

GROUP HEALTH COOPERATIVE OF SOUTH CENTRAL WISCONSIN

<http://www.ghc-hmo.com>

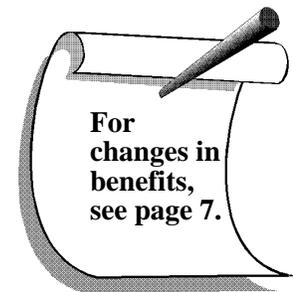


2007

A Health Maintenance Organization

Serving: South Central Wisconsin

Enrollment in this plan is limited. You must live or work in our Geographic service area to enroll. See page 7 for requirements.



Enrollment code for this Plan:

WJ1 High Option – Self Only

WJ2 High Option – Self and Family



This plan has Excellent accreditation from NCQA. See the 2006 Guide for more information on accreditation.

RI 73-061

Authorized for distribution by the:



**United States
Office of Personnel Management**
Center for
Retirement and Insurance Services
<http://www.opm.gov/insure>

73-061

Filing a complaint will not affect your benefits under the FEHB Program. You also may file a complaint with the Secretary of the United States Department of Health and Human Services.

By law, OPM is required to follow the terms in this privacy notice. OPM has the right to change the way your personal medical information is used and given out. If OPM makes any changes, you will get a new notice by mail within 60 days of the change. The privacy practices listed in this notice are effective April 14, 2003.

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

OPM has determined that the Group Health Cooperative of South Central Wisconsin's prescription drug coverage is, on average, expected to pay out as much as the standard Medicare prescription drug coverage will pay for all plan participants and is considered Creditable Coverage. Thus you do not need to enroll in Medicare Part D and pay extra for prescription drug benefit 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 terminate your FEHB coverage, you may not re-enroll in the FEHB Program.

Please be advised

If you lose or drop your FEHB coverage and go 63 days or longer without prescription drug coverage that's at least as good as Medicare's prescription drug coverage, your monthly 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'll 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 (November 15th through December 31st) to enroll in Medicare Part D.

Medicare's Low Income Benefits

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

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

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

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Introduction

This brochure describes the benefits of under our contract (CS 1828) with the United States Office of Personnel Management, as authorized by the Federal Employees Health Benefits law. The address for Group Health Cooperative of South Central Wisconsin administrative offices is:

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

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

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled in Self and Family coverage, each eligible family member is also entitled to these benefits. You do not have a right to benefits that were available before January 1, 2007, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2007, and changes are summarized on page 8. Rates are shown at the end of this brochure.

Plain Language

All FEHB brochures are written in plain language to make them responsive, accessible, and understandable to the public. For instance,

- Except for necessary technical terms, we use common words. For instance, “you” means the enrollee or family member, “we” means Group Health Cooperative of South Central Wisconsin.
- 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 first.
- Our brochure and other FEHB plans’ brochures have the same format and similar descriptions to help you compare plans.

If you have comments or suggestions about how to improve the structure of this brochure, let OPM know. Visit OPM’s “Rate Us” feedback area at www.opm.gov/insure or e-mail OPM at fehwebcomments@opm.gov. You may also write to OPM at the U.S. Office of Personnel Management, Insurance Services Programs, Program Planning & Evaluation Group, 1900 E Street, NW, Washington, DC 20415-3650.

Stop Health Care Fraud!

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

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

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

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

- If you suspect that a provider has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:

Call the provider and ask for an explanation. There may be an error.

If the provider does not resolve the matter, call us at 608/828-4853 and explain the situation.

If we do not resolve the issue:

CALL - THE HEALTH CARE FRAUD HOTLINE

202-418-3300

OR WRITE TO:

United States Office of Personnel Management

Office of the Inspector General Fraud Hotline

1900 E Street NW Room 6400

Washington, DC20415-1100

- 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); o
 - Your child over age 22 (unless he/she is disabled and incapable of self support).
- If you have any questions about the eligibility of a dependent, check with your personnel office if you are employed, with your retirement office (such as OPM) if you are retired, or with the National Finance Center if you are enrolled under Temporary Continuation of Coverage.
- You can be prosecuted for fraud and your agency may take action against you if you falsify a claim to obtain FEHB benefits or try to obtain services for someone who is not an eligible family member or who is no longer enrolled in the Plan.

Preventing medical mistakes

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

1. Ask questions if you have doubts or concerns.

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

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

- Bring the actual medicines or give your doctor and pharmacist a list of all the medicines that you take, including non-prescription (over-the-counter) medicines.
- Tell them about any drug allergies you have.
- Ask about any risks or side effects of the medication and what to avoid while taking it. Be sure to write down what your doctor or pharmacist says.

- Make sure your medicine is what the doctor ordered. Ask the pharmacist about your medicine if it looks different than you expected.
- Read the label and patient package insert when you get your medicine, including all warnings and instructions.
- Know how to use your medicine. Especially note the times and conditions when your medicine should and should not be taken.
- Contact your doctor or pharmacist if you have any questions.

3. Get the results of any test or procedure.

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

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

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

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

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

Visit these Web sites for more information about patient safety.

Ø www.ahrq.gov/path/beactive.htm. The Agency for Healthcare Research and Quality makes available a wide-ranging list of topics not only to inform consumers about patient safety but to help choose quality health care providers and improve the quality of care you receive.

Ø www.npsf.org. The National Patient Safety Foundation has information on how to ensure safer health care for you and your family.

Ø www.talkaboutrx.org. The National Council on Patient Information and Education is dedicated to improving communication about the safe, appropriate use of medicines.

Ø www.leapfroggroup.org. The Leapfrog Group is active in promoting safe practices in hospital care.

Ø www.ahqa.org. The American Health Quality Association represents organizations and health care professionals working to improve patient safety.

Ø www.quic.gov/report. Find out what federal agencies are doing to identify threats to patient safety and help prevent mistakes in the nation's health care delivery system.

Section 1 Facts about this HMO plan

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

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

When you receive services from Plan providers, you will not have to submit claim forms or pay bills. You pay only the copayments and coinsurances 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.

How we pay providers

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

Who provides your health care

Group Health Cooperative of South Central Wisconsin is a Group-Practice Prepayment (GPP) plan. We select qualified, experienced doctors for our medical staff. The group medical practice at GHC allows for in-house consultations, peer review, and regular staff audits of medical care so that we can assure quality care for you and your family members.

The first and most important decision you must make is to select your primary care provider. Specialists who represent every possible specialty area also serve GHC members. Your Primary Care Provider (PCP) makes any necessary referrals, with the following exceptions: a woman may see her Plan gynecological provider for her annual routine examination without a referral (certified nurse midwives are not covered providers under this plan), Vision care, Dental care, Mental Condition care, Substance Abuse care, Chiropractic care and Complementary Medicine practitioners.

GHC uses the facilities of four hospitals in the South Central Wisconsin area. Your primary care site (clinic) determines the assigned hospital for your routine care. Most specialty care is referred to University of Wisconsin Hospital and Clinics, Meriter Hospital, and St. Mary's Hospital - all in Madison. Babies are delivered at St. Mary's Hospital in Madison.

Your Rights

OPM requires that all FEHB Plans provide certain information to their FEHB members. You may request information about us, our networks, and our providers. OPM's FEHB Web site (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** **30**
- **Profit status** **Not-for-profit**

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

Service Area

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

Columbia County Dodge County Green County Iowa County
Jefferson County Lafayette County Rock County Sauk County

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

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

Section 2 How we change for 2007

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

Changes to this Plan

- Your share of the non-Postal premium will increase by 12.0% for Self only and 24.3% for Self and family.
- We have restated the "You Pay" for Routine physical every year to \$10 office visit copay and Routine Preventive Screenings to show that such screenings are covered at 100%. (see page 16)
- We have increased the annual number of covered visits for physical and occupational therapies to 50 visits per year. Previously the annual limit was 40 visits. (see page 19)
- We have added an annual maximum out of pocket limit of \$2500 per person to Orthopedic and Prosthetic devices combined with Durable Medical Equipment. (see page 21)
- We have added coverage for TENS units. Previously this was not a covered benefit. (see page 22)
- We have restated the annual maximum out of pocket limit for Durable Medical Equipment, now combined with Orthopedic and Prosthetic devices. (see page 22)
- We have increased the maximum annual benefit for Complementary Medicine services (Alternative Treatments) to \$750 per year. Previously it was \$500 per year. (see page 23)
- We have increased the copay for Emergency Services to \$75 per visit. Previously it was \$50 per visits (see page 33)
- We will cover Glucose Blood Monitors as Prescription Drug supplies. Previously they were covered as Durable Medical Equipment. (see page 36)

