2022 PPO MEMBER CERTIFICATE

LARGE EMPLOYER GROUP

Administrative Offices
PO Box 44971
Madison, Wisconsin 53744-4971
Marketing: (608) 251-3356
Member Services: (608) 828-4853
www.ghcscw.com

Welcome to Group Health Cooperative of South Central Wisconsin

Group Health Cooperative of South Central Wisconsin (GHC-SCW) respects the confidence you have shown in choosing our health plan and our many Providers. This Policy outlines the features of your Policy and is used in connection with the Benefit Summary and any plan amendments to describe your coverage with GHC-SCW. Together these documents will help you get the most out of your health care plan.

GHC-SCW Quality Improvement Statement

Each year, GHC-SCW develops a Quality Improvement Work Plan to use as a tool to focus on and monitor performance, and to identify areas in which GHC-SCW can improve care and service to its Members. The GHC-SCW Quality Improvement Work Plan is divided into the following two sections and five categories, each containing several specific initiatives. The first section, Clinical Quality, addresses (1) disease management projects that seek to improve care to Members with chronic illnesses, (2) preventive health projects, which seek to improve the delivery of preventive services such as screening exams and immunizations, and (3) general clinical monitoring projects, which measure how well GHC-SCW maintains improvements achieved in the past. The second section, Service Quality, includes (1) quality improvement projects that seek to improve the level of service experienced by Members as they use the GHC-SCW system, (2) Member satisfaction monitoring that provides annual measures of how well GHC-SCW Members are satisfied with various aspects of the system, and (3) service projects that require problem evaluation, root cause analysis, solution development and ongoing evaluation. The GHC-SCW Board of Directors approves the plan annually.

Reasonable and Customary Disclosure

GHC-SCW bases claims settlement for Out-of-Network Providers on the “Reasonable and Customary Fees and Charges” for covered Benefits. The “Reasonable and Customary Fees and Charges” may be less than the billed amount. For additional information, please refer to the following parts of this Certificate: Article I: Definitions and Article V: Covered Health Services; or contact the GHC-SCW Member Services Department. A range of payment methodologies may be utilized for Out-of-Network Providers.

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IMPORTANT INFORMATION

KEEP THIS NOTICE WITH YOUR INSURANCE PAPERS

The full corporate name of this organization is:

Group Health Cooperative of South Central Wisconsin (GHC-SCW)

Important Notice Concerning Statements In The Application For Your Insurance

Please read the copy of your application you received when you were approved for this Policy. Omissions or misstatements in the application could cause an otherwise valid claim to be denied. Carefully check your application and write to GHC-SCW within 10 days if any information shown on the application is not correct and complete or if any required medical history has not been included. The application is part of the insurance contract. The insurance contract was issued on the basis that the answers to all questions and any other material information shown on the application are correct and complete.

Notice Regarding Pediatric Dental Coverage

This policy does not include pediatric dental services as required under the federal Patient Protection and Affordable Care Act (PPACA). This coverage is available in the insurance market and can be purchased as a stand-alone product. Please contact your insurance carrier, agent, or the Federally Facilitated Exchange if you wish to purchase pediatric dental coverage or a stand-alone dental services product.

If you have a complaint:

You may resolve your problem by taking the steps outlined in your health plan's Grievance procedure. You may also contact the **OFFICE OF THE COMMISSIONER OF INSURANCE**, a state agency that enforces Wisconsin's insurance laws, and file a complaint. You can file a complaint electronically with the **OFFICE OF THE COMMISSIONER OF INSURANCE** at its website at http://oci.wi.gov/, or by writing to:

Office of the Commissioner of Insurance
Complaints Department
P.O. Box 7873
Madison, WI 53707-7873

Or you can call (800) 236-8517 outside of Madison, (608) 266-0103 in Madison, or e-mail ocicomplaints@wisconsin.gov, and request a complaint form.

IMPORTANT NOTICE

CONCERNING STATEMENTS IN THE ENROLLMENT FORM FOR YOUR INSURANCE

Please read the copy of the enrollment form attached to your Certificate or which has been otherwise previously delivered to you by the insurer or group policyholder. Omissions or misstatements in the enrollment form could cause an otherwise valid claim to be denied. Carefully check the enrollment form and write to the insurer within 10 days if any information shown on the form is not correct and complete or if any requested medical history has not been included. The insurance coverage was issued on the basis that the answers to all questions and any other material information shown on the enrollment form are correct and complete.

This Certificate is effective in accordance with the Group's term of coverage. Most employer Groups have a 12-month term of coverage. Subscribers should contact their employer's benefits department to determine the Group's actual term of coverage.

Group Health Cooperative of South Central Wisconsin

Administrative Offices
P. O. Box 44971
Madison, WI 53744-4971

2022 LARGE GROUP PPO PLAN MEMBER CERTIFICATE

About this plan: The GHC-SCW PPO Plan is a Preferred Provider Option (PPO) Plan. GHC-SCW has arranged for its Members to have access to a large network of preferred, In-Network Providers that may be accessed directly by Members while receiving an In-Network level of Benefits. GHC-SCW Members may also see an Out-of-Network Provider and receive an Out-of-Network level of Benefits for covered services. Designated services do require Prior Authorization from GHC-SCW. Members are encouraged to read the entire Member Certificate to gain a complete understanding of GHC-SCW PPO Plan Benefits and procedures.

This Member Certificate is issued by Group Health Cooperative of South Central Wisconsin (GHC-SCW). The purpose of this Certificate is to help you (the Subscriber) or your dependent (Subscriber's Dependent) understand the Benefits you will receive under this policy.
If you are a Member of a Group, the terms and conditions of the Group Service Agreement are a part of this Certificate.

GHC-SCW will not be, and is not, a plan sponsor, plan administrator, or fiduciary for any purpose under ERISA, or any other state or federal law. The Group is solely responsible for carrying out any obligation created, required, or imposed by ERISA or any other law, as it may apply to such group insurance policies. The Group is also obligated to provide notice and information to its employees with regard to special enrollment rights and consequences of late enrollment under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended, and state law.

GHC-SCW provides your Benefits by agreement with Providers, Hospitals, and other health care Providers. When GHC-SCW does not have an agreement in place with a provider, we will pay for services based on Reasonable and Customary Fees and Charges.

We are issuing this Certificate with the understanding that you or someone on your behalf will pay a monthly Premium for the coverage we are providing. Monthly Premiums are subject to change. GHC-SCW may cancel coverage under this Certificate if timely payment is not made.

GHC-SCW may adopt policies, procedures and rules to help determine Benefits under this Certificate. You agree to follow the terms and conditions of these policies, procedures, rules and interpretation of them.

Services provided by GHC-SCW are available to you without regard to race, color, handicap, age, sex, creed, national origin, ancestry, sexual orientation, arrest or conviction status, marital status, religion or any other legally impermissible criterion. GHC-SCW does reserve the right to adopt and interpret policies, procedures and rules applicable to all services being provided. Consistent with acceptable medical practice and applicable legal and contractual requirements, including this Certificate, GHC-SCW is committed to assisting patients with special needs and providing interpreter services and written materials to persons whose language is other than English.

This Certificate limits covered expenses received from an Out-of-Network Provider to a maximum allowable fee. The maximum allowable fee may be less than the billed amount.

GUARANTEED RENEWABLE. This policy is issued on an annual basis. We will renew this policy at the option of the Group unless the Group: fails to pay the Premium when due; engages in fraud or misrepresentation; substantially breaches contractual duties, conditions or warranties; ceases to be a Member of a bona fide association on which coverage is based; fails to maintain participation or employer contribution requirements; or no longer meets the required participation requirements for Members who reside or work in the Service Area.

STOP HEALTH CARE FRAUD!

Fraud increases the cost of health care for everyone and increases your Premium.

Protect Yourself From Fraud – Here are some things that 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 Provider, other health care Providers, or authorized plan representative.
- Let only the appropriate medical professional 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 Provider 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 GHC-SCW Member Services at (608) 828-4853 or GHC-SCW's Compliance Helpline at (608) 251-4156 and explain the situation.
- Do not maintain as a family Member on your policy if:
    - Your former spouse after a divorce decree or annulment is final; or
    - Your child over the age limit specified in this policy (unless they are disabled and incapable of self-support).
    - If you have any questions about the eligibility of a Dependent, check with your human resource department or employee Benefits department.

PRIVACY AT GHC-SCW

We understand that information about individuals and their health is personal. At GHC-SCW, we're committed to protecting personal information to the fullest extent possible and limiting disclosures to the minimum necessary to provide cost-effective, quality care.

Our On-going Commitment

GHC-SCW employees receive on-going training and education regarding patient confidentiality and privacy, along with GHC-SCW privacy policies and procedures. GHC-SCW regularly monitors access of confidential health information to ensure its appropriate use within the organization. We take our responsibility seriously, and each year we renew our promise to protect patient confidentiality by signing a Confidentiality Agreement.

GHC-SCW's Notice of Privacy Practices

Our Notice of Privacy Practices, which describes how medical information may be used and disclosed, certain obligations we have regarding the use and disclosure of medical information and how you can get access to this information, is distributed to all Members as a part of new Member enrollment materials, is posted and available in GHC-SCW Clinics, and is readily available on our Website, at www.ghcscw.com.

If you have questions or concerns regarding privacy at GHC-SCW, please contact the GHC-SCW Member Services Department at (608) 828-4853.

GHC-SCW NONDISCRIMINATION NOTICE

Group Health Cooperative of South Central Wisconsin (GHC-SCW) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. GHC-SCW does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

GHC-SCW:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
    - Qualified sign language interpreters
    - Written information in other formats (large print, audio, accessible electronic formats, other formats)

- Provides free language services to people whose primary language is not English, such as:
    - Qualified interpreters
    - Information written in other languages

If you need these services, contact GHC-SCW Member Services at (608) 828-4853 or (800) 605-4327, ext. 4504 (TTY: (608) 828-4815).

If you believe that GHC-SCW has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with GHC-SCW's Corporate Compliance Officer, 1265 John Q. Hammons Drive, Madison, WI 53717, Telephone: (608) 251-4156, TTY: (608) 828-4815, or Fax: (608) 257-3842. If you need help filing a grievance, GHC-SCW's Corporate Compliance Officer is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW.
Room 509f, HHH Building
Washington, DC 20201
1-800-368-1019, 1-800-537-7697 (TDD).

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

GHC-SCW LANGUAGE ASSISTANCE SERVICES

English:
ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-608-828-4853 or 1-800-605-4327, ext. 4504 (TTY: 1-608-828-4815).

Español (Spanish):
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-608-828-4853 or 1-800-605-4327, ext. 4504 (TTY: 1-608-828-4815).

Hmoob (Hmong):
LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-608-828-4853 or 1-800-605-4327, ext. 4504 (TTY: 1-608-828-4815).

繁體中文 (Chinese):
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-608-828-4853 or 1-800-605-4327, ext. 4504 (TTY: 1-608-828-4815)。

Deutsch (German):
ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-608-828-4853 or 1-800-605-4327, ext. 4504 (TTY: 1-608-828-4815).

العربية (Arabic):
ملحوظة: إذا كنت تتحدث العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-608-828-4853, 1-800-605-4327, ext. 4504 (رقم هاتف الصم والبكم 1-608-828-4815)

Русский (Russian):
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-608-828-4853 or 1-800-605-4327, ext. 4504 (TTY: 1-608-828-4815).

한국어 (Korean):
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-608-828-4853 or 1-800-605-4327, ext. 4504 (TTY: 1-608-828-4815) 번으로 전화해 주십시오.

Tiếng Việt (Vietnamese):
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-608-828-4853 or 1-800-605-4327, ext. 4504 (TTY: 1-608-828-4815).

Deitsch (Pennsylvania Dutch):
Wann du Deitsch (Pennsylvania German / Dutch) schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-608-828-4853 or 1-800-605-4327, ext. 4504 (TTY: 1-608-828-4815).

ພາສາລາວ (Lao):
ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-608-828-4853 or 1-800-605-4327, ext. 4504 (TTY: 1-608-828-4815).

Français (French):
ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-608-828-4853 or 1-800-605-4327, ext. 4504 (TTY: 1-608-828-4815).

Polski (Polish):
UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-608-828-4853 or 1-800-605-4327, ext. 4504 (TTY: 1-608-828-4815).

हिंदी (Hindi):
ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-608-828-4853 or 1-800-605-4327, ext. 4504 (TTY: 1-608-828-4815) पर कॉल करें।

Shqip (Albanian):
KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1-608-828-4853 or 1-800-605-4327, ext. 4504 (TTY: 1-608-828-4815).

Tagalog (Tagalog – Filipino):
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-608-828-4853 or 1-800-605-4327, ext. 4504 (TTY: 1-608-828-4815).

Article I: Definitions

A. THE FOLLOWING TERMS, WHEN USED AND CAPITALIZED IN THIS CERTIFICATE OR ANY ATTACHMENTS, SUPPLEMENTS, ENDORSEMENTS, AMENDMENTS, OR RIDERS HERETO, ARE DEFINED AS FOLLOWS AND LIMITED TO THAT MEANING ONLY:

1. **Adverse Benefit Determination** means either: (a) any rescission of coverage, or (b) a determination by or on behalf of GHC-SCW in which all of the following apply:

   a. GHC-SCW has reviewed an admission to a health care facility, the availability of care, the continued stay or other treatment that is a covered Benefit;

   b. The treatment does not meet GHC-SCW's requirements for Medical Necessity, appropriateness, health care setting, level of care or effectiveness;

   c. GHC-SCW reduced, denied or terminated the treatment or payment for the treatment; and

   d. The amount of the reduction or the cost or expected cost of the denied or terminated treatment or payment exceeds, or will exceed, the amount determined by the Independent Review Organization, during the course of treatment. This amount is available on the Wisconsin Office of the Commissioner of Insurance Website: http://oci.wi.gov/oci_home.htm.

2. **Audio Visit** means a real-time (synchronous) audio-only interaction between a Member and a Designated Audio Visit Network Provider.

3. **Autism Spectrum Disorder Treatment** means Intensive-level services and Nonintensive-level services for Autism Spectrum Disorder as classified in the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association.

4. **Benefit(s)** means the Covered Health Services contained in this Certificate, including any attachments to the policy.

   a. **In-Network Services and Benefits** means Covered Health Services provided by a PPO network contracted Provider or received at a PPO network contracted facility. It is Your responsibility to ensure that Your PPO network contracted Provider coordinates all of Your services by requesting Prior Authorization from GHC-SCW. You can verify that a Prior Authorization has been received by calling Your PPO network contracted Provider, the GHC-SCW Care Management Department or GHC-SCW Member Services.

      If Medically Necessary services are not available from an In-Network Provider, You may be eligible to receive Benefits coverage from an Out-of-Network Provider at the In-Network Cost-Sharing responsibility if Prior Authorized by GHC-SCW. All Benefits to be paid are limited to Reasonable and Customary Fees and Charges, which may be less than the billed amount.

   b. **Out-of-Network Services and Benefits** means all services and benefits provided by an Out-of-Network Provider or received at an Out-of-Network Facility. Certain Out-of-Network Benefits require Prior Authorization by GHC-SCW. Emergency Conditions and Urgent Conditions do not require Prior Authorization. All Out-of-Network Services and Benefits are limited to Reasonable and Customary Fees and Charges, which may be less than the billed amount. For additional information, please refer to Article III: General Provisions.

5. **Benefit Summary** means an outline of certain covered services provided by the policy but does not include all covered services or limitations. It includes such things as Copayments, Coinsurance, Deductibles, Benefit limitations and plan maximums.

6. **Calendar Year** means the period of time from January 1 of any year through December 31 of the same year, inclusive.

7. **Child** means a Subscriber's natural blood-related child, stepchild, legally adopted child, child placed in the custody of the Subscriber for adoption, or a child for whom the Subscriber or the Subscriber's covered spouse has been appointed as legal guardian. Stepchild means the biological or legally adopted child of a family Subscriber's spouse. Adopted children become Dependents when the court order for adoption is signed or when the Child is placed in the custody of the Subscriber who is to be the adoptive parent, whichever occurs first.

8. **Clinical Trial** means a trial for the treatment of any of the following:

   a. Cancer;

   b. Cardiovascular disease (cardiac/stroke);

   c. Surgical musculoskeletal disorders of the spine, hip, and knees; or

   d. Other life-threatening diseases or conditions for which, as GHC-SCW determines, a clinical trial meets the criteria stated below. "Life threatening" is defined as any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

   Additionally, a Clinical Trial must satisfy all of the following criteria:

   e. Is a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of the diseases discussed above;

   f. Meets at least one of the following three criteria;

      i. Is approved, funded (which may include funding through in-kind contributions), sponsored and/or provided by one or more of the following;

         1. The National Institutes of Health (NIH);

         2. The Centers for Disease Control and Prevention (CDC);

         3. The Agency for Health Care Research and Quality (AHCRQ);

         4. The Centers for Medicare & Medicaid Services (CMS);

         5. A cooperative group or center of any of the entities described in clauses (1) through (4) or the Department of Defense (DOD) or the Department of Veterans Affairs (VA);

         6. A qualified non-governmental research entity identified in the guidelines issued by the NIH for center support grants;

7. The VA, the DOD or the Department of Energy (DOE) if the following conditions are met; or

a. The study or investigation has been reviewed and approved through a system of peer review that the Secretary determines to be:

i. Comparable to the system of peer review of studies and investigations used by the NIH; and

ii. Assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.

8. A cancer center that has been designated by the National Cancer Institute (NCI) as a Clinical Cancer Center or Comprehensive Cancer Center.

ii. Is conducted under an investigational new drug application reviewed by the Food and Drug Administration (FDA); or

iii. Is a drug trial that is exempt from such an investigational new drug application.

g. Has a written protocol that describes a scientifically sound study and has been approved by all relevant institutional review boards (IRBs) before participants are enrolled in the trial. We may, at any time, request documentation about the trial to confirm the trial meets current standards for scientific merit and has the relevant IRB approvals; and

h. The subject or purpose of the trial is the evaluation of an item or service that meets the definition of a Covered Health Service and is not otherwise excluded under this Policy.

9. **COBRA (Consolidated Omnibus Budget Reconciliation Act)** means a federal law that requires employers to offer continued health insurance coverage to certain employees and their beneficiaries who have had their Group health insurance coverage terminated.

10. **Congenital** means a condition that exists at birth but is not hereditary.

11. **Congenital Anomaly** means a defective development or formation of a part of the body, such as cleft lip or palate, which is determined by a Provider to have been present at the time of birth.

12. **Coinsurance** means the percentage of covered health care cost for which the Member has a financial responsibility, according to a fixed percentage. The applicable Coinsurance amounts are specified in the Member's Benefit Summary and/or in this Member Certificate.

13. **Complementary Medicine** means forms of therapy used alone or in combination with standard/conventional medicine (for example: acupuncture and massage therapy).

14. **Confinement/Confined** means:

a. The period of time between admission to, and discharge from, an inpatient or outpatient health care facility. The health care facility may include a Hospital, Long-Term Acute Care Hospital (LTACH), Substance Use Disorder facility, Skilled Nursing Facility or licensed ambulatory surgical center; and/or

b. The time spent receiving Emergency Care for Illness or Injury in a Hospital. Hospital swing bed Confinement is considered the same as Confinement in a Skilled Nursing Facility. If the Member is transferred or discharged to another facility for continued treatment of the same or a related condition, it is one Confinement.

15. **Consulting Provider** means the Provider with whom the Member's Provider elects to consult regarding care, including but not limited to consultations about second opinions and developing an ongoing plan of care.

16. **Copayment** means a specified dollar amount for which the Member has a financial responsibility for paying when receiving treatment, services, or supplies. The applicable Copayment amounts are specified in the Member's Benefit Summary.

17. **Cost-Sharing** means a Member's out-of-pocket costs (Copayments, Coinsurance and/or Deductibles) for the Member's Covered Health Services.

18. **Coverage Month** means the monthly period of time commencing on the effective date of the Certificate and on the same date of each month thereafter.

19. **Covered Health Services** means the specific Benefits covered under this Certificate and the Group Service Agreement when covered services are:

    a. Received in accordance with the procedures set forth in this Certificate and the Group Service Agreement;

    b. Obtained while a Member is covered under this Certificate and the Group Service Agreement;

    c. Ordered by a Provider or other properly licensed health care provider when Prior Authorized pursuant to the terms of this Certificate;

    d. Medically Necessary; and

    e. Prior Authorized, when required by GHC-SCW.

20. **Custodial Care** means the provision of room and board, nursing care, personal care or other care that is designed to assist an individual in the activities of daily living (e.g., eating, dressing, assistance in walking and preparing meals). Custodial Care is care and treatment that is generally received by an individual who has reached the maximum level of recovery in the opinion of GHC-SCW. In the case of an institutionalized person, Custodial Care also includes room and board, nursing care or such other care provided to an individual for whom it cannot reasonably be expected, in the opinion of the Provider, that medical or surgical treatment will enable that person to live outside an institution. Custodial Care includes rest care, respite care and home care provided by family members. Care may be considered Custodial Care as determined by GHC-SCW even if: (a) the Member is under the care of a Provider; (b) the Provider prescribes services to support and maintain the Member's condition; or (c) services and supplies are being provided by a registered nurse or licensed practical nurse.

21. **Deductible** means a specified dollar amount which an individual Member or family must pay per year before Benefits will be payable by GHC-SCW. Only charges that qualify as covered expenses may be used to satisfy the Deductible. The amount of the Deductible is listed on the Benefit Summary.

22. **Dependent** means one or more of the following:

a. A Subscriber's lawful spouse.

i. A spouse will cease to be a Dependent on the last day of the month in which a divorce decree is granted, and coverage may be terminated, subject to continuation and conversion rights. Other children cease to be Dependents at the end of the calendar month in which they reach age 26.

b. A Subscriber's Child under the age of 26.

i. If a Member is the father of a Child born outside of marriage, the Child does not qualify as a Dependent unless and until there is a court order declaring paternity, or on the date the acknowledgment of paternity is filed with the Wisconsin Department of Health Services, or its equivalent if the birth was outside the State of Wisconsin. Once a Child becomes eligible for coverage, coverage will be effective according to the rules specified in the "Eligibility and Effective Date of Coverage" section of this Certificate.

ii. Stepchildren will cease to be Dependents on the last day of the month in which a divorce decree is granted, and coverage may be terminated, subject to continuation and conversion rights. Other children cease to be Dependents at the end of the calendar month in which they reach age 26.

c. A Subscriber's adult Child who satisfies all of the following:

i. The Child was under 27 years of age when they were called to federal active duty in the National Guard or in a reserve component of the U.S. Armed Forces;

ii. The Child was attending, on a full-time basis, an institution of higher education;

iii. The Child applied to an institution of higher education as a full-time student within 12 months from the date the Child has fulfilled their active duty obligation; and

iv. The Child is a Full-Time Student.

d. A Subscriber's grandchild, if the parent of the grandchild is a Dependent Child. The Dependent grandchild is covered until the end of the month in which the Dependent Child turns age 18.

e. Disabled Dependents: If otherwise eligible, children who are or become incapable of self-support because of a physical or mental disability that is expected to be of a long-continued or indefinite duration may continue or resume their status as Dependents, regardless of age or student status, as long as they remain so disabled.

