Group Health Cooperative of South Central Wisconsin

SUBSCRIBER POLICY

2023 Medicare Select Healthy You Policy

The Wisconsin Insurance Commissioner has set standards for Medicare Select policies. This policy meets those standards. It, along with Medicare, may not cover all of your medical costs. You should review carefully all policy limitations. For an explanation of these standards and other important information, see "Wisconsin Guide to Health Insurance for People with Medicare," given to you when you applied for this policy. Do not buy this policy if you did not get this guide.

GUARANTEED RENEWABLE FOR LIFE—PREMIUM SUBJECT TO CHANGE

This policy is issued for a defined period. For members joining the plan due to special enrollment and who have an effective date of:

- November 1st, the initial period of coverage is 14 months. For all subsequent renewals, the coverage period is the calendar year;
- December 1st, the initial period of coverage is 13 months. For all subsequent renewals, the coverage period is the calendar year.

For all other members, the coverage period is the calendar year. We will renew this policy for as long as you pay the Premium on time. It is guaranteed renewable and will remain in force as long as none of the events stated in Article II has occurred. Your Subscriber Policy cannot be cancelled because you have used Benefits. Your Premium rate will change only if we raise the Premium for all policies like yours. Your Premium will also change on the next January 1st following your birthday if it places you in a new age category. Age categories are listed on the Premium Information page of this policy.

YOUR RIGHT TO RETURN THIS POLICY

Please read this Subscriber Policy right away. If you are not satisfied with it for any reason, you may return it to us within 30 days. Upon return, the Policy is no longer valid. If you return the Policy within the 30 days, we will refund payments you have made on it.

YOUR RIGHT TO CANCEL THIS POLICY MIDTERM

You may cancel this Subscriber Policy midterm, either per your request or in the event of your death. Upon cancellation, GHC-SCW will issue a pro rata refund to you or to your estate.

IMPORTANT NOTICE CONCERNING STATEMENTS IN THE APPLICATION FOR YOUR PLAN

Please read the copy of the application attached to your plan. Omissions or misstatements in the application could cause an otherwise valid claim to be denied. Carefully check the application and write to us within 10 days if any information shown in the application is not correct and complete or if any medical history has not been included. The application is part of the plan. The plan was issued on the basis that the answers to all questions and any other material information shown on the application are correct and complete.

REASONABLE AND CUSTOMARY DISCLOSURE

GHC-SCW bases claims settlement for out-of-network providers on the "Reasonable and Customary Charge" for covered Benefits. The "Reasonable and Customary Charge" may be less than the billed amount. For additional information, please refer to the following parts of this Policy: Definitions; Hospital and Related Services; and Professional and Other Services or contact the GHC-SCW Member Services Department. A range of payment methodologies may be utilized for out-of-network or In-Network Providers.

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GHC-SCW Quality Improvement Statement:
Each year Group Health Cooperative of South Central Wisconsin (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. GHC-SCW's Quality Improvement Work Plan is divided into the following two sections and six 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.

HMO MEDICARE SELECT HEALTHY YOU PREMIUM INFORMATION

Rates:

DANE County			
Age	Monthly Premium	Quarterly Premium	Annual Premium
0 – 64	$312.99	$938.97	$3,755.88
65 – 69	$181.43	$544.29	$2,177.16
70 – 74	$215.11	$645.33	$2,581.32
75 – 79	$252.86	$758.58	$3,034.32
80+	$291.53	$874.59	$3,498.36

NON-DANE County			
Age	Monthly Premium	Quarterly Premium	Annual Premium
0 – 64	$278.26	$834.78	$3,339.12
65 – 69	$161.29	$483.87	$1,935.48
70 – 74	$191.24	$573.72	$2,294.88
75 – 79	$224.80	$674.40	$2,697.60
80+	$259.17	$777.51	$3,110.04

GHC-SCW will not underwrite you if you buy the policy during your open enrollment period or when you have a guaranteed issue right.

Basic Medicare Select Policy:

1. Part A Deductible
   100% of Part A deductible

2. Additional Home Health Care
   An aggregate of 365 visits per year including those covered by Medicare.

3. Foreign Travel Emergency Care
   100% of emergency or urgent care needed while traveling outside of the United States.

