standard GHC prior authorization channels. Incomplete submissions may delay the review and determination process. You may also find more information on our member website at www.ghcscw.com. If you disagree with our decision on your exception, please contact GHC-SCW Member Services at 608-828-4853 or see Section 8 of your brochure for the disputed claims process.

Individuals under age 19 are not eligible for exceptions related to services for ongoing surgical or hormonal treatment for diagnosed gender dysphoria

• **Hospital care**

Your Plan primary care provider 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 services

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

It is the Member's responsibility to ensure a Prior Authorization has been obtained when required. If Prior Authorization is not received prior to the date of service and/or receipt of supplies, your Provider should contact GHC-SCW's Care Management Department for a determination of Medical Necessity.

You must get prior approval for certain services. Failure to obtain Prior Authorization when required may result in the Member receiving a reduction in or no Benefit.

• **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 provider 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
- Inpatient and transitional Mental Health services
- Inpatient and transitional Substance Abuse 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 nutritional 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 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 or not it is an urgent care claim by applying the judgment of a prudent layperson that possesses an average knowledge of health and medication.

If you fail to provide sufficient information, we will contact you within 24 hours after we receive the claim to let you know what information we need to complete our review of the claim. You will then have up to 48 hours after to provide the required information. We will make our decision on the claim within 48 hours of (1) the time we received the additional information or (2) the 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 FEHB 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 termination of our pre-approved course of treatment before the end of the approved period of time or number of treatments as an appealable decision. This does not include reduction 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 termination takes effect.

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

- **Emergency inpatient admission**

If you have an emergency admission due to a condition that you reasonably believe puts your life in danger or could cause serious damage to bodily function, you, your representative, the physician, or the hospital must phone us within two business days following the day of the emergency admission, even if you have been discharged from the hospital.

• 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 physician or hospital must contact us for prior authorization of additional days for your baby. Note: When a newborn requires definitive treatment during or after the mother's hospital stay, the newborn is considered a patient in their own right. If the newborn is eligible for coverage, regular medical or surgical benefits apply rather than maternity benefits.
• 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, 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 your claim is in reference to a contraceptive, call 608-828-4811. 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 decision within 72 hours after receipt of your reconsideration request. 1. Pre-certify your hospital stay or, if applicable, arrange for the healthcare 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 phone, 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/or 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: High Option - When you see your primary care provider you pay nothing per office visit and when you go in for a specialist office visit, you pay \$10 per visit. Example: Standard Option - When you see your primary care provider you pay \$20 per office visit and when you go in for a specialist office visit, you pay \$40 per visit.
Deductible	A deductible is a fixed amount of covered expenses you must incur for certain covered services and supplies before we start paying benefits. Under the High Option there is no deductible. Under the Standard Option the deductible is \$1,000 for Self Only enrollment, \$2,000 for Self Plus One and \$2,000 for Self and Family enrollment. Note: If you change plans during Open Season, you do not have to start a new deductible under your prior plan between January 1 and the effective date of your new plan. If you change plans at another time during the year, you must begin a new deductible under your new plan. If you change options in this Plan during the year, we will credit the amount of covered expenses already applied toward the deductible of your old option to the deductible of your new option.
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 the High Option 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. Example: In the Standard Option plan, you pay 20% coinsurance after deductible for lab, X-ray and other diagnostic tests.
Differences between our Plan allowance and the bill	You should also see section Important Notice About Surprise Billing - Know your Rights below that describes your protections against surprise billing under the No Surprises Act.
Your catastrophic protection out-of-pocket maximum	After your out-of-pocket expenses in the High and Standard Options, including any applicable deductibles, copayments and coinsurance total \$7,150 for Self Only, or \$14,300 for a Self Plus One or Self and Family enrollment in any calendar year, you do not have to pay any more for covered services. <i>The maximum annual limitation on cost sharing listed under Self Only of \$7,150 applies to each individual, regardless of whether the individual is enrolled in Self Only, Self Plus One, or Self and Family.</i> High Option Example Scenario: Your plan has a \$7,150 Self Only maximum out-of-pocket limit and a \$14,300 Self Plus One or Self and Family maximum out-of-pocket limit. If you or one of your eligible family members has out-of-pocket qualified medical expenses of \$7,150 or more for the calendar year, any remaining qualified medical expenses for that individual will be covered fully by your health plan. With a Self and Family enrollment out-of-pocket maximum of \$14,300, a second family member, or an aggregate of other eligible family members, will continue to accrue out-of-pocket qualified medical expenses up to a maximum of \$7,150 for the calendar year before their qualified medical expenses will begin to be covered in full.

Standard Option

Example Scenario: Your plan has a \$7,150 Self Only maximum out-of-pocket limit and a \$14,300 Self Plus One or Self and Family maximum out-of-pocket limit. If you or one of your eligible family members has out-of-pocket qualified medical expenses of \$7,150 or more for the calendar year, any remaining qualified medical expenses for that individual will be covered fully by your health plan. With a Self and Family enrollment out-of-pocket maximum of \$14,300, a second family member, or an aggregate of other eligible family members, will continue to accrue out-of-pocket qualified medical expenses up to a maximum of \$7,150 for the calendar year before their qualified medical expenses will begin to be covered in full.

Carryover

If you changed to this Plan during Open Season from a plan with a catastrophic protection benefit and the effective date of the change was after January 1, any expenses that would have applied to that plan's catastrophic protection benefit during the prior year will be covered by your prior plan if they are for care you received in January before your effective date of coverage in this Plan. If you have already met your prior plan's catastrophic protection benefit level in full, it will continue to apply until the effective date of your coverage in this Plan. If you have not met this expense level in full, your prior plan will first apply your covered out-of-pocket expenses until the prior year's catastrophic level is reached and then apply the catastrophic protection benefit to covered out-of-pocket expenses incurred from that point until the effective date of your coverage in this Plan. Your prior plan will pay these covered expenses according to this year's benefits; benefit changes are effective January 1.

Note: If you change options in this Plan during the year, we will credit the amount of covered expenses already accumulated toward the catastrophic out-of-pocket limit of your old option to the catastrophic protection limit of your new option.

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.

Important Notice About Surprise Billing – Know Your Rights

The No Surprises Act (NSA) is a federal law that provides you with protections against “surprise billing” and “balance billing” for out-of-network emergency services; out-of-network non-emergency services provided with respect to a visit to a participating health care facility; and out-of-network air ambulance services.

A surprise bill is an unexpected bill you receive for

- emergency care – when you have little or no say in the facility or provider from whom you receive care, or for
- non-emergency services furnished by nonparticipating providers with respect to patient visits to participating health care facilities, or for
- air ambulance services furnished by nonparticipating providers of air ambulance services.

Balance billing happens when you receive a bill from the nonparticipating provider, facility, or air ambulance service for the difference between the nonparticipating provider's charge and the amount payable by your health plan.

Your health plan must comply with the NSA protections that hold you harmless from surprise bills

For specific information on surprise billing, the rights and protections you have, and your responsibilities go to www.ghcscw.com or contact the health plan at 608-828-4853.

**The Federal
Flexible Spending
Account Program –
FSAFEDS**

- HealthCare FSA (HCFSAs) – Reimburses an FSA participant for eligible out-of-pocket healthcare expenses (such as copayments, deductibles, over-the-counter drugs and medications, vision and dental expenses, and much more) for their tax dependents, and their adult children (through the end of the calendar year in which they turn 26).
- FSAFEDS offers paperless reimbursement for your HCFSAs 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.

Section 5. High and Standard Option Benefits

See page 15 for how our benefits changed this year. Pages 88 and 89 show the benefits summaries for the High and Standard Options.

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Section 5. High and Standard Option Overview

This Plan offers both a High Option and Standard Option. The benefit packages are described in Section 5. Make sure you review the benefits that are available.

The High & Standard Options in Section 5 are 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 the High Option and Standard Option benefits, contact GHC-SCW Member Services at 608-828-4853 or on our website at www.ghcscw.com.

Each Option Offers Unique Features.

- **High Option**
- **Standard Option**

Section 5(a). Medical Services and Supplies Provided by Physicians and Other Healthcare 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.
- Under the Standard Option the calendar year deductible is \$1,000 Self Only; \$2,000 Self Plus One and Self and Family. The calendar year deductible applies to some benefits in this section. When the calendar year deductible applies we added “after deductible.” The High Option does not have a deductible.
- The coverage and cost-sharing listed below are for services provided by physicians and other health care professionals for your medical care. See Section 5(c) for cost-sharing associated with the facility (i.e., hospital, surgical center, etc.).