Written proof of incapacity and dependency must be provided to GHC-SCW in a form that is satisfactory to GHC-SCW within 31 days after the Dependent has attained the limiting age. Prior to granting continued coverage, GHC-SCW, in its sole discretion, may require that the Dependent be examined from time to time by a Provider for the purpose of determining the existence of incapacity. Examinations may occur at reasonable intervals during the first two years after continuation under this provision is granted. Following that two-year period, such examinations may occur on an annual basis.

The Subscriber must notify GHC-SCW immediately in the event the incapacity or dependency ends.

f. A Dependent ceases to be a Dependent on the date they are on active duty with the military service, including National Guard or reserves, other than for duty of less than 30 days.

23. **Designated Audio Visit Network Provider** means a GHC-SCW Provider or other In-Network Provider who has specifically contracted with GHC-SCW to provide certain non-emergency Covered Health Services in an Audio Visit setting or has otherwise been designated by GHC-SCW, in its sole discretion, to provide such services.

24. **Designated E-Visit Network Provider** means a GHC-SCW Provider or other In-Network Provider who has specifically contracted with GHC-SCW to provide certain non-emergency Covered Health Services in an E-Visit setting or has otherwise been designated by GHC-SCW, in its sole discretion, to provide such services.

25. **Designated Video Visit Network Provider** means a GHC-SCW Provider or other In-Network Provider who has specifically contracted with GHC-SCW to provide certain non-emergency Covered Health Services in a Video Visit setting or has otherwise been designated by GHC-SCW, in its sole discretion, to provide such services.

26. **Developmental Delay** means a condition due to a Congenital Anomaly, trauma, deprivation or disease that interrupts or delays the sequence and rate of normal growth, development and maturation, but excluding Autism Spectrum Disorder.

27. **Disenrollment** means coverage under the Plan has ended or has been revoked by GHC-SCW.

28. **Duplicate Service** means, if there is more than one medically established standard treatment approach available nationally and the approaches are relatively equivalent in terms of proven medical outcomes, a non-Medically Necessary request for coverage of more than one of the same medically established standard treatment approaches for identification or treatment of a Member's illness, disease or injury.

29. **Eligible Employee** means an Employee who meets the requirements for eligibility as specified in the Group Service Agreement and in the Group Application, including completing any applicable Waiting Period. Unless otherwise specified in the Group Service Agreement, an Eligible Employee is one who works on a permanent basis and who has a work week of 30 or more hours per week or, if less than 30 hours, at least as many hours specified in the Group Service Agreement. The term includes a sole proprietor, a business owner, including the owner of a farm business, a partner of a partnership, and a member of a limited liability company if the sole proprietor, business owner, partner or member is included as an employee under a health Benefit plan of an employer. The term does not include a retired employee or an employee who works on a temporary or substitute basis unless their status is specifically identified or included as part of the Group Service Agreement.

30. **Embedded** means each individual Member has their own Deductible and Maximum Out-Of-Pocket (MOOP) for a Benefit plan. In addition, there is a shared family Deductible and Maximum Out-Of-Pocket (MOOP).

31. **Emergency Condition(s)** means a medical condition that, if a person does not seek medical attention for it, could result in death or serious injury. It means a condition that manifests itself by acute symptoms of sufficient severity, including severe pain, to lead a prudent layperson who possesses an average

knowledge of health and medicine to reasonably conclude that a lack of immediate medical attention will likely result in any of the following:

a. Serious jeopardy to the person's health or, with respect to a pregnant person, serious jeopardy to the health of the pregnant person or their unborn child;

b. Serious impairment to the person's bodily functions; or

c. Serious dysfunction of one or more of the person's body organs or parts.

32. **Employee** means an individual whose employment or other status is the basis for their eligibility to enroll in this Plan.

33. **End of Life Services** means supportive care for a terminally ill Member whose life-expectancy is six months or less if the illness runs its normal course.

34. **ERISA** means the Employee Retirement Income Security Act of 1974, as amended. This law mandates certain reporting and disclosure requirements for group life and health plans.

35. **Experimental, Investigational or Unproven Services** means a health service, treatment, or supply used for an illness or injury which, at the time it is used, meets one or more of the following criteria:

a. Is subject to approval by an appropriate governmental agency for the purpose it is being used for such as, but not limited to the FDA, which has not granted that approval;

b. Is not currently a commonly accepted medical practice in the American medical community, or was not recognized as an accepted medical practice at the time the charges were incurred;

c. Is the subject of a written investigational or research protocol;

d. Requires a written investigational or research protocol;

e. Requires a written informed consent by a treating facility that makes reference to it being Experimental, Investigational, educational, for a research study, or posing an uncertain outcome, or having an unusual risk;

f. Is the subject of an ongoing FDA Phase I, II, III clinical trial;

g. Is undergoing review by an institutional review board;

h. Lacks recognition and endorsement of nationally accepted medical panels;

i. Does not have the positive endorsement of supporting medical literature published in an established, peer reviewed scientific journal;

j. Has unacceptable failure rates, side effects, or poses uncertain risks and outcomes;

k. Is being used in place of other, more conventional and proven methods of treatment;

l. Is associated with a Category III CPT code developed by the American Medical Association;

m. Has been disapproved by the GHC-SCW Pharmacy and Technology Assessment Committee; or

n. Reliable evidence shows that the consensus of opinion among experts regarding the treatment, procedure, device, drug or medicine is that further studies or clinical treatments are necessary to determine its maximum tolerated dose, toxicity, safety, or efficacy as compared with standard means of treatment or diagnosis. "Reliable evidence" shall include anything determined to be such by GHC-SCW, within the exercise of its discretion, and may include published reports and articles in the medical and scientific literature generally considered to be authoritative by the national medical professional community, the written protocol(s) used by the treating facility or the protocol(s) of another facility studying substantially the same treatment, procedure, device, drug or medicine; or the written informed consent used by the treating facility or by another facility studying substantially the same treatment, procedure, device, drug or medicine.

A procedure, treatment, supply, device or drug may be considered Experimental, Investigational or Unproven for a particular indication even if approved by the FDA or if the Provider has performed, prescribed, recommended, ordered, or approved it, or if it is the only available procedure or treatment for the condition.

GHC-SCW has full discretionary authority to determine whether a health service, treatment, or supply is Experimental, Investigational or Unproven. In any dispute arising as a result of GHC-SCW's determination, such determination will be upheld if it is based on any credible evidence.

36. **E-Visit** means a non-real-time (asynchronous) electronic visit between a GHC-SCW Member and a Designated E-Visit Network Provider. For certain symptoms, a Member can answer a series of questions. These answers, along with a Member's medical record information, give a Provider the information needed to treat the Member.

37. **Formulary** means a list of drugs and certain medical devices currently covered under the Outpatient Prescription Drugs benefit in this Certificate. Non-prescription (over-the-counter) drugs listed on the Formulary are only covered if prescribed by a participating health care Provider.

38. **Full-Time Student** means that the Child is in regular full-time attendance in one of the following types of schools:

    a. An accredited post-secondary vocational, technical or adult education school; or

    b. An accredited college or university that provides a schedule of courses or classes and whose principal activity is the provision of an education.

    GHC-SCW may require proof of attendance. Full-Time Student status is defined by the institution in which the student is enrolled. Coverage begins on the first day that the Child becomes a Full-Time Student.

    Student status includes any intervening vacation period if the Child continues to be a Full-Time Student.

39. **Gene Therapy** means the intentional, expected permanent, and specific alteration of the DNA sequence of the cellular genome, for a clinical purpose.

40. **Gestational Carrier** means a person who receives a transfer of an embryo created by an egg and sperm from either the intended parents or a donor(s). A gestational carrier shares no genetic material with the child with which they are impregnated.

41. **GHC-SCW Clinic** means a clinic owned and operated by GHC-SCW.

42. **GHC-SCW Provider** means a Provider who is employed by GHC-SCW and is qualified to provide one or more of the Benefits described in Article V of this Certificate. A contracted Provider who is not employed by GHC-SCW but provides services in a GHC-SCW Clinic is included in the definition of a GHC-SCW Provider.

43. **Grievance** means any dissatisfaction with the administration, claims practices or provision of services by GHC-SCW which is expressed in writing by or on behalf of a Member.

44. **Group** means the employer, union, trust, association, organization or other entity to which GHC-SCW has issued a Group Service Agreement. The Group is the basis for Eligible Employees and their Dependents to become entitled to coverage under the Plan described by this Certificate.

45. **Group Service Agreement (GSA)** means the agreement that GHC-SCW issued to the employer, union, trust, association, organization or other entity known as the Group that entitles Eligible Employees of the employer to become Subscribers of the Plan according to the terms of such agreement.

46. **Habilitation Therapies** means health care services that help you keep, learn, or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology, and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

47. **Health Insurance Benefit Plan** means any health benefit plan that is any hospital or medical policy or certificate, as defined by Wis. Stat. §§ 632.745 and 632.746.

    A Health Insurance Benefit Plan does not include any of the following:

    a. Accident insurance or disability income insurance, or any combination of those two types.

    b. Liability insurance or coverage issued as a supplement to liability insurance.

    c. Worker's compensation or similar insurance.

    d. Automobile medical payment insurance.

    e. Credit-only insurance.

    f. Coverage for on-site medical clinics.

    g. If provided under a separate policy, certificate or contract of insurance, or, if the following is not an integral part of a policy, certificate or other contract of insurance:

        i. Limited-scope dental or vision benefits;

        ii. Benefits for long-term care, nursing home care, home health care, community-based care, or any combination of those benefits; or

        iii. Other similar, limited benefits as are specified in regulations issued by the Federal Department of Health and Human Services under sec. 2791 of P.L. 104-191.

    h. Other similar coverage as specified in Wis. Stat. § 632.745(11)(b).

48. **Health Plan (or Benefit Plan or Plan)** means the overall program of health services insured and administered by GHC-SCW.

49. **High Deductible Health Plan** is a health plan that satisfies certain requirements with respect to minimum deductibles and Maximum Out-of-Pocket (MOOP) limits set annually by the Internal Revenue Service.

50. **Hospital(s)** means an institution which is licensed as a Hospital providing 24-hour continuous service to patients confined therein; which is primarily engaged in providing diagnostic and therapeutic facilities for the surgical and medical diagnosis, treatment, and care of sick and injured persons by and under the supervision of a professional staff of duly licensed Providers; which provides general and specialty Hospital facilities; and which is not a place for rest, for the aged, or a nursing home.

51. **Immediate Family Member** means the spouse of the Member; the Dependents, parents, grandparents, brothers and sisters of the Member and their spouses.

52. **Independent Review Organization (IRO)** means an organization not affiliated with GHC-SCW that is certified by the Commissioner of Insurance to offer clinical expertise, confidential and unbiased decision-making regarding GHC-SCW's Adverse Determinations based on Medical Necessity and/or Experimental, Investigational, or Unproven Services.

53. **Individual Effective Date** means the date on which the coverage of the Member becomes effective under the terms and conditions of this Certificate.

54. **Infertility** means the inability to conceive or carry a pregnancy to term after twelve (12) months of trying to conceive if Member is age 34 or younger, or after six (6) months of trying to conceive if Member is age 35 or older.

55. **Intermittent Care** means skilled nursing care that is provided or needed either:

    a. Fewer than seven days each week; or

    b. Fewer than eight hours each day for periods of 21 days or less.

56. **In-Network Facility** means a clinic or complex of Providers' offices and related Outpatient diagnostic and therapeutic facilities who has entered into an agreement with GHC-SCW for the purpose of providing Benefits to Members. A GHC-SCW Clinic is included in the definition of In-Network Facility.

57. **In-Network Provider** means a Provider who has entered into an agreement with GHC-SCW and is qualified to provide one or more In-Network Benefits described in Article V of the Certificate; or any individual, organization or entity pre-approved by the GHC-SCW Medical Director to deliver In-Network Benefits. A GHC-SCW Provider is included in the definition of In-Network Provider.

58. **Large Employer Group** are employers that employ an average of at least 51 full-time employees and full-time equivalents on business days during the preceding calendar year, or, is reasonably expected to employ an average of at least 51 full-time employees and full-time equivalents during the current Calendar Year if the employer was not in existence during the preceding Calendar Year. The precise method for calculating full-time equivalents can be found in § 4980H of the Internal Revenue Code.

59. **Late Applicant** means an individual who:

    a. Requests enrollment under the Plan more than 31 days after the initial date on which they become eligible; and

    b. Who is not otherwise entitled to enroll during a Special Enrollment Period.

    A Late Applicant who does not enroll during a Special Enrollment Period will be enrolled in this Plan with an Effective Date that is delayed twelve (12) months following the date of their application.

60. **Late Applicant Waiting Period** means the 12-month period of time, or that period up through an Open Enrollment Period, if available, whichever comes first, for which a Late Applicant will not be covered under this Health Plan. A Late Applicant must remain continuously employed with the employer during the 12-month period or up to an Open Enrollment Period, if available, whichever comes first. A Dependent of an Eligible Employee must remain a Dependent of that Eligible Employee during the 12-month period, or up to an Open Enrollment Period, if available, whichever comes first. The Late Applicant Waiting Period must be served with the same employer.

61. **Life-Threatening Disease or Condition** means:

    a. Diseases or conditions where the likelihood of death is high, unless the disease is interrupted; and

    b. Diseases or conditions with potentially fatal outcomes, where the endpoint of clinical trial analysis is survival.

62. **Maintenance and Supportive Care and/or Therapy** means continuing treatment or care for a chronic condition after the patient has reached maximum therapeutic benefit(s) of care. Maintenance and Supportive Care and/or Therapy is usually provided on a routine or regular basis. The determination of what constitutes Maintenance and Supportive Care and/or Therapy is made by GHC-SCW's Medical Director after reviewing the Member's case history and/or treatment plan. End of Life Services are not considered Maintenance and Supportive Care and/or Therapy. Maintenance Therapy and Supportive Care may be used interchangeably.

63. **Maximum Out-of-Pocket (MOOP)** means the maximum amount of Cost-Sharing a Member or a family pays every year. The Maximum Out-of-Pocket an individual Member can incur for covered expenses for prescription and medical is no more than the Patient Protection and Affordable Care Act (PPACA) individual maximum. The family Maximum Out-of-Pocket for an individual Member can be no more than the maximum for self-only coverage. There is a separate Maximum Out-of-Pocket for In-Network Providers and Out-of-Network Providers. Members should check their plan's Benefit Summary for details. Once the Maximum Out-of-Pocket for Covered Health Services is reached, Covered Health Services are payable at 100%.

    The following items do not apply to the Maximum Out-of-Pocket:

    a. Any charges for non-covered health services;

    b. Charges that exceed eligible expenses; and

    c. Any Copayments, Coinsurance, Deductibles or Cost-Sharing for services that specifically do not apply to the Maximum Out-of-Pocket.

64. **Medicaid** means a federal program administered and operated individually by participating state and territorial governments that provide medical Benefits to eligible low-income persons needing health care. The costs of the program are shared by the federal and state governments.

65. **Medical Food** means:

    a. Food which is formulated to be administered enterally under the supervision of a physician and which is intended for the specific dietary management of a disease or condition for which distinctive nutritional requirements, based on recognized scientific principles, are established by medical evaluation; and

    b. Oral and enterally administered formula or nutritional supplement for infants (i.e., up to 12 months of age), which is specifically formulated for the treatment of an inborn error of metabolism.

66. **Medical Necessity/Medically Necessary** means a service, treatment, procedure, equipment, Prescription Drug (or combination thereof), device or supply provided by a Hospital, Provider or other health care Provider that is required to identify or treat a Member's illness, disease or injury and which is, as determined by the GHC-SCW Medical Director:

    a. Consistent with the symptom(s) or diagnosis and treatment of the Member's illness, disease or injury;

    b. Appropriate under the standards of acceptable medical practice to treat that illness, disease or injury;

    c. Not solely for the convenience of the Member, Provider, Hospital or other health care Provider; and

    d. The most appropriate service, treatment, procedure, equipment, Prescription Drug (or combination thereof), device or supply which can be safely provided to the Member and accomplishes the desired end result in the most economical manner. This means if there is more than one medically established standard treatment approach available nationally, and these approaches are relatively equivalent in terms of proven medical outcomes, GHC-SCW will make the determination on the selected approach to be covered.

    The Member's Provider makes decisions regarding service and treatment. GHC-SCW, through its Medical Director, using criteria developed by recognized sources, has the authority to determine whether a service, treatment, procedure, Prescription Drug (or combination thereof), device or supply is Medically Necessary and eligible for coverage under the Plan.

67. **Medicare** means the health insurance Benefits for the Aged and Disabled program established by the Social Security Amendments of 1965, as now or hereafter amended.

68. **Member** means any Subscriber or enrolled Dependent, as defined herein.

69. **Member Certificate (Certificate)** means a Certificate, inclusive of its attachments and Subscriber Application, issued to You, the Subscriber, by GHC-SCW, setting forth the Benefits and essential terms and conditions affecting eligibility, coverage conditions and termination of coverage.

70. **Mental Health Services** means Medically Necessary treatments, therapies, procedures, or services provided by a qualified Provider for the treatment of conditions classified as a mental health disorder by the current Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association.

71. **Non-Embedded** (may also be referred to as **Aggregate**) means every Member on Your Benefit plan shares one Deductible and one Maximum Out-Of-Pocket (MOOP).

72. **Obstetrical Services** means medical services dealing with the care of women during pregnancy, childbirth and the recuperative period following delivery. Obstetrical Services do not include those medical services provided to any newborn child(ren).

73. **Open Enrollment Period** means a period of time when all potential Members are allowed to enroll for coverage, whether or not they are currently enrolled in any of the employer's other Plans. The Open Enrollment Period shall be established by GHC-SCW and the Group from time to time, but not less frequently than once in any 12 consecutive months.

74. **Out-of-Network Facility** means any clinic or complex of Providers' offices and related Outpatient diagnostic and therapeutic facilities who has not entered into an agreement with GHC-SCW for the purpose of providing Benefits to Members.

75. **Out-of-Network Provider** means any health care Provider who has not entered into an agreement with GHC-SCW to provide services to GHC-SCW Members.

76. **Outpatient** means that the Member is not a bed patient in a Hospital, Skilled Nursing Facility, or other institution of medical or health care at the time services are rendered.

77. **Outpatient Habilitation Services** means Habilitation Therapies provided in an Outpatient setting.

78. **Outpatient Rehabilitation Therapies** means Rehabilitation Therapies provided in an Outpatient setting.

79. **Plan Year** means a consecutive 12-month period during which a group receives coverage for health Benefits from GHC-SCW. A Plan Year may align with a Calendar Year or otherwise.

80. **Premium** means the monthly amount of money charged by GHC-SCW for Benefits under the Group Service Agreement or this Certificate, whether or not any such Benefits are actually required by or received by the Member in any month. Premium is payable by the Group or Subscriber to GHC-SCW.

81. **Prescription Drug** means any drug that has been approved by the FDA and labeled "For Prescription Use Only." Prescription Drugs may include biological products, but does not include blood or blood components intended for transfusion or biological products that are also medical devices.

82. **Preventive Health Services** means services, as required by Federal law, that must be covered without Cost-Sharing requirements. Preventive Health Services include:

    a. Evidence-based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force (USPSTF) with respect to the individual involved;

    b. Immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention with respect to the individual involved;

c. With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration (HRSA); and

d. With respect to women, to the extent not included in paragraph a. above, evidence-informed preventive care and screenings provided for in binding comprehensive health plan coverage guidelines supported by HRSA.

83. **Primary Care Provider(s)** means a GHC-SCW physician, a nurse practitioner or a physician's assistant employed, contracted or engaged by GHC-SCW to provide a Benefit to Members.

84. **Prior Authorization** means the advance authorization, with appropriate documentation, by the GHC-SCW Medical Director or their designee for specific medical services or treatment.

85. **Provider** means a person properly licensed, certified or otherwise authorized, pursuant to the law of the jurisdiction in which care or treatment is received, to provide one or more Covered Health Services within the scope of their license.

86. **Provider's Services** means services rendered by a Provider and billed for by the Provider rendering and regularly charging for such services.

87. **Reasonable and Customary Fees and Charges** (may also be referred to as **Reasonable and Customary**) means the fees of professional Providers of care and other Providers of services or items which, as determined by GHC-SCW neither:

a. Exceed the rate, fee, or cost usually charged by the professional or other Provider for such services or items; nor

b. Exceed the general level of rates, fees, or costs for similar services or items charged by others within the community where rendered or provided. In determining whether fees and charges are Reasonable and Customary, GHC-SCW will give consideration to the nature and severity of the condition being treated and any medical complications or unusual circumstances which require additional time, skill, or experience.

88. **Referral** is an order from Your Provider to receive care outside of a GHC-SCW Clinic or through a specialty care Provider. When You visit Your Primary Care Provider, they may determine that a referral to another specialty care Provider is necessary. After receiving a referral, a Member may still need to obtain Prior Authorization from the GHC-SCW Care Management Department in order for the service to be covered.

89. **Rehabilitation Therapies** means health care services that help you keep, get back, or improve skills and functioning for daily living that have been lost or impaired because you were sick, hurt, or disabled. These services may include physical and occupational therapy, speech-language pathology, and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

90. **Renewal Date** means the date each year when Benefits and/or Premium may be adjusted for a future contract year. The Renewal Date is usually the same as the Group's contract anniversary date.

91. **Rescission** is a cancellation or discontinuance of coverage that has a retroactive effect. However, a cancellation or discontinuance of coverage is not a rescission if:

a. The cancellation or discontinuance of coverage has only a prospective effect; or

b. The cancellation or discontinuance of coverage is effective retroactively to the extent it is attributable to a failure to timely pay required Premiums or contributions towards the cost of coverage.

