General Health Plan Limitations and Exclusions

This is an outline of the Limitations and Exclusions for the Group Health Cooperative of South Central Wisconsin (GHC-SCW) group and individual health plans. It is designed for reference only. Consult the Policy, Policy Amendments, Certificate of Coverage and Benefits Summary for a complete list of Limitations and Exclusions.

The following services and expenses are not covered, and no benefits will be payable unless stated otherwise for expenses arising from:

- For HMO plans, services received from an Out-of-Plan Provider, unless for an Emergency Condition or Urgent Condition, or unless prior authorized by GHC-SCW. Services must be received from an In-Network Provider.
- For HMO plans, if services can be provided by a GHC-SCW Provider (for example, Dermatology, Physical Therapy, etc.), services received from a Non-GHC-SCW Provider or Out-of-Plan Provider, unless prior authorized.
- Services that are not Medically Necessary, are experimental, investigative or for research purposes
- Billed amounts that are over and above the GHC-SCW Reasonable and Customary Fees and Charges for covered benefits
- Items or services required as a result of war or any act of war, insurrection, riot, terrorism, or sustained while performing military services
- Services provided before the effective date or after the termination date of the Policy or Certificate of coverage
- Services related to an admission or confinement which occurs prior to and continues on or after the Member's effective date when GHC-SCW coverage replaces other group coverage
- Services while incarcerated, except as specifically required by state or federal law
- Services and supplies obtained while outside the United States, except for Urgent Conditions and Emergency conditions
- Charges for missed appointment(s)
- Services for injuries incurred during the commission of a crime
- Blood donor services
- Common use supplies
- Complementary Medicine services not specifically covered under the Policy or Certificate of coverage
- Complications, consultations, services and procedures related to a non-covered procedure
- Cosmetic services
- Custodial care
- Couples Counseling that is not medically necessary for the treatment of a primary DSM-V diagnosis
- Dental services not specifically covered under the Policy or Certificate of coverage
- Drug screening, except as specifically covered under the Policy or Certificate of coverage
- Duplicate services
- Durable Medical Equipment and Medical Supplies not specifically covered under the Policy or Certificate of coverage
- Elective Abortions
- Electrolysis services
- Emergency Outpatient Services when a Member leaves the emergency room prior to seeing a physician
- End of Life Services not specifically included under the Policy or Certificate of coverage
- Food or nutrition that is not Medical Food that is specifically covered under the Policy or Certificate
- Functional capacity evaluations
- Gastro-intestinal surgical procedures for purposes of weight loss
- Gene Therapy
- Growth Hormone for the treatment of idiopathic short stature
- Hair implants/transplants
- Hearing Aid repair costs, batteries, and ancillary equipment
- Home health visits beyond the amount specified in the Policy or Certificate of coverage
- Home modifications
- Hospital services for a Skilled Nursing Facility beyond the amount specified in the Policy or Certificate of coverage
- Housecleaning
- Hypnotherapy services
- Infertility services not specifically covered under the Policy or Certificate of coverage, and services beyond the Benefit Maximum specified in the Benefits Summary

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- Insulin injection pens not included in the GHC formulary.
- Keratorefractive surgery
- Maintenance care and/or therapy
- Mental Health and Substance Use Disorder services beyond the services specified in the Policy or Certificate of coverage
- New-to-Market Drugs and Treatments are subject to an exclusion period of six (6) months
- Obesity-related services
- Outpatient Rehabilitation Therapies and Habilitation Services beyond the services specified in the Policy or Certificate of coverage
- Over the counter supplies
- Personal comfort items
- Prescription drugs or contraceptive devices unless specifically included under the Policy or Certificate of coverage
- Private duty nursing services
- Prolotherapy
- Services performed by a family member
- Scar revisions
- Sensory integration therapy
- Specialty medical care provided by a non-GHC-SCW Provider, whether or not under contract with GHC-SCW, when the service requested may be provided by a GHC-SCW Specialty Provider
- Sperm banking or egg harvesting
- Supportive care and/or therapy
- Surgical Services and treatment to correct or reverse complications and/or dissatisfaction resulting from surgery, cosmetic treatment, or reconstruction when no functional impairment exists, as determined by GHC-SCW
- Surrogate maternity services
- Tattoos: services for the removal of tattoos or complications related to tattoos
- Transplant donor services when the recipient is not a current Member under this Certificate
- Recreational and Educational therapy, therapy for congenital conditions (unless specifically included under the Policy or Certificate of coverage), telephonic mental health care therapy session, sexual dysfunction therapy, financial and occupational counseling, and therapies beyond the services specified in the Policy or Certificate of coverage
- Therapies (including, but not limited to physical therapy, occupational therapy, vision therapy, speech therapy, and hearing treatments) for the treatment of non-acute medical conditions, which may include but are not limited to: chronic brain injuries, Developmental Delay, intellectual disability, and cerebral palsy
- Third-party examinations
- Tongue thrust services or treatment
- Transplants, except for those specified in the Policy or Certificate of coverage and services, any organ or tissue which is sold rather than donated, involving non-human or artificial organs and tissues, and human to human organ or tissue transplant other than those specifically listed and specified within the Policy or Certificate of coverage
- Transportation services and costs, except Medically Necessary ambulance services
- Travel Immunizations, unless specifically included under the Policy or Certificate of Coverage
- Vocational Rehabilitation services
- Vision services, and eyewear for all Members (to include lenses, frames, contact lenses, contact lens prescriptions or contact lens fitting), unless specifically included under the Policy or Certificate of coverage
- Workers' Compensation items and services incidental to an injury or conditions covered by any Workers' Compensation law or occupational disease law
- For HMO plans, Out-of-Area Dependents (who do not reside in the Service Area) are only eligible for Out-of-Area Care as specified in the Policy or Certificate of coverage, unless the plan provides for the use of non-GHC-SCW Providers