Benefit Description		You pay	
Diagnostic and treatment services		High	Standard
Professional services of physicians • In a primary care providers office • During a hospital stay • In a skilled nursing facility • Initial Examination of a newborn child		Nothing	\$20 per office visit in a primary care providers office
Professional services of physicians • In specialty physician's office • In an urgent care center • Office medical consultations with a specialty physician • Second surgical opinion • At home Note: Specialty medical care provided by a non GHC-SCW Practitioner must be prior authorized if the service requested can be provided by a GHC-SCW Specialty Practitioner.		\$10 per office visit	\$40 per office visit
Telehealth Services		High	Standard
• Telehealth services are covered when provided by In-Plan providers specifically contracted with GHC-SCW to provide telehealth services.		Nothing	Nothing

Benefit Description	You pay	
Lab, X-ray and other diagnostic tests	High	Standard
Tests, such as: • Blood tests • Urinalysis • Non-routine pap test • Pathology • X-rays • Non-routine mammogram • CT/CAT Scan • MRI • Ultrasound • Electrocardiogram and EEG • Cologuard Prior authorization is required.	Nothing	20% coinsurance after deductible
Preventive care, adult	High	Standard
Routine Physical every year. The following preventive services are covered at the time interval recommended at each of the links below. • U.S. Preventive Services Task Force (USPSTF) A and B recommended screenings such as cancer, osteoporosis, depression, diabetes, high blood pressure, total blood cholesterol, HIV, and colorectal cancer. For a complete list of screenings go to the U.S. Preventive Services Task Force (USPSTF) website at https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations • Individual counseling on prevention and reducing health risks • Preventive care benefits for women such as Pap smears, gonorrhea prophylactic medication to protect newborns, annual counseling for sexually transmitted infections, contraceptive methods, and screening for interpersonal and domestic violence. For a complete list of preventive care benefits for women go to the Health and Human Services (HHS) website at https://www.hrsa.gov/womens-guidelines • To build your personalized list of preventative services go to https://health.gov/myhealthfinder	Nothing	Nothing
• Routine mammogram Note: Mammograms require a Prior Authorization from the GHC-SCW Care Management Department if they are performed outside a facility either owned or operated by GHC-SCW, or contracted with GHC-SCW to provide mammograms.	Nothing	Nothing

Preventive care, adult - continued on next page

Benefit Description	You pay	
Preventive care, adult (cont.)	High	Standard
Adult immunizations endorsed by the Centers for Disease Control and Prevention (CDC): based on the Advisory Committee on Immunization Practices (ACIP) schedule. For a complete list of endorsed immunizations go to the Centers for Disease Control (CDC) website at: https://www.cdc.gov/vaccines/imzchedules/index.htmlhttps://www.cdc.gov/vaccines/schedules/ Note: Any procedure, injection, diagnostic service, laboratory, or x-ray service done in conjunction with a routine examination and is not included in the preventive recommended listing of services will be subject to the applicable member copayments, coinsurance, and deductible.	Nothing	Nothing
Obesity counseling, screening and referral for those persons at or above the USPSTF obesity prevention risk factor level, to intensive nutrition and behavioral weight-loss therapy, counseling, or family centered programs under the USPSTF A and B recommendations are covered as part of prevention and treatment of obesity as follows: - Intensive nutrition and behavioral weight-loss counseling therapy - Family centered programs when medically identified to support obesity prevention and management by an in-network provider. When anti-obesity medication is prescribed. See Section 5(f) When Bariatric or Metabolic surgical treatment or intervention is indicated for severe obesity. See Section 5(b). Note: GHC covers the services above when medically necessary, care is provided through the UW Medical Weight Management Program.	Nothing	Nothing
<i>Not covered:</i> <i>Physical examinations for services and/or treatments including, but not limited to:</i> <i>Supplies requested by a third party for any reason.</i> <i>Any testing or procedures such as, but not limited to, echocardiograms, blood tests, ultrasounds, etc. requested by a third party for any reason</i> <i>Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, athletic exams, or travel.</i> <i>Immunizations, boosters, and medications for travel or work-related exposure.</i>	<i>All Charges</i>	<i>All Charges</i>

Benefit Description	You pay	
Preventive care, children	High	Standard
- Well-child visits, examinations, and other preventive services as described in the Bright Future Guidelines provided by the American Academy of Pediatrics. For a complete list of the American Academy of Pediatrics Bright Futures Guidelines go to https://brightfutures.aap.org - Children's immunizations endorsed by the Centers for Disease Control (CDC) including DTaP/Tdap, Polio, Measles, Mumps, and Rubella (MMR), and Varicella. For a complete list of immunizations go to the website at https://www.cdc.gov/vaccines/schedules/index.html - You may also find a complete list of U.S. Preventive Services Task Force (USPSTF) A and B recommendations online at https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendation Note: Any procedure, injection, diagnostic service, laboratory, or X-ray service done in conjunction with a routine examination and is not included in the preventive recommended listing of services will be subject to the applicable member copayments, coinsurance, and deductible.	Nothing	Nothing
Obesity counseling, screening and referral for those persons at or above the USPSTF obesity prevention risk factor level, to intensive nutrition and behavioral weight-loss therapy, counseling, or family centered programs under the USPSTF A and B recommendations are covered as part of prevention and treatment of obesity as follows: - Intensive nutrition and behavioral weight-loss counseling therapy - Family centered programs when medically identified to support obesity prevention and management by an in-network provider. When anti-obesity medication is prescribed. See Section 5(f) When Bariatric or Metabolic surgical treatment or intervention is indicated for severe obesity. See Section 5(b). Note: GHC covers the services above when medically necessary, care is provided through the UW Medical Weight Management Program.	Nothing	Nothing

Benefit Description	You pay	
Maternity care	High	Standard
Complete maternity (obstetrical) care, such as: • Screening for gestational diabetes • Prenatal and Postpartum care • Delivery • Screening and counseling for prenatal and postpartum depression	Nothing for prenatal care or the first postpartum care visit; \$10 per office visit for all postpartum care visits thereafter. Nothing for Inpatient professional delivery services.	Nothing for prenatal care or for the first postpartum care visit; \$20 per office visit for all postpartum care visits thereafter. 20% coinsurance for Inpatient professional and facility delivery services.
Breastfeeding and lactation support, supplies and counseling for each birth	Nothing	Nothing
Notes: • You do not need to pre-certify your vaginal delivery; see page 20 for other circumstances, such as extended stays for you or your baby. • As part of your coverage, you have access to in-network certified nurse midwives, home nurse visits and board-certified lactation specialists during the prenatal and post-partum period. • You may remain in the hospital up to 48 hours after a vaginal 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 Plus One or Self and Family enrollment. • We pay hospitalization and surgeon services for non-maternity care the same as for illness and injury. • Hospital services are covered under Section 5(c) and Surgical benefits Section 5(b). • In-network providers who are certified nursing midwives when services are provided at an in-network facility. Note: When a newborn requires definitive treatment during or after the mother's hospital stay, the newborn is considered a patient in their own right. If the newborn is eligible for coverage, regular medical or surgical benefits apply rather than maternity benefits. In addition, circumcision is covered at the same rate as for regular medical or surgical benefits.	<i>All Charges</i>	<i>All Charges</i>
Not Covered: • <i>Birthing Centers</i> • <i>Costs related to home births</i>	<i>All Charges</i>	<i>All Charges</i>

Benefit Description	You pay	
Family planning	High	Standard
Contraceptive counseling on an annual basis	Nothing	Nothing
A range of voluntary family planning services, without cost sharing, that includes at least one form of contraception in each of the categories in the HRSA supported guidelines. This list includes: • Voluntary female sterilization • Surgically implanted contraceptives • Injectable contraceptive drugs (such as Depo Provera) • Intrauterine devices (IUDs) • Diaphragms Note: See additional Family Planning and Prescription drug coverage in Section 5(f). Note: Your plan offers some type of voluntary female sterilization surgery coverage at no cost to members. The contraceptive benefit includes at least one option in each of the HRSA-supported categories of contraception (as well as the screening, education, counseling, and follow-up care). Any type of voluntary female sterilization surgery that is not already available without cost sharing can be accessed through the contraceptive exceptions process described below. To initiate an exception request, a Plan physician (or member or member's representative) may submit via facsimile or telephone information about the member's diagnosis, other therapies tried, and medical necessity rationale to the Plan. GHC-SCW Pharmacy Administration may be contacted via telephone at 608-828-4811 for questions about the exceptions process. If you have difficulty accessing contraceptive coverage or other reproductive healthcare, you can contact contraception@opm.gov.	Nothing	Nothing
Voluntary male sterilization	Nothing	Nothing
<i>Not covered:</i> • <i>Reversal of voluntary surgical sterilization</i>	<i>All Charges</i>	<i>All Charges</i>
Genetic Testing	High	Standard
• Prior Authorization is required. Genetic testing is only covered when the test is Medically Necessary and when the test will directly affect treatment decisions, frequency of screening for a disease, or reproductive choices. Note: BRCA genetic counseling for women at higher risk and BRCA1/2 genetic testing, if Medically Necessary, are covered preventative services for women.	Nothing	Nothing
<i>Not covered:</i>	<i>All Charges</i>	<i>All Charges</i>