Section 3. How you get care

Identification cards	<p>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.</p> <p>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 write to us at PO Box 44971, Madison WI 53744-4971. You may also request replacement cards through our Web site: www.ghc-hmo.com.</p>
Where you get covered care	<p>You get care from “Plan providers” and “Plan facilities.” You will only pay copayments and coinsurance.</p>
<ul style="list-style-type: none">• Plan providers	<p>Plan providers are physicians and other health care professionals in our service area that we contract with to provide covered services to our members. We credential Plan providers according to national standards.</p> <p>Members must receive care through GHC 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's Care Management Department.</p> <p>We list Plan providers in the provider directory, which we update periodically. The list is also on our Web site.</p>
<ul style="list-style-type: none">• Plan facilities	<p>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 Web site.</p>
What you must do to get covered care	<p>It depends on the type of care you need. First, you and each family member must choose a primary care physician. This decision is important since your primary care physician provides or arranges for most of your health care. If you need assistance, please call the GHC Member Services Department at 608-828-4853.</p>
<ul style="list-style-type: none">• Primary care	<p>Your primary care physician can be a family practitioner, internist or pediatrician. (You may also select physician assistants or nurse practitioners). Your primary care practitioner will provide most of your health care, or give you a referral to see a specialist.</p> <p>If you want to change primary care physicians or if your primary care physician leaves the Plan, call us. We will help you select a new one</p>
<ul style="list-style-type: none">• Specialty care	<p>Your primary care physician will refer you to a specialist for needed care. When you receive a referral from your primary care physician, you must return to the primary care physician after the consultation, unless your primary care physician authorized a certain number of visits without additional referrals. The primary care physician must provide or authorize all follow-up care. Do not go to the specialist for return visits unless your primary care physician gives you a referral. However, you may see the following plan providers without a referral: mental health, substance abuse, vision, dental, chiropractic, complementary medicine.</p> <p>Here are some other things you should know about specialty care:</p>

- If you need to see a specialist frequently because of a chronic, complex, or serious medical condition, your primary care physician will develop a treatment plan that allows you to see your specialist for a certain number of visits without additional referrals. Your primary care physician will use our criteria when creating your treatment plan (the physician may have to get an authorization or approval beforehand).
- If you are seeing a specialist when you enroll in our Plan, talk to your primary care physician. Your primary care physician will decide what treatment you need. If he or she decides to refer you to a specialist, ask if you can see your current specialist. If your current specialist does not participate with us, you must receive treatment from a specialist who does. Generally, we will not pay for you to see a specialist who does not participate with our Plan.
- If you are seeing a specialist and your specialist leaves the Plan, call your primary care physician, who will arrange for you to see another specialist. You may receive services from your current specialist until we can make arrangements for you to see someone else.
- If you have a chronic and disabling condition and lose access to your specialist because we:
 - Terminate our contract with your specialist for other than cause; or
 - Drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB program Plan; or
 - Reduce our service area and you enroll in another FEHB Plan,

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

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

- Hospital care

If you are hospitalized when your enrollment begins

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

If you are 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 reimburse you for your covered expenses 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; or
- 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.

How to get approval for...

- **Your hospital stay** Prior authorization is the process by which - prior to your inpatient hospital admission, GHC evaluates the medical necessity of your proposed stay and the number of days required to treat your condition.

In most cases, your physician or hospital will take care of Prior Authorization. Because you are still responsible for ensuring that we are asked to prior authorize your care, you should always ask your physician or hospital whether they have contacted us. If the stay is not medically necessary, we will not pay any benefits.
- **How to precertify an admission**
- **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 90 hours after a cesarean section, your practitioner or hospital must contact us for prior authorization of additional days. Further, if your baby stays after you are discharged, your practitioner or hospital must contact us for prior authorization of additional days for your baby.
- **If your hospital stay needs to be extended:** If your hospital stay - including for maternity care - needs to be extended, you, your representative, your practitioner or the hospital must ask us to approve the additional days.
- **What happens when you do not follow the precertification rules when using non-network facilities** If no one contacted us, we will decide whether the hospital stay was medically necessary.

If we determine that it was not medically necessary for you to be an inpatient, we will not pay inpatient hospital benefits. We will only pay for any covered medical supplies and services that are otherwise payable on an outpatient basis.

If we denied the prior authorization request, we will not pay inpatient hospital benefits. We will only pay for any covered medical supplies and services that are otherwise payable on an outpatient basis.

When we prior authorized the admission and you remained in the hospital beyond the number of days we approved, and did not get the additional days prior authorized, then:
 - For the part of the admission that was medically necessary, we will pay inpatient benefits.
 - For the part of the admission that was not medically necessary, we will pay only medical services and supplies otherwise payable on an outpatient basis and will not pay inpatient benefits.

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.

Services requiring our prior approval

Your primary care physician has authority to refer you for most services. For certain services, however, your physician must obtain approval from us. Before giving approval, we consider if the service is covered, medically necessary, and follows generally accepted medical practice.

We call this review and approval process **Prior Authorization**. Your physician must obtain Prior Authorization for services such as, but not limited to:

- Inpatient hospital services
- Outpatient surgical/non-surgical services
- The following outpatient diagnostic and therapeutic services: MRI, MRA, CT/CAT and PET
- Inpatient maternity care
- Home Health Agency services

- Skilled Nursing Facility services
- Orthopedic and Prosthetic devices and Durable Medical Equipment
- End of Life (Hospice) Services
- Outpatient Rehabilitative Therapy (physical therapy, occupational therapy, speech therapy)
- All transplant services
- All Inpatient and Transitional Mental Health and AODA Services
- All Infertility Services
- Surgical and/or Non-Surgical Treatment of Temporomandibular Joint (TMJ) syndrome
- 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 formulary

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

Section 4 Your costs for covered services

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

Copayments A copayment is a fixed amount of money you pay to the provider, facility, pharmacy, etc., when you receive certain services.

Example: when you see your primary care provider, you pay a copayment of \$10 per office visit.

Deductible We do not have a deductible.

Coinsurance Coinsurance is the percentage of our allowance that you must pay for your care.

Example: In our Plan, you pay 20% of our allowance for Durable Medical Equipment, disposable medical supplies, and Orthopedic and Prosthetic devices, and 50% of our allowances for sexual dysfunction drugs and preventive dental care services if a non-participating dentist is used.

Your catastrophic protection out-of-pocket maximum We do not have a catastrophic protection out-of-pocket maximum.

HMO Benefits

See page 8 for how our benefits changed this year. Page 57 is a benefits summary of this option.

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

Important things you should keep in mind about these benefits:

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

Benefit Description	You pay
Diagnostic and treatment services	
Professional services of physicians <ul style="list-style-type: none"> • In physician's office • In an urgent care center • Office medical consultations • Second surgical opinion • At home 	\$10 per office visit
Professional services of physicians <ul style="list-style-type: none"> • During a hospital stay • In a skilled nursing facility 	Nothing
Out of Area Care Medically necessary, non-urgent, non-emergent follow-up medical care will be covered at 50% of eligible charges with Prior Authorization from GHC	50% of eligible charges with Prior Authorization
Lab, X-ray and other diagnostic tests	
Tests, such as: <ul style="list-style-type: none"> • Blood tests • Urinalysis • Non-routine Pap tests • Pathology • X-rays • Non-routine mammograms • CAT Scans/MRI • Ultrasound • Electrocardiogram and EEG 	Nothing