92. **Service Area** means the geographic area from which GHC-SCW accepts Members that have been approved by the appropriate regulatory agency. GHC-SCW's Service Area is different for the standard HMO network and the Select Network. Please visit www.ghcscw.com or contact Member Services for more information about the geographic area GHC-SCW serves. The Service Area may change from time to time.

93. **Short-Term Therapy** means Rehabilitative Therapies that are likely to significantly improve a Member's condition within 60 days from the date the therapy begins, as determined by GHC-SCW.

94. **Skilled Nursing Facility** means a convalescent or chronic disease facility that:

a. Is operated pursuant to law;

b. Is primarily engaged in providing, in addition to room and board accommodations, skilled nursing care under the supervision of a duly licensed physician;

c. Provides continuous, 24-hours a day nursing service by or under the supervision of a registered graduate professional nurse (RN); and

d. Maintains a daily medical record of each patient.

Facilities providing services primarily for domiciliary or custodial care do not meet our definition of a Skilled Nursing Facility.

95. **Skilled Nursing Facility Care** means the observation and/or services which require a qualified nurse or therapist (e.g., dressing changes, tube feedings, physical therapy, occupational therapy) and which are rendered on a daily basis (e.g., physical therapy five days per week) in a Skilled Nursing Facility.

96. **Sound, Natural Teeth** means teeth that would not have required repair in the absence of accidental injury, with pre-existing restoration limited to composite or amalgam filling.

97. **Special Enrollment Period** means a 31-day period of time during which a Late Applicant is allowed to enroll in the Plan without having to serve a Late Applicant Waiting Period. The Special Enrollment Period begins on the date the Late Applicant:

a. Loses coverage under a Health Insurance Benefit Plan or other health plan; or

b. Gains a Dependent through marriage, birth, legal guardianship, adoption or placement for adoption.

98. **Subscriber** means the Eligible Employee:

a. Who has applied for coverage;

b. Whose Subscriber Application or Enrollment Form has been received and accepted by GHC-SCW;

c. For whom we have received the initial Premium;

d. To whom a Certificate has been issued by GHC-SCW; and

e. Whose coverage is in force by the terms of the Group Service Agreement or this Certificate.

A Subscriber may be:

f. An **Individual Subscriber**, who is a person enrolled for themself alone and on whose behalf the appropriate Premium is paid; or

g. A **Family Subscriber**, who is a person enrolled for themself and one or more Dependents, and on whose behalf the appropriate Premium is paid.

99. **Subscriber Application (Enrollment Form)** means the application for enrollment under the Group Service Agreement or a Member Certificate, which is completed by the Eligible Employee to signify that they and any eligible Dependents wish to become Members of the Plan.

100. **Substance Use Disorder (SUD) Services** means Medically Necessary treatments, therapies, procedures, or services provided by a qualified Provider for the treatment of conditions classified as substance use disorders by the current Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association.

101. **Telehealth Services** are Covered Health Services provided through the use of medical information exchanged from one site to another via electronic communications. Telehealth Services include Audio Visits, E-Visits, and Video Visits, but do not include services provided only through email messages, text messages, facsimile transmission, mail or parcel service, or any combination thereof.

102. **Total Disability/Totally Disabled** means, if a Member is the Subscriber, that the Member is unable, because of illness or injury, to perform any duties of their occupation for either wage or profit. If the Member is a Dependent or does not currently have a regular occupation, this means the Member's inability, because of illness or injury, to engage in the normal activities of a person of the same age and sex. The Totally Disabled Member must be under the regular care of a Provider. The GHC-SCW Medical Director will make the determination as to whether or not a Member is Totally Disabled.

103. **Traditional Surrogate** means a person whose own egg is fertilized using donor sperm or the intended parent's sperm. A traditional surrogate contributes half of the genetic material to the child with which they are impregnated.

104. **Urgent Condition** means the rapid onset of symptoms of an illness or injury which requires medical care but is not life-threatening. Treatment for an Urgent Condition should be obtained from the nearest medical facility. Services received for an Urgent Condition are subject to the terms of Article V.

105. **Waiting Period** means the period of time specified in the Application for Group Service Agreement, if any, an Eligible Employee must wait after the date of hire before coverage under this Member Certificate becomes effective.

106. **You/Your** means a Member enrolled under a policy with Group Health Cooperative of South Central Wisconsin.

107. **Video Visit** means a real-time (synchronous) audio-visual interaction between a Member and a Designated Video Visit Network Provider.

Article II: Coverage

A. EMPLOYEE COVERAGE

1. Eligibility

An Employee must legally reside or work in the Service Area. GHC-SCW considers an Employee's "residence" to be the location in which they spend at least 9 months out of a 12-month period. Eligibility for coverage begins on the date an Employee meets all eligibility criteria specified on the Group Application.

2. Enrollment and Effective Date

An Employee may apply for enrollment in the Plan by submitting a completed Subscriber Application. Application must be made during an annual enrollment period or within 31 days of becoming eligible. The Subscriber Application may be obtained from the Group's benefit administrator.

GHC-SCW, at its discretion and with the mutual agreement of the employer, may allow for an Open Enrollment Period.

3. New Entrant

A new entrant may enroll within 31 days from the date they are eligible to enroll and will be covered on the date GHC-SCW specifies. A new entrant is an Employee who becomes part of the Group after the first enrollment period.

4. Late Applicant

If an Employee is a Late Applicant who is not entitled to enroll during a Special Enrollment, then the Employee will be enrolled in the Plan as of the date of application and subject to a Late Applicant Waiting Period. The Effective Date will be delayed by 12 months or that period of time up to the Open Enrollment Period, if any, whichever comes first, and coverage will be effective as of that date.

5. Late Applicant/Special Enrollment

An Employee is a Late Applicant if they have previously waived or otherwise declined coverage under the Plan. A Late Applicant is entitled to enroll during a Special Enrollment Period when the Employee marries or has a new Child as a result of marriage, birth, adoption or placement for adoption.

A Late Applicant entitled to enroll during a Special Enrollment Period must submit an Enrollment Application to GHC-SCW within 31 days of the date of the marriage, birth, adoption or placement for adoption. Coverage will be effective:

a. With respect to a marriage, the date of; or

b. With respect to a birth, adoption or placement for adoption, on the date of birth, adoption or placement for adoption.

6. **Late Applicant/Special Enrollment for Loss of Other Coverage**

An Employee who is not enrolled, but who is eligible for coverage under the terms of the Group Plan, or an Employee's Dependent who is not enrolled but who is eligible for coverage under the terms of the Group Plan, may enroll for coverage during a Special Enrollment Period if there is a Special Enrollment period pursuant to any state or federal law available, or if all of the following apply:

a. The Employee or Dependent was covered under another group health plan or had Health Insurance Benefit Plan coverage at the time coverage was previously offered to the Employee or Dependent; and

b. The Employee or Dependent stated in writing at the time GHC-SCW coverage was previously offered that coverage under another group health plan or Health Insurance Benefit Plan was the reason for declining enrollment under this Plan; and

c. Either:

i. The Employee or Dependent is currently covered under that prior group health plan or Health Insurance Benefit Plan or, under the terms of the Group Plan, the Employee or Dependent requests enrollment no later than 31 days after the date on which the coverage under paragraph a. is exhausted or terminated; or

ii. The Employee or Dependent requests enrollment within 60 days of losing or being determined as eligible for Medicaid or Children's Health Insurance Program (CHIP) under title XXI of the Social Security Act.

B. DEPENDENT COVERAGE

1. **Eligibility**

Except for a covered Dependent Child, GHC-SCW considers a Dependent's "residence" to be the location in which they spend at least 9 months out of a 12-month period. Eligibility for coverage begins on:

a. The date the Employee is eligible for coverage, if the Employee has Dependents who may be covered on that date; or

b. Either the date of the Employee's marriage or the first day of the month following the date of the marriage (as determined by the employer) for any Dependent (spouse or stepchild) acquired through the marriage; or

c. The date of birth of the Employee's natural-born Child; or

d. The date a Child is placed in the Employee's home for adoption, or the date that a court issues a final order granting adoption or legal guardianship of the Child to the Employee, whichever occurs first; or

e. The date of birth of a Child born to an Employee's covered Dependent Child who is under the age of 18. The Dependent grandchild will be covered until the end of the month in which the Dependent Child turns age 18; or

f. For Dependent Full-Time Students age 26 or older, the first day they become Full-Time Students if:

i. The Child was under 27 years of age when they were called to federal active duty in the National Guard or in a reserve component of the U.S. Armed Forces while the Child was attending, on a full-time basis, an institution of higher education, and applied to an institution of higher education as a Full-Time Student within 12 months from the date the Child has fulfilled their active duty obligation; and

ii. The Child is a Full-Time Student.

Except for continuation and conversion coverage, an Employee may cover Dependents only if the Employee is covered.

2. **Enrollment and Effective Date**

a. Each Dependent must be enrolled on a Subscriber Application.

b. The Effective Date of coverage for each Dependent (other than a newborn, adopted child, or child eligible through legal guardianship) is the date they are eligible.

i. A Dependent's Effective Date may never be prior to the Employee's Effective Date.

ii. A new entrant may enroll within 31 days from the date they are notified of the opportunity to enroll and will be covered on the date GHC-SCW specifies. A Dependent is a new entrant:

1. If they are a Dependent of an Employee who becomes part of the Group after the first enrollment period; or

2. If a court orders them to be covered under the Policy and if they request coverage after issuance of the court order; or

3. They did not enroll during an enrollment period and, at that time, was covered by a Health Insurance Benefit Plan, loses that coverage, and requests coverage under this Plan within 31 days after the termination of the Health Insurance Benefit Plan coverage.

3. **Late Applicant**

If the Subscriber seeks to enroll a Dependent who is a Late Applicant who is not entitled to enroll during a Special Enrollment Period, then the Dependent will be enrolled in the Plan as of the date of application and subject to a Late Applicant Waiting Period. The Effective Date will be delayed by 12 months or that period of time up to an Open Enrollment Period, if any, whichever comes first, and coverage will be effective as of that date.

4. **Newborn Effective Date of Coverage**

The Employee has 60 days from the date of birth of a Child to apply for Dependent coverage effective on the newborn's birth date. The Employee may apply for Dependent coverage for a newborn up to one year after the newborn's birth date if the Employee pays all past Premium plus interest on such Premium at the rate of 5-1/2% per year.

5. **Adopted Child Effective Date of Coverage**

The Employee has 60 days from the date a Child is placed in the custody of the Employee or from the date a court issues a final order granting adoption of the Child by the Employee, whichever occurs first, to apply for Dependent coverage effective on the date of eligibility.

6. **Child Eligible Through Legal Guardianship Effective Date of Coverage**

The Employee has 60 days from the date the child is eligible as a Legal Guardian to apply for Dependent coverage effective on the date of eligibility.

C. CHANGES TO SUBSCRIBER APPLICATION

Changes to the original Subscriber Application, other than Provider changes, must be made by completing a new Subscriber Application.

D. TERMINATION OF COVERAGE

1. The Group shall be notified 60 days prior to the non-renewal of the Group Service Agreement. It is the responsibility of the Group to inform each Subscriber of the date that coverage terminates. In cases of non-renewal due to cancellation of an entire class of business, the Group shall be notified at least 90 days before the date on which the coverage will be discontinued.

2. Coverage terminates for Employees and covered Dependents on the date that one of the following occurs:

   a. The Policy terminates; or

   b. A service is no longer a Covered Health Service under the Policy, except that termination then relates only to that Covered Health Service.

3. Coverage also terminates for Employees and covered Dependents for any of the following reasons:

   a. The Employee's employment terminates; or

   b. The Employee ceases to meet eligibility requirements or is no longer in a class of Employees that is eligible for coverage under the Policy; or

   c. The Member requests voluntary Disenrollment; or

   d. The Employee retires, unless the employer requests retiree coverage on the Group Application Form and GHC-SCW approves such request; or

   e. The Dependent no longer qualifies as an eligible Dependent.

   The termination date is determined by the Group pursuant to the terms of the Group Service Agreement. GHC-SCW may backdate terminations no more than 90 days from the date of the request.

4. **Termination of Coverage – Hospital Confinement**

   A Member confined in an inpatient Hospital/facility or Skilled Nursing Facility on the date coverage ends shall be entitled to have Benefits hereunder continued only for the condition that initiated the hospital confinement and only for those Inpatient Hospital Services related to that condition, until that time they

are released from the inpatient Hospital/facility or Skilled Nursing Facility for that specific confinement, subject to the terms, conditions, and limitations of such care as set forth in this Certificate.

Coverage will not be extended beyond the date on which:

a. The confinement ends;

b. The Benefit period specified in the policy ends;

c. The maximum Benefit available is exhausted;

d. 90 consecutive days pass since the Member's coverage ends; or

e. Similar coverage for the condition or conditions causing the hospital confinement is provided under another group policy.

E. RIGHT TO CONTINUE GROUP MEDICAL COVERAGE

1. The Member may have the right to continue coverage under the Plan if they cease to meet eligibility requirements. A Member may elect this option if:

   a. They are an Employee whose eligibility for Group coverage terminates (the option is not available if the Employee was fired for misconduct on the job); or

   b. They are the former spouse of an Employee, and the marriage ends due to divorce or annulment while Dependent coverage is in effect; or

   c. They are a surviving Dependent spouse or Child of an Employee who dies while Dependent coverage is in effect.

2. Wisconsin continuation law applies to employer Groups with fewer than 20 Employees. This option is available only if the Member has been covered under the Plan for at least 3 consecutive months. The maximum continuation period is 18 months. The employer must provide the Member with written notice of continuation rights within 5 days after the date the Member's eligibility for coverage terminates. The Member has 30 days from the date of the notice to elect the continuation option and pay the Premium due to the Group. The employer will tell the Member when and how much payment is due and will send payment to GHC-SCW. The Member must complete a new Subscriber Application if they are a former spouse or a surviving Dependent spouse or Child.

3. Federal continuation law is governed by the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA applies to Groups with 20 or more Employees. The maximum continuation period is 18 consecutive months from the date the Member elects to continue coverage. This period of time is modified to:

   a. 29 months if the Member (i) is disabled at the time Group coverage terminates due to cessation of employment or reduction of hours, or (ii) becomes disabled within the first 60 days thereafter, provided that the Member has been determined to be disabled for Social Security purposes and the Member provides GHC-SCW with notice of such determination within 60 days of the determination and before the end of the 18-month continuation period.

b. 36 months if a Dependent loses coverage due to (i) divorce or death of the Employee, or (ii) the Employee becomes eligible for Medicare, or (iii) if a Child of an enrolled Employee no longer meets the definition of "Dependent" under the Policy.

c. Special COBRA rights apply to Subscribers who have been terminated or experience a reduction of hours and who qualify for a "trade readjustment allowance" or "alternative trade adjustment assistance" under a federal law called the Trade Act of 1974. These Subscribers are entitled to a second opportunity to elect COBRA coverage for themselves and certain family members (if they did not already elect COBRA coverage) but only within a limited period of 60 days or less and only during the 6 months immediately after their group health plan coverage ended.

If You qualify for assistance under the Trade Act of 1974, contact Your employer promptly after qualifying for assistance or You will lose these special COBRA rights.

4. The continuation coverage period is measured from the exact date continuation coverage is elected or becomes effective to the same calendar date of the succeeding months. Coverage continues until:

a. The date the Member is covered under another similar group medical plan; or

b. The end of the last month for which Premium was paid by the Member when due; or

c. If the Member is the former spouse of an Employee, the date the Employee is no longer covered by the Group Plan or replacement group policy.

5. A Child born to a Member or placed for adoption with a Member is eligible for continuation coverage and may be enrolled in accordance with the provisions contained in the section entitled "Dependent Coverage."

F. MEDICAL CONVERSION PRIVILEGE

Group Subscribers and Dependents who remain within Dane County, Wisconsin, and who become ineligible for Group coverage have the right to convert to an individual direct-pay conversion plan within 30 days after Group coverage terminates.

G. DISENROLLMENT FROM THE PLAN

"Disenrollment" means that a Member's coverage under the Plan is revoked. Coverage is contingent upon the Subscriber's continued eligibility and timely payment of Premium. GHC-SCW may disenroll a Member only for the reasons listed below:

1. The Member no longer works within the Service Area and Member and/or any Dependents have moved outside GHC-SCW's Service Area. This does not include Full-Time Student Dependents who attend school outside the Service Area or Dependent children residing outside the Service Area. However, it must be noted that coverage for such Dependents while outside the Service Area is limited to Emergency Conditions and Urgent Conditions; or

2. Required Premium is not paid by the end of the 31-day grace period;

3. The Member commits acts of physical or verbal abuse which pose a threat to Providers or GHC-SCW employees; or

4. The Member allows a non-member to use the Member's Identification Card to obtain services; or

5. The Member has performed an act, practice or omission that constitutes fraud in applying for coverage and at least 30 days advance written notice has been provided to each Member who would be affected by the disenrollment; or

6. The Member demands access to a Primary Care Provider but is unable to establish or maintain a satisfactory physician-patient relationship with that Provider. Disenrollment for this reason is permitted only if it can be demonstrated that GHC-SCW:

   a. Provided the Member an opportunity to select another Primary Care Provider;

   b. Made a reasonable effort to assist in establishing a satisfactory physician-patient relationship; and

   c. Properly communicated Grievance procedures to the Member.

   Except in the case of non-payment of Premium, GHC-SCW will arrange to provide similar alternative medical coverage for a terminated Member until the Member finds their own coverage or until the next opportunity to change insurers, whichever occurs first.

H. EXTENSION OF COVERAGE DUE TO TOTAL DISABILITY

If GHC-SCW terminates coverage under this Certificate for any reason other than the employer's failure to pay required Premiums for all Members of the Group, and a Member is Totally Disabled on the date of termination, GHC-SCW will continue to provide benefits related to the disabling condition until the earliest of the following occurrences:

1. Total Disability terminates;

2. The end of the 12 consecutive months immediately following the termination of coverage;

3. The benefit period specified in the Policy ends;

4. The maximum benefit is paid; or

5. Similar coverage for the condition or conditions causing the Total Disability is provided under another group policy.

This extended coverage does not apply to dental or uncomplicated pregnancy expenses or to a condition other than the condition or conditions causing the Total Disability.

I. THIRD-PARTY PREMIUM PAYMENTS

GHC-SCW will not accept premium payments made directly or indirectly (indirect payments include, for example, a third party making a check out to or otherwise paying an enrollee to enable the enrollee to make a payment) by third parties on behalf of enrollees of its health plans, except as noted below.

GHC-SCW will accept premium payments made on behalf of enrollees from the following third parties:

1. A family member of the enrollee.

2. A Ryan White HIV/AIDS program under title XXVI of the Public Service Act;

3. An Indian tribe, tribal organization, or urban Indian organization; and/or

4. A local, State, or Federal government program, including a grantee directed by a government program to make payments on its behalf.

GHC-SCW may, in its sole discretion, accept premium payments made on behalf of enrollees from bona fide not-for-profit organizations. GHC-SCW may, in its sole discretion, require such organizations to provide certain information for GHC-SCW's consideration, which may include, but is not limited to, documentation in support of the following:

1. The not-for-profit organization provides premium assistance on the basis of the enrollee's financial need, and not on the basis of the enrollee's health status or medical condition;

2. The not-for-profit organization is not a healthcare clinic or facility, or otherwise a provider of healthcare services or supplies; and

3. The not-for-profit organization does not have any direct or indirect financial interests in making premium payments.

Any premium payments received in violation of this policy will not be applied to the enrollee's account. Reimbursement to providers of healthcare services and/or supplies may be subject to retroactive adjustment.

GHC-SCW maintains sole discretion with respect to its acceptance of third-party payments. In accordance with applicable law and regulatory guidance, GHC-SCW may make changes to its administration of third-party payments at any time.

Article III: General Provisions

A. RIGHTS OF SUBROGATION AND REIMBURSEMENT

When used in this section the term "Expenses" shall mean the costs of all medical, surgical and Hospital care furnished to a Member and provided, arranged or paid by GHC-SCW, computed on the basis of Reasonable and Customary Fees and Charges by health care Providers of such services. If any Member is injured by an act or omission of a Third Party, and if such Third Party and/or any other entity, including but not limited to any liability insurer, health and accident, motor vehicle or property medical payments insurer, uninsured/underinsured motorist, school and/or no fault insurer(s) (each referred to hereafter as a "Third Party") is subsequently determined to be liable and/or contractually responsible for the Expenses incurred because of such act or omission, GHC-SCW will be subrogated to, and may enforce the rights of the Member against the Third Party for such Expenses.

GHC-SCW shall have the right to subrogate against a Third Party or seek reimbursement from a Member for the full amount of Reasonable and Customary Fees and Charges necessarily incurred by the Member and related to injuries caused by a Third Party, less any percentage of causal negligence reasonably attributable to the Member. In paying Expenses for the Member, GHC-SCW may obtain discounts from health care Providers, compensate Providers on a capitated basis or enter into other arrangements under which GHC-SCW may pay less than the reasonable value of the Expenses provided to the Member. Regardless of any such arrangement, when GHC-SCW pays such Expenses it is subrogated to the Member's rights to recover the reasonable value of the Expenses even if the reasonable value of the Expenses exceeds the amount paid by GHC-SCW.

In addition to and notwithstanding the subrogation rights granted to GHC-SCW, by becoming a Member of GHC-SCW and/or accepting Benefits or the provision of health care services by GHC-SCW, including payment for Expenses, each Member does hereby assign and shall be deemed to have assigned to GHC-SCW all rights and claims against any Third Party for such Expenses, including the right to compromise claims independently of the Member.

These Subrogation and Reimbursement rights granted to GHC-SCW shall not apply until such time as the Member has been "made whole." The Member is made whole if a claim results in payment to the Member, by way of settlement, compromise or judgment of an amount less than the combined total of any available Third Party payments, including liability, uninsured or underinsured motorist policy proceeds. In the event of the settlement or compromise of a disputed claim, the Member is made whole when a claim results in payment for less than the total available Third Party proceeds after reducing the Member's total damages to account for any contributory negligence attributable to Member. GHC-SCW and the Member each have a right to a hearing by a trial judge if there is a dispute as to the amount of contributory negligence reasonably attributable to the Member.