Genetic Testing - continued on next page

Benefit Description	You pay	
Genetic Testing (cont.)	High	Standard
- Genetic testing when the result would not affect treatment decisions, frequency of screening for the disease, or reproductive choices. - Genetic testing when the sole outcome would be labeling the disorder when symptoms cannot or will not be treated. - Genetic testing when a diagnosis has been made, and the sole outcome would be to determine the gene variant that is causing the disease. - Pre-implantation genetic testing of embryos	All Charges	All Charges
Infertility services	High	Standard
Diagnosis of infertility - Artificial Insemination (limited to three (3) cycles annually): - Intravaginal insemination (IVI) - Intracervical insemination (ICI) - Intrauterine Insemination (IUI) Note: See the Iatrogenic fertility services benefit for additional benefits for Members facing iatrogenic infertility. Note: See Section 5(f) for limited fertility drug coverage. Note: Infertility- see section 10 for definition	50% coinsurance	50% coinsurance
Not covered: - Consultation, treatment, procedures, services, and supplies for Assisted Reproductive Technology (ART), except for IVF-related drugs covered on the formulary (limited to three cycles annually) and limited fertility preservation for Members facing Iatrogenic Infertility. ART includes all fertility treatments in which either eggs or embryos are handled. In general, ART procedures involve surgically removing eggs from a woman's ovaries, combining them with sperm in the laboratory, and returning them to the woman's body or donating them to another woman. They do NOT include treatments in which only sperm are handled (i.e., intrauterine—or artificial—insemination) or procedures in which a woman takes medicine only to stimulate egg production without the intention of having eggs retrieved. ART includes, but is not limited to: - in vitro fertilization (IVF) - embryo transfer, gamete intra-fallopian transfer (GIFT) and zygote intra-fallopian transfer (ZIFT) - Cost of donor sperm - Cost of donor egg - Cryopreservation storage costs for members not facing Iatrogenic infertility (see Iatrogenic fertility services benefit for additional coverage information).	All Charges	All Charges

Infertility services - continued on next page

Benefit Description	You pay	
Infertility services (cont.)	High	Standard
Fertility drugs, except for Clomiphene Citrate, Progesterone, drugs necessary for fertility preservation for Members facing Iatrogenic Infertility, and up to three cycles of covered IVF-related drugs annually (See Section 5(f) for Prescription Drug Benefits)	All Charges	All Charges
Iatrogenic fertility services	High	Standard
Iatrogenic Infertility*: - Fertility preservation procedures for persons facing the possibility of infertility caused by a medically necessary intervention (“Iatrogenic Infertility”), limited to: - Procurement of sperm or eggs including medical, surgical, and pharmacy claims associated with retrieval (see Section 5(f) for Prescription Drug Benefits and cost-sharing); - Cryopreservation of sperm and mature oocytes; - Cryopreservation of testicular tissue; - Cryopreservation of ovarian tissue; and - Cryopreservation storage costs for one year, so long as Member maintains coverage under this Plan. *See Not covered section below.	50% coinsurance	50% coinsurance
Not covered: - Cryopreservation storage costs after Member leaves plan or otherwise loses coverage under this Plan. Member will be responsible for making arrangements with their provider for continued storage. - Consultation, treatment, procedures, services, and supplies for Assisted Reproductive Technology (ART), except for IVF-related drugs covered on the formulary (limited to three cycles annually) and limited fertility preservation for Members facing Iatrogenic Infertility. ART includes all fertility treatments in which either eggs or embryos are handled. In general, ART procedures involve surgically removing eggs from a woman’s ovaries, combining them with sperm in the laboratory, and returning them to the woman’s body or donating them to another woman. They do NOT include treatments in which only sperm are handled (i.e., intrauterine—or artificial—insemination) or procedures in which a woman takes medicine only to stimulate egg production without the intention of having eggs retrieved. ART includes, but is not limited to: - in vitro fertilization (IVF) - embryo transfer, gamete intra-fallopian transfer (GIFT) and zygote intra-fallopian transfer (ZIFT) - Cost of donor sperm - Cost of donor egg	All Charges	All Charges

Iatrogenic fertility services - continued on next page

Benefit Description	You pay	
Iatrogenic fertility services (cont.)	High	Standard
Fertility drugs, except for Clomiphene Citrate, Progesterone, drugs necessary for fertility preservation for Members facing Iatrogenic Infertility, and up to three cycles of covered IVF-related drugs annually (See Section 5(f) for Prescription Drug Benefits)	All Charges	All Charges
Allergy care	High	Standard
Testing and treatment	\$10 per office visit	\$20 per primary care office visit or \$40 per specialty office visit
- Allergy antigen injections - Allergy serum injections	Nothing	20% coinsurance after deductible
Treatment therapies	High	Standard
- 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 pages 48-52 - Chimeric antigen receptor (CAR) T-cell therapy – Prior Authorization required - 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 18. - 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 enteral and/or other nutritional support supplies are covered as DME. See page 41.	Nothing	20% coinsurance after deductible

Treatment therapies - continued on next page

Benefit Description	You pay	
Treatment therapies (cont.)	High	Standard
Nutritional formula specifically formulated and prescribed to treat phenylketonuria (PKU) or other inborn errors of metabolism.	Nothing	20% coinsurance after deductible
- Applied Behavior Analysis (ABA) - children with 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 for diagnosis and treatment Nothing for Intensive-Level Services and Non-Intensive Services or Evidence Based Therapies	\$40 per office visit for diagnosis and treatment 20% coinsurance after deductible for Intensive-Level Services and Non-Intensive Services or Evidence Based Therapies
<i>Not covered:</i> - Food or nutrition that is not Medical Food - Regular grocery products that can be mixed in blenders, pre-blenderized food, infant food, and all other foods, nutritional supplements, and formulas available without prescription, other than nutritional formula specifically formulated for the treatment of infants (i.e., up to 12 months of age) with an inborn error of metabolism. - Gene therapy, which includes the intentional and specific alteration of the DNA sequence of the cellular genome, for a clinical purpose. This exclusion does not apply to chimeric antigen receptor (CAR) T-cell therapy.	<i>All Charges</i>	<i>All Charges</i>
Physical and occupational therapies	High	Standard
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 physician: - orders the care - identifies the specific professional skills the patient requires and the medical necessity for skilled services; and - indicates the length of time the services are needed	Nothing	20% coinsurance after deductible
<i>Not covered:</i> - Long-term rehabilitative therapy - Exercise programs except for those named above - Dry Needling	<i>All Charges</i>	<i>All Charges</i>

Benefit Description	You pay	
Speech therapy	High	Standard
Rehabilitative and Habilitative Services of each of the following 60 consecutive days per condition for the services of qualified speech therapists	Nothing	20% coinsurance after deductible
<i>Not covered:</i> <i>Treatment for tongue thrust</i>	<i>All Charges</i>	<i>All Charges</i>
Hearing services (testing and treatment)	High	Standard
- 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) <i>Preventive Care, children on page 31</i>. - External Hearing Aids - Implanted hearing-related devices, such as bone anchored hearing aids (BAHA) and cochlear implants Prior authorization will be required for external hearing aids and implanted hearing-related devices, such as bone anchored hearing aids (BAHA) and cochlear implants. Note: For benefits for the devices, see Section 5(a) <i>Orthopedic and prosthetic devices on pages 38-40</i>.	\$10 per office visit	\$40 per office visit
<i>Not covered</i> <i>Hearing services that are not shown as covered.</i>	<i>All Charges</i>	<i>All Charges</i>
Vision services (testing, treatment, and supplies)	High	Standard
- Annual routine vision examination to determine the need for corrective eyeglass lenses and the written prescription for corrective eyeglass lenses for Members performed by an In-Network Optometrist (OD). - Annual eye refraction Note: See <i>Preventive care, children</i> for eye exams for children on page 31.	\$10 per office visit	\$40 per office visit
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.	Nothing	20% coinsurance after deductible
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	All charges above cost of covered lens
<i>Not covered:</i> <i>Eyewear: including lenses, frames, contact lenses, contact lens prescriptions and contact lens services except as shown above</i>	<i>All Charges</i>	<i>All Charges</i>

Vision services (testing, treatment, and supplies) - continued on next page

Benefit Description	You pay	
Vision services (testing, treatment, and supplies) (cont.)	High	Standard
• <i>Eye exercises and orthoptics</i> • <i>Radial keratotomy and other refractive surgery</i> • <i>Routine vision examinations performed by providers other than an optometrist (for example, ophthalmologists).</i>	<i>All Charges</i>	<i>All Charges</i>
Foot care	High	Standard
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes.	\$10 per office visit	20% coinsurance after deductible
<i>Not covered:</i> • <i>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</i> • <i>Treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (except for surgical treatment)</i>	<i>All Charges</i>	<i>All Charges</i>
Orthopedic and prosthetic devices	High	Standard
• Artificial limbs and eyes • Prosthetic sleeve or sock • 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 • 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 24 months. Prior authorization is required. 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	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.	20% coinsurance