Benefit Description	You pay
Preventive care, adult	
Routine physical every year Routine screenings, such as: <ul style="list-style-type: none"> • Total Blood Cholesterol • Colorectal Cancer Screening, including <ul style="list-style-type: none"> - Fecal occult blood test - Sigmoidoscopy, screening – every five years starting at age 50 - Double contrast barium enema – every five years starting at age 50 - Colonoscopy screening – every ten years starting at age 50 	\$10 office visit copay Nothing
Routine Prostate Specific Antigen (PSA) test – one annually for men age 40 and older	Nothing
Routine Pap test	Nothing
Routine mammogram – covered for women age 35 and older, as follows: <ul style="list-style-type: none"> • From age 35 through 39, one during this five year period • From age 40 and older, one every calendar year Note: Mammograms require a Prior Authorization from the GHC Care Management Department if they are performed outside of a GHC owned and operated facility.	Nothing
Routine immunizations endorsed by the Centers for Disease Control and Prevention (CDC): <ul style="list-style-type: none"> • Tetanus-diphtheria (Td) booster – once every 10 years, ages 19 and over (except as provided for under Childhood immunizations) • Influenza vaccine, annually • Pneumococcal vaccine, age 65 and older Physical exams required for travel or for attending school or camp. Note: Travel related immunizations may be provided in accordance with CDC recommendations and GHC protocols.	Nothing
<i>Not covered:</i> <i>Third party examinations for services and/or treatments including, but not limited to:</i> <ul style="list-style-type: none"> • <i>Supplies requested by a third party for any purpose.</i> 	<i>All charges</i>

Preventive care, adult - continued on next page

Benefit Description	You pay
Preventive care, adult (cont.)	
<ul style="list-style-type: none"> Any routine physical exam requested by a third party except for those exams provided to an eligible dependent child for camp, school and sports. Physical exams for employment, licensing, insurance, marriage, adoption, or exams ordered by a court 	All charges
Preventive care, children	
<ul style="list-style-type: none"> Childhood immunizations recommended by the American Academy of Pediatrics 	Nothing to age 18
<ul style="list-style-type: none"> Well-child care charges for routine examinations, immunizations and care (up to age 22) Examinations, such as: <ul style="list-style-type: none"> Eye exams through age 17 to determine the need for vision correction Hearing exams through age 17 to determine the need for hearing correction Examinations done on the day of immunizations (up to age 22) Physical examinations required for travel or for attending school or camp <p>NOTE: travel related immunizations may be provided in accordance with CDC recommendations and GHC protocols.</p>	Nothing to age 18; \$10 per office visit age 18 and older
Maternity care	
<p>Complete maternity (obstetrical) care, such as:</p> <ul style="list-style-type: none"> Prenatal care Delivery Postnatal care <p>Note: Here are some things to keep in mind:</p> <ul style="list-style-type: none"> You do not need to precertify your normal delivery; see page 11 for other circumstances, such as extended stays for you or your baby. You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will extend your inpatient stay if medically necessary. 	\$10 for initial maternity office visit; Nothing for all other maternity related office visits.

Maternity care - continued on next page

Benefit Description	You pay
Maternity care (cont.)	
<ul style="list-style-type: none"> We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self and Family enrollment. Surgical benefits, not maternity benefits, apply to circumcision. We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See Hospital benefits (Section 5c) and Surgery benefits (Section 5b). 	\$10 for initial maternity office visit; Nothing for all other maternity related office visits.
<i>Not covered: Routine sonograms to determine fetal age, size or sex.</i>	<i>All charges.</i>
Family planning	
<p>A range of voluntary family planning services, limited to:</p> <ul style="list-style-type: none"> Voluntary sterilization (See Surgical procedures Section 5 (b)) Surgically implanted contraceptives Intrauterine devices (IUDs) Diaphragms <p>Note: We cover oral contraceptives under the prescription drug benefit.</p>	\$10 per office visit
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <i>Reversal of voluntary surgical sterilization</i> <i>Genetic counseling</i> 	<i>All charges.</i>
Infertility services	
<p>Diagnosis and treatment of infertility such as:</p> <ul style="list-style-type: none"> Artificial insemination: <ul style="list-style-type: none"> - intracervical insemination (ICI) Fertility drugs <p>Note: We cover oral fertility drugs - Clomiphene Citrate and Progesterone - at one year per lifetime. No other injectable or oral fertility drugs are covered.</p>	\$10 per office visit
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <i>Assisted reproductive technology (ART) procedures, such as:</i> <ul style="list-style-type: none"> - <i>in vitro fertilization</i> 	<i>All charges</i>

Infertility services - continued on next page

Benefit Description	You pay
Infertility services (cont.)	
<p>- embryo transfer, gamete intra-fallopian transfer (GIFT) and zygote intra-fallopian transfer (ZIFT)</p> <ul style="list-style-type: none"> • Services and supplies related to ART procedures • Cost of donor sperm • Cost of donor egg. • Injectable and oral fertility drugs, except for Clomiphene Citrate and Progesterone 	All charges
Allergy care	
<ul style="list-style-type: none"> • Testing and treatment <p style="padding-left: 40px;">Allergy antigen injections</p> <p style="padding-left: 40px;">Allergy serum injections</p>	<p>\$10 per office visit</p> <p>Nothing</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Provocative food testing • Sublingual allergy desensitization 	All charges.
Treatment therapies	
<ul style="list-style-type: none"> • Chemotherapy and radiation therapy <p>Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under Organ/Tissue Transplants on page 27.</p> <ul style="list-style-type: none"> • Respiratory and inhalation therapy • Dialysis – hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy • Growth hormone therapy (GHT) <p>Note: Growth hormone is covered under the prescription drug benefit.</p> <p>Note: – We only cover GHT when we preauthorize the treatment. If we determine GHT is not medically necessary, we will not cover the GHT or related services and supplies. See <i>Services requiring our prior approval</i> in Section 3.</p>	Nothing

Benefit Description	You pay
Physical and occupational therapies	
<p>50 visits for the services of each of the following:</p> <ul style="list-style-type: none"> • qualified physical therapists and • occupational therapists <p>Note: We only cover therapy to restore bodily function when there has been a total or partial loss of bodily function due to illness or injury.</p> <p>Phase II Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction is provided for up to 36 sessions.</p> <p>We cover one follow-up visit six months after the date of your last physical or occupational therapy treatment</p>	Nothing
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Long-term rehabilitative therapy • Exercise programs except for those named above 	<i>All charges.</i>
Speech therapy	
60 consecutive days per condition for the services of qualified speech therapists	Nothing
<i>Not covered: treatment for tongue thrust</i>	<i>All charges</i>
Hearing services (testing, treatment, and supplies)	
<ul style="list-style-type: none"> • Hearing testing • Hearing aid coverage: limited to one (1) hearing aid per ear every thirty-six (36) months. GHC pays 50% of first \$2,000 for a maximum payment of \$1,000 by GHC. 	<p>Nothing to age 18; \$10 office visit age 18 and older</p> <p>All hearing aid charges above benefit maximum</p>
Vision services (testing, treatment, and supplies)	
<ul style="list-style-type: none"> • Annual visit examination • Annual eye refraction <p>Note: See <i>Preventive care, children</i> for eye exams for children.</p> <ul style="list-style-type: none"> • One eyeglass lens (frame not covered) or contact lens to correct the affected eye for impairment directly caused by ocular injury or intraocular surgery (such as for cataracts). 	<p>Nothing to age 18; \$10 per office visit age 18 and older</p> <p>All charges above cost of covered lens.</p>
<i>Not covered:</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.)	
<ul style="list-style-type: none"> • <i>Eyewear: including lenses, frames, contact lenses, contact lens prescriptions and contact lens services except as shown above</i> • <i>Eye exercises and orthoptics</i> • <i>Radial keratotomy and other refractive surgery</i> 	<i>All charges.</i>
Foot care	
<p>Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes.</p>	\$10 per office visit
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <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 (unless the treatment is by open cutting surgery)</i> 	<i>All charges.</i>
Orthopedic and prosthetic devices	
<ul style="list-style-type: none"> • Artificial limbs and eyes • Stump hose • Externally worn breast prostheses and surgical bras, including necessary replacements following a mastectomy • Internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, and surgically implanted breast implant following mastectomy. <p>Note: Internal prosthetic devices are paid as hospital benefits; see Section 5(c) for payment information. Insertion of the device is paid as surgery; see Section 5(b) for coverage of the surgery to insert the device.</p> <ul style="list-style-type: none"> • Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome. • Foot orthotics for: <ul style="list-style-type: none"> - Diabetic patients with a history of disease-related foot complications - Rheumatoid arthritis patients with a disease-related foot complication 	<p>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 may nothing thereafter.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Orthopedic and corrective shoes</i> • <i>Arch supports</i> 	<i>All charges</i>