If GHC-SCW compromises a claim for expenses against a Third Party liable and/or responsible for any Expenses, then the Member shall be deemed to have released any claim they may have against the Third Party for the expenses. No Member shall settle, compromise, or release a claim for expenses against a Third Party, unless:

1. The rights of GHC-SCW are expressly reserved in the settlement, compromise or release; or
2. The claim of GHC-SCW is paid in full; or
3. GHC-SCW has given a written waiver of the claim after being provided written notice of the claim.

Each Member shall execute such forms as GHC-SCW deems necessary or appropriate, to permit GHC-SCW to enforce these Subrogation and Reimbursement rights. The Member, their relatives, heirs, and/or assignees shall notify GHC-SCW in writing within 31 days after the commencement of any legal proceeding against a Third Party related to the payment of the expenses, and will join GHC-SCW as a party in such proceeding in order for GHC-SCW to pursue its rights of Subrogation and Reimbursement. The Member shall not enter into any settlement, compromise, agreed judgment, or release of claims against such a Third Party without the prior written consent of GHC-SCW. The Member and GHC-SCW shall each have the right to participate or intervene in any legal proceeding against a Third Party at their own expense.

GHC-SCW and the Member shall each have the right to be represented by their own counsel in any lawsuit or to enforce any claim with regard to the Expenses, and the Expenses due GHC-SCW shall not be reduced in order to pay the Member's attorneys' fees or court costs, regardless of whether or not a lawsuit is filed, and regardless in whether or not the Member prevails. GHC-SCW and the Member shall be bound by the result of a legal proceeding of which they had notice and in which they had an opportunity to participate, including a judgment or settlement that terminates the claims of GHC-SCW or the Member without payment.

By becoming a Member of GHC-SCW and/or accepting medical Benefits from GHC-SCW, the Member shall be deemed to have granted GHC-SCW a first lien and security interest up to the reasonable cash value of the expenses upon any award, settlement or judgment the Member may receive, and the Member shall be deemed to have assigned said award, settlement or judgment to GHC-SCW up to the amount of the Expenses, and any funds received by the Member shall be held in trust by the Member and/or their attorney or other representative and paid to GHC-SCW without any deductions for attorneys' fees or other costs.

B. COORDINATION OF BENEFITS

1. **Definitions**. For purpose of this Section B.

   a. **Allowable Expense** shall mean the Reasonable and Customary Fees and Charges for health care, when the item of expense is covered at least in part by one or more plans covering the person for whom the claim is made. When a plan provides Benefits in the form of services, the reasonable cash value of each service rendered shall be considered both an Allowable Expense and a Benefit paid.

   b. **Claim Determination Period** shall mean the **Plan Year**. It is the time over which Allowable Expenses are compared with total Benefits payable in the absence of a coordination of Benefits provision to determine whether over insurance exists and how much each plan will pay or provide.

2. **Interpretation.** For purposes of this Article III. B., the term "health Benefit plan" or "insurance policy" shall be broadly construed and interpreted. It shall include, but not be limited to:

   a. Group insurance or group-type coverage under self-insured plans; HMO and LSHO coverage and other prepayment group practice and individual practice plans; the medical Benefits coverage in group, group-type and individual automobile "fault" and "no-fault" contracts, and premises medical expense coverage.

   b. Coverage under a governmental plan or coverage that is required or provided by law. This does not include a state plan under Medicaid Title XIX, Grants to States for Medical Assistance Programs, or the United States Social Security Act as amended from time to time. It also does not include any plan whose Benefits by law, are excess to those of any private insurance program, or other non-governmental program.

Each contract or other arrangement for coverage under (a) or (b) is a separate plan. If an arrangement has two parts and coordination of Benefits rules apply only to one of the two, each part would be a separate plan.

3. **Where Other Plan Has No Provision**. The Benefits of a health Benefit plan or insurance policy which does not have a coordination of Benefits provision shall in all cases be determined and exhausted before the Benefits provided or payable under this Certificate.

4. **Where Other Plan Does Have Provision.** Benefits to which a Member is entitled under this Certificate may also be covered under another health Benefit plan or insurance policy. If so, the Benefits provided or payable hereunder shall be reduced to the extent that Benefits are available to such Member under such other plan or policy whether or not a claim is made for the same. In such cases, the following rules shall establish the order of Benefit determination:

   a. The Benefits of the plan which cover such Member other than as a Dependent will be determined before the Benefits of the plan which cover such Member as a Dependent;

   b. For Members who are Dependent children of parents who are not legally separated or divorced:

      i. except as provided in subparagraph (b)(ii.) below, the Benefits of the plan which covers such Member as a Dependent child of a parent whose date of birth, excluding year of birth, occurs earlier in a Calendar Year shall be determined before the Benefits of the plan which covers the Member, as a Dependent child of a parent whose date of birth occurs later in a Calendar Year;

      ii. if both parents have the same birthday, the Benefits of the plan which covered the parent longer are determined before those of the plan which covered the other parent for the shorter period of time;

      iii. if the other plan does not have the rules described in subparagraphs (b)(i.) and (b)(ii.) above and does not have a rule based upon the gender of the parent, then the Benefits of that other plan shall be determined before the Benefits under this Certificate;

      iv. however, if the other plan does not have the rules described in subparagraphs (b)(i.) and (b)(ii.) above and does have a rule based upon the gender of the parent, and if as a result, the plans do not agree on the order of Benefits, the rule of the other plan shall determine the order of Benefits.

   c. For Members who are Dependent children of parents who are legally separated or divorced:

      i. if the parent with custody of the child has not remarried, the Benefits of the plan which covers the child as a Dependent of the parent with custody of the child shall be determined before the Benefits of a plan which covers the child as a Dependent of the parent without custody;

      ii. if the parent with the custody of the child has remarried, the Benefits of the plan which covers the child as a Dependent of the parent with custody shall be determined before the Benefits of the plan which covers that child as a Dependent of the step-parent shall be determined before the Benefits of the plan which covers that child as a Dependent of the parent without custody.

Notwithstanding subparagraphs (c)(i.) and (c)(ii.) above, if there is a court decree which would otherwise establish financial responsibility for the medical, dental or other health care expenses with respect to the child who otherwise meets the eligibility requirements, the Benefits of the plan which covers such child as a Dependent of the parent with such financial responsibility shall be determined before the Benefits of any other plan which covers the child as a Dependent child.

If, however, the specific terms of a court decree state that the parents have joint custody of the child and do not specify that one parent has responsibility for the child's health care expenses or if the court decree states that both parents shall be responsible for the health care needs of the child but gives physical custody of the child to one parent, and the entities obligated to pay or provide the Benefits of the respective parents' plans have actual knowledge of those terms, then the Benefits for the Dependent child shall be determined pursuant to paragraph (b) above.

d. The Benefits of the plan covering the Member who is laid-off or a retired employee or enrolled Dependent of such Member, shall be determined after the Benefits of any other plan covering the person as an active employee, or Dependent of such person.

e. The Benefits of the plan covering a Member as an actively at work employee or as that employee's Dependent shall be primary. The plan that covers a Member through a continuation plan issued pursuant to state or federal law shall be secondary. If the other plan does not have this rule and as a result the plans do not agree, this rule will not apply.

f. When rules (a), (b), (c), (d), and (e) above do not establish an order of Benefit determination, the Benefits of the plan which has covered such Member for the longer period of time shall be determined first.

g. Benefits under this Certificate will be reduced when the sum of:

i. the Benefits that would be payable for the Allowable Expenses under the Certificate in the absence of this Article III. B., and

ii. the Benefits that would be payable for the Allowable Expenses under any other health Benefit plan or insurance policy, in the absence of provisions with a purpose like that of this Article III. B., whether or not claim is made, exceeds those Allowable Expenses in a Claim Determination Period. In that case, the Benefits under this Certificate shall be reduced so that they and the Benefits payable under such other plan or policy do not total more than those Allowable Expenses.

When Benefits under this Certificate are reduced as described above, each Benefit is reduced in proportion. It is then charged against any applicable Benefit limitation under this Certificate.

5. **No Barrier to Receipt of Services**. None of the above rules as to coordination of Benefits will serve as a barrier to the Member first receiving from GHC-SCW Benefits which are covered under this Certificate.

6. **Right to Recover**. In the event it is determined that Benefits under this Certificate should have been reduced because of Benefits available under another health Benefit plan or insurance policy, GHC-SCW shall have the right to recover any payments made or to assess a reasonable charge for Benefits rendered beyond its obligation hereunder.

7. **Primary Payer Shall Pay First**. The health Benefit plan or insurance policy that is determined to provide primary coverage under the coordination of Benefits rules set forth in this Article III. B. shall be required to make payments to the extent of its available coverage before the health Benefit plan or insurance policy that is determined to provide secondary coverage shall be required to make payment.

8. **Noncomplying Plans.** In the event a Noncomplying Plan is determined to be secondary, GHC-SCW will pay or provide Benefits on a primary basis. A "Noncomplying Plan" is a plan which declares its Benefits to be excess or always secondary or which uses coordination-of- Benefit guidelines inconsistent with those contained in Wis. Ins. 3.40.

   If the Noncomplying Plan is determined by GHC-SCW to be primary, GHC-SCW will pay first, but the amount of the Benefits payable shall be determined as if GHC-SCW were secondary. In this situation, the payment shall be the limit of GHC-SCW's liability.

   If the Noncomplying Plan fails to provide necessary information for purposes of determining Benefits within a reasonable time after it is requested to do so, GHC-SCW shall assume that the Benefits of the Noncomplying Plan are identical to its own and shall pay its Benefits accordingly. However, GHC-SCW shall adjust any payments it makes based on such assumption whenever information becomes available as to the actual Benefits of the Noncomplying Plan.

   GHC-SCW shall advance to or on behalf of the Member an amount equal to the difference if the Noncomplying Plan reduces its Benefits so that the Member receives less in Benefits than they would have received had GHC-SCW paid or provided its Benefits as the Secondary Plan and the Noncomplying Plan paid or provided its Benefits as the Primary Plan.

   In no event shall GHC-SCW advance more than it would have paid had it been the primary plan less any amount it previously paid. In consideration of such advance, GHC-SCW shall be subrogated to all rights of the Member against the Noncomplying Plan. Such advance by GHC-SCW shall also be without prejudice to any claim it may have against the Noncomplying Plan in the absence of such subrogation.

9. **Information and Cooperation to be Provided**. Any Member claiming Benefits under this Certificate must furnish to GHC-SCW all information deemed necessary by it to implement the provisions of this Article III. B. GHC-SCW may require a Member to take such action as may be necessary or appropriate and to cooperate fully with GHC-SCW to preserve its right to recover as a result of Benefits which may be available under another health plan or insurance policy as set forth in the provision of subsection III.B.6, above.

C. MEDICARE

Benefits provided under a Group Service Agreement or this Certificate for Members entitled to Medicare payments are not designed to duplicate Benefits to which they are entitled under the Medicare Act. All sums payable for Benefits provided pursuant to a Group Service Agreement or this Certificate shall be payable to and retained by GHC-SCW. Each Member shall complete and submit such consents, releases, assignments and other documents reasonably requested by GHC-SCW in order to obtain or assure Medicare reimbursement. This Section C., however, shall not be applicable when the Member has remained employed by the Member's employer with whom GHC-SCW has a Group Service Agreement and:

1. where the Group employs 20 or more employees; or

2. where the Member is part of a Group which employs 20 or more employees and is entitled to Medicare due to End Stage Renal Disease (ESRD). In such a case, this Section C. is not applicable to the Member

for the first 30 months following the earlier of (a) the first month the Member would have become entitled to Medicare had the Member applied; or (b) the Member's entitlement to Medicare; or

3. where the Member is entitled to Medicare due to disability and the Member's Group employs 100 or more employees.

In the event that a Group has any Member for whom Medicare coverage is primary and coverage under the Group Service Agreement as secondary, Group shall promptly notify GHC-SCW in writing at such time as Group employs 20 or more full and/or part-time employees for each working day in each of 20 or more calendar weeks in the current year or in the preceding year.

PLEASE NOTE: GHC-SCW suggests that, if a Member is eligible for Medicare and Medicare would be the primary plan for that Member, that the Member enroll in both Medicare Part A and Part B. Except for kidney disease treatment required under s. 632.895 (4), Wis. Stat., failure to enroll in Medicare Part A and B will result in the Member paying out-of-pocket expenses for services that Medicare might have covered, because GHC-SCW will process the Member's claims as if the Member is enrolled in Medicare.

D. WORKERS' COMPENSATION

This Certificate is not issued in lieu of, nor does it affect, any requirements for coverage by Workers' Compensation. Items or services for injuries or sickness which are job, employment or work related for which Benefits are provided or payable under any Workers' Compensation or Occupational Disease Act of Law, are excluded from coverage by GHC-SCW. However, if Benefits are paid by GHC-SCW and it determines the Member is eligible to receive Workers' Compensation for the same incident, GHC-SCW has the right to recover as described in the Rights of Subrogation and Reimbursement in (Article III). As a condition of receiving Benefits on a contested work or occupational claim, the Member will consent to reimburse GHC-SCW when entering into any settlement, compromise agreement or at any Workers' Compensation Division Hearing. GHC-SCW reserves the right to recover against the Member even though:

1. The Workers' Compensation Benefits are in dispute or are made by means of settlement or compromise;

2. No final determination is made that the injury or sickness was sustained in the course of, or resulted from employment;

3. The amount of Workers' Compensation due to medical or health care is not agreed upon or defined by the Member or the Workers' Compensation carrier; or

4. The medical or health care Benefits are specifically excluded from the Workers' Compensation settlement or compromise.

A Member will not enter into a compromise or hold harmless agreement relating to any work related claims paid by GHC-SCW, whether or not such claims are disputed by the Workers' Compensation insurer, without the express written agreement of GHC-SCW.

E. ALL BENEFITS PAYABLE HEREUNDER SHALL, AT THE OPTION OF GHC-SCW, BE PAID TO THE PROVIDER OF SERVICES RENDERING THE SERVICE AND BILLING FOR THE SAME. Indemnity in the form of cash will not be paid to any Member except in reimbursement for payments made by the Member to a Provider or other Provider of service for which the Member had express authorization by GHC-SCW, and for which GHC-SCW was liable at the time of payment.

F. **ANY MEMBER MAKING CLAIM FOR CASH REIMBURSEMENT FOR THE COST OF BENEFITS** provided under Article V shall furnish, as soon as possible and no later than 12 months from the date of service, to GHC-SCW affirmative proof of the Benefits received and the charges thereof. Proof shall be provided using GHC-SCW's Subscriber Reimbursement Medical Claim Form and shall include full particulars of the illness, injury or condition, treatment received and contemplated, and such other information as may assist GHC-SCW in determining the amount due and payable. Please contact GHC-SCW's Member Services Department at (608) 828-4853 or visit www.ghcscw.com to obtain the appropriate form.

G. **STIPULATIONS OF LEGAL ACTION.** No action at law or suit in equity shall be commenced to recover under this Certificate or under the Group Service Agreement until 60 days after written proof of claim shall be given to GHC-SCW. Nor shall any such action or suit be brought more than three years after the Benefits to which such related claim shall have been rendered.

H. **GHC-SCW DETERMINATION OF BENEFITS.** In the event that a Subscriber is a Member of a Group, this Certificate constitutes an "employee welfare Benefit plan" in accordance with and subject to the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), and constitutes the plan instrument. GHC-SCW is the named fiduciary for purpose of determining Benefits and reviewing Grievances under this Certificate. The Group has delegated to GHC-SCW the discretion to determine whether Members are entitled to Benefits under the Certificate. In making such determinations, GHC-SCW has authority to review requests for Benefits and Grievances in accordance with the procedures contained herein and any policies, procedures, rules and interpretations adopted pursuant to the terms of the Group Service Agreement or the Certificate and to construe this Certificate to determine whether Members are entitled to Benefits.

I. **GHC-SCW MAY ADOPT REASONABLE POLICIES, PROCEDURES, RULES AND INTERPRETATIONS TO PROMOTE THE ORDERLY AND EFFICIENT ADMINISTRATION OF THIS CERTIFICATE.** Members agree to abide by the terms and conditions of such policies, procedures, rules and interpretations.

J. **NO INTEREST IN THIS CERTIFICATE MAY BE TRANSFERRED OR ASSIGNED.**

K. **NO PERSON OTHER THAN A MEMBER IS ENTITLED TO ANY BENEFIT UNDER THIS CERTIFICATE OR THE GROUP SERVICE AGREEMENT.** This Certificate shall not be transferable and shall be forfeited if any Member attempts to transfer it or aids, or attempts to aid, any other person in obtaining any Benefit under it.

L. **PRIOR AUTHORIZATION SERVICES.**

Prior Authorization is the process by which GHC-SCW provides prior written approval for coverage of specific Benefits, treatments, Prescription Drugs, and Durable Medical Equipment (DME) and Medical Supplies. The purpose of Prior Authorization is to determine and authorize the following:

1. The specific type and extent of care, Durable Medical Equipment, Medical Supply, or Prescription Drug that is necessary;
2. The number of visits, or the period of time, during which care will be provided;
3. The Provider to whom the Member is being referred; and
4. Whether the Member should receive coverage for the services from an Out-of-Network Provider because necessary services are not available from an In-Network Provider.

Prior Authorization does not guarantee that services will be fully covered. Coverage is determined by the terms and conditions of the Certificate. Services and items requiring Prior Authorization are listed on GHC-SCW's

website at www.ghcscw.com. Contact GHC-SCW's Member Services Department at (608) 828-4853 for details on the Prior Authorization process.

Additional services recommended by a Provider after rendering the services authorized by the original Prior Authorization are covered only if a new Prior Authorization is issued by GHC-SCW prior to receiving additional services from the Provider.

Member Responsibility Regarding Prior Authorization

It is the Member's responsibility to ensure a Prior Authorization has been obtained when required. Failure to obtain Prior Authorization when required may result in the Member receiving a reduction in or no Benefit. If Prior Authorization is not received prior to the date of service and/or receipt of supplies, Your Provider should contact GHC-SCW's Care Management Department for a determination of Medical Necessity.

Prior Authorization Penalty

If a Member fails to obtain written Prior Authorization for Covered Health Services from GHC-SCW, a Prior Authorization penalty shall apply (the "Prior Authorization Penalty"). The Prior Authorization Penalty requires the Member to pay 50% of the Reasonable and Customary Fees and Charges billed to GHC-SCW for the Covered Health Service(s) that required Prior Authorization. The maximum Prior Authorization Penalty shall be $500. The Prior Authorization Penalty shall be assessed prior to any applicable Deductible, Coinsurance and/or Copayment. The Prior Authorization Penalty does not apply toward the Member's Maximum Out-of-Pocket. All Covered Health Services remain subject to the Member's Deductible, Coinsurance and/or Copayment following assessment of the Prior Authorization Penalty. To obtain Prior Authorization, call (608) 257-5294.

Prior Authorization Guidance

Article V identifies GHC-SCW's Prior Authorization requirement for each Covered Health Service. Members should also be aware that many services, treatments, supplies and procedures will overlap multiple Benefits and, therefore, Members are encouraged to always contact GHC-SCW for a Prior Authorization regarding their own unique medical needs. For Your reference:

Prior Authorization Not Required: For the identified Benefit and all subparagraphs pertaining to the identified Benefit, no Prior Authorization is required by GHC-SCW.

Prior Authorization Required: For the identified Benefit and all subparagraphs pertaining to the identified Benefit, Prior Authorization is always required by GHC-SCW.

Prior Authorization May Be Required: For the identified Benefit and all subparagraphs pertaining to the identified Benefit, Prior Authorization may be required by GHC-SCW. Prior Authorization requirements may vary depending on the Benefit, Provider, and/or location where the Benefit is received. Members should contact GHC-SCW's Member Services and/or Care Management for confirmation of whether or not a specific Benefit will require Prior Authorization.

M. **PAYMENT DOES NOT GUARANTEE FUTURE PAYMENT.** Coverage determinations are made using current clinical guidelines that are derived from evidence based practices and are subject to change over time. Additionally, GHC-SCW's interpretation of benefits and administrative or claims processing system capability may change over time. Prior determinations of coverage or prior payments of claims by GHC-SCW do not guarantee future coverage or payment.

N. **SECOND OPINIONS** are a covered Benefit when provided by another Provider.

O. **CONTINUITY OF CARE.** With respect to covered Benefits, coverage shall be provided to a Member for the services of a Provider whose participation with the plan terminates under the following circumstances and for the following lengths of time:

1. Members shall be provided coverage from their chosen Primary Care Provider until the end of the current year; or

2. Members who are undergoing a course of treatment with a Consulting Provider shall be provided coverage for the remainder of the course of treatment, 90 days after the consulting Provider's participation with the plan terminates, or until the end of the current year, whichever is shortest; or

3. If maternity care is the course of treatment and the Member is in the 2nd or 3rd trimester of pregnancy when the Provider's participation with the plan terminates, coverage shall be provided until the completion of postpartum care for the pregnant Member and infant.

Continuity of care will be discontinued if the Provider no longer practices in the Service Area or is terminated for misconduct.

P. **GHC-SCW PROVIDER CONTRACT DISCOUNTS.** GHC-SCW delivers most care through contracted arrangements with Providers. Coinsurance amounts are typically applied to the GHC-SCW contracted fee. In limited situations, a Provider may calculate Coinsurance amounts as a percentage of their charges rather than as a percentage of their contracted rate. GHC-SCW has no liability or responsibility for Provider Coinsurance calculations based on these amounts.

Q. **AUTHORIZATION DOES NOT GUARANTEE BENEFITS.** GHC-SCW authorizes services or supplies based on the information that is available at the time of the authorization. Such authorization does not guarantee a Member's eligibility or Benefits under their health plan. GHC-SCW makes Benefit determinations in accordance with all the terms, conditions, limitations and exclusions of this Certificate and the Group Service Agreement. Payment may be required in accordance with plan Benefits. In addition, GHC-SCW reserves the right to review each claim if there are questions regarding Medical Necessity. Any subsequent adjustment of Benefits as a result of this claim review will be given to the Member in writing.

R. **NOTICE REQUIREMENTS.** To qualify for Benefits for health services listed in the Member Certificate, GHC-SCW must be notified within the timeframes stated below. The phone number to call for Prior Authorization is listed on Members' GHC-SCW Identification Card, and on the Benefit Summary.

1. **Services requiring Prior Authorization.** As soon as possible, but not later than 15 working days before health services are received unless it is for an Urgent Condition or Emergency Condition.