Orthopedic and prosthetic devices - continued on next page

Benefit Description	You pay	
Orthopedic and prosthetic devices (cont.)	High	Standard
- 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.	20% coinsurance
Hearing aids for members under age 18. Limited to one aid, per ear, every 36 months.	Nothing	20% Coinsurance
Hearing aids for members age 18 and older. Limited to one aid, per ear, every 36 months.	20% Coinsurance for models specifically designated by GHC-SCW. If the hearing aid that has been recommended to you by Your Provider is not designated as covered by GHC-SCW, you will pay 20% Coinsurance, but coverage will be limited to \$2,500 every three years (total for both ears).	20% Coinsurance for models specifically designated by GHC-SCW. If the hearing aid that has been recommended to you by Your Provider is not designated as covered by GHC-SCW, you will pay 20% Coinsurance, but coverage will be limited to \$2,500 every three years (total for both ears).
Bone anchored hearing aids (BAHA). Member must meet the BAHA criteria and be prior authorized by the GHC-SCW Care Management Department.	20% Coinsurance and all charges above benefit maximum.	20% Coinsurance after deductible
<i>Not covered:</i> <i>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</i> <i>Lumbosacral supports</i> <i>Corsets, trusses, elastic stockings, support hose, and other supportive devices</i> <i>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.</i> <i>Prosthetic replacements not meeting covered criteria.</i>	<i>All Charges</i>	<i>All Charges</i>

Benefit Description	You pay	
Durable medical equipment (DME)	High	Standard
We cover rental or purchase of prescribed 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 (other than disposable diabetic supplies specifically covered below), including Insulin Infusion Pump supplies • Disposable needles and syringes (other than insulin needles and syringes covered as diabetic disposable supplies below) 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 healthcare 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 \$2,500 per member per year, combined with Orthopedic and prosthetic devices. You pay nothing thereafter.	20% Coinsurance
• 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 \$500 per member per year	20% to a maximum of \$500 per member per year
<i>Not covered:</i>	<i>All Charges</i>	<i>All Charges</i>

Durable medical equipment (DME) - continued on next page

Benefit Description	You pay	
Durable medical equipment (DME) (cont.)	High	Standard
- 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	All Charges
Home health services	High	Standard
- Home healthcare 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. - Home health visits are limited to 60 visits per calendar year. <i>Note: Rehabilitative and Habilitative physical and occupational therapy services provided in-home are covered under the Physical and occupational therapies benefit.</i>	Nothing	20% Coinsurance after deductible
<i>Not covered:</i> - 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	All Charges
Chiropractic	High	Standard
Manipulation of the spine and extremities	\$10 per office visit	\$20 per office visit
<i>Not covered:</i> - Chiropractic services for chronic conditions or for maintenance - Adjunctive procedures such as ultrasound, electrical muscle stimulation, vibratory therapy and cold pack application.	All Charges	All Charges
Alternative treatments	High	Standard
<i>Not covered</i>	All charges	All charges

Benefit Description	You pay	
Educational classes and programs	High	Standard
Coverage is provided for: Tobacco and nicotine cessation programs, including individual, group, phone counseling, over-the-counter (OTC) and prescription drugs approved by the FDA to quit smoking (vaping) or other nicotine use.	Nothing for individual counseling for up to two quit attempts per year. Nothing for OTC and prescription drugs approved by the FDA to treat tobacco dependence	Nothing for individual 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	Nothing
Coverage may include: - Nutrition Education - Weight Management - Stress Management - Prenatal Education - First Aid Training Note: Contact the GHC-SCW Member Services at 608-828-4853 for program and fee schedules.	Fees apply to some but not all classes and programs.	Fees apply to some but not all classes and programs.

Section 5(b). Surgical and Anesthesia Services Provided by Physicians and Other Healthcare 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 healthcare professionals for your surgical care. See in Section 5(c) for charges associated with a facility (i.e. hospital, surgical center, etc.).
- Under the Standard Option the calendar year deductible is \$1,000 Self Only; \$2,000 Self Plus One and Self and Family. The calendar year deductible applies to some benefits in this section. When the calendar year deductible applies we added “after deductible.” The High Option does not have a deductible.

YOUR PHYSICIAN MUST GET PRIOR AUTHORIZATION FOR MOST 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	Standard Option
A comprehensive range of services, such as: • Operative procedures • Treatment of fractures, including casting • Routine 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 <i>Reconstructive surgery</i>) • Surgical treatment of severe 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.	Nothing	20% Coinsurance after deductible

Surgical procedures - continued on next page

Benefit Description	You pay	
Surgical procedures (cont.)	High Option	Standard Option
- 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 us for specific information regarding Covered and Not covered Bariatric Surgery procedures. • Insertion of internal prosthetic devices . See 5(a) – <i>Orthopedic and prosthetic devices</i> for device coverage information • Treatment of burns Note: For female surgical family planning procedures see Family Planning Section 5(a) Note: For male surgical family planning procedures see Family Planning Section 5(a) 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.	Nothing	20% Coinsurance after deductible
• We now cover bilateral cochlear implants and cochlear implants (as well as BAHAs) for members of any age when medically necessary.	Nothing	20% Coinsurance after deductible
<i>Not covered:</i> • <i>Reversal of voluntary sterilization</i> • <i>Routine treatment of conditions of the foot; (see Section 5(a) Foot care)</i>	<i>All Charges</i>	<i>All Charges</i>

Benefit Description	You pay	
Reconstructive surgery	High Option	Standard 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 resulting in asymmetry, such as: - surgery to produce a symmetrical appearance of breasts - treatment of any physical complications, such as lymphedema - 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.	Nothing	20% Coinsurance after deductible
<i>Not covered:</i> • <i>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 (see section 5(d) Accidental injury). This includes any cosmetic services or surgical procedures performed for psychological reasons.</i> • <i>Surgery for Sex-Trait Modification to treat gender dysphoria</i>	<i>All Charges</i>	<i>All Charges</i>

Reconstructive surgery - continued on next page

Benefit Description	You pay	
Reconstructive surgery (cont.)	High Option	Standard Option
If you are mid-treatment, within a surgical or chemical regimen for Sex-Trait Modification for diagnosed gender dysphoria, for services formerly covered under the 2025 Plan brochure, you may seek an exception to continue care. Our exception process is as follows: The GHC Medical Director will determine if a member qualifies as being in Gender Dysphoria Mid-Treatment Care, and therefore eligible for continued care, by reviewing relevant medical records. Gender Dysphoria Mid-Treatment Care refers to members who meet one or more of the following criteria at the time of enrollment: • Are currently receiving gender-dysphoria chemical treatment. There is no period of treatment requirement. • Have previously been approved by a qualified surgeon as meeting clinical criteria for gender-dysphoria sex-trait modification surgical care. • Are currently scheduled for sex-trait modification surgery, and scheduling of the surgery (or initial surgery if multiple surgeries are medically necessary) has occurred prior to the effective date of coverage under this plan. The surgery (and any necessary subsequent surgeries) may be scheduled for a date after the effective date of coverage under this plan. The exception process will be applied on a case-by-case basis. To initiate the review process, providers must submit a prior authorization request along with all pertinent medical documentation supporting the member's current treatment status. This includes, but is not limited to, hormone therapy records, surgical evaluations, and scheduled procedure documentation. All materials should be submitted through the standard GHC prior authorization channels. Incomplete submissions may delay the review and determination process. You may also find more information on our member website at www.ghcscw.com. If you disagree with our decision on your exception, please contact GHC-SCW Member Services at 608-828-4853 or see Section 8 of your brochure for the disputed claims process.	<i>All Charges</i>	<i>All Charges</i>

Reconstructive surgery - continued on next page

Benefit Description	You pay	
Reconstructive surgery (cont.)	High Option	Standard Option
Individuals under age 19 are not eligible for exceptions related to services for ongoing surgical or hormonal treatment for diagnosed gender dysphoria	<i>All Charges</i>	<i>All Charges</i>
Oral and maxillofacial surgery	High Option	Standard 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 cellulitis • 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 • alveolotomy • removal of retained residual root • non-dental treatment of TMJ syndrome	Nothing	20% Coinsurance after deductible
• Dental treatment of temporomandibular (TMJ) syndrome Note: a physical therapy evaluation is required before an intraoral splint is considered as a treatment option.	Nothing	20% Coinsurance after deductible
<i>Not covered:</i> • <i>Oral implants and transplants</i> • <i>Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)</i>	<i>All Charges</i>	<i>All Charges</i>