Orthopedic and prosthetic devices - continued on next page

Benefit Description	You pay
Orthopedic and prosthetic devices (cont.)	
<ul style="list-style-type: none"> • <i>Foot orthotics except as noted above</i> • <i>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>All charges</i>
Durable medical equipment (DME)	
<p>We cover rental or purchase of durable medical equipment, at our option, including repair and adjustment. Covered items include:</p> <ul style="list-style-type: none"> • Oxygen; • Dialysis equipment; • Hospital beds; • Wheelchairs (standard, motorized) - Medicare criteria will apply; • Crutches; • Walkers; • Insulin infusion pumps; • TENS Unit; and • Compression Stocking (limited to 3 pair per calendar year. Requires a prescription from a plan provider. <p>Note: See section 5(f) for Blood glucose monitors</p> <p>Note: Call us at 608-257-5294 as soon as your Plan physician prescribes this equipment. We will arrange with a health care provider to rent or sell you durable medical equipment at discounted rates and will tell you more about this service when you call.</p>	20% of the plan allowance per item (per purchase or rental period) up to a maximum out of pocket expense of \$2500 per member per year, combined with Orthopedic and prosthetic devices. You pay nothing thereafter.
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Scooters</i> • <i>DME replacment 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>All charges</i>

Benefit Description	You pay
Home health services	
<ul style="list-style-type: none"> • Home health care ordered by a Plan physician and provided by a registered nurse (R.N.), licensed practical nurse (L.P.N.), licensed vocational nurse (L.V.N.), or home health aide. • Services include oxygen therapy, intravenous therapy and medications. 	Nothing
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Nursing care requested by, or for the convenience of, the patient or the patient's family;</i> • <i>Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative.</i> 	<i>All charges.</i>
Chiropractic	
<ul style="list-style-type: none"> • Manipulation of the spine and extremities • Adjunctive procedures such as ultrasound, electrical muscle stimulation, vibratory therapy, and cold pack application 	\$10 per office visit
<i>Not covered: chiropractic services for chronic problems or for maintenance</i>	<i>All Charges:</i>
Alternative treatments	
<p>Complementary Medicine Services, when provided by a GHC Complementary Medicine practitioner at a GHC owned and operated facility, are limited to fifty percent (50%) of the first seven hundred fifty dollars (\$750) of all combined Complementary Medicine services, with a maximum payment by GHC of three hundred and seventy-five dollars (\$375) per member per calendar year.</p> <p>Note: "End-of-Life" patients, see Section 5(c) Hospice.</p> <p>Complementary Medicine includes forms of therapy used alone or in combination with standard/conventional medicine (sometimes referred to as allopathic medicine).</p> <p>Services or treatments include but are not limited to: acupuncture, homeopathy, naturopathy, various types of manual therapy, various types of massage therapy and energy work, various types of stress reduction and mind/body medicine, various types of mindfulness therapy, various types of Eastern practices, yoga, Tai Chi, movement therapy, wellness classes, lifestyle change classes and herbal medicine.</p> <p>Contact GHC for a complete list of available Complementary Medicine services.</p>	All charges above the \$750 plan maximum

Alternative treatments - continued on next page

Benefit Description	You pay
Alternative treatments (cont.)	
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Any Complementary Medicine services that are not within the scope of a practitioner's professional license, and services not provided at a GHC facility by a GHC practitioner. The Complementary Medicine services available do not represent the full spectrum of Complementary Medicine services that are available to the public. • Non-formulary medications and devices. 	<p><i>All charges.</i></p>
Educational classes and programs	
<p>Coverage may include:</p> <ul style="list-style-type: none"> • Smoking Cessation • Diabetes self-management • Nutrition Education • Weight Management • Stress Management • Prenatal Education • First Aid Training • Fitness Programs - GHC's 'Exercise for Excellence' program offers reimbursements to qualified participants. <p>Note: Contact the GHC Health Promotion Department at 608-257-9705 for program and fee schedules.</p>	<p>Fees apply to some but not all classes and programs</p>

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

Important things you should keep in mind about these benefits:

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

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

Benefit Description	You pay
Surgical procedures	
<p>A comprehensive range of services, such as:</p> <ul style="list-style-type: none"> • Operative procedures • Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedures • Biopsy procedures • Removal of tumors and cysts • Correction of congenital anomalies (see <i>Reconstructive surgery</i>) • Insertion of internal prosthetic devices . See 5(a) – <i>Orthopedic and prosthetic devices</i> for device coverage information • Voluntary sterilization (e.g., tubal ligation, vasectomy) • Treatment of burns • Surgical treatment of morbid obesity (bariatric surgery) <ul style="list-style-type: none"> - An individual must weigh 100 pounds or 100% over his or her normal weight according to the current underwriting standards. - An individual must be age 18 or over. - An individual's health must be endangered, that is, have a BMI of 40 or greater or a BMI between 35-39 with documented high-risk, comorbid medical conditions that have not responded to medical management and are a threat to life. 	\$10 per office visit; nothing for in-patient hospital visits

Surgical procedures - continued on next page

Benefit Description	You pay
Surgical procedures (cont.)	
<ul style="list-style-type: none"> - An individual must have tried conservative measures such as, but not limited to: psychological evaluation, behavior modification, diet restrictions/supplements, physician supervised weight loss plans, physical activity programs, prescription drugs such as appetite suppressants. - The following are excluded from coverage even if a physician prescribes or administers them: vitamins, nutrients and food supplements. • Note: contact plan for specific information regarding Covered and Not covered Bariatric Surgery procedures. <p>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.</p>	<p>\$10 per office visit; nothing for in-patient hospital visits</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Reversal of voluntary sterilization</i> • <i>Routine treatment of conditions of the foot; see Foot care</i> 	<p><i>All Charges.</i></p>
Reconstructive surgery	
<ul style="list-style-type: none"> • Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: <ul style="list-style-type: none"> - 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, such as: <ul style="list-style-type: none"> - surgery to produce a symmetrical appearance of breasts; - treatment of any physical complications, such as lymphedemas; - breast prostheses and surgical bras and replacements (see <i>Prosthetic devices</i>) 	<p>\$10 per office visit; nothing for in-patient hospital visits</p>

Reconstructive surgery - continued on next page

Benefit Description	You pay
Oral and maxillofacial surgery (cont.)	
<ul style="list-style-type: none"> • Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone) 	All charges.
Organ/tissue transplants	
<p>Solid organ transplants limited to:</p> <ul style="list-style-type: none"> • Cornea • Heart • Heart/lung • Single, double or lobar lung • Kidney • Liver • Pancreas • Intestinal transplants <ul style="list-style-type: none"> - Small intestine - Small intestine with the liver - Small intestine with multiple organs, such as the liver, stomach, and pancreas 	Nothing
<p>Blood or marrow stem cell transplants limited to the stages of the following diagnoses: (The medical necessity limitation is considered satisfied if the patient meets the staging description.)</p> <p>Allogeneic transplants for</p> <ul style="list-style-type: none"> • Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia • Advanced Hodgkin’s lymphoma • Advanced non-Hodgkin’s lymphoma • Advanced neuroblastoma • Chronic myelogenous leukemia • Multiple myeloma • Severe combined immunodeficiency • Severe or very severe aplastic anemia • Sickle Cell Anemia <p>Nonmyeloablative allogeneic transplants for:</p> <ul style="list-style-type: none"> • Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia • Advanced Hodgkin’s lymphoma • Advanced non-Hodgkin’s lymphoma • Breast Cancer • Chronic myelogenous leukemia • Multiple myeloma 	Nothing

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	
<ul style="list-style-type: none"> • Sarcomas (Ewing) <p>Autologous transplants for:</p> <ul style="list-style-type: none"> • Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia • Advanced Hodgkin's lymphoma • Advanced non-Hodgkin's lymphoma • Advanced neuroblastoma <p>Autologous tandem transplants for recurrent germ cell tumors (including testicular cancer)</p> <p>Blood or marrow stem cell transplants for</p> <ul style="list-style-type: none"> • Allogeneic transplants for • Phagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome) <p>Autologous transplants for</p> <ul style="list-style-type: none"> • Multiple myeloma • Chronic myelogenous leukemia • Testicular, mediastinal, retroperitoneal, and ovarian germ cell tumors • Breast Cancer • Epithelial ovarian cancer • Ewings Sarcoma <p>National Transplant program (NTP)</p> <p>Note: We cover related medical and hospital expenses of the donor when we cover the recipient.</p>	Nothing
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Donor screening tests and donor search expenses, except those performed for the actual donor</i> • <i>Implants of artificial organs</i> • <i>Transplants not listed as covered</i> 	<i>All Charges</i>
Anesthesia	
<p>Professional services provided in –</p> <ul style="list-style-type: none"> • Hospital (inpatient) 	Nothing
<p>Professional services provided in –</p> <ul style="list-style-type: none"> • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Office 	\$10 per office visit