4. Complementary Medicine Professional Services
   Coverage for select procedures will be provided by a GHC-SCW Complementary Medicine Provider at GHC-SCW clinics is subject to copayments, with no annual limit.

Group Health Cooperative of South Central Wisconsin (GHC-SCW) will send you Premium statements monthly. You may pay monthly, quarterly or annually.

DESCRIPTION OF MEDICARE SELECT POLICY

This Subscriber Policy is issued by Group Health Cooperative of South Central Wisconsin ("GHC-SCW") to describe the terms and conditions under which Subscribers will be provided with certain Hospital and Related Services and Professional and Other Services as specified herein.

Subject to all the terms and conditions of this Subscriber Policy, GHC-SCW will provide the Subscriber the Hospital and Related Services and Professional and Other Services specified in this Subscriber Policy. Depending on the circumstances, such services will be provided directly by GHC-SCW, by agreement with Providers, Hospitals, and other providers.

Use of In-Network Providers: Except as described below, Members must receive care through GHC-SCW In-Network Providers for services to be covered. Full coverage is provided under this policy for covered services that are not available through In-Network Providers. If, however, care is available from In-Network Providers, use of Out-of-Network Providers will result in the Member being financially responsible for full payment of services, unless written approval (Prior Authorization) for such Out-of-Network services has been obtained from GHC-SCW's Care Management Department.

Coverage under this Subscriber Policy begins as of 12:01 a.m. Central Standard Time on the date on which the Subscriber becomes entitled to coverage as specified in this Subscriber Policy.

This Subscriber Policy is issued in consideration of the timely payment by or on behalf of the Subscriber of the monthly Premium in effect for the coverage being provided. Such monthly Premium is subject to change by GHC-SCW. GHC-SCW reserves the right to cancel coverage under this Subscriber Policy if timely payment is not made.

GHC-SCW may adopt reasonable policies, procedures, rules and interpretations to promote the orderly and efficient administration of this Subscriber Policy. The Subscriber agrees to abide by the terms and conditions of such policies, procedures, rules and interpretations.

Consistent with acceptable medical practice and applicable legal and contractual requirements, including this Subscriber Policy, GHC-SCW has discretion to adopt and interpret policies, procedures and rules applicable to the services being provided. All such services are available to Subscribers 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 is committed to assisting patients with special needs and providing interpreter services and written materials to persons whose language is other than English.

ARTICLE I

DEFINITIONS

A. The following terms, when used and capitalized in this Subscriber Policy or any supplements, endorsements, amendments, or riders to it, are defined as follows and limited to that meaning only:

1. **Adverse Determination** means 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.
   (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 Web site: http://oci.wi.gov/oci_home.htm.

2. **Benefit Period** means the period that begins on the first day you receive services as an inpatient in a Hospital and ends after you have been out of the Hospital and have not received skilled care in any other facility for 60 days in a row. The next time you enter a Hospital or Skilled Nursing Facility a new Benefit Period begins.

3. **Benefit(s)** means the covered services contained in this Subscriber Policy, including the attachments hereto.

4. **Centers for Medicare and Medicaid Services (CMS)** means that agency of the federal government responsible for administration of the Medicare Program.

5. **Complaint** means any dissatisfaction expressed by a Subscriber or a Subscriber's authorized representative concerning GHC-SCW or GHC-SCW's In-Network Providers.

6. **Cancer Clinical Trial** means a clinical trial that satisfies all of the following criteria:

   (a) A purpose of the trial is to test whether the intervention potentially improves the trial participant's health outcomes.
   (b) The treatment provided as part of the trial is given with the intention of improving the trial participant's health outcomes.
   (c) The trial has therapeutic intent and is not designed exclusively to test toxicity or disease pathophysiology.
   (d) The trial does one of the following:
      1. Tests how to administer a health care service, item, or drug for the treatment of cancer.
      2. Tests responses to a health care service, item, or drug for the treatment of cancer.
      3. Compares the effectiveness of health care services, items, or drugs for the treatment of cancer with that of other health care services, items, or drugs for the treatment of cancer.
      4. Studies new uses of health care services, items, or drugs for the treatment of cancer.
   (e) The trial is approved by one of the following:
      1. A National Institute of Health, or one of its cooperative groups or centers, under the federal department of health and human services.
      2. The federal food and drug administration.
      3. The federal department of defense.
      4. The federal department of veterans affairs.