2. **Maternity notice.** GHC-SCW should be notified during the 5th month, but no later than one month prior to the anticipated delivery date.

S. **CONCURRENT REVIEW.** GHC-SCW will also conduct a concurrent review of those health services listed in the Benefit Summary and the Member Certificate. GHC-SCW will remain in contact with the treating Provider throughout the course of treatment to review extensions due to medical complications. Each extension will be reviewed on a case-by-case basis.

T. **COORDINATED CARE.** GHC-SCW will provide case management services for cases that are potentially complex, chronic, catastrophic or costly. GHC-SCW will assess each case individually, look beyond the current medical episode and manage the underlying illness on an ongoing basis, if appropriate. GHC-SCW will facilitate and coordinate Medically Necessary and appropriate, cost-effective care in the most appropriate setting. This is a

collaborative process that includes the Member, family, physician and any other Provider to maintain continuity of care and promote health within the confines of this Benefit plan.

U. MEDICAL DIRECTOR DISCRETION. GHC-SCW, at the sole discretion of the Medical Director, may provide coverage for treatment for which benefits are not otherwise payable, when:

1. The treatment offers at least equal medical therapeutic value, and
2. The current treatment program may be changed without jeopardizing the Member's health, and
3. GHC-SCW determines, in its sole discretion, that covering the treatment is expected to result in reduced costs paid out by the plan.

Payment of benefits will be as determined by GHC-SCW.

V. RIGHT TO EXCHANGE INFORMATION. Each Member agrees that GHC-SCW may obtain all information (including medical records) with respect to that Member from any medical Provider and provide this information to any person or organization where it is reasonably necessary to administer the Benefits under the policy. Each Member agrees to give and authorize others to give GHC-SCW medical information and records relating to the Member. This includes test results and records of care for mental illness/substance abuse. By acceptance of coverage under the policy, each Member shall be deemed to have waived any claim of privilege or confidentiality to such information when released or obtained for these purposes.

W. MEMBER GHC-SCW RECORD CHANGE OF SEX /GENDER DESIGNATION:

A Member may modify their legal sex designation in their GHC-SCW records by providing documentation to GHC-SCW of one of the following:

1. Full-validity, 10-year U.S. passport showing the Member's new legal sex;
2. State-issued amended birth certificate showing the new legal sex;
3. State-issued Identification (ID) card showing the new legal sex;
4. Court order directing legal recognition of change of legal sex; or

X. PHYSICAL EXAMINATION. GHC-SCW, at its own expense, may examine a Member when reasonably necessary, to determine the Member's eligibility for claimed services or Benefits (including issues relating to subrogation and coordination of Benefits). Each Member shall be deemed to have waived any legal rights they may have to refuse to consent to an examination or autopsy, by acceptance of coverage from GHC-SCW.

Y. NON-WAIVER AND SEVERABILITY. No delay or failure by GHC-SCW to exercise any remedy or right accruing to GHC-SCW under the terms of this Certificate shall impair any such remedy or right, be construed to be a waiver of any such remedy or right, nor shall it affect any subsequent remedy or rights GHC-SCW may have under this Certificate, whether or not the circumstances are the same. The unenforceability or invalidity of any provision or provisions of this Certificate as to any person or circumstances shall not render them unenforceable or invalid. Also the unenforceability or invalidity of any provision shall not render the remainder of this Certificate invalid or unenforceable.

Z. BENEFIT DETERMINATION AND CERTIFICATE INTERPRETATION. GHC-SCW has the discretionary authority to determine eligibility for Benefits and to construe the terms of this Certificate. Any such determination or construction shall be final and binding for all parties unless arbitrary and capricious.

AA. CONFORMITY WITH STATUTES. Any provisions which, on the effective date of this policy, are in conflict with federal or Wisconsin law are amended to conform to the minimum requirements of those laws.

BB. SERVICES OUTSIDE OF THE UNITED STATES. Services and supplies obtained while in a foreign country, with the exception of Urgent Conditions and Emergency Conditions, are excluded.

CC. PROVIDER AND HOSPITAL REPORTS. Providers and Hospitals, from time to time, must give us reports to help us determine Member Benefits. By accepting coverage under this Policy, You have agreed to authorize Providers and Hospitals to release any necessary records to us. This is a condition of our issuing this contract and paying Benefits.

DD. MISREPRESENTATION/RIGHT OF RESCISSION. Intentional misrepresentation or fraudulent statements made when applying for coverage could cause an otherwise valid claim to be denied, or Your Policy to be rescinded. Carefully check the information provided when applying for coverage and write to us within 10 days if any information given on the application is not correct and complete or if any medical history has not been included. The application is part of the insurance policy. The insurance Policy was issued on the basis that the statements and representations when applying for coverage are correct and complete.

We will rescind coverage if the information received indicates an intentional misrepresentation or fraudulent statement was made by an individual when applying for insurance and the person knew the representation was false and:

1. we relied on the misrepresentation or fraudulent information, which was material; or
2. the misrepresentation was made with intent to deceive; or
3. the fact misrepresented or fraudulently stated contributes to a loss under the Policy.

We will notify You within 60 days after acquiring knowledge of an intentional misrepresentation or fraudulent information of our intention to either rescind coverage or defend against a claim if one should arise, or within 120 days if we determine that it is necessary to secure additional medical information.

If Your coverage is rescinded due to an intentional misrepresentation or fraudulent information, You will not be eligible for continuation or conversion coverage.

EE. SUBMIT CLAIMS TO:

Group Health Cooperative of South Central Wisconsin
c/o GHC-SCW Claims Department
P.O. Box 44971
Madison, WI 53744-4971

Article IV: Complaint Resolution/Grievance Process

A. COMPLAINT RESOLUTION PROCESS

Members are encouraged to discuss their complaints with the GHC-SCW staff involved as soon as possible. If the complaint is not resolved to the Member's satisfaction, it should be brought to the attention of the Member Services Department. The Department will:

1. Interview the Member and record the details.

2. Investigate the complaint and seek resolution.

3. Refer those cases which require further review or investigation to the appropriate committee.

4. Act as ombudsperson for the Member, including facilitating the processing and resolution of the complaint.

The Department will attempt to resolve the complaint of the Member within 10 days of the filing of the complaint.

B. GRIEVANCE PROCESS

1. Member Appeals Committee

A Member, or authorized representative on behalf of the Member, may file a written expression of dissatisfaction (a Grievance) with the administration, policy rescission, claims practices or provisions of services by GHC-SCW following receipt of GHC-SCW's notification of denial. (Expedited Appeals do not require a written grievance, see below.) The Grievance will be evaluated by the Member Appeals Committee and a response will be made to the Member within 30 calendar days. The Grievance should be mailed to:

ATTN: Member Appeals
GHC-SCW Member Services Department
P.O. Box 44971
Madison, WI 53744-4971

GHC-SCW will acknowledge receipt of the Grievance within five business days of receipt and the Grievance will be added to the agenda of the next scheduled Member Appeals Committee meeting. No fewer than seven calendar days prior to the meeting, the Member will be notified of the date and time in case the Member would like to present their Grievance in person. GHC-SCW will provide the Member with any new or additional evidence considered, relied upon, or generated by GHC-SCW in connection with the appeal. GHC-SCW will send the Member a written determination of the Grievance within 30 calendar days of receipt of the Grievance. GHC-SCW will notify the Member in writing that (a) GHC-SCW has not resolved the Grievance, (b) when the resolution of the Grievance may be expected, and (c) the reason additional time is needed.

2. Expedited Appeal

A Member, or the authorized representative on behalf of the Member, may request GHC-SCW to resolve a Grievance for an urgent care situation. Grievances handled on an expedited basis will be resolved within 24 hours of the date the Grievance is received. GHC-SCW's Medical Director will determine if the Member's request for an expedited Grievance meets the criteria for an urgent care situation. An urgent care situation is one where medical care and/or treatment is required to prevent serious deterioration in an individual's health; or, may jeopardize the life or health of the individual to regain maximum function; or in the opinion of a physician with knowledge of the individual's medical situation, would subject the individual to severe pain that cannot be adequately managed without the care or treatment that is the subject of the expedited appeal. These criteria will be used to determine whether a Grievance should be processed on an expedited basis.

3. Independent (External) Review

GHC-SCW provides Members with an Independent (External) Review process according to the processes developed by the federal law under PPACA. This process becomes available to the Member after the Member has exhausted the GHC-SCW Internal Appeals process (outlined above) or when federal law allows the Member to bypass the internal appeals process.

a. **Qualification for Independent (External) Review.** In order to qualify for Independent (External) Review process, the following criteria must be met:

i. The situation or issue must involve an adverse Benefit coverage determination based on:

1. Medical judgment (for example: Medical Necessity, appropriateness, health care setting, level of care, effectiveness of a covered Benefit, or experimental and investigational treatments).

2. A denial of a request for Out-of-Network services when the Member believes that the clinical expertise of the Out-of-Network Provider is Medically Necessary (but only if the treatment or service would otherwise be a covered Benefit under the plan).

3. A policy rescission.

ii. Exhaustion of Internal Grievance Process. In most cases, the Member must have completed GHC-SCW's internal grievance process prior to requesting an Independent (External) Review. Exceptions to this circumstance are:

1. The Member and GHC-SCW agree that the matter may proceed directly to Independent (External) Review; or

2. The Member needs immediate medical care or services. If this is the case, a Member may submit an Urgent Independent (External) Review appeal (see below) if they believe that the time period for resolving an internal grievance would cause a delay that could jeopardize their life or health.

b. **Decisions not subject to Independent (External) Review.** A Member may not request an Independent (External) Review if:

i. The requested treatment is not a covered Benefit under this Certificate.

ii. The decision involves contractual or legal interpretation without any use of medical judgment. For example, if this Certificate or any amendments to or the Summary of Benefits specifically excludes coverage for weight loss treatment and the Member requests coverage for weight loss treatments, such issue would not be eligible for Independent (External) Review even if the Member believes that the treatment is/was Medically Necessary.

iii. For administration issues such as the application of Premiums to the correct account. (However, this could be reviewed under the Internal Appeals process).

GHC-SCW publishes and provides Members with information regarding the availability of their right to Independent (External) Review Process at least once annually through the Member newsletter (HouseCalls) and in this Certificate and other Member materials.

C. PROCEDURE

1. Once the Member has completed the internal appeals process, Member Services will send the Member a written notification of their Independent (External) Review rights. The notice will include information about the Member's right to request an Independent (External) Review in the following manner:

a. in writing by sending the request electronically (through email) to: DisputedClaim@opm.gov;

b. by faxing it to 202-606-0036; or

c. by sending a written request to:

Disputed Claims
P O Box 791
Washington, DC 20044

Member questions or concerns during the Independent (External) Review process may be directed to:

d. Disputed Claims at 877-549-8152.

Members may submit written comments and information to the Independent (External) Reviewer at the mailing address (above) and such information will be shared with GHC-SCW.

2. Limitations

A Member may file a request for an Independent (External) Review within 4 months after the date of notice of GHC-SCW's adverse Benefit determination or final internal adverse Benefit determination.

3. Independent (External) Review Determination Process

If the External Review Disputed Claim examiner determines that the claim is not eligible for Independent (External) Review the examiner will notify the Member and GHC-SCW in writing or electronically that the claim is not eligible.

If the claim proceeds through the process, the External Review Disputed Claim examiner will provide written notice of their decision within 45 days (from the initial request for the Independent (External) Review by the Member). Notice of the decision will be sent to the Member and to GHC-SCW.

If the External Review Disputed Claim examiner reverses GHC-SCW's previous decision GHC-SCW will:

a. promptly provide coverage or payment (including promptly authorizing or promptly paying Benefits) for the claim.

4. Process for Expedited Independent (External) Review

The Member may make a written or oral request to the Disputed Claim representative for an Expedited Independent (External) Review at the time the Member receives:

a. an adverse Benefit determination that involves a medical condition for which the timeframe for completion of an Internal (External) appeal would seriously jeopardize the life or health of the Member: or, would jeopardize the Member's ability to regain maximum function; and

b. if the adverse Benefit determination concerns an admission, availability of care, continued stay, or health care item or service for which the Member has received services but has not been discharged from the facility and the Member has filed a request for an Expedited Internal (External) Appeal; or

c. if the Member's medical condition is such that the timeframe for completion of the standard Independent (External) Review would seriously jeopardize the life or health of the Member or would jeopardize their ability to regain maximum function or the final adverse Benefit determination concerns an admission, availability of care, continued stay or health care item or service for which the Member received services but has not been discharged from the facility.

The External Review Disputed Claim examiner will provide a notice of their decision within 72 hours of the request for expedited Independent (External) Review. For urgent care situations an external review decision will be provided within 24 hours.

D. COMMISSIONER OF INSURANCE

A Member may resolve their problem by taking the steps outlined in the above Complaint Resolution/ Grievance Process. A Member may also contact the OFFICE OF THE COMMISSIONER OF INSURANCE, a state agency which enforces Wisconsin's insurance laws, and file a complaint. A Member may contact the OFFICE OF THE COMMISSIONER OF INSURANCE by writing to:

Office of the Commissioner of Insurance, Complaints Department
P.O. Box 7873
Madison, WI 53707-7873

or by visiting http://oci.wi.gov

Call (800) 236-8517 outside of Madison or (608) 266-0103 in Madison and request a complaint form.

Article V: Covered Health Services

Members are entitled to Covered Health Services subject to the terms and conditions of their Health Plan, as set forth in this Certificate, Benefit Summary, Summary of Benefits and Coverage and any Amendments attached to this Certificate.

Covered Health Services may also be subject to coverage limitations and/or exclusions as stated in Article VI: Exclusions and Limitations.

Services and supplies that are not Medically Necessary are excluded. Services and supplies must meet the definition of Covered Health Services for coverage. **Certain services are only available when provided by or at the direction of a GHC-SCW Provider, and/or received at a GHC-SCW Clinic.**

In addition to the Benefits specified in this Certificate, please refer to the Benefit Summary, Summary of Benefits and Coverage, and Amendments for additional information related to:

- Coinsurance
- Copayments
- Annual Deductible
- Maximum Out-of-Pocket

Prior Authorization

Prior Authorization is the process by which GHC-SCW provides prior written approval for coverage of specific Benefits, treatments, Prescription Drugs, and Durable Medical Equipment (DME) and Medical Supplies. The purpose of Prior Authorization is to determine and authorize the following:

1. The specific type and extent of care, Durable Medical Equipment, Medical Supply, or Prescription Drug that is necessary;
2. The number of visits, or the period of time, during which care will be provided;
3. The Provider to whom the Member is being referred; and
4. Whether the Member should receive coverage for the services from an Out-of-Network Provider because necessary services are not available from an In-Network Provider.

Prior Authorization does not guarantee that services will be fully covered. Coverage is determined by the terms and conditions of the Certificate. Services and items requiring Prior Authorization are listed on GHC-SCW's website at www.ghcscw.com. Contact GHC-SCW's Member Services Department at (608) 828-4853 for details on the Prior Authorization process.

Additional services recommended by a Provider after rendering the services authorized by the original Prior Authorization are covered only if a new Prior Authorization is issued by GHC-SCW prior to receiving additional services from the Provider.

Member Responsibility Regarding Prior Authorization

It is the Member's responsibility to ensure a Prior Authorization has been obtained when required. Failure to obtain Prior Authorization when required may result in the Member receiving a reduction in or no Benefit. If Prior Authorization is not received prior to the date of service and/or receipt of supplies, Your Provider should contact GHC-SCW's Care Management Department for a determination of Medical Necessity.

Prior Authorization Penalty

If a Member fails to obtain written Prior Authorization for Covered Health Services from GHC-SCW, a Prior Authorization penalty shall apply (the "Prior Authorization Penalty"). The Prior Authorization Penalty requires the Member to pay 50% of the Reasonable and Customary Fees and Charges billed to GHC-SCW for the Covered Health Service(s) that required Prior Authorization. The maximum Prior Authorization Penalty shall be $500. The Prior Authorization Penalty shall be assessed prior to any applicable Deductible, Coinsurance and/or Copayment. The Prior Authorization Penalty does not apply toward the Member's Maximum Out-of-Pocket. All Covered Health Services remain subject to the Member's Deductible, Coinsurance and/or Copayment following assessment of the Prior Authorization Penalty. To obtain Prior Authorization, call (608) 257-5294.

Prior Authorization Guidance

This Article identifies GHC-SCW's Prior Authorization requirement for each Covered Health Service. Members should also be aware that many services, treatments, supplies and procedures will overlap multiple Benefits and, therefore, Members are encouraged to always contact GHC-SCW for a Prior Authorization regarding their own unique medical needs. For Your reference:

Prior Authorization Not Required: For the identified Benefit and all subparagraphs pertaining to the identified Benefit, no Prior Authorization is required by GHC-SCW.

Prior Authorization Required: For the identified Benefit and all subparagraphs pertaining to the identified Benefit, Prior Authorization is always required by GHC-SCW.

Prior Authorization May Be Required: For the identified Benefit and all subparagraphs pertaining to the identified Benefit, Prior Authorization may be required by GHC-SCW. Prior Authorization requirements may vary depending on the Benefit, Provider, and/or location where the Benefit is received. Members should contact GHC-SCW's Member Services and/or Care Management for confirmation of whether or not a specific Benefit will require Prior Authorization.

On or after the Individual Policy Effective Date, subject to the Exclusions and Limitations contained in Article VI, a Member is entitled to:

A. ADVANCED RADIOLOGY

I. **Covered Health Services - *Prior Authorization Required***

Services for Medically Necessary CT scans, PET scans, MRI, MRA, nuclear medicine and other advanced diagnostic imaging services received on an outpatient basis at a Hospital or another facility.

Benefits under this section include:

1. The facility charge and the charge for supplies and equipment; and

2. Physician services.

B. AMBULANCE SERVICES

I. Covered Health Services - *Prior Authorization May Be Required*

GHC-SCW will pay the Reasonable and Customary Fees and Charges for ground ambulance service for a Member requiring emergency medical or Hospital services, provided that such Benefit is determined by GHC-SCW, prospectively or retrospectively, to be Medically Necessary. Air ambulance will be covered only:

1. When, in the professional judgment of the GHC-SCW Medical Director, medical circumstances are such that ground ambulance transportation would further endanger the Member's health; or

2. For emergency transportation from locations where a ground ambulance or any other appropriate form of transportation is not available.

C. AUTISM SPECTRUM DISORDER DIAGNOSIS

I. Covered Health Services - *Prior Authorization Required*

Diagnostic services used to verify the diagnosis of Autism Spectrum Disorder when conducted by a Provider skilled in testing. For the diagnosis to be valid, the testing tool shall be appropriate to the age of the Member and use an empirically validated tool for the determination of Autism Spectrum Disorder. GHC-SCW may require confirmation of a primary diagnosis through completion of empirically validated tools or tests from each of the following categories: intelligence, parent report, language skills, adaptive behavior, and direct observation of the child. The evaluation should also assess language impairment, cognitive functioning, and the presence of nonspecific behavioral disorders. In addition, GHC-SCW may require a second opinion from a Provider experienced in the use of empirically validated tools specific for Autism Spectrum Disorders. If GHC-SCW requires the second opinion, we will cover the cost of the second opinion and such cost will not be counted against the total Benefit for Autism Spectrum Disorders.

D. AUTISM SPECTRUM DISORDER TREATMENT

I. Covered Health Services - *Prior Authorization Required*

Treatment of Autism Spectrum Disorder is covered as required by Wis. Stat. 632.895 (12m).

1. **Intensive-Level Services** means evidence-based behavioral Autism Spectrum therapy (efficacious treatment) that is directly based on, and related to, a Member's therapeutic goals and skills as prescribed by a treating physician and provided by an Autism Qualified Provider, and when the prescribed therapy is for the treatment of Autism Spectrum Disorder, where the majority of treatment is provided in the Member's home where a parent or legal guardian is present and engaged in the therapy session(s) and meets the following requirements:

    a. Is based upon a treatment plan developed by an Autism Qualified Provider. The treatment plan must include at least 20 or more hours of therapies per week over a six-month period of time with specific cognitive, social, communicative, self-care, or behavioral goals that are clearly defined, directly observed and continually measured and address the characteristics of Autism Spectrum Disorders. The treatment plan shall require that the Member be diagnosed with a primary diagnosis of Autism Spectrum Disorder, be present and engaged in the intervention and that progress be assessed and documented throughout the course of treatment. GHC-SCW may request and review the Member's treatment plan and summary of progress on a periodic basis;

b. Provides evidence-based behavioral intensive therapy, treatment, and services in an environment most conducive to achieving the goals of the Member's treatment plan;

c. Provides training and consultation, participation in team meetings and active involvement of the Member's family and treatment team for implementation of the therapeutic goals developed by the team;

d. Commences after the Member is two years of age and before the Member is nine years of age; and

e. Intensive-Level Services are provided for no more than four years regardless of the payer. GHC-SCW may require documentation including medical records and treatment plans to verify any evidence-based behavior therapy the Member received for Autism Spectrum Disorders. GHC-SCW will consider any evidence-based behavioral therapy that was provided to the Member for an average of 20 or more hours per week over a continuous six-month period to be Intensive-Level Services.

2. **Nonintensive-Level Services** means evidence-based behavioral therapy that occurs after the completion of treatment with Intensive-Level Services and that is designed to sustain and maximize gains made during Intensive-Level Services or, for the Member who has not and will not receive Intensive-Level Services, evidence-based therapy that will improve the Member's condition as prescribed by an Autism Qualified Provider when the prescribed therapy meets the following requirements:

a. Is based upon a treatment plan developed by an Autism Qualified Provider that develops, supervises and implements a treatment plan with specific cognitive, social, communicative, self-care, or behavioral goals that are clearly defined, directly observed and continually measured and addresses the characteristics of Autism Spectrum Disorders. The treatment plan shall require that the Member be diagnosed with a primary diagnosis of Autism Spectrum Disorder, be present and engaged in the intervention and that progress be assessed and documented throughout the course of treatment. GHC-SCW may request and review the Member's treatment plan and summary of progress on a periodic basis;

b. Provides evidence-based behavioral therapy, treatment, and services in an environment most conducive to achieving the goals of the Member's treatment plan;

c. Provides training and consultation, participation in team meetings and active involvement of the Member's family and treatment team for implementation of the therapeutic goals developed by the team; and

d. Provides supervision for Autism Qualified Providers by a qualified Supervising Provider on the treatment plan team.