Benefit Description	You pay	
Organ/tissue transplants	High Option	Standard Option
These solid organ and tissue transplants are subject to medical necessity and experimental/investigational review by the Plan. Refer to <i>Other Services</i> in Section 3 for prior authorization procedures. • Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis. • 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 • Kidney-pancreas • Liver • Lung: Single, bilateral/lobar • Pancreas These tandem blood or marrow stem cell transplants for covered transplants are subject to medical necessity review by the Plan. Refer to <i>Other services</i> 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 The Plan extends coverage for the diagnoses as indicated below.	Nothing	20% Coinsurance after deductible

Organ/tissue transplants - continued on next page

Benefit Description	You pay	
Organ/tissue transplants (cont.)	High Option	Standard Option
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., myelogenous) leukemia - Acute myeloid leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Advanced Myeloproliferative Disorders (MPDs) - Amyloidosis - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Hemoglobinopathy - Marrow Failure and Related Disorders (i. e., Fanconi's, Paroxysmal Nocturnal Hemoglobinuria, Pure Red Cell Aplasia) - Myelodysplasia/Myelodysplastic syndromes - Paroxysmal Nocturnal Hemoglobinuria - Phagocytic/Hemophagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome) - Severe combined immunodeficiency - Severe or very severe aplastic anemia - Sickle cell anemia - X-linked lymphoproliferative syndrome - Hematopoietic stem cell transplant • Autologous transplants for: - Acute lymphocytic or non-lymphocytic (i. e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed)	Nothing	20% Coinsurance after deductible

Organ/tissue transplants - continued on next page
Section 5(b)

Benefit Description	You pay	
Organ/tissue transplants (cont.)	High Option	Standard Option
- Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Amyloidosis - Breast Cancer - Ependymoblastoma - Epithelial ovarian cancer - Ewings Sarcoma - Multiple myeloma - Neuroblastoma - Testicular, Mediastinal, Retroperitoneal, and ovarian germ cell tumors - Hematopoietic stem cell transplant 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 <i>Other services</i> in Section 3 for prior authorization procedures. • Allogeneic transplants for - Acute lymphocytic or non-lymphocytic (i. e., myelogenous) 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/Myelodysplastic syndromes - Paroxysmal Nocturnal Hemoglobinuria - Severe combined immunodeficiency - Severe or very severe aplastic anemia • Autologous transplants for:	Nothing	20% Coinsurance after deductible

Organ/tissue transplants - continued on next page

Benefit Description	You pay	
Organ/tissue transplants (cont.)	High Option	Standard Option
- Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin's lymphoma 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 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 - Aggressive non-Hodgkin's lymphomas (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-Hodgkin 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	20% Coinsurance after deductible

Benefit Description	You pay	
Organ/tissue transplants (cont.)	High Option	Standard Option
<i>Not covered:</i> • Donor screening tests and donor search expenses, except as shown above • Implants of artificial organs • Transplants not listed as covered	<i>All Charges</i>	<i>All Charges</i>
Anesthesia	High Option	Standard Option
Professional services provided in • Hospital (inpatient) • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Office	Nothing	20% Coinsurance after deductible

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).
- Under the Standard Option the calendar year deductible is \$1,000 Self Only; \$2,000 Self Plus One and Self and Family. The calendar year deductible applies to some benefits in this section. When the calendar year deductible applies we added “after deductible.” The High Option does not have a deductible.

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	
	High Option	Standard Option
Inpatient hospital		
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 medications • 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	20% Coinsurance after deductible
<i>Not covered:</i>	<i>All Charges</i>	<i>All Charges</i>

Inpatient hospital - continued on next page

Benefit Description	You pay	
Inpatient hospital (cont.)	High Option	Standard Option
• Custodial care • Non-covered facilities, such as nursing homes, schools • Personal comfort items, such as phone, television, barber services, guest meals and beds • Private nursing care • Hospital stays, which are extended for reasons other than Medical Necessity, including, but not limited to lack of transportation, lack of caregiver, inclement weather and other like reasons. • A continued Hospital stay, if the attending physician has documented that care could effectively be provided in a less acute care setting, for example, Skilled Nursing Facility.	All Charges	All Charges
Outpatient hospital or ambulatory surgical center	High Option	Standard Option
• Operating, recovery, and other treatment rooms • Prescribed drugs and medications • 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	20% Coinsurance after deductible
Not covered: • Blood and blood derivatives not replaced by the member	All charges	All Charges

Benefit Description	You pay	
Extended care benefits/Skilled nursing care facility benefits	High Option	Standard Option
Extended care benefit: We provide a comprehensive range of benefits for up to 30 days per inpatient stay. Multiple stays per year may be covered. Coverage must be certified as Medically Necessary and is recertified as Medically Necessary every seven (7) days.	Nothing	20% Coinsurance after deductible
<i>Not covered:</i> • <i>Custodial care</i>	<i>All Charges</i>	<i>All Charges</i>
Hospice care	High Option	Standard Option
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 - Medical supplies, drugs, and medications 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	Nothing	20% Coinsurance after deductible

Hospice care - continued on next page

Benefit Description	You pay	
Hospice care (cont.)	High Option	Standard Option
- 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	20% Coinsurance after deductible
<i>Not covered:</i> Independent nursing, homemaker services	<i>All Charges</i>	<i>All Charges</i>
End of life care	High Option	Standard 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.	Nothing	20% Coinsurance after deductible
Ambulance	High Option	Standard Option
Local professional ambulance service when medically appropriate	Nothing	20% Coinsurance after deductible
<i>Not covered:</i> ambulance services to home following an inpatient stay	<i>All Charges</i>	<i>All Charges</i>

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.
- Under the Standard Option the calendar year deductible is \$1,000 Self Only; \$2,000 Self Plus One and Self and Family. The calendar year deductible applies to some benefits in this section. When the calendar year deductible applies we added “after deductible.” The High Option does not have a deductible.

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 phone 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	Standard Option
- Emergency care at a doctor's office - Emergency care at an urgent care center	\$10 per office visit	\$40 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	\$100 per visit
<i>Not covered:</i> <i>Elective care</i>	<i>All Charges</i>	<i>All Charges</i>
Emergency outside our service area	High Option	Standard Option
- Emergency care at a doctor's office - Emergency care at an urgent care center	\$10 per office visit	\$40 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	\$100 per visit
<i>Not covered:</i> <i>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</i> <i>Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area</i> <i>Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area</i>	<i>All Charges</i>	<i>All Charges</i>

Benefit Description	You pay	
Ambulance	High Option	Standard Option
Professional ambulance service when medically appropriate. Note: See 5(c) for non-emergency service.	Nothing	20% coinsurance after deductible
<i>Not covered:</i> • <i>Ambulance services to home following an in-patient stay.</i>	<i>All Charges</i>	<i>All Charges</i>

Section 5(e). Mental Health and Substance Use Disorder 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.
- Please refer to Section 3 to be sure which services require prior authorization.
- **Mental Health:** Call a GHC-SCW Mental Health Coordinator at 608-441-3290 (after hours 608-257-9700). If out of area, call 800-605-4327.
- **Substance Abuse:** contact UW Health Behavioral Health and Recovery Clinic at 608-282-8270.
- We will provide medical review criteria or reasons for treatment plan denials to enrollee, members or providers upon request or as otherwise required.
- Under the Standard Option the calendar year deductible is \$1,000 Self Only; \$2,000 Self Plus One and Self and Family. The calendar year deductible applies to some benefits in this section. When the calendar year deductible applies we added “after deductible.” The High Option does not have a deductible.
- 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	Standard Option
When part of a treatment plan we approve, we cover professional services by licensed professional mental health and substance use disorder treatment 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 substance use disorders including detoxification, treatment and counseling	Your cost-sharing responsibilities are no greater than for other illness or conditions.	Your cost-sharing responsibilities are no greater than for other illness or conditions.

Professional Services - continued on next page

Benefit Description	You pay	
Professional Services (cont.)	High Option	Standard Option
- 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.	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 use, including detoxification, treatment and counseling - Professional charges for intensive outpatient treatment in a provider's office or other professional setting - Couples Counseling	Nothing	\$20 per office visit
Diagnostics	High Option	Standard Option
- Outpatient diagnostic tests provided and billed by a licensed mental health and substance use disorder treatment 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	20% Coinsurance after deductible
Inpatient hospital or other covered facility	High Option	Standard 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	20% Coinsurance after deductible
Outpatient hospital or other covered facility	High Option	Standard 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	20% coinsurance after deductible

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.
- Federal law prevents the pharmacy from accepting unused medications.
- Your prescribers must obtain prior approval/authorizations for certain prescription drugs and supplies before coverage applies. Prior 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.
- Under the Standard Option the calendar year deductible is \$1,000 Self Only; \$2,000 Self Plus One and Self and Family. The calendar year deductible applies to some benefits in this section. When the calendar year deductible applies we added “after deductible.” The High Option does not have a deductible.
- The exclusion for hormone treatments for Sex-Trait Modification for gender dysphoria only pertains to chemical and surgical modification of an individual's sex traits (including as part of "gender transition" services). We do not exclude coverage for entire classes of pharmaceuticals, e.g., GnRH agonists may be prescribed during IVF, for reduction of endometriosis or fibroids, and for cancer treatment or prostate cancer/tumor growth prevention.