7. **Complementary Medicine** includes forms of therapy used along or in combination with standard/conventional medicine (sometimes referred to as allopathic or integrated medicine). Services or treatments include, but are not limited to: acupuncture, homeopathy, naturopathy, biofeedback, various types of manual therapy, various types of massage therapy and energy work, various types of stress reduction and mind/body medicine, various types of mindfulness therapy, various types of eastern practices, yoga, movement therapy, wellness classes, lifestyle change classes.

8. **Consulting Provider** means the In-Network Provider with whom the Subscriber's Primary Care Provider elects to consult regarding care, including but not limited to consultations about second opinions and developing an ongoing plan of care.

9. **Coverage Month** means the monthly period of time commencing on the Individual Effective Date of this Subscriber Policy and on the same date of each month after that.

10. **Custodial Care** means care which is primarily for the purpose of meeting personal needs. It could be provided by persons without professional skills or training. For example, Custodial Care includes helping the Subscriber walk, get in and out of bed, bathe, dress, eat, prepare special diets and take medicine. Most nursing home care is considered Custodial Care.

11. **Creditable Coverage** means coverage under any of the following: a group health plan; health insurance; part A or part B of title XVIII of the federal Social Security Act; Title XIX of the federal Social Security Act, except for coverage consisting solely of benefits under section 1928 of that act; Chapter 55 of title 10 of the United States Code; a medical care program of the Federal Indian Health Service or of an American Indian tribal organization; a state health benefits risk pool; a health plan offered under chapter 89 of title 5 of the United States Code; a public health plan, as defined in regulations issued by the federal government Department of Health and Human Services; or a health coverage plan under section 5(e) of the Federal Peace Corps Act. Creditable Coverage does not include coverage consisting solely of coverage of excepted benefits.

12. **Dentist** means a duly licensed dentist.

13. **Due Date** means the day of the month on which the Premium is due to be paid to GHC-SCW by the Subscriber.

14. **Durable Medical Equipment (DME)** means those items of equipment which are: (a) able to withstand repeated use; (b) primarily and customarily used to serve a medical purpose; and (c) generally not necessary to a person when not sick or injured.

15. **Eligible Person** means a person who:

    (a) Is eligible for and covered by Medicare Parts A and B; and
    (b) Lives within the GHC-SCW Service Area; and
    (c) Has completed and signed a Subscriber Application; and
    (d) Has been accepted for enrollment by GHC-SCW; and
    (e) Agrees to abide by the rules disclosed along with the enrollment process.

16. **Emergency Condition** 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: serious jeopardy to the person's health or, with respect to a pregnant woman, serious jeopardy to the health of the woman or her unborn child; serious impairment to the persons bodily functions; or serious dysfunction of one or more of the person's body organs or parts. In the absence of a finding by the GHC-SCW Medical Director of justifying circumstances,

obstetrical delivery of a child or children outside the Service Area during or after the 9th month of pregnancy will not constitute an Emergency Condition. It is the responsibility of the Subscriber to notify GHC-SCW of the Subscriber's hospitalization within 48 hours of the onset of the Emergency Condition, or a soon thereafter as reasonably possible.

17. **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 Food and Drug Administration (FDA), which has not granted that approval
    (b) is not a commonly accepted medical practice in the American medical community
    (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, investigative, 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 and side effects or poses uncertain risks and outcomes
    (k) is being used in place of other more conventional and proven methods of treatment
    (l) has been disapproved by the GHC-SCW Technology Assessment Committee
    (m) reliable evidence shows that the consensus of opinion among experts regarding the treatment, procedure, device, drug or medicine is that further studies or clinical treats are necessary to determine its maximum tolerated dose, toxicity, safety, efficacy 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 or protocols 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.

18. **GHC-SCW Clinic** means a clinic or complex of Providers' offices and related Outpatient diagnostic and therapeutic facilities operated by or for GHC-SCW for the purpose of providing services to Subscribers.

19. **GHC-SCW Provider** means a Provider who has entered into an agreement with GHC-SCW and is qualified to provide one or more of the Benefits described in Articles III and IV of this Subscriber Policy at a GHC-SCW owned and operated facility.

20. **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 Subscriber.