3. **Notification of Transition from Intensive-Level Services to Nonintensive-Level Services:** GHC-SCW will notify the Member or the Member's authorized representative regarding a change in the Member's level of treatment. The notice will indicate the reason for transition that may include any of the following:

a. The Member no longer requires Intensive-Level Services supported by documentation from a Qualified Provider or Supervising Provider; or

b. The Member no longer receives evidence-based behavioral therapy at least 20 hours per week over a six-month period of time.

4. **Request for Postponement of Intensive-Level Services by Member:** The Member or the Member's authorized representative must notify GHC-SCW if the Member still requires Intensive-Level Services but is unable to receive these services for an extended period of time due to the following:

   a. A significant medical condition;

   b. Surgical intervention and recovery;

   c. A catastrophic event; or

   d. Other significant event GHC-SCW determines to be acceptable.

   e. In this case, GHC-SCW will affirm the Member's notification and GHC-SCW's acceptance of the Intensive-Level treatment plan postponement. GHC-SCW will not deny Intensive-Level Services to the Member for failing to maintain at least 20 hours of evidence-based behavior therapy over a six month period during the accepted postponement period.

5. **Verification of Autism Qualified Providers, to include Supervising Provider(s), Qualified Therapist(s), Qualified Professional(s) and Paraprofessional(s):** GHC-SCW will verify the licensure, certification, training and credentials of Qualified Providers, Supervising Providers, Qualified Therapists, Qualified Professionals and Paraprofessionals as defined within Wis. Admin. Code 3.36 (3) and (14). Only Providers who meet these standards will be approved for providing services and care to our Members. GHC-SCW Members must receive care through Providers for services to be covered.

6. Coverage for pharmaceuticals and durable medical equipment is covered according to the Durable Medical Equipment (DME) and Medical Supplies Benefit and the Outpatient Prescription Drugs Benefit.

II. **Non-Covered Health Services**

1. Travel time by Providers, Therapists, Professionals or Paraprofessionals. Travel time will not be used to calculate the number of hours of care provided per week to the Member.

2. Services provided by a non-qualified Provider or a non-qualified professional.

3. Services provided by an Immediate Family Member who is otherwise an Autism Qualified Provider for treatment rendered to the Member.

4. Services provided to a Member who is residing in a residential treatment center, inpatient treatment or day treatment facility.

5. The cost for the facility or location or for the use of a facility or location when treatment, therapy or service is provided outside of the Member's home.

6. Custodial or respite care.

7. Chelation therapy.

8. Special diets or supplements.

9. Animal-based therapy including hippotherapy.

10. Acupuncture and Cranial Sacral therapy (these services may be eligible pursuant to the Complementary Medicine Services coverage of this Plan and are subject to Complementary Medicine Services Cost-Sharing).

11. Hyperbaric oxygen therapy.

12. Child care fees.

13. Auditory integration training.

14. Services or treatment provided by a school.

E. AUTOLOGOUS BLOOD TRANSFUSIONS AND STORAGE

I. **Covered Health Services - *Prior Authorization May Be Required***

Autologous blood transfusions and storage are covered Benefits. Autologous transfusion is the process of donating one's own blood prior to a surgical procedure to be used if a blood transfusion is necessary.

F. CHIROPRACTIC SERVICES

I. **Covered Health Services - *Prior Authorization Not Required***

Medically Necessary Chiropractic Services when provided by a chiropractor designated by GHC-SCW. Chiropractic Services are Medically Necessary when all of the criteria are met:

1. The Member has a neuromusculoskeletal disorder;

2. The Medical Necessity for the treatment is clearly documented; and

3. Improvement is documented within the initial two (2) weeks of chiropractic care.

II. **Non-Covered Health Services**

Maintenance and Supportive Care and/or Therapy.

G. CLINICAL TRIALS

I. **Covered Health Services – *Prior Authorization Required***

1. Routine patient care costs for Clinical Trials, which includes:

   a. Covered Health Benefits provided under the Plan in which the Member is enrolled;

   b. Conventional care or items that are typically provided outside of a Clinical Trial;

   c. Care required for administration of the Clinical Trial, clinically appropriate monitoring of the affects or the prevention of complications; and

   d. Care required or needed for reasonable and necessary care due to administration and/or completion of the Clinical Trial.

2. Coverage of routine patient care costs for Clinical Trials is subject to all the terms, conditions, restrictions, exclusions and limitations that apply to any Covered Health Service under this Benefit Plan, including the treatment coverage provided under the Plan, or contract of services performed by In-Network Providers and Out-of-Network Providers.

II. **Non-Covered Health Services**

1. Non-routine patient care costs for the Clinical Trial, which includes:

   a. The Experimental, Investigational or Unproven Service, item, or device itself;

   b. Items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; and

   c. A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

2. Expenses for preventive Clinical Trials.

3. Items and services provided by the research sponsors free of charge for any individual enrolled in the Clinical Trial.

H. COMPLEMENTARY MEDICINE SERVICES

I. **Covered Health Services - *Prior Authorization Not Required***

Complementary Medicine Services, when provided at a GHC-SCW Clinic by a GHC-SCW Provider designated to provide Complementary Medicine professional services.

II. **Non-Covered Health Services**

1. All Complementary Medicine Services not provided at a GHC-SCW Clinic by a GHC-SCW Provider designated to provide Complementary Medicine professional services.

2. Non-Formulary medications and devices recommended by a Complementary Medicine GHC-SCW Provider.

3. Complementary Medicine Services do not apply to the Member's Maximum Out-of-Pocket (MOOP).

I. DENTAL RELATED SERVICES

I. **Covered Health Services - *Prior Authorization May Be Required***

1. **Initial Repair of Accidental Injury to Sound, Natural Teeth**. Coverage for Members under this section is only available for injury that is the result of a single event or occurrence. Injury due to consistent, repetitive, or prolonged damage will not be covered under this section (ex. grinding of teeth/bruxism). Damage to teeth caused by chewing or biting does not constitute an accidental injury. Treatment must be initiated within 90 days of the accident unless extenuating circumstances exist (such as prolonged hospitalization or the presence of fixation wires from fracture care). Treatment must be completed within 12 months of the accident unless an extension is provided under the sole discretion of the GHC-SCW Medical Director.

2. **Treatment of Temporomandibular Joint (TMJ)**. Medically Necessary diagnostic procedures and Medically Necessary surgical or non-surgical treatment (including intraoral splint therapy devices) for the correction of temporomandibular disorders caused by Congenital, developmental, or acquired deformity, disease or injury. Coverage is limited to procedures or devices used to control or eliminate infection, pain, disease or dysfunction. Intraoral splints are covered under this provision. A physical therapy evaluation is required before an intraoral splint is considered as a treatment option.

3. **Dental-related hospital and anesthetic services** for Dependent children under the age of 5 years old, Members with a chronic disability, or Members with a medical condition that requires hospitalization or general anesthesia for dental care.

4. **Oral Surgical Procedures** (including local anesthesia and related x-rays) when received from a dentist, dental Provider or dental group designated by GHC-SCW, is limited to:

   a. Incision and drainage of cellulitis;

   b. Incision and removal of a foreign body;

   c. Surgical procedures to correct accidental injuries to the lips and oral soft tissues;

   d. Surgical correction of cleft lip, cleft palate and severe functional malocclusion;

   e. Treatment of fractures and dislocations to facial bones;

   f. Hard and soft tissue biopsies;

   g. Excision of tumors, cysts, and lesions of the jaws, oral mucous membrane, and underlying soft tissue that require pathological examination;

   h. Incision of maxillary sinus and salivary glands or ducts for removal of a foreign body;

   i. Extraction of impacted teeth;

   j. Frenectomy;

   k. Apicoectomy;

   l. Excision of exostoses;

   m. Alveloctomy; and

   n. Removal of retained residual root.

   Coverage for emergency oral surgical procedures must also meet the definition of an Emergency Condition.

II. **Non-Covered Health Services**

1. Preventive, intermediate, and major dental services and supplies.

2. Orthodontia dental services and supplies unrelated to the Initial Repair of Accidental Injury to Sound, Natural Teeth and not for elective or cosmetic purposes only.

3. Cosmetic and elective services.

4. Services and supplies, including but not limited to intraoral splint therapy devices, for the treatment of bruxism.

J. DIABETIC EDUCATION

I. Covered Health Services - *Prior Authorization May Be Required*

Diabetic education services are covered under this section when deemed Medically Necessary.

Insulin and other drugs for the treatment of diabetes, syringes for insulin administration, blood glucose meters, and disposable blood glucose testing supplies, when on the Formulary, are covered under the Outpatient Prescription Drugs Benefit.

Insulin infusion pumps and related supplies are covered under the Durable Medical Equipment (DME) and Medical Supplies Benefit only when Medically Necessary.

K. DIAGNOSTIC X-RAY AND LABORATORY TESTS

I. Covered Health Services - *Prior Authorization May Be Required*

Diagnostic X-ray and Laboratory Tests, when ordered or prescribed by a Provider.

Diagnostic laboratory tests shall include blood tests for lead poisoning for children, which shall be conducted in accordance with recommended lead screening methods and intervals contained in rules promulgated by the Wisconsin Department of Health and Family Services (DHFS).

L. DURABLE MEDICAL EQUIPMENT (DME) AND MEDICAL SUPPLIES

I. Covered Health Services - *Prior Authorization May Be Required*

Durable Medical Equipment (DME) means those items or equipment that are able to withstand repeated use, are primarily and customarily used to serve a medical purpose, and are generally not necessary to a person in the absence of illness or injury. Medical Supplies may be durable or disposable.

DME and Medical Supplies are Covered Health Services when: (1) Medically Necessary; and (2) provided by a GHC-SCW Contractor, provided by GHC-SCW, or arranged by GHC-SCW, at GHC-SCW's option.

1. GHC-SCW retains the right to reclaim such DME and Medical Supplies in the event that GHC-SCW determines that there is no medical basis for its continued use by a Member or if the Member is no longer entitled to receive Benefits from GHC-SCW. Examples of covered DME and Medical Supplies include, but are not limited to:

    a. Bone Anchored Hearing Aid (BAHA) Transmitter;

        i. Coverage under the DME and Medical Supplies Benefit is limited to BAHA transmitters; BAHA devices and other hearing assistive devices are covered under the Hearing Assistive Devices Benefits. Hearing aids are covered under the Hearing Aid Benefit.

    b. Breast pump in conjunction with each birth, for the duration of breastfeeding;

    c. Compression garments with compression strength greater than 20 mmHg;

i. The Benefit is limited to three (3) pairs /units per Member per condition every 12-months.

d. Durable diabetic equipment;

i. Durable diabetic equipment includes insulin infusion pumps and related supplies. Insulin and other drugs for the treatment of diabetes, syringes for insulin administration, blood glucose meters, and disposable blood glucose testing supplies, when on the Formulary, are covered under the Outpatient Prescription Drugs Benefit.

ii. In accordance with s. 632.895 (6), Wis. Stat., insulin infusion pump coverage may be limited to the purchase of one pump per year. Member may be required to use a pump for 30 days before purchase.

e. Foot orthotics that are custom molded to the Member's foot;

i. The Benefit is limited to one pair of orthotics every 24 months.

f. Oral splints for obstructive sleep apnea (OSA) and temporal mandibular joint (TMJ) dysfunction only;

g. Medical feeding supplies, including tubes and catheters used for the delivery of Medical Foods;

i. Medical Foods are covered under the Medical Foods Benefit.

h. Prosthetic appliances, which are artificial devices used to replace all or part of an external body part; and

i. TENS units and related electrodes.

i. The Benefit is limited to one TENS unit every twenty-four (24) months, and four (4) pairs of electrodes per twenty-four (24) months.

2. Unless otherwise required by state or federal law, or benefit limits described in paragraph 1 of this subsection specifically provide for additional coverage, replacement or repair of DME and Medical Supplies is available if (1) the item is no longer under warranty from the manufacturer and, in the judgment of the GHC-SCW Medical Director, the item has exceeded its reasonable lifetime under normal use and is no longer adequate to meet Medical Necessity , or (2) in the judgment of the GHC-SCW Medical Director, the Member's condition has significantly changed so as to make the original equipment inappropriate.

II. **Non-Covered Health Services**

1. DME is limited to one of the same item per Member at any one time.

2. DME and Medical Supplies not: (1) arranged and/or provided by GHC-SCW; or (2) provided by a GHC-SCW contracted vendor.

3. DME and Medical Supplies that have features over and above that which is Medically Necessary, including DME and Medical Supplies that have features over and above those of the standard model, as determined by GHC-SCW, unless Prior Authorized by GHC-SCW. Prior Authorization for DME and Medical Supplies that have features over and above that which is Medically Necessary must be in

accordance with current DME policies in place, which may change at any time at the direction of the GHC-SCW Medical Director. In no case will benefits paid for DME and Medical Supplies that have features over and above that which is Medically Necessary exceed the amount that would be paid for the standard model as determined by GHC-SCW. Please contact GHC-SCW for more information on the current policy regarding DME and Medical Supplies that have features over and above that which is Medically Necessary.

4. Replacement or repair of DME and Medical Supplies not pre-approved by GHC-SCW.

5. DME and Medical Supplies for comfort, personal hygiene and convenience including, but not limited to: air conditioners, air cleaners, humidifiers, portable nebulizers, physical fitness equipment, alternative communication devices and self-help devices not medical in nature.

6. DME and Medical Supplies used for work, athletic or job enhancement.

7. Compression garments with compression strength of 20 mmHg or less.

8. Hair implants, hair pieces, and wigs. A cranial prosthesis is considered a hair piece.

9. Home testing and monitoring supplies and related equipment except those used in connection with the treatment of diabetes or long-term anticoagulation therapy.

10. Oral splints for bruxism (teeth grinding).

11. Purchase or rental of motorized equipment unless specifically listed in Article V, including but not limited to: escalators or elevators, saunas, steam baths, swimming pools, whirlpools, exercise equipment, or blood pressure kits.

12. Shoes or orthotics not custom made.

13. Undergarments.

M. EMERGENCY OUTPATIENT CARE

I. Covered Health Services - *Prior Authorization Not Required*

GHC-SCW covers Emergency Outpatient Care provided on an outpatient basis in a Hospital emergency room including necessary related diagnostic tests and procedures performed at the time of the emergency visit. Outpatient status is determined by a Member not being assigned a hospital bed for receipt of these services. Coverage will be provided for treatment of an Emergency Condition outside the GHC-SCW Service Area. GHC-SCW reserves the right to determine whether a specific medical situation constitutes an Emergency Condition. Copayments associated with Emergency Outpatient Care will be waived, and the Inpatient Hospital Services Benefit will apply, if (1) the Member is admitted for Inpatient Hospital Services directly from a Hospital emergency room, or (2) the Member is placed in Observation Status and remains in Observation Status for a period of time that spans one midnight.

Services in Emergency Conditions. GHC-SCW will pay the Reasonable and Customary Fees and Charges for Emergency Conditions, subject to applicable limitation amounts, for the Benefits to which the Member would otherwise have been entitled under this Certificate, when performed under an Emergency Condition for a Member, without the order, Prior Authorization, or prior concurrence of a Provider.

II. **Non-Covered Health Services**

Services including evaluation by medical personnel received by a GHC-SCW Member who leaves a Hospital emergency room prior to being seen by a physician.

N. END OF LIFE SERVICES

I. **Covered Health Services - *Prior Authorization Required***

GHC-SCW will provide End of Life Services for in-home and inpatient care. Certification of the terminal illness must be given to GHC-SCW's Care Management Department upon request.

1. End of Life Services are available if:

   a. The terminally ill person is a GHC-SCW Member; and

   b. The care is ordered by a Provider.

2. **Outpatient End of Life covered charges include:**

   a. Part-time or intermittent nursing care by an RN or LPN;

   b. Medical and social services under the direction of a Provider including;

      i. Assessment of the terminally ill person's social, emotional and medical needs, and home and family situation;

      ii. Identification of community resources available to the terminally ill person; and

      iii. Assistance to the terminally ill person in obtaining the community resources needed to meet their assessed needs.

   c. Psychological and dietary counseling;

   d. Consultation or case management services by a Provider;

   e. Physical and occupational therapy;

   f. Part-time or intermittent home health aide services consisting mainly of caring for the terminally ill person;

   g. Medical Supplies;

   h. Charges made by any other covered health care Provider for the services and supplies listed above (only if the Provider is not part of nor employed by a hospice care agency, and the hospice care agency retains responsibility for the care of the terminally ill person); and

   i. Bereavement counseling.

3. **Inpatient End of Life Services includes:**

   a. Charges made by an end of life facility for room and board; and

   b. Other services and supplies furnished to the terminally ill person for uncontrolled, new onset, acute symptom management when, in the determination of the GHC-SCW Medical Director, an inpatient stay is Medically Necessary.

II. **Non-Covered Health Services**

End of Life Benefits will not be paid for:

1. Room and board beyond Medically Necessary stays.
2. Funeral arrangements.
3. Pastoral counseling.
4. Financial or legal counseling, including but not limited to estate planning or the drafting of a will.
5. Homemaker or caretaker services not solely related to care of the Member, including but not limited to:

   a. Sitter or companion services for either the terminally ill Member or other family Member;

   b. Transportation;

   c. Housecleaning;

   d. House maintenance; and

   e. Respite or residential care furnished by any Provider or facility during a period of time when the Member's family or usual caretaker cannot or chooses not to attend the Member's needs for any reason.

O. FAMILY PLANNING SERVICES

I. **Covered Health Services - *Prior Authorization May Be Required***

Family Planning Services consisting of such consultation and treatment deemed Medically Necessary by a Provider are covered Benefits under this policy. This includes a broad range of voluntary family planning services such as physical examinations, office visits, testing, intrauterine devices (IUDs), implanted contraceptives, related counseling services, tubal ligation and vasectomy.

Contraceptives provided over the counter, such as spermicides and sponges, are covered only if the method is both FDA-approved, prescribed for a person by their health care Provider, and included in the Formulary. Other over the counter approved contraceptive methods may be covered pending approval from Your Health Care Provider. Prescription drugs for birth control not included in the Formulary are covered when Prior Authorized by GHC-SCW.

Cost-Sharing will apply for branded drugs when a generic version is available. However, brand name contraceptives will be covered without Cost-Sharing if a generic equivalent is not available.

P. GENETIC TESTING

I. Covered Health Services - *Prior Authorization Required*

Genetic testing is only covered when it is Medically Necessary for treating an illness, or when Medically Necessary to develop a Member's individual health screening program. In addition, genetic counseling and Breast Cancer (BRCA) genetic testing coverage is to be available for women with positive screening results, or women with a personal history of cancer.

Q. HEARING AID

I. Covered Health Services - *Prior Authorization Required*

This Benefit is limited to one hearing aid per ear per 36 months, including custom ear molds. GHC-SCW may designate specific models and types of hearing aids that will be covered under this Benefit. Please contact GHC-SCW Member Services at (608) 828-4853 to obtain information on covered models. For Members who are not Dependent children under age 18, if a hearing aid that is recommended to you by your Provider has not been specifically designated as covered by GHC-SCW, coverage will be limited to $2,500 every three years (total for both ears). Hearing aid coverage for enrolled Dependent children under age 18 is not subject to dollar maximums and shall be as required by Wisconsin law.

II. Non-Covered Health Services

1. More than one hearing aid per ear per 36 months.
2. Batteries, and any ancillary equipment and services related to hearing aids.

R. HEARING ASSISTIVE DEVICES

I. Covered Health Services - *Prior Authorization Required*

Hearing Assistive Devices include cochlear implants and Bone Anchored Hearing Aids (BAHAs) and are covered when Medically Necessary.

II. Non-Covered Health Services

Batteries, and any ancillary equipment and services related to hearing assistance devices.

S. HOME HEALTH CARE SERVICES

I. Covered Health Services - *Prior Authorization Required*

Upon the order or with the concurrence of a Provider, GHC-SCW will arrange to provide home health care services, for a condition of a Member which, in the opinion of the attending Provider, does not require hospitalization but which cannot satisfactorily be treated on an ambulatory basis at a Provider office or clinic. Home health care means a program providing part-time, in-home, Intermittent Care services to a Member in lieu of Hospital services or Skilled Nursing Facility services. Coverage is limited to sixty (60) visits per Member per year. One visit equals up to four hours of skilled care services. This visit limit does not include any service which is billed only for the administration of intravenous infusion.

Rehabilitation Therapies and Habilitation Services provided in-home are covered under the Outpatient Rehabilitation Therapies and Habilitation Services Benefit.

T. HOSPITAL AND RELATED SERVICES

I. Covered Health Services - *Prior Authorization Required*

Hospital and related services includes the medical diagnosis, care and treatment by one or more Providers. For admissions on and after the Individual Effective Date, a Member is entitled to, if admitted on the order of or with the concurrence of a Provider, subject to Medical Necessity, and the provisions below:

1. **Inpatient Hospital Services**, which means the Medically Necessary services and supplies furnished to a registered patient by a Hospital and regularly included in its charges.

   Inpatient Hospital Services are limited to the following:

   a. Hospital rooms as available, including general duty nursing care;

   b. Meals, including special meals and diets when Medically Necessary in the professional judgment of the attending Provider;

   c. Use of operating, delivery, recovery, and treatment rooms and equipment;

   d. Laboratory tests, electrocardiograms, electroencephalograms, diagnostic x-ray services, and other diagnostic tests;

   e. Drugs, medications, intravenous injections other than blood or blood fraction, and other biologicals;

   f. Administration and processing of whole blood and plasma;

   g. Anesthetics and their administration;

   h. Oxygen and its administration;

   i. Dressings, casts, and special equipment when supplied by the Hospital for use in the Hospital;

   j. Radiation therapy;

   k. Diathermy;

   l. Physical therapy;

   m. Inhalation therapy;

   n. Short-Term Therapy received as an inpatient when deemed appropriate in the professional judgment of the attending Provider;

   o. Use of intensive care units and services;

   p. Detoxification services. Covered services include Medically Necessary detoxification services. These services are not applied to the Mental Health and Substance Use Disorder (SUD) Services Benefit, as detoxification services are covered under the medical Benefit; and

   q. Other Medically Necessary services customary in modern Hospital procedure and not excluded by this Certificate.

2. **Observation Status** means outpatient services a Member receives at a Hospital pending determination of inpatient admission or discharge. Members may be in Observation Status in the Hospital emergency room or another area of the Hospital.

