Group Health Cooperative of Eau Claire

Cooperative of Eau Claire

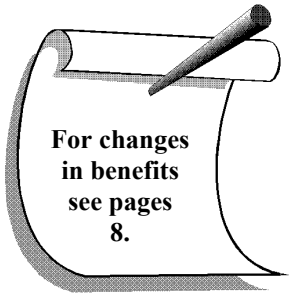
http://www.group-health.com

2003

A Health Maintenance Organization

Serving: West Central Wisconsin

Enrollment in this Plan is limited. You must live or work in this Geographic service area to enroll. See page 6 for requirements.



Enrollment codes for this Plan:

WT1 Self Only
WT2 Self and Family

Authorized for distribution by the:

United States
Office of Personnel Management
Retirement and Insurance Service
http://www.opm.gov/insure

Federal Employees
Health Benefits Program

RI 73-555

UNITED STATES
OFFICE OF PERSONNEL MANAGEMENT
WASHINGTON, DC 20415-0001

OFFICE OF THE DIRECTOR

Dear Federal Employees Health Benefits Program Participant:

I am pleased to present this Federal Employees Health Benefits (FEHB) Program plan brochure for 2003. The brochure explains all the benefits this health plan offers to its enrollees. Since benefits can vary from year to year, you should review your plan's brochure every Open Season. Fundamentally, I believe that FEHB participants are wise enough to determine the care options best suited for themselves and their families.

In keeping with the President's health care agenda, we remain committed to providing FEHB members with affordable, quality health care choices. Our strategy to maintain quality and cost this year rested on four initiatives. First, I met with FEHB carriers and challenged them to contain costs, maintain quality, and keep the FEHB Program a model of consumer choice and on the cutting edge of employer-provided health benefits. I asked the plans for their best ideas to help hold down premiums and promote quality. And, I encouraged them to explore all reasonable options to constrain premium increases while maintaining a benefits program that is highly valued by our employees and retirees, as well as attractive to prospective Federal employees. Second, I met with our own FEHB negotiating team here at OPM and I challenged them to conduct tough negotiations on your behalf. Third, OPM initiated a comprehensive outside audit to review the potential costs of federal and state mandates over the past decade, so that this agency is better prepared to tell you, the Congress and others the true cost of mandated services. Fourth, we have maintained a respectful and full engagement with the OPM Inspector General (IG) and have supported all of his efforts to investigate fraud and waste within the FEHB and other programs. Positive relations with the IG are essential and I am proud of our strong relationship.

The FEHB Program is market-driven. The health care marketplace has experienced significant increases in health care cost trends in recent years. Despite its size, the FEHB Program is not immune to such market forces. We have worked with this plan and all the other plans in the Program to provide health plan choices that maintain competitive benefit packages and yet keep health care affordable.

Now, it is your turn. We believe if you review this health plan brochure and the FEHB Guide you will have what you need to make an informed decision on health care for you and your family. We suggest you also visit our web site at www.opm.gov/insure.

Sincerely,

Kay Coles James
Director

Notice of the Office of Personnel Management's

Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

By law, the Office of Personnel Management (OPM), which administers the Federal Employees Health Benefits (FEHB) Program, is required to protect the privacy of your personal medical information. OPM is also required to give you this notice to tell you how OPM may use and give out ("disclose") your personal medical information held by OPM.

OPM **will** use and give out your personal medical information:

- To you or someone who has the legal right to act for you (your personal representative),
- To the Secretary of the Department of Health and Human Services, if necessary, to make sure your privacy is protected,
- To law enforcement officials when investigating and/or prosecuting alleged or civil or criminal actions, and
- Where required by law.

OPM **has the right** to use and give out your personal medical information to administer the FEHB Program. For example:

- To communicate with your FEHB health plan when you or someone you have authorized to act on your behalf asks for our assistance regarding a benefit or customer service issue.
- To review, make a decision, or litigate your disputed claim.
- For OPM and the General Accounting Office when conducting audits.

OPM **may** use or give out your personal medical information for the following purposes under limited circumstances:

- For Government healthcare oversight activities (such as fraud and abuse investigations),
- For research studies that meet all privacy law requirements (such as for medical research or education), and
- To avoid a serious and imminent threat to health or safety.

By law, OPM must have your written permission (an "authorization") to use or give out your personal medical information for any purpose that is not set out in this notice. You may take back ("revoke") your written permission at any time, except if OPM has already acted based on your permission.

By law, you **have the right** to:

- See and get a copy of your personal medical information held by OPM.
- Amend any of your personal medical information created by OPM if you believe that it is wrong or if information is missing, and OPM agrees. If OPM disagrees, you may have a statement of your disagreement added to your personal medical information.
- Get a listing of those getting your personal medical information from OPM in the past 6 years. The listing will not cover your personal medical information that was given to you or your personal representative, any information that you authorized OPM to release, or that was given out for law enforcement purposes or to pay for your health care or a disputed claim.
- Ask OPM to communicate with you in a different manner or at a different place (for example, by sending materials to a P.O. Box instead of your home address).

- Ask OPM to limit how your personal medical information is used or given out. However, OPM may not be able to agree to your request if the information is used to conduct operations in the manner described above.
- Get a separate paper copy of this notice.

For more information on exercising your rights set out in this notice, look at www.opm.gov/insure on the web. You may also call 202-606-0191 and ask for OPM's FEHB Program privacy official for this purpose.

If you believe OPM has violated your privacy rights set out in this notice, you may file a complaint with OPM at the following address:

Privacy Complaints
Office of Personnel Management
P.O. Box 707
Washington, DC 20004-0707

Filing a complaint will not affect your benefits under the FEHB Program. You also may file a complaint with the Secretary of the 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 will be effective April 14, 2003.