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

Important things you should keep in mind about these benefits:

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

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

Benefit Description	You pay
Inpatient hospital	
Room and board, such as <ul style="list-style-type: none"> • Ward, semiprivate, or intensive care accommodations; • General nursing care; and • 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.	Nothing
Other hospital services and supplies, such as: <ul style="list-style-type: none"> • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and X-rays • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen 	Nothing
<ul style="list-style-type: none"> • Anesthetics, including nurse anesthetist services • Take-home items • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home 	Nothing
<i>Not covered:</i> <ul style="list-style-type: none"> • Custodial care • Non-covered facilities, such as nursing homes, schools • Personal comfort items, such as telephone, television, barber services, guest meals and beds • Private nursing care 	<i>All Charges</i>

Benefit Description	You pay
Outpatient hospital or ambulatory surgical center	
<ul style="list-style-type: none"> • Operating, recovery, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests, X-rays , and pathology services • Administration of blood, blood plasma, and other biologicals • Blood and blood plasma , if not donated or replaced • Pre-surgical testing • Dressings, casts, and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service <p>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.</p>	Nothing
<i>Not covered: Blood and blood derivatives not replaced by the member</i>	<i>All charges.</i>
Extended care benefits/Skilled nursing care facility benefits	
<p>Extended care benefit: We provide a comprehensive range of benefits for up to 100 days per calendar year when full-time skilled nursing care is necessary and confinement in a skilled nursing facility is medically appropriate as determined by a Plan doctor and approved by the Plan.</p>	Nothing
<i>Not covered: Custodial care</i>	<i>All charges</i>
Hospice care	
<p>GHC 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 a terminal illness must be given to GHC's Care Management Department by the Primary Care Practitioner upon request</p> <p>GHC will provide an expanded Complementary Medicine benefit of 50% up to \$2,000 with a maximum payment by GHC of \$1,000 per member per calendar year. This benefit replaces the Complementary Medicine Benefit listed in Section 5 (a). Expanded treatments for End-of-Life patients only. Prior authorization required.</p> <p>End of life services are available if:</p> <ul style="list-style-type: none"> • the terminally ill persin is a GHC member, and • the care is ordered by a GHC Practitioner. 	<p>Nothing</p> <p>All charges above the \$2,000 plan maximum</p>

Hospice care - continued on next page

Benefit Description	You pay
Hospice care (cont.)	
<p>Outpatient End of Life covered charges include:</p> <ul style="list-style-type: none"> • Part-time or intermittent nursing care by an RN or LPN • Medical social services under the direction of a GHC Practitioner, including: <ul style="list-style-type: none"> - 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 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 medicines prescribed by a GHC practitioner - Charges made by any other covered health care practitioner for the services and supplies listed above only if the provider is not part of or employed by a hospice care agency, and the hospice care agency retains responsibility for the care of the terminally ill person - Bereavement counseling • Inpatient End of Life Services include: <ul style="list-style-type: none"> - 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 Medical Director, an inpatient stay is Medically Necessary 	
<i>Not covered: Independent nursing, homemaker services</i>	<i>All Charges</i>

Benefit Description	You pay
Ambulance	
Local professional ambulance service when medically appropriate <i>Not covered: ambulance services to home following an inpatient stay</i>	Nothing <i>All charges</i>

Section 5(d) Emergency services/accidents

	<p>Important things you should keep in mind about these benefits:</p> <ul style="list-style-type: none">• 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. <p>Be sure to read Section 4, <i>Your costs for covered services</i>, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.</p>	
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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.

The absence of a finding by the GHC 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. It is the responsibility of the Member, or of the Subscriber in the case of a minor Member, to notify GHC of the Member's hospitalization without the order or concurrence of a GHC Physician within forty-eight (48) hours of the onset of the Emergency Condition, or as soon thereafter as reasonably possible.

What to do in case of emergency:

Emergencies within our service area:

If you are in an emergency, please call your primary care provider. In extreme emergencies, if you are unable to contact your provider, contact the nearest emergency system (e.g., the 911 telephone system) or go to the nearest hospital emergency room. Be sure to tell emergency room personnel that you are a GHC plan member so that they can notify us. You or a family member must also notify us within 48 hours. It is your responsibility to make certain that the Plan is notified.

If you need to be hospitalized in a non-Plan facility, you or a family member must notify the Plan within 48 hours or on the first working day following your admission, unless it is not reasonably possible to do so. If a GHC 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 or provided by GHC plan providers.

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 you need to be hospitalized, you or a family member must notify the Plan within 48 hours or on the first working day following your admission, unless it is not reasonably possible to do so. If a GHC 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 or provided by GHC plan providers.

Benefit Description	You pay
Emergency within our service area	
<ul style="list-style-type: none"> • Emergency care at a doctor’s office • Emergency care at an urgent care center <p>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 reserves the right to determine whether a specific medical situation actually constitutes an Emergency Condition. Prior authorization is not required.</p> <p>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.</p>	<p>\$10 per office visit...</p> <p>\$75 per visit</p>
<i>Not covered: Elective care or non-emergency care</i>	<i>All Charges.</i>
Emergency outside our service area	
<ul style="list-style-type: none"> • Emergency care at a doctor’s office • Emergency care at an urgent care center <p>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 reserves the right to determine whether a specific medical situation actually constitutes an Emergency Condition. Prior authorization is not required.</p> <p>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.</p>	<p>\$10 per office visit</p> <p>\$75 per visit</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <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>

Benefit Description	You pay
Ambulance	
Professional ambulance service when medically appropriate. Note: See 5(c) for non-emergency service.	\$xx per
<i>Not covered: Ambulance services to home following an in-patient stay.</i>	<i>All Charges.</i>

Section 5(e) Mental health and substance abuse benefits

When you get our approval for services and follow a treatment plan we approve, cost-sharing and limitations for Plan mental health and substance abuse benefits will be no greater than for similar benefits for other illnesses and conditions.

Important things you should keep in mind about these benefits:

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

YOU MUST GET PREAUTHORIZATION OF THESE SERVICES. See the instructions after the benefits description below.

Benefit Description	You pay
Mental health and substance abuse benefits	
<p>All diagnostic and treatment services recommended by a Plan provider and contained in a treatment plan that we approve. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure.</p> <p>Note: Plan benefits are payable only when we determine the care is clinically appropriate to treat your condition and only when you receive the care as part of a treatment plan that we approve.</p>	<p>Your cost sharing responsibilities are no greater than for other illnesses or conditions.</p>
<ul style="list-style-type: none"> • Professional services, including individual or group therapy by providers such as psychiatrists, psychologists, clinical social workers, or advanced practice nurse practitioners • Medication management 	<p>Nothing</p>
<p>Diagnostic tests</p> <ul style="list-style-type: none"> • Services provided by a hospital or other facility • Services in approved alternative care settings such as partial hospitalization, full-day hospitalization, facility based intensive outpatient treatment 	<p>Nothing Nothing</p>
<p><i>Not covered: Services we have not approved.</i></p> <p><i>Note: 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.</i></p>	<p><i>All Charges.</i></p>
<p>Preauthorization</p>	<p>To be eligible to receive these benefits you must obtain a treatment plan and follow all of the following network authorization processes.</p> <p>GHC plan patients may make their own out-patient appointments without a referral for Mental Health and/or Substance Abuse services as follows:</p>

	<ul style="list-style-type: none"> • Mental Health: contact GHC Mental Health Department at 608-661-7227 (after hours 608-257-9700). If out of area, call 1-800-605-4327. • Substance Abuse: contact Gateway Recovery Services, Inc. 608-278-8200.
Limitation	We may limit your benefits if you do not obtain a treatment plan.

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.
- 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.

