


HMO Option 1

| | |
|---|---|
| Lifetime Maximum | Unlimited |
| Deductible | \$1,000 Single / \$2,000 Family |
| Health Reimbursement Account (Employer Funded Deductible) | \$1,000 Single / \$2,000 Family |
| Health Promotion Package | Employee and covered spouse will need to complete the Three Step process by October 31, 2011 in order to obtain or maintain reduced premium. Steps must be completed by September 30, 2011 to earn gift certificates. |
| Coinsurance | 100% |
| Coinsurance Out-of-Pocket Limit | Not applicable |
| Emergency Services (waived if admitted) | 100% after \$100 copay |
| Ambulance | 100% after deductible |
| Surgical Services | 100% after deductible |
| Office Visits: Primary Care, Chiropractic, Maternity | 100% after \$18 copay Maternity limited to 1 copay |
| Physical, Speech, Occupational Therapy | 100% after \$18 copay |
| Preventive Care Office Visits | 100% to no annual maximum |
| Specialist Care Office Visits | 100% after \$18 copay |
| Urgent Care Office Visits | 100% after \$28 copay |
| Immunizations | 100% |
| Lab & X-Ray (in clinic setting) | 100% |
| Optical Exams (one routine exam per plan year) | 100% |
| Home Health Care | 100% after \$18 copay |
| Hospice Care | 100% after deductible |
| Oral Surgery | 100% after deductible |
| Organ Transplant Service | 100% after deductible |
| Kidney Disease Treatment | 100% after deductible |
| Hospital Inpatient Services | 100% after deductible |
| Hospital Outpatient - Surgery or Surgi-Center | 100% after deductible |
| Hospital Outpatient - Diagnostic Services | 100% after deductible |
| Non-Inpatient Imaging Services | 100% after deductible |
| Skilled Nursing Facilities/Services (30 day limit) | 100% after deductible |
| Mental Health/AODA | |
| Inpatient Services | 100% after deductible |
| Outpatient Services | 100% after \$18 copay |
| Transitional Services | 100% after \$18 copay |
| Prescription Drugs Limited to a 31-day supply per drug/refill (100-day supply if the drug is on the maintenance list) | \$0 Generic \$25 Brand 50% Non-Formulary Drugs to a maximum of \$75 per fill. Diabetic supplies paid at 100%, must be received from a GHC network pharmacy. |
| Durable Medical Equipment | 100% after deductible |
| Prosthetics | 100% after deductible |
| TMJ Services (non-surgical max \$1,250) | |
| Office Visits | 100% after \$18 copay |
| Appliances & Therapy | 100% after deductible |
| Dependency Criteria | 19/27: to end of month |
| Network* | Standard GHC Network |

* Provider Network Note: Mayo Clinic, St. Mary's and Methodist Hospital in Rochester, Minnesota are available to GHC members only after receiving a prior event authorization by the health plan. This provision does not apply to Mayo Clinic affiliated providers in Wisconsin.

|  | Point of Service Option 2 | |
|---|---|--|
| | In-Network | Out-of-Network |
| Lifetime Maximum | Unlimited | Unlimited |
| Deductible | \$1,000 Single /\$2,000 Family | |
| Health Reimbursement Account (Employer Funded Deductible) | \$1,000 Single /\$2,000 Family | |
| Health Promotion Package | Employee and covered spouse will need to complete the Three Step process by October 31, 2011 in order to obtain or maintain reduced premium. Steps must be completed by September 30, 2011 to earn gift certificates. | |
| Coinsurance | 90% | 70% |
| Coinsurance Out-of-Pocket Limit | \$1,000/\$2,000 | \$1,000/\$2,000 |
| Emergency Services (waived if admitted) | 100% after \$100 copay | 100% after \$100 copay |
| Ambulance | 90% after deductible | 70% after deductible |
| Surgical Services | 90% after deductible | 70% after deductible |
| Office Visits: Primary Care, Chiropractic, Maternity | 100% after \$18 copay Maternity limited to 1 copay | 70% after deductible |
| Physical, Speech, Occupational Therapy | 100% after \$18 copay | 70% after deductible |
| Preventive Care Office Visits | 100% to no annual maximum | 70% after deductible |
| Specialist Care Office Visits | 100% after \$18 copay | 70% after deductible |
| Urgent Care Office Visits | 100% after \$28 copay | 100% after \$28 copay |
| Immunizations | 100% | 70% after deductible |
| Lab & X-Ray (in clinic setting) | 100% | 70% after deductible |
| Optical Exams (one routine exam per plan year) | 100% | 70% after deductible |
| Home Health Care | 100% after \$18 copay | 70% after deductible |
| Hospice Care | 90% after deductible | 70% after deductible |
| Oral Surgery | 90% after deductible | 70% after deductible |
| Organ Transplant Service | 90% after deductible | 70% after deductible |
| Kidney Disease Treatment | 90% after deductible | 70% after deductible |
| Hospital Inpatient Services | 90% after deductible | 70% after deductible |
| Hospital Outpatient - Surgery or Surgi-Center | 90% after deductible | 70% after deductible |
| Hospital Outpatient - Diagnostic Services | 90% after deductible | 70% after deductible |
| Non-Inpatient Imaging Services | 90% after deductible | 70% after deductible |
| Skilled Nursing Facilities/Services (30 day limit) | 90% after deductible | 70% after deductible |
| Mental Health/AODA | | |
| Inpatient Services | 90% after deductible | 70% after deductible |
| Outpatient Services | 100% after \$18 copay | 70% after deductible |
| Transitional Services | 100% after \$18 copay | 70% after deductible |
| Prescription Drugs Limited to a 31-day supply per drug/refill (100-day supply if the drug is on the maintenance list) | \$0 Generic \$25 Brand 50% Non-Formulary Drugs to a maximum of \$75 per fill. Diabetic supplies paid at 100%, must be received from a GHC network pharmacy. | |
| Durable Medical Equipment | 90% after deductible | 70% after deductible |
| Prosthetics | 90% after deductible | 70% after deductible |
| TMJ Services (non-surgical max \$1,250) | | |
| Office Visits | 100% after \$18 copay | 70% after deductible |
| Appliances & Therapy | 90% after deductible | 70% after deductible |
| Dependency Criteria | 19/27: to end of month | |
| Network* | Standard GHC Network | Non-Contracted Licensed Providers. UCR Applies. |