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Introduction

This brochure describes the benefits of Group Health Cooperative of Eau Claire under our contract (CS 2615) with the Office of Personnel Management (OPM), as authorized by the Federal Employees Health Benefits law. The address for Group Health Cooperative of Eau Claire's administrative offices is:

Group Health Cooperative of Eau Claire
2503 North Hillcrest Parkway
Altoona, WI 54720

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, 2003 unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2003 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 Eau Claire, Group Health Cooperative, or Group Health.
- We limit acronyms to ones you know. FEHB is the Federal Employees Health Benefits Program. OPM is the 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 us know. Visit OPM's "Rate Us" feedback area at www.opm.gov/insure or e-mail us at fehbwebcomments@opm.gov. You may also write to OPM at the Office of Personnel Management, Office of Insurance Planning and Evaluation Division, 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 (FEHB) 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 you can do to prevent fraud:

- Be wary of giving your plan identification (ID) number over the telephone or to people you do not know, except to your doctor, other provider, or authorized 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) 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 888/203-7770 and explain the situation.
    - If we do not resolve the issue:

CALL -- THE HEALTH CARE FRAUD HOTLINE
202-418-3300

OR WRITE TO:
The United States Office of Personnel Management
Office of the Inspector General Fraud Hotline
1900 E Street, NW, Room 6400
Washington, DC 20415

- 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); or
    - 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 or with OPM if you are retired.
- 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

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 only pay the co-payments, coinsurance, and deductibles described in this brochure. When you receive emergency services from non-Plan providers, you may have to submit claim forms.

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

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 co-payments and deductible.

Who provides my health care?

Group Health Cooperative of Eau Claire is a network model, non-profit, member directed health maintenance organization. Group Health has been in operation since 1976 and provides services through twenty-five clinics. Four clinics are located in Eau Claire; three in Chippewa Falls; two in Rice Lake, Thorp and Stanley; and one each in Augusta, Bruce, Cadott, Chetek, Cornell, Cumberland, Ladysmith, Osseo, Owen and Radisson. Group Health has over 120 primary care physicians to choose from and over 600 referral specialists. Primary care is the professional focus at Group Health, which includes specialists in family practice, obstetrics/gynecology, internal medicine, pediatrics, and sports medicine. Also included in our team of professionals are the services of our physicians assistants, certified family and pediatric nurse practitioners and nurse midwives.

Your Rights

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

- We are a State licensed HMO that meets all Federal and State requirements
- Group Health has been a Cooperative for 28 years
- Group Health is a non-profit organization

If you want more information about us, call 888/203-7770 or write to: Group Health Cooperative of Eau Claire; P.O. Box 3217; Eau Claire, WI 54702. You may also contact us by fax at 715/552-3500 or visit our website at www.group-health.com.

Service Area

To enroll in this plan, you must live in or work in our Service Area. This is where our providers practice. This plan considers its service area to be a 25-mile radius around each primary care clinic. Please see this Plan's Provider Directory for a list of those clinics. You may also enroll with us if you live or work in the following counties: Barron, Buffalo, Chippewa, Clark, Dunn, Eau Claire, Jackson, Pepin, Rusk, Sawyer, Taylor, Trempealeau, and Washburn.

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 2003

Do not rely on these change descriptions; this page 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.

Program-wide changes

- We increased speech therapy benefits by removing the requirement that services must be required to restore functional speech. (Section 5(a)).
- A Notice of the Office of Personnel Management's Privacy Practices is included.
- A section on the Children's Equity Act describes when an employee is required to maintain Self and Family coverage.
- Program information on TRICARE and CHAMPVA explains how annuitants or former spouses may suspend their FEHB Program enrollment.
- Program information on Medicare is revised.
- By law, the DoD/FEHB Demonstration project ends on December 31, 2002.

Changes to this Plan

- Your share of the non-Postal premium will decrease by 3.9% for Self Only or 2.0% for Self and Family.
- Rehabilitation therapies (physical, occupational and speech) will now require a $10 member copayment per office visit. Previously, they were covered without an office visit copayment.
- Emergency room visit will now require a $50 member copayment. Previously, was covered with a $25 member copayment.
- Prescription drugs will now require a $10 member copayment for generic drugs and a $20 member copayment for brand name drugs. Previously, all prescription drugs were covered with a $10 copayment.

Section 3. How you get care

Identification cards

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

If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call us at 888/203-7770.

Where you get covered care

You get care from "Plan providers" and "Plan facilities." You will only pay co-payments and deductibles, and you will not have to file claims.

- **Plan providers**

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

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

- **Plan facilities**

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

What you must do to get covered care

It depends on the type of care you need. First, you and each family member must choose a primary care clinic. This decision is important since your primary care physician, at your clinic, provides or arranges for most of your health care. Each member of the family can choose a different clinic for their care. You may change clinics twice a year by calling Member Services at 888/203-7770.

- **Primary care**

Your primary care physician can be a family practitioner, internist, OB/GYN, or pediatrician. Your primary care physician will provide most of your health care, or give you a referral to see a specialist.

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

- **Specialty care**

Your primary care physician will refer you to a specialist for needed care. When you receive a referral from your primary care physician, you must return to the primary care physician after the consultation, unless your primary care physician authorized a certain number of visits without additional referrals. The primary care physician must provide or authorize all follow-up care. Do not go to the specialist for return visits unless your primary care physician gives you a referral. However, you may see the Group Health Cooperative contracted providers for Chiropractic and Optometry (one annual exam) care without a referral

Here are other things you should know about specialty care:

- If you need to see a specialist frequently because of a chronic, complex, or serious medical condition, your primary care physician will develop a treatment plan that allows you to see your specialist for a certain number of visits. 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 or 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 Plan; or
  - reduce our service area and you enroll in another FEHB Plan,

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

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

• Hospital care

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

If you are in the hospital when your enrollment in our Plan begins, call our customer service department immediately at 715/552-4300. If you are new to the FEHB Program, we will arrange for you to receive care.

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.

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.

Group Health's primary care physicians are supported by an extensive network of more than 600 specialty and tertiary care physicians to ensure access to the complete continuum of high-quality healthcare services.