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 it, licensed/ certified providers with prescriptive authority prescribing within their scope of practice must prescribe your medication.
- **Where you can obtain them.** You must fill the prescription at a Plan pharmacy. Specialty Drugs must be obtained 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.
- **A generic equivalent will be dispensed if it is available.** When a covered drug is available as both a brand-name and equivalent generic product, only the generic will be on the Your physician/ practitioner may request coverage for non-formulary branded drugs when clinically necessary. An exception to coverage for the branded product may be granted based on criteria established by GHC-SCW. If coverage is approved, Member responsibility for brand-name drugs that have a generic equivalent will be limited to the highest tier copay assigned to the plan (tier 4). See below for more information about tiers.
- **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.
- **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. Tier 3 includes drugs that have a lower cost alternative in level 1 or 2 but you select this brand of medication. 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 (d) Individual quantity limits identified for that specific drug, or (e) The quantity limit assigned to that drug by Prior Authorization, or (f) 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, a copay tier will be assigned by the plan. 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.
- **Biosimilar Drugs.** Certain drugs, including, but not limited to, drugs recognized as biosimilar by the FDA, may have preferred status in a manner similar to how generics are preferred over equivalent branded drugs. An exception to coverage for the non-preferred product may be granted based on criteria established by GHC-SCW. Member responsibility for the non-preferred drug will include the highest-tier copay available (Tier 4).
- **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 participating 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	Standard 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 medications that by Federal law of the United States require a physician's prescription for their purchase, except those listed as <i>Not covered</i>- • Insulin • Diabetic Supplies limited to: - Disposable needles and syringes for the administration of covered medications. • Drugs for Sexual Dysfunction • Medications prescribed to treat obesity • Fertility Drugs: - in vitro fertilization (IVF)-related drugs – limited to three cycles annually - Clomiphene citrate and Progesterone - Drugs necessary for fertility preservation for Members facing Iatrogenic Infertility	Retail - (30-day supply) Tier 1 (Preferred Generics & Selected Brands)- \$5 Tier 2 (Preferred Brands & Selected Generics) - \$20 Tier 3 (Lower Cost Alternative's available in tier 1 and tier 2) - \$50 Tier 4 (Specialty Drugs) - \$100 Mail Order (3x 90-day supply) Tier 1 (Preferred Generics & Selected Brands)- \$15 Tier 2 (Preferred Brands & Selected Generics) - \$60 Tier 3 (Lower Cost Alternative's available in tier 1 and tier 2) - \$150 Tier 4 (Specialty Drugs) - \$300	Retail - (30-day supply) Tier 1 (Preferred Generics & Selected Brands)- \$5 Tier 2 (Preferred Brands) \$20 Tier 3 (Lower Cost Alternative's available in tier 1 and tier 2) - \$50 Tier 4 (Specialty Drugs) - \$100 Mail Order- (3x for 90-day supply) Tier 1 (Preferred Generics & Selected Brands) - \$15 Tier 2 (Preferred Brands & Selected Generics) - \$60 Tier 3 (Lower Cost Alternative's available in tier 1 and tier 2)- \$150 Tier 4 (Specialty Drugs)- \$300

Covered medications and supplies - continued on next page

Benefit Description	You pay	
Covered medications and supplies (cont.)	High Option	Standard Option
- Injectable 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. - Drugs used for weight reduction. Note: Specialty drugs - see Section 10 for definition Note: When a covered drug is available as both a brand-name and equivalent generic product, only the generic will be on the Formulary. Prior Authorization for the branded product may be granted based on criteria established by GHC-SCW. Member responsibility for brand-name drugs that have a generic equivalent will be the highest-tier copay assigned to the plan (Tier 4). Note: Compound prescriptions are covered, so long as: all active ingredients are on the Formulary and are FDA-approved as drugs; the resulting product is well-supported by medical literature as reasonable and generally accepted medical practice; and equivalent or similar products are not available commercially. Compounds above a cost threshold require Prior Authorization.	Retail - (30-day supply) Tier 1 (Preferred Generics & Selected Brands)- \$5 Tier 2 (Preferred Brands & Selected Generics) - \$20 Tier 3 (Lower Cost Alternative's available in tier 1 and tier 2) - \$50 Tier 4 (Specialty Drugs) - \$100 Mail Order (3x 90-day supply) Tier 1 (Preferred Generics & Selected Brands)- \$15 Tier 2 (Preferred Brands & Selected Generics) - \$60 Tier 3 (Lower Cost Alternative's available in tier 1 and tier 2) - \$150 Tier 4 (Specialty Drugs) - \$300	Retail - (30-day supply) Tier 1 (Preferred Generics & Selected Brands)- \$5 Tier 2 (Preferred Brands \$20 Tier 3 (Lower Cost Alternative's available in tier 1 and tier 2) - \$50 Tier 4 (Specialty Drugs) - \$100 Mail Order- (3x for 90-day supply) Tier 1 (Preferred Generics & Selected Brands) - \$15 Tier 2 (Preferred Brands & Selected Generics) - \$60 Tier 3 (Lower Cost Alternative's available in tier 1 and tier 2)- \$150 Tier 4 (Specialty Drugs)- \$300
Contraceptive drugs and devices prescribed by a health care professional and obtained from a Plan pharmacy or through our mail order program.	Nothing	Nothing

Covered medications and supplies - continued on next page

Benefit Description	You pay	
Covered medications and supplies (cont.)	High Option	Standard Option
Contraceptive drugs and devices as listed in the Health Resources and Services Administration site https://www.hrsa.gov/womens-guidelines. Contraceptive coverage is available at no cost to FEHB members. The contraceptive benefit includes at least one option in each of the HRSA-supported categories of contraception (as well as the screening, education, counseling, and follow-up care). Any contraceptive that is not already available without cost sharing on the formulary can be accessed through the contraceptive exceptions process described below. • Over the counter and prescription drugs approved by the FDA to prevent unintended pregnancy. • To initiate an exception request, a Plan physician (or member or member's representative) may submit via facsimile or telephone information about the member's diagnosis, other therapies tried, and medical necessity rationale to the Plan. GHC-SCW Pharmacy Administration may be contacted via telephone at 608-828-4811 for questions about the exceptions process. If you have difficulty accessing contraceptive coverage or other reproductive healthcare, you can contact contraception@opm.gov. The "morning after pill" is considered 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) emergency contraceptive drug. Reimbursement for covered over-the-counter contraceptives can be submitted in accordance with Section 7. Note: For additional Family Planning benefits see Section 5(a)	Nothing	Nothing
Note: Over-the-counter and appropriate prescription drugs approved by the FDA to treat tobacco dependence are covered under the Tobacco Cessation Educational Classes and Programs in Section 5(a)	.	.
<i>Not Covered</i>	<i>All Charges</i>	<i>All Charges</i>

Covered medications and supplies - continued on next page

Benefit Description	You pay	
Covered medications and supplies (cont.)	High Option	Standard Option
• <i>Drugs and supplies for cosmetic purposes</i> • <i>Drugs to enhance athletic performance</i> • <i>Drugs obtained at a non-Plan pharmacy; except for out-of-area emergencies</i> • <i>Nonprescription medications</i> • <i>Drugs prescribed in connection with Sex-Trait Modification for treatment of gender dysphoria</i> Sex-Trait Modification: If you are mid-treatment, within a surgical or chemical regimen for Sex-Trait Modification for diagnosed gender dysphoria, for services formerly covered under the 2025 Plan brochure, you may seek an exception to continue care. Our exception process is as follows: The GHC Medical Director will determine if a member qualifies as being in Gender Dysphoria Mid-Treatment Care, and therefore eligible for continued care, by reviewing relevant medical records. Gender Dysphoria Mid-Treatment Care refers to members who meet one or more of the following criteria at the time of enrollment: • Are currently receiving gender-dysphoria chemical treatment. There is no period of treatment requirement. • Have previously been approved by a qualified surgeon as meeting clinical criteria for gender-dysphoria sex-trait modification surgical care. • Are currently scheduled for sex-trait modification surgery, and scheduling of the surgery (or initial surgery if multiple surgeries are medically necessary) has occurred prior to the effective date of coverage under this plan. The surgery (and any necessary subsequent surgeries) may be scheduled for a date after the effective date of coverage under this plan.	All Charges	All Charges