* Provider Network Note: Mayo Clinic, St. Mary's and Methodist Hospital in Rochester, Minnesota are available to GHC members only after receiving a prior event authorization by the health plan. This provision does not apply to Mayo Clinic affiliated providers in Wisconsin.

** The amount you pay towards the in-network coinsurance will only apply toward the in-network benefit levels, and the amounts you pay toward the out-of-network coinsurance will only apply toward the out-of-network benefit levels. In other words, the in-network and out-of-network coinsurance maximums are completely separate and cannot be combined. The deductible is a combined deductible for both in and out-of-network.



HMO Option 3

| | |
|---|---|
| Lifetime Maximum | Unlimited |
| Deductible | \$1,500 Single /\$3,000 Family |
| Health Reimbursement Account (Employer Funded Deductible) | \$1,000 Single /\$2,000 Family |
| Health Promotion Package | Employee and covered spouse will need to complete the Three Step process by October 31, 2011 in order to obtain or maintain reduced premium. Steps must be completed by September 30, 2011 to earn gift certificates. |
| Coinsurance | 80% |
| Coinsurance Out-of-Pocket Limit | \$1,000/\$2,000 |
| Maximum Out of Pocket Includes Deductible and Coinsurance; copays do not apply to this maximum. | \$2,500 Single /\$5,000 Family |
| Emergency Services (waived if admitted) | 100% after \$100 copay |
| Ambulance | 80% after deductible |
| Surgical Services | 80% after deductible |
| Office Visits: Primary Care, Chiropractic, Maternity | 100% after \$18 copay |
| Physical, Speech, Occupational Therapy | 100% after \$18 copay |
| Preventive Care Office Visits | 100% |
| Specialist Care Office Visits | 100% after \$18 copay |
| Urgent Care Office Visits | 100% after \$18 copay |
| Immunizations | 100% |
| Lab & X-Ray (in clinic setting) | 100% |
| Optical Exams (one routine exam per plan year) | 100% |
| Home Health Care | 100% after \$18 copay |
| Hospice Care | 80% after deductible |
| Oral Surgery | 80% after deductible |
| Organ Transplant Service | 80% after deductible |
| Kidney Disease Treatment | 80% after deductible |
| Hospital Inpatient Services | 80% after deductible |
| Hospital Outpatient - Surgery or Surgi-Center | 80% after deductible |
| Hospital Outpatient - Diagnostic Services | 80% after deductible |
| Non-Inpatient Imaging Services | 80% after deductible |
| Skilled Nursing Facilities/Services (30 day limit) | 80% after deductible |
| Mental Health/AODA | |
| Inpatient Services | 80% after deductible |
| Outpatient Services | 100% after \$18 copay |
| Transitional Services | 100% after \$18 copay |
| Prescription Drugs Limited to a 31-day supply per drug/refill (100-day supply if the drug is on the maintenance list) | \$0 Generic \$25 Brand 50% Non-Formulary Drugs to a maximum of \$75 per fill. Diabetic supplies paid at 100%, must be received from a GHC network pharmacy. |
| Durable Medical Equipment | 80% after deductible |
| Prosthetics | 80% after deductible |
| TMJ Services (non-surgical max \$1,250) | |
| Office Visits | 100% after \$18 copay |
| Appliances & Therapy | 80% after deductible |
| Dependency Criteria | 19/27: to end of month |
| Network* | Standard GHC Network |

* Provider Network Note: Mayo Clinic, St. Mary's and Methodist Hospital in Rochester, Minnesota are available to GHC members only after receiving a prior event authorization by the health plan. This provision does not apply to Mayo Clinic affiliated providers in Wisconsin.