3. **Emergency Outpatient Care**. GHC-SCW covers Emergency Outpatient Care provided on an outpatient basis in a Hospital emergency room including necessary related diagnostic tests and procedures performed at the time of the emergency visit. Outpatient status is determined by a Member not being assigned a hospital bed for receipt of these services.

4. **Skilled Nursing Facility Care**. Determinations for care are made by the GHC-SCW Medical Director. The Benefit is limited to 30 days per Inpatient stay. Coverage must be certified as Medically Necessary and is recertified as Medically Necessary every seven (7) days.

   Members who enter a licensed Skilled Nursing Facility within 24 hours after discharge from a general Hospital and receive continued treatment for the same medical or surgical condition for which the Member had been treated at such Hospital prior to entry to the Skilled Nursing Facility shall have a Benefit of no more than the maximum amount specified in this Certificate, when determined to be Medically Necessary and in lieu of inpatient Hospital care.

   Benefits can be denied or shortened for Members who are not progressing in goal-directed rehabilitation services or if discharge rehabilitation goals have previously been met.

5. **Hospitalization for an Emergency Condition**. The final determination of whether care provided to the Member or Subscriber is for an Emergency Condition will be made by the GHC-SCW Medical Director. GHC-SCW retains the right to designate the Provider of the assessment and treatment services, including possible transfer back into the Service Area.

6. **Inpatient Benefits beyond date of release**. The time period for which Benefits under this Article shall be available to a Member while this Certificate or the Group Service Agreement is in effect shall be unlimited, except as otherwise specifically provided in this Article V; however, the duration of any Hospital or Skilled Nursing Facility Confinement shall be determined by the Provider attending the Member, or by the attending Provider when admission is under an Emergency Condition. No inpatient Benefits will be provided under this Certificate or the Group Service Agreement beyond the date a Member's release from the Hospital or Skilled Nursing Facility unless ordered or authorized by the attending Provider.

7. **Inpatient Mental Health Care**. Benefits for a Member admitted to or confined in a Hospital or state-certified or licensed behavioral health residential facility, whether by a Provider or in an Emergency Condition by any Provider, for mental, nervous, emotional, personality, or eating disorders, or for attempted suicide, as specified in this Certificate, and shall be limited to care in a Hospital or in a state-certified or licensed behavioral health residential facility.

8. **Inpatient Treatment for Substance Use Disorder**. Benefits for a Member admitted to or confined in a Hospital or state-certified or licensed behavioral health residential facility, whether by a Provider or in an Emergency Condition by any Provider, for substance use disorder, and shall be limited to care in a Hospital or in a state-certified or licensed behavioral health residential facility.

9. **Hospital Room and Accommodations**. If, at the time a Member applies for admission to a Hospital, there is available for such Member's care a bed in a room regularly containing two beds, then the Member shall be entitled to such accommodations. If no such bed in a two-bed room is then available, the Member shall be entitled to accommodations in a room containing three or four beds. If there is not

then available a bed in a room containing two to four beds, the Member shall be entitled to accommodations of a different classification until a bed in a room containing from two to four beds is available. If, for any reason, without the order or concurrence of a Provider, a Member occupies a private room (i.e., a room containing only one bed), GHC-SCW will pay for such private room the amount of the Hospital's most common semi-private room charge, and the additional private-room charge, if any, shall be the responsibility of the Member.

II. **Non-Covered Health Services**

1. Inpatient Hospital Services:

   a. Hospital stays, which are extended for reasons other than Medical Necessity, including, but not limited to lack of transportation, lack of caregiver, inclement weather and other like reasons.

   b. A continued Hospital stay, if the attending physician has documented that care could effectively be provided in a less acute care setting, for example, Skilled Nursing Facility.

2. Skilled Nursing Facility Care:

   a. Custodial Care or domiciliary services for chronic conditions.

U. INFERTILITY SERVICES

I. **Covered Health Services - *Prior Authorization May Be Required***

Services for the treatment of Infertility (Infertility Services) received at an infertility clinic include, but are not limited to consultation, physical examinations, office visits and other non-experimental, non-investigational procedures designed to reverse involuntary medical sterility.

II. **Non-Covered Health Services**

1. All costs related to:

   a. The procurement and purchase of fresh or frozen semen;

   b. The storage of semen;

   c. In vitro fertilization (IVF);

   d. Gamete intrafallopian transfer (GIFT);

   e. Zygote Intra Fallopian Transfer (ZIFT);

   f. Cervical lavage and related procedures and treatments; and

   g. The reversal of voluntarily induced sterility.

2. Artificial insemination services that exceed a period of one (1) year.

3. More than one (1) Laparoscopy procedure per Member per lifetime for diagnostic or therapeutic purposes for Infertility Services.

4. More than one (1) Tuboplasty procedure for the removal of fallopian tube obstruction per Member per lifetime.

5. Laboratory tests and x-rays, including hysterosalpingograms, for the evaluation and treatment of infertility at Out-of-Network Facilities.

6. Medications for the induction of ovulation treatment of infertility, or to promote carrying a pregnancy to completion and tests and procedures related to the monitoring of these medications.

7. Infertility Services do not apply to the Member's Maximum Out-of-Pocket (MOOP). This may vary for Members enrolled on a High Deductible Health Plan. For additional information on Infertility Services and High Deductible Health Plans, please contact GHC-SCW Member Services at (608) 828-4853.

V. INJECTABLE PRESCRIPTION DRUGS

I. Covered Health Services - *Prior Authorization Required*

Coverage of specialty drugs administered by intravenous (medication administered directly into the blood) or intramuscular injection (a shot in the arm, leg or buttocks) in the clinic or office setting are covered only when coverage criteria are met, unless required for immediate treatment of an acute medical problem.

Subcutaneously administered drugs that are labeled for self-administration are considered Outpatient Prescription Drugs, regardless if self-administered or administered by a health care Provider and are subject to Cost-Sharing per Your Plan's Outpatient Prescription Drugs Benefit.

W. MATERNITY SERVICES

I. Covered Health Services - *Prior Authorization May Be Required*

You do not need Prior Authorization from GHC-SCW or from any other person (including a Primary Care Physician) in order to obtain access to obstetrical or gynecological care from an In-Network Provider that specializes in obstetrics or gynecology. The Provider, however, may be required to obtain Prior Authorization for certain services, follow a pre-approved treatment plan, or follow other procedures.

Newborns' Act Disclosure – Mandated Disclosure: *Inpatient care for the insured mother and the insured newborn child will be covered for at least forty-eight (48) hours following a vaginal delivery and at least ninety-six (96) hours following a cesarean section. However, federal law does not prohibit the attending Provider, after consultation with the mother, from discharging the mother or their newborn earlier than forty-eight (48) hours (or ninety-six (96) hours as applicable). No Prior Authorization is required for the hospital length of stay (forty-eight (48) hours or ninety-six (96) hours as applicable) when the hospitalization is with an In-Network Facility. However, You should notify GHC-SCW of Your inpatient stay within forty-eight (48) hours of an inpatient admission. Prior Authorization is required for any portion of a hospital stay after the forty-eight (48) hours (or ninety-six (96) hours in the case of a cesarean section). Prior Authorization is required for any inpatient services from an Out-of-Network Provider.*

Medically Necessary In-Network Provider services for prenatal and postnatal care provided in a hospital and/or office visit setting; labor and deliveries; ectopic pregnancies; medically indicated cesarean sections; anesthesia; complications of pregnancy and miscarriages. Maternity Services are defined to be related to the birth of a child and occur no later than six (6) weeks following the date of birth.

Newly enrolled Members who are at least twenty-eight (28) weeks pregnant may elect to remain with the Provider who has been providing the Member Maternity Services prior to their enrollment, until completion of postpartum care for them and their infant.

Lactation support and counseling is covered when provided by a trained, In-Network Provider. See the Durable Medical Equipment (DME) and Medical Supplies Benefit for breast pump coverage.

II. **Non-Covered Health Services**

1. **Birthing Centers and Home Births**. Home or intentional out of hospital deliveries, including services provided in a stand-alone birthing center (this does not include birthing centers at a hospital).

2. **Surrogate maternity services**. Treatment, services and supplies for any third party or non-Member Traditional Surrogate or Gestational Carrier who is not covered under this Member Certificate.

X. MEDICAL DIAGNOSIS

I. **Covered Health Services - *Prior Authorization May Be Required***

Medical diagnosis, care, and treatment by one or more Providers:

1. At a Hospital or Skilled Nursing Facility in which the Member is confined on the order or with the concurrence of a Provider;

2. At a Provider office or clinic; or

3. At any other location authorized by GHC-SCW.

Y. MEDICAL FOODS

I. **Covered Health Services - *Prior Authorization Required***

Medical Foods may be covered for those Members with normal or abnormal gastrointestinal absorptive capacity that, due to non-function or disease of the gastrointestinal tract, or with respect to infants (i.e., up to 12 months of age), due to an inborn error of metabolism, require alternative formulas or routes of administration to provide sufficient nutrients.

II. **Non-Covered Health Services**

1. Food or nutrition that is not Medical Food.

2. Regular grocery products that can be mixed in blenders, pre-blenderized food, infant food, and all other foods, nutritional supplements, and formulas available without prescription, other than nutritional formula specifically formulated for the treatment of infants (i.e., up to 12 months of age) with an inborn error of metabolism.

3. For Members over 12 months of age, Medical Foods consumed or administered orally.

4. Medical Foods not Prior Authorized by GHC-SCW.

Z. MENTAL HEALTH AND SUBSTANCE USE DISORDER (SUD) SERVICES

I. **Covered Health Services - *Prior Authorization May Be Required***

1. In this section, the below terms are defined as follows:

a. **Inpatient Hospital Services** means Mental Health Services and/or SUD Services provided to a Member in a Hospital as a bed patient or in state-certified or licensed behavioral health residential facility.

b. **Outpatient Services** means Member office visits with a behavioral health or addiction treatment health care Provider for assessment and treatment (including individual, group, and family therapy when covered) of Mental Health Services and/or SUD Services. Examples of Providers from whom a Member may receive Outpatient Services include:

i. Psychiatrist (a licensed Physician who has completed a residency in psychiatry);

ii. Licensed Clinical Psychologist;

iii. Licensed Clinical Social Worker;

iv. Licensed Marriage and Family Therapist;

v. Licensed Professional Counselor; or a

vi. Licensed Advanced Practice Nurse Prescriber who specializes and is certified as a psychiatric nurse practitioner

c. **Transitional Treatment Services** means Mental Health Services and/or SUD Services that are provided in a less intensive manner than are Inpatient Hospital Services but in a more intensive manner than Outpatient Services.

2. Medically Necessary Inpatient Services, Outpatient Services, Transitional Treatment Services are covered for Mental Health Services and Substance Use Disorder (SUD) Services when received from a Provider.

3. Court-ordered services must be Medically Necessary and may not be covered if provided by an Out-of-Network Provider, unless the services are a result of an Emergency Detention or there is an Emergency Condition and You or Your Provider notifies GHC-SCW within 72 hours after the initial services.

4. Transitional Treatment Services are limited to:

a. Mental Health Services and/or SUD Services for children, adolescents, or adults in a licensed or certified day treatment program offered by a Provider;

b. Mental Health Services for persons with chronic mental illness provided through a licensed or certified community support program offered by a Provider;

c. Mental Health Services and/or SUD Services provided through a licensed or certified intensive outpatient program offered by a Provider;

d. Mental Health Services and/or SUD Services provided through a licensed or certified partial hospitalization program offered by a Provider;

e. Coordinated emergency Mental Health Services for persons who experience a mental health crisis or who are in a situation likely to turn into a mental health crisis if support is not provided. Services must be provided by a state-licensed or certified program. Services are covered for the period of time the Member is experiencing a mental health crisis until the Member is stabilized or referred to other Providers for stabilization. Certified emergency mental health service

Providers shall provide timely notice to the GHC-SCW Care Management Department to facilitate coordination of services for Members who are experiencing or are in a situation likely to turn into a mental health crisis; and

f. Services required by the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008.

5. Related diagnostic services, DME and prescription drugs are not subject to this Covered Health Service. Please see the Diagnostic X-Ray and Laboratory Tests Benefit; Durable Medical Equipment (DME) and Medical Supplies Benefit; and Outpatient Prescription Drugs Benefit.

6. Coverage of Mental Health Services and Substance Use Disorder Services are provided in accordance with the Mental Health Parity and Addiction Equity Act of 2008.

II. **Non-Covered Health Services**

1. Maintenance and Supportive Care and/or Therapy.

2. Custodial Care.

3. Items and services provided in any Hospital or other institution operated primarily for care of the mentally ill, unless services are provided pursuant to Wis. Stat. § 609.65.

4. Items and services for care for mental, nervous, emotional, personality or eating disorders, or for attempted suicide, beyond the services specified under this Article V.

5. Substance Use Disorder Services beyond the services specified in Article V.

6. Couples Counseling

AA. NUTRITIONAL AND DIETARY PROFESSIONAL SERVICES

I. **Covered Health Services - *Prior Authorization Required***

General Nutrition Education is covered when provided by a Provider.

Medical Nutrition Therapy (MNT) associated with disease management is considered on a case by case basis for coverage by the GHC-SCW Care Management Department.

BB. OUTPATIENT PRESCRIPTION DRUGS

Please refer to Your Outpatient Prescription Drug Rider for detail on Your Outpatient Prescription Drugs Benefit.

I. **Covered Health Services - *Prior Authorization May Be Required***

1. Covered drugs are those which:

a. Are prescribed by a Provider, a GHC-SCW Consulting Provider, a GHC-SCW Provider to whom the member has an approved written referral, or a contracted dental provider in conjunction with covered dental services;

b. Are prescribed in direct and necessary connection with medical or surgical treatment of the injury, illness or condition which is prescribed specifically in association with a GHC-SCW covered benefit;

c. Are FDA approved, and require a prescription, except for non-prescription drugs listed on the Formulary;

d. Are on the Formulary; and

i. The content of the Formulary may change over time. GHC-SCW maintains several drug formularies; the number of covered drugs will vary.

ii. Are compounded prescriptions, so long as: all active ingredients are on the Formulary and are FDA-approved as drugs; the resulting product is well-supported by medical literature as reasonable and generally accepted medical practice; and equivalent or similar products are not available commercially. Compounds above a cost threshold require Prior Authorization.

iii. Drugs granted coverage via Prior Authorization may be subject to adherence requirements, which may include, but are not limited to, taking the medication as prescribed and maintaining appropriate provider follow-up, including labs and/or office visits.

e. Are obtained from an In-Network pharmacy. If the member uses a non-authorized pharmacy, reimbursement for that prescription may be limited to the amount the Plan would be responsible for if the member had used an authorized pharmacy.

Please refer to www.ghcscw.com or contact GHC-SCW Member Services at (608) 828-4853 or (800) 605-4327, ext. 4504 for a current GHC-SCW Formulary list.

2. Covered drug quantities are limited to the amount prescribed, up to a 30-day supply, with the following exceptions:

a. If the drug is assigned a quantity limit on the Formulary or by Prior Authorization, the lesser quantity limit will apply.

b. Certain drugs may be dispensed in 90 days' supply at participating pharmacies, so long as the cost of the resulting quantity does not exceed the current maximum cost limit established by GHC-SCW.

3. Covered drugs are subject to Cost-Sharing as specified in the Benefit Summary.

a. Covered drugs are placed in various categories, also referred to as Tiers Specialty Drugs may only be available from certain designated In-Network pharmacies. See www.ghcscw.com for In-Network pharmacy locations.

b. Copayments are applied to the lesser of the prescribed amount, a 30-day supply, the quantity limit for that drug, or the quantity contained in manufacturer packaging. For prescriptions where the quantity allowed is greater than a 30-day supply, Copayments are applied for each 30-day increment, such that prescriptions containing a 31 to 60 day supply will incur two Copayments, and those containing a 61 to 90 day supply will incur three Copayments.

Coinsurance is applied to the contracted approved price of the prescription, subject to quantity limits.

c. GHC-SCW may sponsor specific temporary programs which may result in reduced Copayments or Coinsurance for certain drugs or certain pharmacies, as approved by the GHC-SCW Medical Director or Chief Medical Officer.

d. When a covered drug is available as both a brand-name and equivalent generic product, only the generic will be on the Formulary. An exception to coverage for the branded product may be granted based on criteria established by GHC-SCW. Member responsibility for brand-name drugs that have a generic equivalent will include the highest-tier copay available.

e. Certain drugs, including, but not limited to, drugs recognized as biosimilar by the FDA, may have preferred status in a manner similar to how generics are preferred over equivalent branded drugs. An exception to coverage for the non-preferred product may be granted based on criteria established by GHC-SCW. Member responsibility for the non-preferred drug will include the highest-tier copay available.

4. Drugs for the treatment of HIV infection are covered if prescribed by the Member's Provider and are approved by the FDA for treatment of HIV infection or a medical condition related to HIV infection, including drugs that are in or have completed a phase 3 clinical investigation.

5. GHC-SCW may require the most cost-effective therapy or dosage form, strength, or combination to achieve the required dose of medication.

II. **Non-Covered Health Services**

1. Drugs that are not on the Formulary, unless an exception to coverage has been granted under criteria established by GHC-SCW.

2. Drugs, unless included on the Formulary, that may be lawfully obtained without a prescription.

3. Refills of prescriptions in excess of the number specified by the Provider.

4. New prescriptions or refills on prescriptions after one year from the date ordered by the Provider.

5. Drugs that are specifically excluded or limited elsewhere in the policy.

6. Drugs that are used for weight control or reduction.

7. Prescriptions for off-label uses or not supported by evidence-based medical literature.

8. Drugs used in conjunction with non-covered services.

9. Experimental drugs or drugs labeled "Caution: Limited by Federal Laws to investigational use."

10. Growth hormone for the treatment of idiopathic short stature.

11. Drugs that are not FDA approved.

12. Any brand-name drug that has an available "authorized generic". For purposes of this section, authorized generic means a generic product marketed under a brand-name drug's New Drug Application submitted to the FDA.

CC. OUTPATIENT REHABILITATION THERAPIES AND HABILITATION SERVICES

I. Covered Health Services - *Prior Authorization May Be Required*

All Outpatient Rehabilitation Therapies and Habilitation Services must be administered by a licensed Provider.

Visit limits apply to all covered Outpatient Rehabilitation Therapies and Habilitation Services, including those provided in-home as well as in a Provider's office.

1. Outpatient Rehabilitation Therapies:

   a. Physical Therapy and Occupational Therapy – limited to forty (40) combined visits per Member per year.

   b. Vision Therapy – limited to twenty (20) visits per Member per year when Medically Necessary for:

      i. Amblyopia;

      ii. Strabismus (concomitant);

      iii. Non-strabismic disorder of binocular eye movements;

      iv. Non-presbyopic accommodative inability for Members over six years old; or

      v. Heterophoria.

   c. Speech Therapy – limited to twenty (20) visits per Member per year.

   d. Cognitive Therapy – limited to twenty (20) visits per Member per year.

   e. Pulmonary Therapy – This Benefit is limited to twenty (20) sessions per Member per year when Medically Necessary or following a Hospital Confinement for lung transplantation.

   f. Cardiac Therapy - This Benefit is limited to thirty-six (36) sessions per Member per year when Medically Necessary or following a Hospital Confinement for:

      i. Myocardial infarction;

      ii. Coronary bypass surgery;

      iii. Unstable angina pectoris;

      iv. Angioplasty;

      v. Heart valve surgery; or

      vi. Cardiac transplantation.

   g. Post-cochlear Implant Aural Therapy – limited to thirty (30) visits per Member per year.

2. Outpatient Habilitation Services:

   a. Physical Therapy and Occupational Therapy – limited to forty (40) combined visits per Member per year.

b. Vision Therapy – limited to twenty (20) visits per Member per year when Medically Necessary for:

i. Amblyopia;

ii. Strabismus (concomitant);

iii. Non-strabismic disorder of binocular eye movements;

iv. Non-presbyopic accommodative inability for Members over six years old; or

v. Heterophoria.

c. Speech Therapy – limited to twenty (20) visits per Member per year.

d. Cognitive Therapy – limited to twenty (20) visits per Member per year.

II. **Non-Covered Health Services**

1. Outpatient Rehabilitation Therapies:

a. Outpatient Rehabilitation Therapies beyond the limit specified in this Certificate.

b. Therapy services such as recreational or educational therapy, or physical fitness or exercise programs, unless specifically covered under this Certificate.

c. Any 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.

d. Vision Therapy for nystagmus, myopia, eccentric fixation, anomalous retinal correspondence, traumatic brain injury (TBI), and any other condition not covered pursuant to Article V: Covered Health Services.

e. Financial and occupational counseling.

f. Vocational Rehabilitation Services.

g. Maintenance and Supportive Care and/or Therapy.

2. Outpatient Habilitation Services**:**

a. Outpatient Habilitation Therapies beyond the limit specified in this Certificate.

b. Any Habilitation Services not related to Developmental Delay.

c. Habilitation services that are solely educational in nature or otherwise paid under State or Federal law for purely educational services.

d. Habilitation services to maintain current levels of function (such as routine joint range of motion).

e. Vision Therapy for nystagmus, myopia, eccentric fixation, anomalous retinal correspondence, traumatic brain injury (TBI), and any other condition not covered pursuant to Article V: Covered Health Services.

f. Maintenance and Supportive Care and/or Therapy.

DD. PERIODIC HEALTH EXAMINATIONS

I. Covered Health Services - *Prior Authorization Not Required*

Periodic Health Examinations, as deemed appropriate by Providers with respect to the age, sex, and health status of the Member.

EE. PHYSICIAN SERVICES

I. Covered Health Services - *Prior Authorization May Be Required*

Physician Services include:

1. Medical diagnosis, surgical services, Obstetrical Services, pediatric care, mental health care, and periodic health examinations, as outlined separately in Article V: Covered Health Services; and

2. Medical team conferences to include face-to-face participation by qualified health care professionals from different specialties or disciplines (each of whom provide direct care to the patient), with or without the presence of the patient, family Member(s), community agencies, surrogate decision maker(s) (e.g., legal guardian), and/or caregiver(s).

FF. PREVENTIVE HEALTH SERVICES

I. Covered Health Services - *Prior Authorization May Be Required*

Preventive Health Services must:

1. Be performed by or ordered by a Primary Care Provider;

2. Be provided by an In-Network Provider and/or In-Network Facility; and

3. Not be performed for the primary reason of diagnosing, monitoring or treating an illness or injury.

II. Non-Covered Health Services

Services that do not meet the definition or requirements for coverage of Preventive Health Services may still be Covered Health Services, but are subject to Cost-Sharing per the terms of the Member's Plan.