Covered medications and supplies - continued on next page

Benefit Description	You pay	
Covered medications and supplies (cont.)	High Option	Standard Option
The exception process will be applied on a case-by-case basis. To initiate the review process, providers must submit a prior authorization request along with all pertinent medical documentation supporting the member's current treatment status. This includes, but is not limited to, hormone therapy records, surgical evaluations, and scheduled procedure documentation. All materials should be submitted through the standard GHC prior authorization channels. Incomplete submissions may delay the review and determination process. You may also find more information on our member website at www.ghcscw.com. If you disagree with our decision on your exception, please contact GHC-SCW Member Services at 608-828-4853 or see Section 8 of your brochure for the disputed claims process. Individuals under age 19 are not eligible for exceptions related to services for ongoing surgical or hormonal treatment for diagnosed gender dysphoria • Fertility drugs, except for Clomiphene Citrate, Progesterone, drugs necessary for fertility preservation for Members facing Iatrogenic Infertility, and up to three cycles of covered IVF-related drugs annually • Gene therapy, which includes the intentional and specific alteration of the DNA sequence of the cellular genome, for a clinical purpose. This exclusion does not apply to chimeric antigen receptor (CAR) T-cell therapy.	<i>All Charges</i>	<i>All Charges</i>
Preventive care medications	High Option	Standard Option
Medications to promote better health as recommended by ACA. The following drugs and supplements are covered without cost-share, even if over-the-counter, are prescribed by a health care professional and filled at a network pharmacy. • Aspirin (81 mg) for men age 45-79 and women age 55-79 and women of childbearing age • Folic acid supplements for women of childbearing age 400 & 800 mcg	Nothing	Nothing

Preventive care medications - continued on next page

Benefit Description	You pay	
Preventive care medications (cont.)	High Option	Standard Option
- Liquid iron supplements for children age 6 months - 1year - Fluoride tablets, solution (not toothpaste, rinses) for children age 0-6 - Statins (low to moderate dose) for adults ages 40-75 who are prescribed statin use by their physician for prevention of cardiovascular disease Note: To receive this benefit a prescription from a doctor must be presented to pharmacy. Note: Over-the-counter and appropriate prescription drugs approved by the FDA to treat tobacco dependence are covered under the Tobacco Cessation Educational Classes and Programs in Section 5(a)	Nothing	Nothing
Opioid rescue agents are covered under this Plan with no cost sharing when obtained with a prescription from a network pharmacy in any over-the-counter or prescription form available such as nasal sprays and intramuscular injections. For more information consult the FDA guidance at https://www.fda.gov/consumers/consumer-updates/access-naloxone-can-save-life-during-opioid-overdose Or call SAMHSA's National Helpline 1-800-662-HELP (4357) or go to https://www.findtreatment.samhsa.gov/	Nothing	Nothing
<i>Not covered:</i> <i>Drugs not on the Formulary, unless prior authorized</i> <i>Drugs and supplies for cosmetic purposes</i> <i>Drugs to enhance athletic performance</i> <i>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.</i> <i>Vitamins, nutrients and food supplements not listed as a covered benefit even if a physician prescribes or administers them</i> <i>Nonprescription medications unless specifically indicated elsewhere</i>	<i>All Charges</i>	<i>All Charges</i>

Preventive care medications - continued on next page

Benefit Description	You pay	
Preventive care medications (cont.)	High Option	Standard Option
- Vitamin D supplements (prescription strength) (400 & 1000 units) for members 65 or older - Any brand-name drug that has an available "authorized generic". An authorized generic is a generic product marketed under the equivalent brand-name drug's FDA New Drug Application.	All Charges	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.
- Under the Standard Option the calendar year deductible is \$1,000 Self Only; \$2,000 Self Plus One and Self and Family. The calendar year deductible applies to some benefits in this section. When the calendar year deductible applies we added “after deductible.” The High Option does not have a deductible.

Benefit Description	You Pay	
	High Option	Standard Option
Accidental injury benefit		
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 and must be completed within 12 months of the accident. NOTE: Damage to teeth caused by chewing or biting does not constitute an accidental injury.	Nothing up to \$1,500 per accident All charges above \$1,500 per accident.	20% Coinsurance after deductible
Dental related hospital and anesthetic services		
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.	20% Coinsurance after deductible if prior authorized and performed at a Plan participating hospital or facility.

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

Section 5(h). Wellness and Other Special Features

Feature	Description
Telehealth services	Telehealth services are covered when provided by In-Plan providers specifically contracted with GHC-SCW to provide telehealth services. See Section 5(a).
Online access to health and insurance information	Available 24/7 through GHCMYChart and KidsChart. Note: MyChart is a registered trademark of Epic Systems Corporation.
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.

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 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.
- Services or supplies we are prohibited from covering under the law.
- Complications, consultations, services and procedures related to a procedure that is non-covered pursuant to the terms and conditions under this plan.
- Any benefits or services required solely for your employment are not covered by this plan.
- Chemical or surgical modification of an individual's sex traits through medical interventions (to include “gender transition” services), other than mid-treatment exceptions, see Section 3. How You Get Care.

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 provider, 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 HIPAA compliant electronic claims for you. In cases where a paper claim must be used, the provider 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 provider 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

Records

Keep a separate record of the medical expenses of each covered family member

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 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.

When we need more information

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.

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 healthcare 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% 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 phone 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 healthcare 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 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 call GHC-SCW's customer service representative at the phone number found on your enrollment card, plan brochure or plan website.

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 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 healthcare 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 will not take into account the initial decision. The review will not be conducted by the same person, or their subordinate, who made the initial decision.

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: - Write to us within 6 months from the date of our decision; and - Send your request to us at: GHC-SCW Member Services Dept., PO Box 44971, Madison WI 53744-4971; and - Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and - Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms. - 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: 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 Employees Insurance Operations, FEHB 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 claim, such as physicians' letters, operative reports, bills, medical records, and explanation 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 include a copy of your specific written consent with the review request. However, for urgent care claims, a healthcare 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 or notify you of the status of OPM's review 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 claim 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 FEHB 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 family member 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 healthcare 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 visit our website at www.ghcscw.com.

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 processes the benefit, 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 healthcare 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 or employing 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**

Every job-related injury or illness should be reported as soon as possible to your supervisor. Injury also means any illness or disease that is caused or aggravated by the employment as well as damage to medical braces, artificial limbs and other prosthetic devices. If you are a federal or postal employee, ask your supervisor to authorize medical treatment by use of form CA-16 before you obtain treatment. If your medical treatment is accepted by the Dept. of Labor Office of Workers’ Compensation (OWCP), the provider will be compensated by OWCP. If your treatment is determined not job-related, we will process your benefit according to the terms of this plan, including use of in-network providers. Take form CA-16 and form OWCP-1500/ HCFA-1500 to your provider, or send it to your provider as soon as possible after treatment, to avoid complications about whether your treatment is covered by this plan or by OWCP.

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.

- **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 or employing 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**

Our right to pursue and receive subrogation and reimbursement recoveries is a condition of, and a limitation on, the nature of benefits or benefit payments and on the provision of benefits under our coverage.

If you have received benefits or benefit payments as a result of an injury or illness and you or your representatives, heirs, administrators, successors, or assignees receive payment from any party that may be liable, a third party's insurance policies, your own insurance policies, or a workers' compensation program or policy, you must reimburse us out of that payment. Our right of reimbursement extends to any payment received by settlement, judgment, or otherwise.

We are entitled to reimbursement to the extent of the benefits we have paid or provided in connection with your injury or illness. However, we will cover the cost of treatment that exceeds the amount of the payment you received.

Reimbursement to us out of the payment shall take first priority (before any of the rights of any other parties are honored) and is not impacted by how the judgment, settlement, or other recovery is characterized, designated, or apportioned. Our right of reimbursement is not subject to reduction based on attorney fees or costs under the "common fund" doctrine and is fully enforceable regardless of whether you are "made whole" or fully compensated for the full amount of damages claimed.

We may, at our option, choose to exercise our right of subrogation and pursue a recovery from any liable party as successor to your rights.

If you do pursue a claim or case related to your injury or illness, you must promptly notify us and cooperate with our reimbursement or subrogation efforts
- **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.gov or by phone (1-877-888-3337) (TTY 1-877-889-5680), 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 the 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 receiving standard therapy.
 - Extra care costs- This plan does not cover these costs.
- **When you have Medicare**

For more detailed information on "What is Medicare?" and "Should I Enroll in Medicare?" please contact Medicare at 800-MEDICARE (1-800-633-4227), (TTY 1-877-486-2048) or at www.medicare.gov.

- **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.

Please review the following examples which illustrates your cost share if you are enrolled in Medicare Part B. If you purchase Medicare Part B, your provider is in our network and participates in Medicare, then we waive some costs because Medicare will be the primary payor.