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

- **Who can write your prescription.** A plan physician or licensed dentist must write the prescription.
- **Where you can obtain them.** You must fill the prescription at a plan pharmacy. Mail service may be available. Contact plan.
- **We use a formulary.** A drug formulary is a list of prescription medications, representing the current judgment of medical practitioners, for the treatment of disease. Not all medications will be listed in the formulary, particularly when there are several similar medications available. The formulary will include the drugs covered by the plan's benefit. Your physician/practitioner may request coverage for non-formulary drugs when clinically necessary.
- **These are the dispensing limitations.** We cover the amount prescribed, up to a 30-day supply maximum, or One (1) commercially prepared unit (such as one vial ophthalmic drops, one inhaler, one tube of ointment), per co-payment. If coverage has been approved for a non-formulary drug, you pay the applicable generic or brand name copayment. For non-formulary drugs when coverage has not been approved, the copayment is equal to the plan calculated total prescription cost, which is generally lower than the retail price.
- **A generic equivalent will be dispensed if it is available**, unless your physician specifically requires a name brand. If you receive a name brand drug when a Federally-approved generic drug is available, and your physician has not specified *Dispense as Written* for the name brand drug, you have to pay the difference in cost between the name brand drug and the generic.
- **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's pharmacy claims computer system.
- **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 when you are out of the area. Forward such claims to the GHC Claims Department, 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 608-828-4853 for assistance obtaining your medication(s).**

Benefit Description	You pay
Covered medications and supplies	
<p>We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy:</p> <ul style="list-style-type: none"> • Drugs and medicines 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 • Contraceptive drugs and devices • Smoking cessation drugs when participating the Plan's behavior modification program • Oral fertility drugs - Clomiphene citrate and Progesterone - limited to one year, per lifetime. 	<p>\$5 copay for generic drugs</p> <p>\$20 copay for name brand drugs</p> <p>Note: If there is no generic equivalent available, you will still have to pay the brand name copay.</p> <p>Note: Patients wishing to use a formulary name brand medication instead of a covered generic equivalent may choose to do so but will pay the cost difference between the formulary brand and the formulary generic in addition to the brand copay.</p>
<ul style="list-style-type: none"> • Diabetic supplies, including insulin syringes, needles, injection pens, glucose test tablets and test tape, Benedict's solution or equivalent, and acetone test tablets. • Disposable needles and syringes for the administration of covered medications • Blood glucose monitors 	<p>20% coinsurance</p>
<ul style="list-style-type: none"> • Drugs for sexual dysfunction are limited. Contact the plan for dose limits. 	<p>50% copayment up to the doses limit and all charges after that</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Drugs and supplies for cosmetic purposes</i> • <i>Drugs to enhance athletic performance</i> • <i>Fertility drugsexcept Clomiphene Citrate and Progesterone</i> • <i>Drugs obtained at a non-Plan pharmacy; except for out-of-area emergencies</i> • <i>Vitamins, nutrients and food supplements even if a physician prescribes or administers them</i> • <i>Nonprescription medicines</i> • <i>Drugs that are used for weight reduction</i> 	<p><i>All Charges.</i></p>

Section 5(g) Special features

Services for deaf and hearing impaired

Hearing impaired interpreter for non-emergency services can be reached at this TDDY line: 608-257-7391.

Centers of excellence

Our local Center of Excellence is associated with the University of Wisconsin Hospital and Clinics in Madison WI.

Travel benefits/services overseas

Travel related immunizations may be provided in accordance with CDC recommendations and GHC protocols.

Online access to health and insurance information

Available 24/7 through GHCMYChart and KidsChart. Note: MyChart is a registered trademark of Epic Systems Corporation.

Section 5(h) 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
- Plan dentists must provide or arrange your care.
- We cover hospitalization for dental procedures only when a non-dental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient. See Section 5(c) for inpatient hospital benefits. We do not cover the dental procedure unless it is described below.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

Benefit Description	You Pay
Accidental injury benefit	
<p>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.</p> <p>You must be seen and evaluated within 48 hours of the accident. However, the start of treatment may be delayed no longer than 90 days following the accidental injury.</p> <p>NOTE: Damage to teeth caused by chewing or biting does not constitute an accidental injury.</p>	<p>Nothing up to \$1500 per accident</p> <p>All charges above \$1500 per accident.</p>
<p>Dental related hospital and anesthetic services</p> <p>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.</p>	<p>Nothing if prior authorized and performed at plan participating hospital or facility.</p>
Dental Benefits	You Pay
Service	
<ul style="list-style-type: none"> • Prophylaxis or cleaning (one in any six month period) • Topical applications of fluoroide through age fifteen (15) - one every six months <p><i>Not covered: all other dental services (i.e., x-rays, fillings, extractions, crowns, orthodontics, etc.)</i></p>	<p>Nothing if you use a GHC Plan dentist</p> <p>50% of charges in you use a non-participating dentist</p> <p><i>All charges</i></p>

Section 6 General exclusions – things we don't cover

The exclusions in this section apply to all benefits. **Although we may list a specific service as a benefit, we will not cover it unless your Plan doctor determines it is medically necessary to prevent, diagnose, or treat your illness, disease, injury, or condition.**

We do not cover the following:

- Care by non-plan providers except for authorized referrals or emergencies (see *Emergency services/accidents*);
- Services, drugs, or supplies you receive while you are not enrolled in this Plan;
- Services, drugs, or supplies not medically necessary;
- Services, drugs, or supplies not required according to accepted standards of medical, dental, or psychiatric practice;
- Experimental or investigational procedures, treatments, drugs or devices (see specifics regarding transplants);
- Services, drugs, or supplies related to abortions, except when the life of the mother would be endangered if the fetus were carried to term, or when the pregnancy is the result of an act of rape or incest;
- Services, drugs, or supplies related to sex transformations;
- Services, drugs, or supplies you receive from a provider or facility barred from the FEHB Program; or
- Services, drugs, or supplies you receive without charge while in active military service.

Section 7 Filing a claim for covered services

When you see Plan physicians, receive services at Plan hospitals and facilities, or obtain your prescription drugs at Plan pharmacies, you will not have to file claims. Just present your identification card and pay your copayment or coinsurance.

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

Medical and hospital benefits

In most cases, providers and facilities file claims for you. Physicians must file on the form HCFA-1500, Health Insurance Claim Form. Your facility will file on the UB-92 form. For claims questions and assistance, call us at 608-828-4853.

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

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

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

Prescription drugs

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

Other supplies or services

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

Deadline for filing your claim

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

When we need more information

Please reply promptly when we ask for additional information. We may delay processing or deny benefits for your claim if you do not respond.

Section 8 The disputed claims process

Follow this Federal Employees Health Benefits Program disputed claims process if you disagree with our decision on your claim or request for services, drugs, or supplies – including a request for preauthorization/prior approval required by Section 3.

1

Ask us in writing to reconsider our initial decision. You must:

- a) Write to us within 6 months from the date of our decision; and
- b) Send your request to us at: GHC Member Services Dept., PO Box 44971, Madison WI 53744-4971; and
- c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and
- d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms.

2

We have 30 days from the date we receive your request to:

- a) Pay the claim (or, if applicable, arrange for the health care provider to give you the care); or
- b) Write to you and maintain our denial - go to step 4; or
- c) Ask you or your provider for more information. If we ask your provider, we will send you a copy of our request—go to step 3.

3

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.

4

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 to 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, Insurance Services Programs, Health Insurance Group 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 in 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.

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.

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

5

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

If you do not agree with OPM's decision, your only recourse is to sue. 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 sue 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 functions or death if not treated as soon as possible), and

- a) We haven't responded yet to your initial request for care or preauthorization/prior approval, then call us at 608-257-5294 and we will expedite our review; or
- b) We denied your initial request for care or preauthorization/prior approval, then:
 - If we expedite our review and maintain our denial, we will inform OPM so that they can give your claim expedited treatment too, or
 - You may call OPM's Health Insurance Group 3 at 202/606-0755 between 8 a.m. and 5 p.m. eastern time.

Section 9 Coordinating benefits with other coverage

When you have other health coverage

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

When you have double coverage, one plan normally pays its benefits in full as the primary payer and the other plan pays a reduced benefit as the secondary payer. We, like other insurers, determine which coverage is primary according to the National Association of Insurance Commissioners’ guidelines.

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

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

What is Medicare?

Medicare is a Health Insurance Program for:

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

Medicare has four parts:

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

• Should I enroll in Medicare?