If both you and your primary care physician feel that you require additional treatment, together you decide about the appropriate type of referral to a specialist. A written referral is required for every visit with a specialist. Your primary care physician will provide you with the referral. Every referral you receive will have a limit of days and/or a specific number of visits for when you can use that referral. Please make sure that you see that specialist within that time allotted.

If you notice that your appointment falls after the referral end date, please contact your primary care physician to receive a new referral.

If the specialist believes it is necessary for you to seek additional treatment, you should contact your primary care physician to discuss the additional referral. The specialist should not make a direct referral for you; it must come from your primary care physician.

Section 4. Your costs for covered services

You must share the cost of some services. You are responsible for:

• **Copayments**	A co-payment is a fixed amount of money you pay to the provider, facility, pharmacy, etc., per office visit when you receive services. Example: When you see your primary care physician, a specialist, a chiropractor, or home health services, you pay a co-payment of $10 per office visit. You would also pay a $50 co-payment for Emergency Room visits.
• **Deductible**	A deductible is a fixed expense you must incur for certain covered services and supplies before we start paying benefits for them. Co-payments do not count toward any deductible • The only deductible you have is for Durable Medical Equipment, which is $50 per person per calendar year.
Your catastrophic protection out-of-pocket maximum	We do not have an out-of-pocket maximum.
Limitations	We may limit your benefits if you do not obtain a treatment plan.

Section 5. Benefits -- OVERVIEW

(See page 8 for how our benefits changed this year and page 51 for a benefits summary.)

NOTE: This benefits section is divided into subsections. Please read the important things you should keep in mind at the beginning of each subsection. Also read the General Exclusions in Section 6; they apply to the benefits in the following subsections. To obtain more information about how to obtain your benefits, contact us at 888/203-7770 or at our website at www.group-health.com.

(a) Medical services and supplies provided by physicians and other health care professionals 14-20

- Diagnostic and treatment services
- Lab, X-ray, and other diagnostic tests
- Preventive care, adult
- Preventive care, children
- Maternity care
- Family planning
- Infertility services
- Allergy care
- Treatment therapies
- Physical and occupational therapies
- Speech therapy
- Hearing services (testing)
- Vision services (one annual routine exam)
- Foot care
- Orthopedic and prosthetic devices
- Durable medical equipment (DME)
- Home health services
- Chiropractic
- Educational classes and programs

(b) Surgical and anesthesia services provided by physicians and other health care professionals 21-23

- Surgical procedures
- Reconstructive surgery
- Oral and maxillofacial surgery
- Organ/tissue transplants
- Anesthesia

(c) Services provided by a hospital or other facility, and ambulance services 24-25

- Inpatient hospital
- Outpatient hospital or ambulatory surgical center
- Extended care benefits/skilled nursing care facility benefits
- Ambulance

(d) Emergency services/accidents 26-28

- Medical emergency
- Ambulance

(e) Mental health and substance abuse benefits 29

(f) Prescription drug benefits 30-31

(g) Special Features 32

- Flexible benefits option 32
- 24 hour Nurseline (FirstCare Nurseline) 32

(h) Dental benefits 33

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

IMPORTANT

Here are some important things to 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*, or valuable information about how cost sharing works. Also, read Section 9 about coordinating benefits with other coverage, including Medicare.

IMPORTANT

Benefit Description	You pay
Diagnostic and treatment services	
Professional services of physicians • In physician's office • In specialist's office • In chiropractor's office	$10 per office visit
Professional services of physicians • In an urgent care center • During a hospital stay • Office medical consultations • Second surgical opinion	 $10 per office visit Nothing $10 per office visit $10 per office visit
Lab, X-ray and other diagnostic tests	
Tests, such as: • Blood tests • Urinalysis • Non-routine pap tests • Pathology • X-rays • Non-routine Mammograms • CAT Scans/MRI • Ultrasound • Electrocardiogram and EEG	Nothing

Preventive care, adult	You pay
Routine physical Routine screenings, such as: • Blood pressure check • Total Blood Cholesterol • Colorectal Cancer Screening, including – Fecal occult blood test – Sigmoidoscopy, screening starting at age 50 • Routine pap test	$10 per office visit and No copayment for tests.
Not covered: Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, or travel.	*All charges*
• Tetanus-diphtheria (Td) booster • Influenza/Pneumococcal vaccines, annually, age 65 and over	Nothing
Preventive care, children	
• Childhood immunizations recommended by the American Academy of Pediatrics	Nothing
• Well-child care charges for routine examinations, immunizations and care (under age 22) • Examinations, such as: – Eye exams through age 17 to determine the need for vision correction. – Ear exams through age 17 to determine the need for hearing correction – Examinations done on the day of immunizations (under age 22)	$10 per office visit Nothing for one annual eye exam Nothing $10 per office visit

Maternity care	You pay
Complete maternity (obstetrical) care, such as: • Prenatal care • Delivery • Postnatal care Note: Here are some things to keep in mind: • You do not need to pre-certify your normal delivery; see page 24 for other circumstances, such as extended stays for you or your baby. • You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will extend your inpatient stay if medically necessary. • We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self and Family enrollment. • 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 first maternity office visit only. Nothing for follow up maternity office visits.
Not covered: Routine sonograms to determine fetal age, size or sex or medial and hospital costs resulting from a normal full-term delivery of a baby outside of the Group Health Cooperative service area.	*All charges*
Family planning	
A range of voluntary family planning services, limited to: • Voluntary sterilization (See Surgical procedures Section 5 (b)) • Injectable contraceptive drugs (such as Depo provera) Note: We cover oral contraceptives under the prescription drug benefit.	$10 per office visit
Not covered: • *Reversal of voluntary surgical sterilization, genetic counseling,* • *Surgically implanted contraceptives, such as Norplant* • *Intrauterine devices (IUD's),* • *Elective abortions*	*All charges*