GG. RECONSTRUCTIVE PROCEDURES

I. Covered Health Services - *Prior Authorization Required*

Reconstructive procedures when the primary purpose of the procedure is either to treat a medical condition or to improve or restore physiologic function. Reconstructive procedures include surgery or other procedures which are associated with an injury, sickness or Congenital Anomaly. The primary result of the procedure is not a changed or improved physical appearance.

Reconstructive surgery due to defect or abnormality at birth. Surgery when performed to restore, improve or repair function due to an abnormal physical condition of a body part that is associated with Congenital defects or birth abnormalities, for example, cleft lip and palate, is considered a covered Benefit under Wis. Stats. 632.895(5).

Coverage for breast reconstruction following a mastectomy includes implants or surgical reconstruction of breast(s) to produce a symmetrical appearance, prostheses, and treatment of physical complications at all stages. Other services required by the *Women's Health and Cancer Rights Act of 1998,* including breast prostheses and treatment of complications, are provided in the same manner and at the same level as those for any other Covered Health Service. You can contact us at the telephone number on Your ID card for more information about Benefits for mastectomy-related services.

HH. REDUCTION MAMMOPLASTY

I. **Covered Health Services - *Prior Authorization Required***

Surgical services, including preoperative and post-operative care, required services of operative assistants, and administration of anesthesia for reduction mammoplasty is covered when Medically Necessary.

II. SURGICAL SERVICES

I. **Covered Health Services - *Prior Authorization Required***

Medically Necessary Surgical Services, which means the performance of surgical procedures by a Provider; also the performance of surgical procedures by a dentist or podiatrist which may legally be rendered by them. Surgical services must be billed, if at all, by the Provider, dentist or podiatrist who renders the services and regularly charges for such services. This Benefit includes preoperative and postoperative care, required services of operative assistants and administration of anesthesia for the correction of a functional defect caused by injury or illness or to correct a significant Congenital Anomaly.

II. **Non-Covered Health Services**

1. Gastro-Intestinal Surgical Procedures, including but not limited to:

   a. Surgical, gastric restrictive procedure, gastric bypass and Roux-en Y gastroenterostomy;

   b. Gastric stapling surgery; and

   c. Biliopancreatic bypass.

   Also see Article VI: Exclusions and Limitations, Obesity-Related Services for related exclusions.

2. Surgical Services not deemed Medically Necessary.

JJ. TELEHEALTH SERVICES

I. **Covered Health Services - *Prior Authorization May Be Required***

Covered Telehealth Services include Covered Health Services provided in Audio Visit, E-Visit, and Video Visit settings by Designated Audio Visit, E-Visit, and Video Visit Network Providers. To be eligible for coverage, Telehealth Services must be provided by a provider who is licensed to provide such service at the location in which, at the time the service is received or accessed, the Member is physically located.

Some Covered Health Services are ineligible for coverage when provided in an Audio Visit, E-Visit, and/or Video Visit setting. Some Covered Health Services may require an in-person visit. A Covered Health Service's eligibility for coverage when provided in a Telehealth Services setting is determined under the sole discretion of the GHC-SCW Medical Director and may be changed from time to time.

1. **Audio Visits.** Covered Health Services provided under this Certificate, which are eligible to be provided in an Audio Visit setting.

2. **E-Visits.** If it is deemed Medically Necessary that the Member be seen by their Primary Care Provider in-person or seek Emergency Medical Treatment, the Member will not be subject to Cost-Sharing for the E-Visit.

3. **Video Visits.** Covered Health Services provided under this Certificate, which are eligible to be provided in a Video Visit setting.

II. **Non-Covered Health Services**

1. Emergency Medical Treatment and other health services for which an in-person visit is Medically Necessary.

2. Services deemed ineligible or inappropriate for delivery via Audio Visit, E-Visit, and/or Video Visit by GHC-SCW, in its sole discretion.

3. Services provided only through email messages, text messages, facsimile transmission, mail or parcel service, or any combination thereof, or any other Telehealth Service that is not an Audio Visit, E-Visit, or Video Visit.

4. Any Audio Visit services not provided by a Designated Audio Visit Network Provider, any E-Visit services not provided by a Designated E-Visit Network Provider, and any Video Visit services not provided by Designated Video Visit Network Provider.

5. Telehealth Services taking place when the Member is located outside the area in which the provider of service is licensed to provide such services.

KK. THERAPEUTIC TREATMENTS

I. **Covered Health Services - *Prior Authorization Required***

1. Therapeutic treatments received on an outpatient basis at a Hospital, other GHC-SCW approved facility, in a Physician's office or in a patient's home including dialysis (both hemodialysis and peritoneal dialysis), intravenous chemotherapy or other intravenous infusion therapy and radiation oncology.

   Orally administered chemotherapy drugs are covered and are subject to GHC-SCW's Formulary. Regardless of the Plan's drug coverage, the Member will never pay more than $100 for a 30-day supply for their oral chemotherapy drugs, in compliance with Wis. Stat. Section 632.867.

   Covered Health Services include medical education services that are provided on an outpatient basis at a Hospital or a GHC-SCW approved facility by appropriately licensed or registered healthcare professionals when both of the following are true:

   a. Education is required for a disease in which patient self-management is an important component of treatment; and

b. There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.

2. Benefits under this section include:

a. The facility charge and the charge for related supplies and equipment; and

b. Physician services.

LL. TRANSPLANTS

I. **Covered Health Services - *Prior Authorization Required***

The following human transplant services are provided only when recommended by a medical Provider. Transplants must be performed at a GHC-SCW approved facility. Transplants at non-GHC-SCW approved facilities are not covered.

1. Corneal transplant (keratoplasty), which includes coverage for the following:

a. Corneal opacity;

b. Keratoconus or any abnormality resulting in an irregular refractive surface not correctable with a contact lens or in a Member who cannot wear a contact lens;

c. Corneal ulcer; and

d. Repair of severe lacerations.

2. Heart Transplants limited to the treatment of:

a. Congestive Cardiomyopathy;

b. End-Stage Ischemic Heart Disease;

c. Hypertrophic Cardiomyopathy;

d. Terminal Valvular Disease;

e. Congenital Heart Disease, based upon individual consideration;

f. Cardiac Tumors, based upon individual consideration;

g. Myocarditis;

h. Coronary Embolization; and

i. Post Traumatic Aneurysm.

3. Heart/Lung.

4. Intestinal Transplants.

5. Kidney Transplants, including dialysis.

6. Liver transplants limited to the treatment of:

a. Extrahepatic Biliary Atresia;

b. Inborn Error of Metabolism;

c. Alpha-1-Antitypsin Deficiency;

d. Wilson's Disease;

e. Glycogen Storage Disease;

f. Tyrosinemia;

g. Hemochromatosis;

h. Primary Biliary Cirrhosis;

i. Hepatic Vein Thrombosis;

j. Sclerosing Cholangitis;

k. Post-necrotic Cirrhosis, Hbe Ag Negative;

l. Chronic Active Hepatitis, Hbe Ag Negative;

m. Alcoholic Cirrhosis, abstinence of 6 or more months;

n. Epithelioid Hemangioepithelioma;

o. Poisoning; and

p. Polycystic Disease.

7. Lung: Single, Bilateral.

8. Pancreas - only covered in conjunction with authorized Kidney transplant available only at the time of a kidney transplant for treatment of end-stage renal disease as a result of diabetic complications.

9. Tandem blood or marrow stem cell transplants for covered transplants. Autologous tandem transplants for:

   a. AL Amyloidosis;

   b. Multiple myeloma (de novo and treated); and

   c. Recurrent germ cell tumors (including testicular cancer).

10. Blood or marrow stem cell transplants.

11. Allogeneic transplants for:

   a. Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia;

   b. Advanced Hodgkin's lymphoma with reoccurrence (relapsed) Advanced non-Hodgkin's lymphoma with reoccurrence (relapsed);

c. Acute myeloid leukemia;

d. Advanced Myeloproliferative Disorders (MPDs);

e. Amyloidosis;

f. Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL);

g. Chronic myelogenous leukemia;

h. Hemoglobinopathy;

i. Infantile malignant osteopetrosis (Albers-Schoenberg disease or marble bone disease);

j. Marrow Failure and Related Disorders (i.e., Fanconi's, PNH, Pure, Red Cell Aplasia);

k. Myelodysplasia/Myelodyplastic syndromes;

l. Paroxysmal Nocturnal Hemoglobinuria;

m. Phagocytic/Hemophagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome);

n. Severe combined immunodeficiency; and

o. Severe or very severe aplastic anemia.

12. Autologous transplants for:

a. Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia;

b. Advanced Hodgkin's lymphoma with reoccurrence (relapsed);

c. Advanced non-Hodgkin's lymphoma with reoccurrence (relapsed);

d. Amyloidosis;

e. Breast Cancer;

f. Epithelial ovarian cancer;

g. Ewings Sarcoma;

h. Multiple myeloma;

i. Neuroblastoma; and

j. Testicular, Mediastinal, Retroperitoneal, and ovarian germ cell tumors.

II. **Non-Covered Health Services**

1. The purchase of any organ or tissue which is sold rather than donated.

2. Transplants involving non-human or artificial organs and tissues (e.g., the Jarvic pump).

3. Human-to-human organ or tissue transplants other than those specifically listed.

MM. TRANSPLANT DONOR SERVICES

I. Covered Health Services - *Prior Authorization Required*

Transplant-related donor, medical, and hospital expense are covered when the recipient's (Member's) transplant is approved and covered under this Certificate and the donor has confirmed compatibility with the recipient (Member). Organ-procurement costs are limited to those costs directly related to the procurement of an organ from a human cadaver or compatible living human donor.

II. Non-Covered Health Services

Medical and hospital expenses for a transplant donor when the recipient is not a current Member under this Certificate.

NN. URGENT CARE

I. Covered Health Services - *Prior Authorization Not Required*

If You have an Urgent Condition and you have a Primary Care Provider, it is recommended You:

1. Contact Your Primary Care Provider's clinic to see if You can make an appointment with Your Primary Care Provider.
2. If Your Primary Care Provider is not available, Your Primary Care Provider's clinic may instruct You to go to an urgent care clinic. You may contact GHC-SCW anytime day or night to speak with a nurse who will triage Your condition and assist in determining whether it is an Urgent Condition.
3. If you have an Urgent Condition and do not have a Primary Care Provider, You should proceed to an urgent care clinic. You may contact GHC-SCW anytime day or night to speak with a nurse who will triage Your condition and assist in determining whether it is an Urgent Condition.
4. GHC-SCW requests notification of services relating to an Urgent Condition prior to receiving such care or as soon as reasonably possible thereafter.
5. GHC-SCW will determine Benefits at the time of claim.

OO. VISION SERVICES

I. Covered Health Services - *Prior Authorization May Be Required*

1. Routine Eye Examinations to determine the need for corrective eyeglass lenses and the written prescription for corrective eyeglass lenses for Members performed by an optometrist (OD). This benefit is limited to one (1) exam per Member per year. Eye examinations performed by other types of Providers (for example, ophthalmologists) are not covered under this benefit.
2. All vision services covered under this section are subject to the terms, conditions, restrictions, exclusions and limitations that apply to any other coverage under this Benefit Plan.

II. Non-Covered Health Services

Eyewear including lenses, lens upgrades such as no-line bifocal and tinting, frames, contact lenses, contact lens prescriptions, contact lens services and any other services unless covered above.

Article VI: Exclusions and Limitations

A. EXCLUSIONS

1. ACT OF WAR

Items and services required as a result of war or any act of war, declared or undeclared, insurrection, riot, acts of terrorism, or sustained while performing military services.

2. ANY CHARGE FOR AN APPOINTMENT A MEMBER DOES NOT ATTEND

This exclusion not apply to a Medically Necessary family psychotherapy appointment without the subject patient present provided the patient is (age 17 or younger) and the purpose is treatment of the patient's condition, and there is a need to assess and assist the capability of the family member(s) care of the patient.

3. COMMON USE SUPPLIES

Purchase or rental of supplies of common use, including but not limited to heating pads, hot water bottles, air purifiers, and air conditioners.

4. COMPLICATIONS, CONSULTATIONS, SERVICES AND PROCEDURES RELATED TO A NON-COVERED PROCEDURE

Complications, consultations, services and procedures related to a procedure that is non-covered pursuant to the terms and conditions under this Certificate. For purposes of this exclusion, a procedure is considered a non-covered procedure regardless of whether the procedure was covered under the health benefit plan or insurance policy at the time the Member received the procedure.

5. CONFINEMENT PRIOR TO EFFECTIVE DATE

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. Eligibility is not affected by this provision.

6. COSMETIC SERVICES

Excluded from coverage: Reconstructive surgery and/or cosmetic treatment undertaken solely to improve the Member's appearance. Also excluded are other treatments, services and supplies for cosmetic or beautifying purposes, unless such treatment 1) represents a medical/surgical necessity; 2) is associated with covered reconstructive surgery due to an Illness or accidental Injury (including subsequent removal of a prosthetic device that was related to such reconstructive surgery); or 3) is otherwise indicated in this policy. Unless medically necessary or otherwise indicated in this policy, examples of cosmetic services not covered include but are not limited to: blepharoplasty, breast augmentation, chalazion treatment, chemical peels, revision of previous procedures done on the face/head, sclerotherapy for varicose veins, septoplasty/rhinoplasty, treatment of benign skin lesions, including sebaceous cysts, keloids, scars, and lipomas.

7. CUSTODIAL CARE

8. **DRUG SCREENING**

Drug Screening of illicit or illegal drugs/substances is excluded, except for Members in active treatment for Substance Use Disorder or for a disease that requires abstinence from a specific drug.

9. **DUPLICATE SERVICES**

10. **ELECTIVE ABORTIONS**

Services, drugs, or supplies related to abortions, except when:

a. The pregnancy is the result of an act of rape or incest;

b. There is a significant fetal abnormality;

c. The life of the Member would be endangered if the fetus were carried to term;

d. The Member suffers from a physical injury, disorder, or illness that would place their life in danger unless an abortion was performed; or

e. Select fetal reduction in multiple pregnancy is recommended by a high-risk obstetrical specialist or neonatologist.

11. **ELECTROLYSIS SERVICES**

12. **EXPERIMENTAL, INVESTIGATIONAL OR UNPROVEN SERVICES**

13. **FAMILY MEMBER PERFORMING SERVICES**

Any prescriptions written by a licensed Provider for use by the Provider or their Immediate Family Member.

Any treatment, services and/or supplies provided by, or supplied at the direction of, a Member, a Member's Immediate Family Member or any other person living with the Member or a Dependent in a similar fashion.

14. **FUNCTIONAL CAPACITY EVALUATIONS**

Functional capacity evaluations, including driver-readiness programs.

15. **GENE THERAPY**

16. **HAIR IMPLANTS/TRANSPLANTS**

17. **HOME MODIFICATIONS**

Home modifications, including but not limited to wheelchair ramps and grab bars.

18. **HOUSECLEANING**

Housecleaning for any reason.

19. **HYPNOTHERAPY**

20. **KERATOREFRACTIVE SURGERY**

21. **MEDICALLY NECESSARY/MEDICAL NECESSITY**

Any services that are not Medically Necessary, as determined by the GHC-SCW Medical Director.

22. **NEW-TO-MARKET DRUGS AND TREATMENTS**

Any new-to-market Prescription Drug and/or treatments, or new indication of an existing Prescription Drug and/or treatment, for the first six (6) months following the date the drug and/or treatment is made commercially available, unless sooner reviewed and approved for coverage by GHC-SCW, at its sole discretion.

23. **OBESITY-RELATED SERVICES**

Obesity-related services including but not limited to: supplies, equipment or facilities in connection with weight control or reduction whether or not prescribed by a Provider or associated with an illness. These are included but not limited to: gastric or intestinal bypasses; gastric balloons; stomach stapling; wiring of the jaw; liposuction; drugs; weight loss programs; physical fitness or exercise programs or equipment.

24. **ONGOING MEDICAL NECESSITY**

Items and services provided or rendered after a Member's condition ceases to require such items or services. The furnishing by GHC-SCW of a portion of such items or services, or payment therefore shall not require GHC-SCW to continue furnishing or providing payment for such items or services.

25. **OVER THE COUNTER SUPPLIES**

Except for items ordered by a Provider and deemed Medically Necessary, services, supplies, equipment, accessories, or other items which can be purchased at retail establishments or over the counter without an order by a Provider are excluded.

26. **PERSONAL COMFORT ITEMS**

Items and services that constitute a personal comfort item or service are excluded. These include but are not limited to: television, telephone and newspapers.

27. **PRIOR AUTHORIZATION**

Items and services provided by or on the order of any Provider of care or service without the Prior Authorization of the GHC-SCW Care Management Department, except for an Emergency Condition or for an Urgent Condition. If Prior Authorization is not received prior to the date of service and/or receipt of supplies, Your Provider should contact GHC-SCW's Care Management Department for a determination of Medical Necessity.

28. **PRIVATE DUTY NURSING SERVICES**

29. **PRIVATE HOSPITAL ROOM**

Additional charges for a private Hospital room unless the private Hospital room is Prior Authorized by GHC-SCW.

30. **PROLOTHERAPY**

31. **SCAR REVISIONS**

Services for the revision of scars resulting from surgical procedures unless Medically Necessary.

32. **SENSORY INTEGRATION THERAPY**

Sensory integration therapy, except for when medically necessary to treat Autism Spectrum Disorder.

33. **SERVICES BEFORE EFFECTIVE DATE AND/OR AFTER TERMINATION DATE**

Services provided before a Member's Individual Effective Date or after the date coverage under a Group Service Agreement or this Certificate terminates with respect to a Member. A Member who is an inpatient in a Hospital at the time coverage terminates will be entitled to Inpatient Hospital Services until discharge, as defined in Article II: Coverage.

34. **SERVICES WHILE INCARCERATED**

Treatment, services (including emergency), and supplies provided while the Member is held, detained or imprisoned in a local, state or federal penal or correctional institution, or in the custody of local, state or federal law enforcement authorities, except as specifically required by state or federal law. Persons who are GHC-SCW Members and have been granted the privilege of partial unsupervised release from imprisonment for work, medical treatment, school, or conducting any self-employed occupation including housekeeping and attending the needs of the person's family, will have coverage for Benefits under this Certificate if no government entity is required to provide the individual with medical care.

35. **SERVICES FOR INJURIES INCURRED DURING THE COMMISSION OF A CRIME**

Services, treatments, and/or supplies associated with a condition, illness, injury or disability to which a contributing cause was (a) a Member's being engaged in an illegal occupation; or (b) a Member's commission of, or attempt to commit, an illegal act that results in a felony charge (not including felony possession of a controlled substance). A Member acquitted of all felony charges shall not be subject to this exclusion and shall be eligible to receive coverage of such services, treatments and/or supplies pursuant to the terms of this Certificate.

This exclusion does not apply to services, treatments and/or supplies for (a) conditions, illnesses, injuries, or disabilities that are the result from an act of domestic violence; or (b) conditions, illnesses, injuries, or disabilities sustained or contracted in consequence of the Member's being intoxicated or under the influence of controlled substances, where no felony unrelated to such intoxication or being under the influence of controlled substances has been attempted or committed.

36. **SERVICES OUTSIDE OF THE UNITED STATES**

Services and supplies obtained while in a foreign country, with the exception of Urgent Conditions and Emergency Conditions, are excluded.

37. **SPERM BANKING OR EGG HARVESTING**

38. **TATTOOS**

Services for the removal of tattoos or complications related to tattoos.

39. **THIRD PARTY REQUESTS**

Non-Medically Necessary Third Party Requests for services, supplies and/or treatment, including but not limited to:

a. Services, supplies, and/or treatment requested or required for an administrative purpose, such as those relating to employment, licensing, insurance, marriage, or adoption;

b. Court-ordered services, unless Medically Necessary and otherwise covered under this Certificate as required by law.

40. **TONGUE THRUST**

Services for the treatment of Tongue Thrust.

41. **TRANSPORTATION**

Transportation of a Member to or from any location for treatment by or under the order is excluded unless Prior Authorized by GHC-SCW, other than Medically Necessary ambulance service, as provided for in Article V. Transportation of a Member to a Provider's office or from the Hospital to Home is not a covered Benefit.

42. **TRAVEL IMMUNIZATIONS**

43. **WORKERS' COMPENSATION**

Items and services incidental to an injury or condition covered by any worker's compensation law or occupational disease law of any state, or of the United States, as provided in Article III, General Provisions.

B. LIMITATIONS

1. **PRIOR AUTHORIZATION**

Covered Services may be subject to Prior Authorization requirements. It is the Member's responsibility to ensure a Prior Authorization has been obtained when required. Failure to obtain Prior Authorization when required may result in the Member receiving a reduction in or no Benefit. If Prior Authorization is not received prior to the date of service and/or receipt of supplies, Your Provider should contact GHC-SCW's Care Management Department for a determination of Medical Necessity.

2. **WAR/MAJOR DISASTERS**

In the event of any epidemic, war, or major disaster, GHC-SCW shall be obligated for the Benefits otherwise provided pursuant to the Group Service Agreement or this Certificate, but only to the extent of the available facilities and medical staff of GHC-SCW. If there is a delay or failure to provide such services due to lack of available Providers, such lack being a result of the epidemic, war, or disaster, then neither GHC-SCW nor any GHC-SCW Provider or group of GHC-SCW Providers shall be liable for such delay or failure, nor for any loss.

3. **GHC-SCW UNCONTROLLABLE CIRCUMSTANCES**

In the event that, due to circumstances not reasonably within the control of GHC-SCW, the rendering of medical and surgical services hereunder is delayed or rendered impractical, neither GHC-SCW nor any Providers or group of Providers shall have any liability on account of such delay or failure to provide services. Such circumstances may include the inability of Providers to arrange admissions of a Member to a Hospital, complete or partial destruction of facilities, war, riot, civil insurrection, labor dispute, disability of a significant number of GHC-SCW medical personnel, or similar causes.

4. **TIMELY CLAIM SUBMISSION**

GHC-SCW will be responsible for payment or reimbursement of claims only if presented to GHC-SCW for payment or reimbursement within one year of the date of service.

5. **COPAYMENTS/COINSURANCE/DEDUCTIBLES**

Specific Copayments, Coinsurance or Deductibles are required for applicable services and procedures specified in Article V and/or the Plan's Benefit Summary.