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

If you can get premium-free Part A coverage, we advise you to enroll in it. Most Federal employees and annuitants are entitled to Medicare Part A at age 65 **without cost**. When you don't have to pay premiums for Medicare Part A, it makes good sense to obtain the coverage. It can reduce your out-of-pocket expenses as well as costs to the FEHB, which can help keep FEHB premiums down.

Everyone is charged a premium for Medicare Part B coverage. The Social Security Administration can provide you with premium and benefit information. Review the information and decide if it makes sense for you to buy the Medicare Part B coverage.

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

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

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

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 payer, we process the claim first.

When Original Medicare is the primary payer, Medicare processes your claim first. In most cases, your claim will be coordinated automatically and we will then provide secondary benefits for covered charges. You will not need to do anything. To find out if you need to do something to file your claim, call us at 608-828-4853 or see our Web site at www.ghc-hmo.com.

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

- **Medicare Advantage (Part C)**

If you are eligible for Medicare, you may choose to enroll in and get your Medicare benefits from a Medicare Advantage plan. These are private health care choices (like HMOs and regional PPOs) in some areas of the country. To learn more about Medicare Advantage plans, contact Medicare at 1-800-MEDICARE (1-800-633-4227) 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), but we will not waive any of our copayments, coinsurance, or deductibles. If you enroll in a Medicare Advantage plan, tell us. We will need to know whether you are in the Original Medicare Plan or in a Medicare Advantage plan so we can correctly coordinate benefits with Medicare.

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

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

When we are the primary payer, we process the claim first. If you enroll in Medicare Part D and we are the secondary payer, 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.

TRICARE and CHAMPVA

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

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

Workers' Compensation

We do not cover services that:

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

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

Medicaid

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

Suspended FEHB coverage to enroll in Medicaid or a similar State-sponsored program of medical assistance: If you are an annuitant or a 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, contract your retirement office. If you later want to re-enroll in the FEHB program, generally you may do so only at the next Open Season unless you involuntarily lose coverage under the State program.

When other Government agencies are responsible for your care

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

When others are responsible for injuries

When you receive money to compensate you for medical or hospital care for injuries or illness caused by another person, you must reimburse us for any expenses we paid. However, we will cover the cost of treatment that exceeds the amount you received in the settlement.

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

Medicare always makes the final determination as to whether they are the primary payer. The following chart illustrates whether Medicare or this Plan should be the primary payer 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.

Primary Payer Chart		
A. When you - or your covered spouse - are age 65 or over and have Medicare and you?	The primary payer for the individual with Medicare is?	
	Medicare	This Plan
1) Have FEHB coverage on your own as an active employee or through your spouse who is an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through your spouse who is an annuitant	✓	
3) 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 #1 above	✓	
4) 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	✓	
5) 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 #1 above	✓	
6) Are enrolled in Part B only, regardless of your employment status	✓ for Part B services	✓ for other services
7) Are a former Federal employee receiving Workers' Compensation and the Office of Workers' Compensation Programs has determined that you are unable to return to duty	✓ *	
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 payer before eligibility due to ESRD		✓ for 30-month coordination period
• Medicare was the primary payer before eligibility due to ESRD	✓	
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.

**TRICARE and
CHAMPVA**

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

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

Workers' Compensation

We do not cover services that:

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

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

Medicaid

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

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

**When other Government
agencies are responsible
for your care**

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

**When others are
responsible for injuries**

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

The words "Third Party," "Any Party" or "Responsible Party" includes not only the insurance carrier(s) for the responsible party, but also any uninsured motorist coverage, underinsured motorist coverage, personal umbrella coverage, medical payments coverage, workers' compensation coverage, no-fault automobile insurance coverage or any other first party insurance coverage. The words "Member," "you" and "your" include anyone on whose behalf the Plan pays or provides any benefits.

If you do not seek damages, you must agree to let us try. This is called subrogation.

You specifically acknowledge our right of subrogation. When we provide health care benefits for injuries or illnesses for which another responsible party is or may be responsible, we shall be subrogated to your rights of recovery against any responsible party to the extent of the full cost of all benefits provided by us, to the fullest extent permitted by law. We may proceed against any responsible party with or without your consent.

Section 10 Definitions of terms we use in this brochure

Calendar year	January 1 through December 31 of the same year. For new enrollees, the calendar year begins on the effective date of their enrollment and ends on December 31 of the same year.
Coinsurance	Coinsurance is the percentage of our allowance that you must pay for your care. You may also be responsible for additional amounts.
Copayment	A copayment is a fixed amount of money you pay when you receive covered services.
Covered services	Care we provide benefits for, as described in this brochure.
Custodial care	Custodial care means care that is primarily for the purpose of meeting personal needs and which could be provided by persons without professional skill or training. For example, custodial care includes help in walking, getting in or out of bed, bathing, dressing, eating, preparing special diets, and taking medicine. Custodial care that lasts 90 days or more is known as Long Term Care.
Deductible	A deductible is a fixed amount of covered expenses you must incur for certain covered services and supplies before we start paying benefits for those services.
Experimental or investigational service	<p>We use the following criteria to determine if a service or procedure is considered experimental or investigational:</p> <ol style="list-style-type: none">1.The technology involved must have final approval from the appropriate government regulatory bodies;2.The scientific evidence must allow conclusions to be drawn based on health outcomes;3.The technology involved must improve the health outcome of the member;4.The technology involved must be as good for a patient as any of the already established alternatives; and5.Possible harm from the procedure (including long term effects) must be well understood and not outweigh the benefits. <p>Contact us if you would like more information about the criteria used in deciding whether a service or procedure is experimental or investigational.</p>
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 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.
Plan allowance	Plan allowance is the amount we use to determine our payment and your coinsurance for covered services.
Us/We	Us and We refer to Group Health Cooperative of South Central Wisconsin.
You	You refers to the enrollee and each covered family member.

Section 11 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.

Where you can get information about enrolling in the FEHB Program

See www.opm.gov/insure/health 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 who participate in Employee Express
- A link to Employee Express
- Information on and links to other electronic enrollment systems

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

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

We don't determine who is eligible for coverage and, in most cases, cannot change your enrollment status without information from your employing or retirement office.

Types of coverage available for you and your family

Self Only coverage is for you alone. Self and Family coverage is for you, your spouse, and your unmarried dependent children under age 22, including any foster children or stepchildren your employing or retirement office authorizes coverage for. Under certain circumstances, you may also continue coverage for a disabled child 22 years of age or older who is incapable of self-support.

If you have a Self Only enrollment, you may change to a Self and Family enrollment if you marry, give birth, or add a child to your family. You may change your enrollment 31 days before to 60 days after that event. The Self and Family enrollment begins on the first day of the pay period in which the child is born or becomes an eligible family member. When you change to Self and Family because you marry, the change is effective on the first day of the pay period that begins after your employing office receives your enrollment form; benefits will not be available to your spouse until you marry.

Your employing or retirement office will **not** notify you when a family member is no longer eligible to receive benefits, nor will we. Please tell us immediately when family members are added or lose coverage for any reason, including your marriage, divorce, annulment, or when your child under age 22 turns 22 or has a change in marital status.

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

Children's Equity Act

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

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

- If you have no FEHB coverage, your employing office will enroll you for Self and Family coverage in the Blue Cross and Blue Shield Service Benefit Plan's Basic Option;
- If you have a Self Only enrollment in a fee-for-service plan or in an HMO that serves the area where your children live, your employing office will change your enrollment to Self and Family in the same option of the same plan; or
- If you are enrolled in an HMO that does not serve the area where the children live, your employing office will change your enrollment to Self and Family in the Blue Cross and Blue Shield Service Benefit Plan's Basic Option.

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

When benefits and premiums start

The benefits in this brochure are effective January 1. If you joined this Plan during Open Season, your coverage begins on the first day of your first pay period that starts on or after January 1. If you changed plans or plan options during Open Season and you receive care between January 1 and the effective date of coverage under your new plan or option, your claims will be paid according to the 2007 benefits of your old plan or option. However, if your old plan left the FEHB Program at the end of the year, you are covered under that plan's 2006 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.

When you retire

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

When you lose benefits

When FEHB coverage ends

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

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

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

You may be eligible for spouse equity coverage or Temporary Continuation of Coverage (TCC), or a conversion policy (a non-FEHB individual policy.)

Upon divorce

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

Temporary Continuation of Coverage (TCC)

If you leave Federal service, 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 job, if you are a covered dependent child and you turn 22 or marry, etc.