Infertility services	You pay
Diagnosis and treatment of infertility, if provided by a Group Health Primary Care Physician, except as shown in *Not Covered*: • Artificial insemination: – intravaginal insemination (IVI) – intracervical insemination (ICI) – intrauterine insemination (IUI)	$10 per office visit
Not covered: • *Assisted reproductive technology (ART) procedures, such as:* – *In vitro fertilization* – *Embryo transfer, gamete GIFT and zygote ZIFT* – *Zygote transfer* • *Services and supplies related to excluded ART procedures* • *Cost of donor sperm* • *Cost of donor egg* • *Fertility drugs*	*All charges*
Allergy care	
Testing and treatment Allergy injection	$10 per office visit Nothing
Allergy serum	Nothing
Not covered: provocative food testing and sublingual allergy desensitization	*All charges*
Treatment therapies	
• Chemotherapy and radiation therapy Note: High dose chemotherapy in association with autologous bone marrow transplants are limited to those transplants listed under Organ/Tissue Transplants on page 23. • Respiratory and inhalation therapy • Dialysis – Hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy • Growth hormone therapy (GHT) Notes: Growth Hormone therapy is covered under the prescription drug benefit. Notes: Growth hormone therapy (GHT) - This requires medical director approval. Call 888/203-7770 for pre-authorization or have your physician call our office.	Nothing

Physical and occupational therapies	You pay

• 60 visits per condition for the services of each of the following:
  • qualified physical therapists and
  • occupational therapists.
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.
• Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction, is provided with approved referral.
	$10 per office visit

Not covered: • *long-term rehabilitative therapy* • *Maintenance therapy* • *exercise programs*	*All charges*
Speech therapy	
Up to two months when medically necessary and subject to prior authorization.	$10 per office visit.
Hearing services (testing, treatment, and supplies)	
• Diagnostic hearing testing only when necessitated by accidental injury. • Hearing testing for children through age 17 (see *Preventive care, children*)	$10 per office visit $10 per office visit
Not covered: • *all other hearing testing* • *hearing aids, testing and examinations for them*	*All charges*
Vision services (testing, treatment, and supplies)	
• Annual eye refractions	Nothing at participating providers.
Not covered: • *Eyeglasses or contact lenses and, after age 17, examinations for them* • *Eye exercises and orthoptics* • *Radial keratotomy and other refractive surgery*	*All charges*

Foot care	You pay
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes. See orthopedic and prosthetic devices for information on podiatric shoe inserts.	$10 per office visit
Not covered: • *Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above* • *Treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery)*	*All charges*
Internal prosthetic devices	
• Internal prosthetic devices, such as artificial joints, pacemakers, and surgically implanted breast implant following mastectomy. Note: We pay internal prosthetic devices as hospital benefits; see Section 5 (c) for payment information. See 5 (b) for coverage of the surgery to insert the device.	Nothing
Durable medical equipment (DME)/Prosthetic/Orthopedic Devices	
Rental or purchase, at our option, including repair and adjustment, of durable medical equipment prescribed by your Plan physician, such as oxygen and dialysis equipment. Under this benefit, we also cover: • Hospital beds; • Wheelchairs; • Crutches; • Walkers; • Blood glucose monitors; • Insulin pumps; • Artificial limbs and eyes; stump hose; • Externally worn breast prostheses and surgical bras, including necessary replacements, following mastectomy; • Prosthetics. • Corrective orthopedic appliances for non-surgical treatment of temporomandibular joint (TMJ) pain dysfunction syndrome. • Custom made foot orthotics and corrective shoes; • Corsets, trusses, and other braces and devices; and	$50 deductible per person, per calendar year. $5,000 lifetime maximum Durable medical equipment (*continued on next page*)

Durable medical equipment (DME)/Prosthetic/Orthopedic Devices (*continued)*	**You pay**
Note: Call us at 888/203-7770 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. Benefits are limited to a lifetime maximum of $5,000. *Not covered:* • *Motorized wheelchairs* • *Replacement of lost or stolen equipment.*	*All charges*
Home health services	
• 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.	$10 per home visit
Not covered: • *Nursing care requested by, or for the convenience of, the patient or the patient's family;* • *Home care primary for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative.*	*All charges*
Chiropractic	**You pay**
• Manipulation of the spine and extremities. • Adjunctive procedures such as ultrasound, electrical muscle stimulation, vibratory therapy, and cold pack application.	$10 per office visit.
Alternative treatments	
Not covered: • *naturopathic services* • *hypnotherapy* • *biofeedback* • *acupuncture*	*All charges*
Educational classes and programs	
Coverage is limited to: • Smoking Cessation – covered for initial consultation.	$10 for initial office visit.

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

IMPORTANT

Here are some important things to 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 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 PRE-CERTIFICATION OF SOME SURGICAL PROCEDURES. Please refer to the pre-certification information shown in Section 3 to be sure which services require pre-certification and identify which surgeries require pre-certification.

IMPORTANT

Benefit Description	You pay
Surgical procedures	
A comprehensive range of services, such as: • Operative procedures • Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedures • Biopsy procedures • Removal of tumors and cysts • Correction of congenital anomalies (see reconstructive surgery) • Surgical treatment of morbid obesity -- a condition in which an individual weighs 100 pounds or 100% over his or her normal weight according to current underwriting standards; eligible members must be age 18 or over • Insertion of internal prosthetic devices. See 5(a) – Orthopedic and prosthetic devices for device coverage information. • Voluntary sterilization (e.g., Tubal ligation, Vasectomy) • Treatment of burns 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.	$10 per office visit
Not covered: • *Reversal of voluntary sterilization* • *Routine treatment of conditions of the foot; see Foot care.*	*All charges*