Benefit Description: Deductible

You pay without Medicare: High: Nothing; Standard: \$1,000 Self Only/\$2,000 Self Plus One and Self and Family

You pay with Medicare Part B: High and Standard: Nothing

Benefit Description: Out-of-Pocket-Maximum

You pay without Medicare: High and Standard: \$7,150 Self Only/\$14,300 Self Plus One and Self and Family

You pay with Medicare Part B: High and Standard: \$7,150 Self Only/\$14,300 Self Plus One and Self and Family

Benefit Description: Part B Premium Reimbursement Offered

You pay without Medicare: N/A

You pay with Medicare Part B: N/A

Benefit Description: Primary Care Provider

You pay without Medicare: High: Nothing; Standard: \$20 copayment

You pay with Medicare Part B: High and Standard: Nothing

Benefit Description: Specialist

You pay without Medicare: High: \$10 copayment; Standard: \$40 copayment

You pay with Medicare Part B: High and Standard: Nothing

Benefit Description: Inpatient Hospital

You pay without Medicare: High: Nothing; Standard: 20% coinsurance after deductible

You pay with Medicare Part B: High and Standard: Nothing

Benefit Description: Outpatient Hospital

You pay without Medicare: High: Nothing; Standard: 20% coinsurance after deductible

You pay with Medicare Part B: High and Standard: Nothing

Benefit Description: Incentives Offered

You pay without Medicare: N/A

You pay with Medicare Part B: N/A

- **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 healthcare choices (like HMOs and regional PPOs) in some areas of the country.

To learn more about Medicare Advantage plans, contact Medicare at 800-MEDICARE (1-800-633-4227), (TTY 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 or employing 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 Prescription Employer Group Waiver Plan (PDP EGWP)**

This Plan does not offer a Medicare Prescription Drug Plan Employer Group Waiver Plan (PDP EGWP).

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		✓ *
9) Are a Federal employee receiving 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

Assignment	An authorization by you (the enrollee or covered family member) that is approved by us (the Carrier), for us to issue payment of benefits directly to the provider. • We reserve the right to pay you directly for all covered services. Benefits payable under the contract are not assignable by you to any person without express written approval from us, and in the absence of such approval, any assignment shall be void. • Your specific written consent for a designated authorized representative to act on your behalf to request reconsideration of a claim decision (or, for an urgent care claim, for a representative to act on your behalf without designation) does not constitute an Assignment. • OPM's contract with us, based on federal statute and regulation, gives you a right to seek judicial review of OPM's final action on the denial of a health benefits claim but it does not provide you with authority to assign your right to file such a lawsuit to any other person or entity. Any agreement you enter into with another person or entity (such as a provider, or other individual or entity) authorizing that person or entity to bring a lawsuit against OPM, whether or not acting on your behalf, does not constitute an Assignment, is not a valid authorization under this contract, and is void.
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	Refer to section 4 page 22.
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	Refer to section 4 page 22.

Cost-sharing	Refer to section 4 page 22.
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 medication. Custodial care that lasts 90 days or more is known as Long Term Care.
Deductible	Refer to section 4 page 22.
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.
Healthcare professional	A physician or other healthcare professional licensed, accredited, or certified to perform specified health services consistent with state law.
Infertility	The inability to conceive or carry a pregnancy to term as documented by 1) twelve (12) months of trying to conceive through egg-sperm contact if member is age 34 or younger; 2) six (6) months of trying to conceive if member is age 35 or older; or 3) diagnosis of infertility by a Provider that is supported by other medical history or diagnostic testing.
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.
Obesity	The US Preventive Services Task Force (USPSTF) defines obesity in adults as a Body Mass Index (BMI) of 30 or higher
Plan allowance	Plan allowance is the amount we use to determine our payment and your coinsurance for covered services.

You should also see section Important Notice About Surprise Billing – Know Your Rights below that describes your protections against surprise billing under the No Surprises Act.

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.
Reimbursement	A carrier's pursuit of a recovery if a covered individual has suffered an illness or injury and has received, in connection with that illness or injury, a payment from any party that may be liable, any applicable insurance policy, or a workers' compensation program or insurance policy, and the terms of the carrier's health benefits plan require the covered individual, as a result of such payment, to reimburse the carrier out of the payment to the extent of the benefits initially paid or provided. The right of reimbursement is cumulative with and not exclusive of the right of subrogation.
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.
Subrogation	A carrier's pursuit of a recovery from any party that may be liable, any applicable insurance policy, or a workers' compensation program or insurance policy, as successor to the rights of a covered individual who suffered an illness or injury and has obtained benefits from that carrier's health benefits plan.
Surprise Bill	An unexpected bill you receive for: • emergency care – when you have little or no say in the facility or provider from whom you receive care, or for • non-emergency services furnished by nonparticipating providers with respect to patient visits to participating health care facilities, or for • air ambulance services furnished by nonparticipating providers of air ambulance services.
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 determine whether or not 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.

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Summary of Benefits for Group Health Cooperative of South Central Wisconsin High Option - 2026

- **Do not rely on this chart alone.** This is a summary. All benefits are subject to the definitions, limitations, and exclusions in this brochure. Before making a final decision, please read this FEHB brochure. You can also obtain a copy of our Summary of Benefits and Coverage as required by the Affordable Care Act at <https://ghcscw.com/members/federal-employee-members/>
- 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.
- There is no deductible for this plan option

High Option Benefits	You pay	Page
Medical services provided by physicians: Diagnostic and treatment services provided in the office	Office visit copay: \$0 Primary Care \$10 Specialist Care	29
Services provided by a hospital: Inpatient	Nothing	55
Services provided by a hospital: Outpatient	Nothing	56
Emergency benefits: In-area	\$75 per visit, waived if admitted	60
Emergency benefits: Out-of-area	\$75 per visit, waived if admitted	60
Mental health and substance use disorder treatment:	Regular cost-sharing	62
Prescription drugs: Retail pharmacy 30-day supply	Tier 1: \$5, Tier 2: \$20, Tier 3:\$50, Tier 4: \$100	65
Prescription drugs: Mail order 90-day supply	Mail order is available - you will pay 3x retail copay	65
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 plan dentist.	73
Vision care:	\$10 office visit	39
Protection against catastrophic costs (out-of-pocket maximum):	\$7,150 for Self Only; \$14,300 for Self Plus One and Self and Family	23

Summary of Benefits for Group Health Cooperative of South Central Wisconsin Standard Option - 2026

- **Do not rely on this chart alone.** This is a summary. All benefits are subject to the definitions, limitations, and exclusions in this brochure. Before making a final decision, please read this FEHB brochure. You can also obtain a copy of our Summary of Benefits and Coverage as required by the Affordable Care Act at <https://ghcscw.com/members/federal-employee-members/>
- 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.
- Below, an asterisk(*) means the item is subject to the \$1,000 calendar year deductible for Self Only enrollment; \$2,000 calendar year deductible for Self Plus One and Self Plus Family enrollment.

Standard Option Benefits	You Pay	Page
Medical services provided by physicians:	\$20 Primary Care	29
Diagnostic and treatment services provided in the office	\$40 Specialist Care	
Services provided by a hospital:	20% Coinsurance after deductible*	55
• Inpatient		
Services provided by a hospital:	20% Coinsurance after deductible*	56
• Outpatient		
Emergency benefits:	\$100 per visit; waived if admitted	60
• In-Area		
Emergency benefits:	\$100 per visit; waived if admitted	60
• Out-of-Area		
Mental health and substance misuse disorder treatment:	Regular cost-sharing	62
Prescription drugs:	Tier 1: \$5, Tier 2: \$20, Tier 3: \$50, Tier 4: \$100	65
• Retail pharmacy 30-day supply		
Prescription drugs:	Mail order is available - you will pay 3x the retail copay.	65
• Mail order 90-day supply		
Dental care:	Nothing if you use a GHC-SCW Plan dentist.	73
• Prophylaxis or cleaning (one in any six month period)		
• Topical applications of fluoride through age fifteen (15) - one every six months		
Vision care:	\$40 per office visit	39
Protection against catastrophic costs (out-of-pocket maximum):	\$7,150 for Self Only; \$14,300 for Self Plus One and Self and Family	23

2026 Rate Information for Group Health Cooperative of South Central Wisconsin

To compare your FEHB health plan options please go to www.opm.gov/fehbcompare

To review premium rates for all FEHB health plan options please go to www.opm.gov/FEHBpremiums or www.opm.gov/Tribalpremium

Premiums for Tribal employees are shown under the Monthly Premium Rate column. The amount shown under employee pay is the maximum you will pay. Your Tribal employer may choose to contribute a higher portion of your premium. Please contact your Tribal Benefits Officer for exact rates.

Type of Enrollment	Enrollment Code	Premium Rate			
		Biweekly		Monthly	
		Gov't Share	Your Share	Gov't Share	Your Share

Wisconsin

Standard Option Self Only	WJ4	\$324.76	\$126.52	\$703.65	\$274.12
Standard Option Self Plus One	WJ6	\$711.17	\$281.65	\$1,540.87	\$610.24
Standard Option Self and Family	WJ5	\$778.03	\$395.28	\$1,685.73	\$856.44
High Option Self Only	WJ1	\$324.76	\$304.42	\$703.65	\$659.57
High Option Self Plus One	WJ3	\$711.17	\$673.03	\$1,540.87	\$1,458.23
High Option Self and Family	WJ2	\$778.03	\$857.84	\$1,685.73	\$1,858.66