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

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

Converting to individual coverage

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

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

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

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

Getting a Certificate of Group Health Plan Coverage

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a Federal law that offers limited Federal protections for health coverage availability and continuity to people who lose employer group coverage. If you leave the FEHB Program, we will give you a Certificate of Group Health Plan Coverage that indicates how long you have been enrolled with us. You can use this certificate when getting health insurance or other health care coverage. Your new plan must reduce or eliminate waiting periods, limitations, or exclusions for health related conditions based on the information in the certificate, as long as you enroll within 63 days of losing coverage under this Plan. If you have been enrolled with us for less than 12 months, but were previously enrolled in other FEHB plans, you may also request a certificate from those plans.

For more information, get OPM pamphlet RI 79-27, *Temporary Continuation of Coverage (TCC) under the FEHB Program*. See also the FEHB Web site at www.opm.gov/insure/health; refer to the "TCC and HIPAA" frequently asked questions. These highlight HIPAA rules, such as the requirement that Federal employees must exhaust any TCC eligibility as one condition for guaranteed access to individual health coverage under HIPAA, and information about Federal and State agencies you can contact for more information.

Section 12 Three Federal Programs complement FEHB benefits

Important information

OPM wants to be sure you are aware of three Federal programs that complement the FEHB Program.

First, the **Federal Long Term Care Insurance Program (FLTCIP)** helps cover long term care costs, which are not covered under the FEHB Program.

Second, the **Federal Flexible Spending Account Program**, also known as **FSAFEDS**, lets you set aside pre-tax money to pay for health and dependent care expenses. The result can be a discount of 20% to more than 40% on services you routinely pay for out-of-pocket.

Third, the new **Federal Employees Dental and Vision Insurance Program (FEDVIP)**, offers a variety of dental plans and vision plans to anyone who is eligible to enroll in the Federal Employees Health Benefits Program. Under **FEDVIP** you may choose self only, self plus one, or self and family coverage for yourself and any qualified dependents. Premiums are on an enrollee-pays-all basis

The Federal Long Term Care Insurance Program – *FLTCIP*

It's important protection

Why should you consider applying for coverage under the **Federal Long Term Care Insurance Program(FLTCIP)**?

- **FEHB plans do not cover the cost of long term care.** Also called “custodial care,” long term care is help you receive to perform activities of daily living – such as bathing or dressing yourself - or supervision you receive because of a severe cognitive impairment. The need for long term care can strike anyone at any age and the cost of care can be substantial.
- **The Federal Long Term Care Insurance Program can help protect you from the potentially high cost of long term care.** This coverage gives you options regarding the type of care you receive and where you receive it. With FLTCIP coverage, you won't have to worry about relying on your loved ones to provide or pay for your care.
- **It's to your advantage to apply sooner rather than later.** To qualify for coverage under the FLTCIP, you must apply and pass a medical screening (called underwriting). Certain medical conditions, or combinations of conditions, will prevent some people from being approved for coverage. By applying while you're in good health, you could avoid the risk of having a future change in your health disqualify you from obtaining coverage. Also, the younger you are when you apply, the lower your premiums. If you are a new or newly eligible employee, you (and your spouse, if applicable) have a limited opportunity to apply using the abbreviated underwriting application, which asks fewer questions. Newly married spouses of employees also have a limited opportunity to apply using abbreviated underwriting.
- **Qualified relatives are also eligible to apply.** Qualified relatives include spouses and adult children of employees and annuitants, and parents, parents-in-law, and stepparents of employees.
- **To request an Information Kit and application.** Call 1-800-LTD-FEDS (1-800-582-3337) (TTY 1-800-843-3557) or visit www.LTCFEDS.com.

The Federal Flexible Spending Account Program – *FSAFEDS*

What is an FSA?

It is a tax-favored benefit that allows you to set aside pre-tax money from your paychecks to pay for a variety of eligible expenses.

There are three types of FSAs offered by FSAFEDS. Each type has a minimum annual election of \$250 and a maximum annual election of \$5,000 per year.

- **Health Care FSA (HCFSA)** – Pays for eligible health care expenses for you and your dependents which are not covered by FEHBP coverage or other insurance.
- **Dependent Care FSA (DCFSA)** – Pays for eligible dependent care expenses that allow you (and your spouse if married) to work, look for work (as long as you have earned income for the year), or attend school full-time.
- **Limited Expense Health Care FSA (LEX HCFSA)** – Designed for employees enrolled in or covered by a High Deductible Health Plan with a Health Savings Account. Eligible expenses are limited to dental and vision care expenses for you and your dependents, which are not covered or reimbursed by FEHBP or FEDVIP coverage or other insurance.

What expenses can I pay with an FSAFEDS account?

For the HCFSA – Health plan copayments, deductibles, over-the-counter medications and products, sunscreen, eyeglasses, contacts, other vision and dental expenses (but not insurance premiums).

For the LEX HCFSA – Dental and vision care expenses including eligible over-the-counter medicines and products related to dental and vision care (but not insurance premiums)

For the DCFSA – daycare expenses (including summer camp) for your child(ren) under age 13, dependent care expenses for dependents unable to care for themselves

AND MUCH MORE! Visit www.FSAFEDS.com

Who is eligible to enroll?

Most Federal employees in the Executive branch and many in non-Executive branch agencies are eligible. For specifics on eligibility, visit www.FSAFEDS.com or call an FSAFEDS Benefits Counselor toll-free at 1-877-FSAFEDS (1-877-372-3337), Monday through Friday, 9 a.m. until 9 p.m., EST. TTY: 1-800-952-0450.

When can I enroll?

If you wish to participate, you must make an election to enroll each year by visiting www.FSAFEDS.com or calling the number above during the FEHB Open Season or within 60 days of employment (for new employees).

Even if you enrolled for 2006, you must make a new election to continue participating in 2007. Enrollment DOES NOT carry over from year to year.

Who is SHPS?

SHPS is the Third Party Administrator hired by OPM to manage the FSAFEDS Program. SHPS is responsible for enrollment, claims processing, customer service, and day-to-day operations of FSAFEDS.

Who is BENEFEDS?

BENEFEDS is the name of the voluntary benefits portal hired by OPM to work with the FSAFEDS Program to set up payroll deductions for FSAFEDS allotments.

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

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Summary of benefits for the High Option of the Group Health Cooperative of South Central Wisconsin - 2007

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

High Option Benefits	You pay	Page
Medical services provided by physicians:	\$10 primary care	16
	\$10 specialist	
Diagnostic and treatment services provided in the office	Office visit copay: \$10 primary care; \$10 specialist	16
Services provided by a hospital:		
• Inpatient	Nothing	29
• Outpatient	Nothing	30
Emergency benefits:		
• In-area	\$75 per visit, waived if admitted	33
• Out-of-area	\$75 per visit, waived if admitted	33
Mental health and substance abuse treatment:	Regular cost sharing	34
Prescription drugs:		xx
• Retail pharmacy	\$5 generic; \$20 brand	35
• Mail order	Not available	
Dental care:	Nothing if provided by a participating dentist; otherwise 50% coinsurance.	38
Vision care:	\$10 office visit copay, age 18 and older	21
Protection against catastrophic costs (out-of-pocket maximum):	We do not have an out-of-pocket catastrophic maximum.	

2007 Rate Information for Group Health Cooperative of South Central Wisconsin

Non-Postal rates apply to most non-Postal employees. If you are in a special enrollment category, refer to the FEHB Guide for that category or contact the agency that maintains your health benefits enrollment.

Postal rates apply to career Postal Service employees. Most employees should refer to the FEHB Guide for United States Postal Service Employees, RI 70-2. Different postal rates apply and a special FEHB guide is published for Postal Service Inspectors and Office of Inspector General (OIG) employees (see RI 70-2IN).

Postal rates do not apply to non-career postal employees, postal retirees, or associate members of any postal employee organization who are not career postal employees. Refer to the applicable FEHB Guide.

Type of Enrollment	Enrollment Code	Non-Postal Premium				Postal Premium	
		Biweekly		Monthly		Biweekly	
		Gov't Share	Your Share	Gov't Share	Your Share	USPS Share	Your Share

Dane County Wisconsin and adjacent counties

High Option Self Only	WJ1	125.3	41.77	271.49	90.5	148.27	18.8
High Option Self and Family	WJ2	321.89	123.5	697.43	267.58	380.01	65.38