Reconstructive surgery	You pay
• Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: – the condition produced a major effect on the member's appearance and – the condition can reasonably be expected to be corrected by such surgery • Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birth marks; webbed fingers; and webbed toes.	Nothing
• All stages of breast reconstruction surgery following a mastectomy, such as: – surgery to produce a symmetrical appearance on the other breast; – treatment of any physical complications, such as lymphedemas; – breast prostheses and surgical bras and replacements (see Prosthetic devices) Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.	Nothing
Not covered: • *Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury* • *Surgeries related to sex transformation*	*All charges*
Oral and maxillofacial surgery	
Oral surgical procedures, limited to: • Reduction of fractures of the jaws or facial bones; • Surgical correction of cleft lip, cleft palate or severe functional malocclusion; • Removal of stones from salivary ducts; • Excision of leukoplakia or malignancies; • Excision of cysts and incision of abscesses when done as independent procedures; • Other surgical procedures that do not involve the teeth or their supporting structures; and • TMJ surgery and other non-dental services	$10 per office visit
Not covered: • *Oral implants and transplants* • *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)*	*All charges*

Organ/tissue transplants	You pay
Limited to: • Cornea • Heart • Heart/lung • Kidney • Kidney/Pancreas • Liver • Lung: Single-Double • Pancreas • Allogeneic (donor) bone marrow transplants • Autologous bone marrow transplants (autologous stem cell and peripheral stem cell support) for the following conditions: acute lymphocytic or non-lymphocytic leukemia; advanced Hodgkin's lymphoma; advanced non-Hodgkin's lymphoma; advanced neuroblastoma; breast cancer; multiple myeloma; epithelial ovarian cancer; and testicular, mediastinal, retroperitoneal and ovarian germ cell tumors • Intestinal transplants (small intestine) and the small intestine with the liver or small intestine with multiple organs such as the liver, stomach, and pancreas. • We do transplants on a referral basis with Medical Director approval. • Limited Benefits - Treatment for breast cancer, multiple myeloma, and epithelial ovarian cancer may be provided in an NCI- or NIH-approved clinical trial at a Plan-designated center of excellence and if approved by the Plan's medical director in accordance with the Plan's protocols. Note: We cover related medical and hospital expenses of the donor when we cover the recipient.	Nothing
Not covered: • *Donor screening tests and donor search expenses, except those performed for the actual donor* • *Implants of artificial organs* • *Transplants not listed as covered*	*All charges*
Anesthesia	
Professional services provided in - • Hospital (inpatient)	Nothing
Professional services provided in - • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Office	Nothing

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

IMPORTANT

Here are some important things to remember 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 covered in Sections 5(a) or (b).

IMPORTANT

Benefit Description	You pay
Inpatient hospital	
Room and board, such as • 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: • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and X-rays • Administration of blood and blood products • Blood or blood plasma, if not donated or replaced • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services • Take-home items	Nothing
Not covered: • *Custodial care* • *Non-covered facilities, such as nursing homes, schools* • *Personal comfort items, such as telephone, television, barber services, guest meals and beds* • *Private nursing care*	*All charges*

Outpatient hospital or ambulatory surgical center	You pay
• Operating, recovery, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests, X-rays, and pathology services • Administration of blood, blood plasma, and other biologicals • Blood and blood plasma, if not donated or replaced • Pre-surgical testing • Dressings, casts, and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service Note: We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. We do not cover the dental procedures.	Nothing
Not covered: blood and blood derivatives not replaced by the member	*All charges*
Extended care benefits/skilled nursing care facility benefits	
Extended Care/Skilled nursing facility (SNF); if medically necessary.	Nothing
Not covered: custodial care	*All charges*
Hospice care	
Not covered: • *Independent nursing, homemaker services* • *Hospice care*	*All charges*
Ambulance	
• Local professional ambulance service when medically appropriate	Nothing

Section 5 (d). Emergency services/accidents

IMPORTANT

Here are some important things to keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure.
- 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.

IMPORTANT

What is a medical emergency?

A medical emergency is the sudden and unexpected onset of a condition or an injury that you believe endangers your life or could result in serious injury or disability, and requires immediate medical or surgical care. Some problems are emergencies because, if not treated promptly, they might become more serious; examples include deep cuts and broken bones. Others are emergencies because they are potentially life threatening, such as heart attacks, strokes, poisonings, gunshot wounds, or sudden inability to breathe. There are many other acute conditions that we may determine are medical emergencies - what they all have in common is the need for quick action.

What to do in case of emergency:

Emergencies within our service area: A medical emergency is a sudden, potentially life-threatening situation where immediate medical treatment is needed. The following are some examples of a medical emergency.

- Heart Attack
- Major Trauma
- Sudden Unconsciousness

When such a situation arises, no authorization is necessary and you should proceed directly to the emergency department. The enclosed Provider Directory has a list of hospitals that will provide quality coverage for such emergency care. You should also look at your Benefit Summary or your Group Health contract policy and rider that will show if you have a co-payment or emergency services.

Emergencies outside our service area: If a true emergency occurs while you are away from the Group Health service area, treatment for the emergency will be covered at any facility. Follow-up care, however, whether it is inpatient or outpatient, must be provided by a contracted provider. To save yourself some confusion and worry when out of the area, you can call our Member Service Representatives at 888/203-7770 to review your coverage in case of an emergency.

FirstCare Nurseline: Call our FirstCare Nurseline before obtaining urgent care services at any of our facilities.

Urgent Care within our service area: Conditions may arise that require urgent medical attention but may not be serious enough to go to the ER. Examples include the following:

- Minor Injuries
- Ear Infections
- Fevers

Unless the condition is a life-threatening emergency, you must call the FirstCare Nurseline or your primary care clinic to discuss the situation with a physician or triage nurse. They will direct you to the proper setting to receive care. In some situations, a physician may even be able to provide the appropriate treatment over the phone. In other cases, you may be instructed to go to the emergency room or to an urgent care facility.

Urgent Care outside our service area: Urgent care means that the member cannot safely return to the Group Health Cooperative service area before needing treatment. In such cases, the FirstCare Nurseline or physician may advise you to seek care at the nearest appropriate facility. If it is not possible to contact your primary care clinic for advice or authorization, you should seek treatment at a physician's office, urgent care facility, or Emergency Department depending on the problem. A coverage decision will be made based on the medical records from you visit.

Benefit Description	You pay
Emergency within our service area	
• Emergency care at a doctor's office • Emergency care at an urgent care center • Emergency care as an outpatient or inpatient at a hospital, including doctors' services	$10 per office visit $10 per office visit $50 per visit
Not covered: Elective care or non-emergency care	*All charges*
Emergency outside our service area	
• Emergency care at a doctor's office • Emergency care at an urgent care center • Emergency care as an outpatient or inpatient at a hospital, including doctors' services	$10 per office visit $10 per office visit $50 per visit
Not covered: • *Elective care or non-emergency care* • *Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area* • *Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area*.	*All charges*
Ambulance	
Professional ambulance service when medically appropriate. See 5(c) for non-emergency service.	Nothing

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

IMPORTANT

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.

Here are some important things to 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 ARE REQUIRED TO USE THE GROUP HEALTH COOPERATIVE MENTAL HEALTH PROVIDERS.** See the instructions after the benefits description below.

IMPORTANT

Benefit Description	You pay
Mental health and substance abuse benefits	
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. 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.	Your cost sharing responsibilities are no greater than for other illness or conditions.
• Professional services, including individual or group therapy by providers such as psychiatrists, psychologists, or clinical social workers • Medication management	$10 per visit
• Diagnostic tests	Nothing
• Services provided by a hospital or other facility	Nothing
Not covered: Services received outside our network. *Note: OPM will base its review of disputes about treatment plans on the treatment plans clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.*	*All charges*

Preauthorization

To be eligible to receive these benefits you must follow your treatment plan and all the following authorization processes:
You are required to use the Group Health Mental Health providers listed in your provider directory. You can obtain a directory or information from our website at www.group-health.com or from our Member Service Representatives at 715/552-4300 or 888/203-7770.

Limitations

We may limit your benefits if you do not obtain a treatment plan!

Section 5 (f). Prescription drug benefits

IMPORTANT

Here are some important things to 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 we are payable only when we determine they are medically necessary.
- You have a $10 co-payment per prescription for generic drugs and a $20 co-payment for brand name drugs.
- 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 Medicare.

IMPORTANT

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

- **Who can write your prescription.** A licensed physician must write the prescription – or – A plan physician or licensed dentist must write the prescription.
- **Where you can obtain them.** You may fill the prescription at a any contracted pharmacy,
- **We use a formulary.** Drugs are prescribed by plan doctors and dispensed in accordance with the plan's drug formulary. Non-formulary drugs will be covered when prescribed by Plan doctor. A list of prescription products that are covered by Group Health Cooperative is available to you. Products are chosen by a Pharmacy & Therapeutics (P&T) Committee consisting of physicians, pharmacists and non-physician clinicians. Inclusion in the formulary is based on medical efficacy and cost effectiveness. New products are automatically reviewed by the P&T Committee, while older products are received at the request of a clinician or when a substantial number of prior authorizations have been requested for its use. Members who wish to have a product added to the formulary should discuss the reasoning with their primary care physician who may then initiate the process with the P&T Committee.

  A generic equivalent will be dispensed if it is available.
- **These are the dispensing limitations.** Prescription drugs prescribed by a Plan or referral doctor and obtained at a Plan pharmacy will be dispensed for up to a 31-day supply, or up to 100-day supply for drugs on the Group Health Extended Supply List.
- **Why use generic drugs?** Generic drugs are lower-priced drugs that are the therapeutic equivalent to more expensive brand-name drugs. They must contain the same active ingredients and must be equivalent in strength and dosage to the original brand-name product. Generics cost less than the equivalent brand-name product. The U.S. Food and Drug Administration sets quality standards for generic drugs to ensure that these drugs meet the same standards of quality and strength as brand-name drugs.
- **When you have to file a claim.** Prescription drugs are automatically paid electronically because the pharmacist's computer bills Group Health directly. You do not have to file any prescription claims. Group Health has pharmacy contracts with all local pharmacies and most national chains. If you are in an area without a provider pharmacy you may have the pharmacy call our pharmacy department at 888-298-7770 (available 24 hours a day, 7 days a week) or you may pay for the prescription and mail in the receipt for reimbursement to: Attn: Claims Department; Group Health Cooperative; P.O. Box 3217; Eau Claire, WI 54702.

Benefit Description	You pay
Covered medications and supplies	
We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy. • Drugs and medicines that by Federal law of the United States require a physician's prescription for their purchase, except those listed as *Not covered*. • Insulin • Disposable needles and syringes for the administration of covered medications • Drugs for sexual dysfunction (up to dosage limitation) • Contraceptive drugs • Zyban (limited to one time, 3 month prescription).	$10 copayment per generic prescription. $20 copayment per brand name prescription.
Not covered: • *Drugs and supplies for cosmetic purposes* • *Drugs to enhance athletic performance* • *Fertility drugs* • *Drugs obtained at a non-Plan pharmacy; except for out-of-area emergencies* • *Vitamins, nutrients and food supplements even if a physician prescribes or administers them* • *Nonprescription medicines* • *Drugs used to control or reduce weight* • *Nicotine patches*	*All charges*

Section 5 (g). Special features

Feature	Description
Flexible benefits option	Under the flexible benefits option, we determine the most effective way to provide services. • We may identify medically appropriate alternatives to traditional care and coordinate other benefits as a less costly alternative benefit. • Alternative benefits are subject to our ongoing review. • By approving an alternative benefit, we cannot guarantee you will get it in the future. • The decision to offer an alternative benefit is solely ours, and we may withdraw it at any time and resume regular contract benefits. • Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process.
24 hour Nurseline	For urgent care or any of your health concerns, 24 hours a day, 7 days a week, call the FirstCare Nurseline and talk with a registered nurse who will discuss treatment options and answer your health questions. The phone number will be on your ID Card when you join Group Health.

Section 5 (h). Dental benefits

IMPORTANT

Here are some important things to 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 or 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; 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 Medicare.

IMPORTANT

Accidental injury benefit	You pay
We cover the initial emergency visit necessary to promptly repair (but not replace) sound natural teeth. The need for these services must result from an accidental injury. (Excludes restorations).	Nothing

Dental benefits

We have no other dental benefits.

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 Benefits);
- Services, drugs, or supplies you receive while you are not enrolled in this Plan;
- Services, drugs, or supplies that are 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;
- 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; or
- Services, drugs, or supplies you receive from a provider or facility barred from the FEHB Program.
- Services, drugs, or supplies you receive without charge while in active military service.

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 co-payment or deductible.

Group Health Cooperative members should not receive a bill for medical services provided, except when an applicable co-payment or deductible applies. Routine office visits, hospitalizations, and specialist services will be covered according to your contract if you stay within the Group Health network and obtain a written referral when required.

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:

Step	Description
1	Ask us in writing to reconsider our initial decision. You must: (a) Write to us within 6 months from the date of our decision; and (b) Send your request to us at: P.O. Box 3217; Eau Claire, WI 54702; 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: Office of Personnel Management, Office of Insurance Programs, Contracts Division 3, 1900 E Street, NW, Washington, DC 20415-3630. **The Disputed Claims process** 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 888/203-7770 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 Benefits Contracts Division 3 at 202/606-0737 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 family member have coverage under another group 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 and older.
- Some people with disabilities, under 65 years of age.
- People with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant).

Medicare has two 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. (Someone who was a Federal employee on January 1, 1983 or since automatically qualifies.) 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.

If you are eligible for Medicare, you may have choices in how you get your health care. Medicare + Choice is the term used to describe the various health plan choices available to Medicare beneficiaries. The information in the next few pages shows how we coordinate benefits with Medicare, depending on the type of Medicare managed care plan you have.

•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. Some things are not covered under Original Medicare, like prescription drugs.

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 probably will never have 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 claims 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 claims, call us at 888/203-7770.

- **We waive costs if the Original Medicare Plan is your primary payer - -** We will waive some out-of-pocket costs, as follows:

    - Medical services and supplies provided by physicians and other health care professionals.

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

The following chart illustrates whether the **Original Medicare Plan** 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 either you -- or your covered spouse -- are age 65 or over and …	**Then the primary payer is…**	
	Original Medicare	**This Plan**
1) Are an active employee with the Federal government (including when you or a family member are eligible for Medicare solely because of a disability),		✓
2) Are an annuitant,	✓	
3) Are a reemployed annuitant with the Federal government when… a) The position is excluded from FEHB, or	✓	
b) The position is not excluded from FEHB (Ask your employing office which of these applies to you.)		✓
4) 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),	✓	
5) Are enrolled in Part B only, regardless of your employment status,	✓ (for Part B services)	✓ (for other services)
6) 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,	✓ (except for claims related to Workers' Compensation.)	
B. When you -- or a covered family member -- have Medicare based on end stage renal disease (ESRD) and…		
1) Are within the first 30 months of eligibility to receive Part A benefits solely because of ESRD,		✓
2) Have completed the 30-month ESRD coordination period and are still eligible for Medicare due to ESRD,	✓	
3) Become eligible for Medicare due to ESRD after Medicare became primary for you under another provision,	✓	
C. When you or a covered family member have FEHB and…		
1) Are eligible for Medicare based on disability, and a) Are an annuitant, or	✓	
b) Are an active employee, or		✓
c) Are a former spouse of an annuitant, or	✓	
d) Are a former spouse of an active employee		✓

- **Medicare managed care plan**

If you are eligible for Medicare, you may choose to enroll in and get your Medicare benefits from another type of Medicare+Choice plan -- a Medicare managed care plan. These are health care choices (like HMOs) in some areas of the country. In most Medicare managed care plans, you can only go to doctors, specialists, or hospitals that are part of the plan. Medicare managed care plans provide all the benefits that Original Medicare covers. Some cover extras, like prescription drugs. To learn more about enrolling in a Medicare managed care plan, contact Medicare at 1-800-MEDICARE (1-800-633-4227) or at www.medicare.gov.

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

This Plan and our Medicare managed care plan: You may enroll in our Medicare managed care plan and also remain enrolled in our FEHB plan. In this case, we do/do not waive any of our co-payments, coinsurance, or deductibles for your FEHB coverage.

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

Suspended FEHB coverage to enroll in a Medicare managed care plan: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in a Medicare managed care plan, eliminating your FEHB premium. (OPM does not contribute to your Medicare managed care 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 managed care plan's service area.

- **If you do not enroll in Medicare Part A or Part B**

If you do not have one or both Parts of Medicare, you can still be covered under the FEHB Program. We will not require you to enroll in Medicare Part B and, if you can't get premium-free Part A, we will not ask you to enroll in it.

TRICARE and CHAMPVA

TRICARE is the health care program for eligible dependents of military persons, and retirees of the military. TRICARE includes the CHAMPVA program. CHAMPVA provides health coverage to disabled Veterans and their eligible dependents. If both 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 the program.

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. You must use our providers.

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 you 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.

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.

Co-payment

A co-payment is a fixed amount of money you pay when you receive covered services. See page 12.

Covered services

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

Custodial care

Provision of room and board, nursing care, or personal care designed to assist an individual who, in the opinion of a plan physician, has reached the maximum level of recovery. In the case of confinement in a Hospital or nursing facility, Custodial Care also includes room and board, nursing care, or such other care which is provided to an individual for whom it cannot reasonably be expected, in the opinion of the plan physician, that the medical or surgical treatment will enable that person to live outside an institution. Custodial Care also includes rest cures, respite care, and home care provided by family members.

Custodial care that lasts 90 days or more is sometimes 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. See page 12.

Experimental or investigative services

Is a health service, treatment, or supply used for an illness or injury which, at the time it is used, meets one or more of the following criteria:

- Is subject to approval by an appropriate governmental agency for the purpose it is being used for such as, but not limited to the Food and Drug Administration (FDA), which has not granted that approval;
- Is not a commonly accepted medical practice in the American medical community;
- Is the subject of a written investigational or research protocol;
- Requires a written investigational or research protocol;
- Requires a written informed consent by a treating facility that makes reference to it being experimental, investigative, educational, for a research study, or posing an uncertain outcome, or having an unusual risk;
- Is the subject of an outgoing FDA Phase I, II, III clinical trial;
- Is undergoing review by an institutional review board;
- Lacks recognition and endorsement of supporting medical literature published in an established, peer reviewed scientific journal;
- Has unacceptable failure rates and side effects or poses uncertain risks and outcomes;
- Is being used in place of other more conventional and proven methods of treatment;
- Has been disapproved by the GHC Technology Assessment Committee.

Medical necessity

A service, treatment, procedure, equipment, drug, device or supply provided by a hospital, physician or other health care provider that is required to identify or treat a participant's illness or injury and which is, as determined by the plan: 1. consistent with symptoms or diagnosis and treatment of the participants; 2. appropriate under the standards of acceptable medical practice to treat that illness or injury; 3. not solely for the convenience of the participant, physician, hospital or other health care provider; 4. the most appropriate service, treatment, procedure, equipment, drug, device or supply which can be safely provided to the participant and accomplishes the desired end result in the most economical manner.

Us/We

Us and we refer to Group Health, Group Health Cooperative, and Group Health Cooperative of Eau Claire.

You

You refers to the enrollee and each covered family member.

Section 11. FEHB facts

No pre-existing condition limitation

We will not refuse to cover the treatment of a condition that 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. 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 to 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 health benefits, nor will we. Please tell us immediately when you add or remove family members from your coverage for any reason, including divorce, or when your child under age 22 marries or turns 22

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 Federal Employees Health Benefits (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 make any changes after retirement. Contact your employing office for further information.

When benefits and premiums start

The benefits in this brochure are effective on January 1. If you joined this Plan during Open Season, you coverage begins on the first day of your first pay period that starts on or after January 1. 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.

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

• Spouse equity coverage

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 supply health coverage to you. But, you may be eligible for your own FEHB coverage under 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 website, 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 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 website (www.opm.gov/insure/health) refer to the "TCC and HIPAA" frequently asked question. 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 have information about Federal and State agencies you can contact for more information.

Long Term Care Insurance Is Still Available!

Open Season for Long Term Care Insurance

- You can protect yourself against the high cost of long term care by applying for insurance in the Federal Long Term Care Insurance Program.
- Open Season to apply for long term care insurance through LTC Partners ends on December 31, 2002.
- If you're a Federal employee, you and your spouse need only answer a few questions about your health during Open Season.
- If you apply during the Open Season, your premiums are based on your age as of July 1, 2002. After Open Season, your premiums are based on your age at the time LTC Partners receives your application.

FEHB Doesn't Cover It

- Neither FEHB plans nor Medicare cover the cost of long term care. Also called "custodial care", long term care helps you perform the activities of daily living such as bathing or dressing yourself. It can also provide help you may need due to a severe cognitive impairment such as Alzheimer's disease.

You Can Also Apply Later, But…

- Employees and their spouses can still apply for coverage after the Federal Long Term Care Insurance Program Open Season ends, but they will have to answer more health-related questions.
- For annuitants and other qualified relatives, the number of health-related questions that you need to answer is the same during and after the Open Season.

You Must Act to Receive an Application

- Unlike other benefit programs, YOU have to take action – you won't receive an application automatically. You must request one through the toll-free number or website listed below.
- Open Season ends December 31, 2002 – act NOW so you won't miss the abbreviated underwriting available to employees and their spouses, and the July 1 "age freeze"!

Find Out More – Contact LTC Partners by calling **1-800-LTC-FEDS (1-800-582-3337) (TDD for the hearing impaired: 1-800-843-3557)** or visiting www.ltcfeds.com to get more information and to request an application.

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Do not rely on this page; it is for your convenience and may not show all pages where the terms appear.

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NOTES:

Summary of benefits for the Group Health Cooperative of Eau Claire --2003

- **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.

Benefits	You pay	Page
Medical services provided by physicians: • Diagnostic and treatment services provided in the office.....	Office visit copay: $10 primary care; $10 specialist.	8, 9, 13, 14, 18, 20, 24, 25, 29
Services provided by a hospital: • Inpatient.....	Nothing	13, 16, 22, 23, 26, 24, 28
• Outpatient	Nothing	13, 23, 25, 26, 28
Emergency benefits: • In-area..... • Out-of-area	$50 co-payment per Emergency Room visit $50 co-payment per Emergency Room visit	13, 26, 28 13, 26, 28, 27
Mental health and substance abuse treatment.....	Regular cost sharing.	13, 26, 29
Prescription drugs	$10 co-payment per generic drug prescription $20 co-payment per brand name drug prescription.	8, 30, 35, 38, 41
Dental Care	*No benefit*.	13, 22, 25, 33, 34
Vision Care	Nothing for one annual exam.	13, 15, 18
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2003 Rate Information for
Group Health Cooperative of Eau Claire

Non-Postal rates apply to most non-Postal enrollees. 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.

		Non-Postal Premium				Postal Premium	
		Biweekly		Monthly		Biweekly	
Type of Enrollment	Code	Gov't Share	Your Share	Gov't Share	Your Share	USPS Share	Your Share
Self Only	WT1	$109.30	$74.67	$236.82	$161.78	$129.03	$54.94
Self and Family	WT2	$249.62	$224.80	$540.84	$487.07	$294.70	$179.72