21. **Home Health Care** means Medically Necessary care and treatment of a Subscriber under a plan of care established, approved in writing and reviewed at least every two months by the attending Provider, unless the attending Provider determines that a longer interval between reviews is sufficient, and consisting of one or more of the following;

    (a) Part-time or intermittent home nursing care by or under the supervision of a registered nurse.

(b) Part-time or intermittent home health aide services which are Medically Necessary as part of the home care plan under the supervision of a registered nurse or medical social worker, which consist solely of caring for the patient.
(c) Physical or occupational therapy, or speech-language pathology or respiratory care.
(d) Medical supplies prescribed by a Provider and laboratory services by or on behalf of a Hospital, if needed under the home care plan, to the extent such items would be covered under the policy if the Subscriber had been hospitalized.
(e) Nutrition counseling provided by or under the supervision of a registered or certified dietician where such services are medically necessary as part of the home care plan.
(f) The evaluation of the need for and development of a plan, by a registered nurse, physician extender or medical social worker, for home care when approved or requested by the attending Provider.

22. **Hospital** means an institution which:

(a) Is operated pursuant to law;
(b) Is primarily and continuously engaged in providing or operating medical, diagnostic and major surgical facilities under the supervision of a staff of duly licensed physicians for the medical care and treatment of sick or injured persons on an inpatient basis for which charge is made. A hospital may operate either on its premises or in facilities available to it on a prearranged basis.
(c) Provides 24-hour nursing service by or under the supervision of registered graduate professional nurses (RNs); and
(d) Is not a convalescent rest home or nursing facility.

23. **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.

24. **Individual Effective Date** means the date on which the Subscriber's coverage becomes effective under the terms and conditions of this Subscriber Policy.

25. **Inpatient Hospital Services** means Medically Necessary services and supplies furnished to a registered bed patient by a Hospital and regularly included in its charges. These are limited to Medicare-Eligible Expenses, including but not limited to:

(a) Semi-private room and board accommodations, including general duty nursing care;
(b) Meals, including special meals and diets when Medically Necessary in the attending Physician's professional judgment;
(c) Use of operating, labor, 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, blood, blood derivatives, and other biologicals;
(f) Administration and processing of whole blood and blood 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) Rehabilitation services when deemed appropriate in the attending Provider's professional judgment;
(o) Use of intensive care units and services;
(p) Private room accommodations when Medically Necessary in the attending Physician's professional judgment, if available in the Hospital in which the Subscriber is confined;

(q) Detoxification for alcohol or drug abuse when determined to be appropriate in the attending Provider's professional judgment; and
(r) Other Medically Necessary services customary in modern Hospital procedure and not excluded by Article V of the Subscriber Policy.

26. **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 Articles III and IV of the Subscriber; 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.

27. **Medical Necessity/Medically Necessary** means a service, treatment, procedure, equipment, drug, 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: 1) consistent with the symptom(s) or diagnosis and treatment of the Member's illness, disease or injury; 2) appropriate under the standards of acceptable medical practice to treat that illness, disease or injury; 3) not solely for the convenience of the Member, Provider, Hospital or other health care provider; and 4) the most appropriate service, treatment, procedure, equipment, drug, device or supply which can be safely provided to the Member and accomplishes the desired end result in the most economical manner.

28. **Medicare** means the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as then constituted or later amended.

29. **Medicare-Eligible Expenses** means health care expenses that are covered by Medicare, recognized as Medically Necessary and reasonable by Medicare, and that may or may not be fully reimbursed by Medicare.

30. **Out-of-Area Service** means any service provided to a Subscriber outside of GHC-SCW's Service Area. Benefits are limited to services for Emergency or Urgent Conditions, Medically Necessary Emergent or Urgent coverage for foreign travel, and services with Prior Authorization from GHC-SCW. Medicare will still pay its share of approved charges if the Out-of-Area Services are Medicare-Eligible Expenses.

31. **Outpatient** means that the Subscriber 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. **Outpatient Emergency Service** means emergency room and operating room services provided and billed by a Hospital and/or Provider. This includes necessary diagnostic services for the initial visit of an Outpatient under the care and treatment of a Provider. Such service must be for an Emergency Condition.

32. **Provider** means a person holding an unrestricted license to practice medicine and surgery under the Wisconsin Statutes or under a statute of the state in which he or she practices, and holding a degree of:

(a) Medical Doctor (M.D.);
(b) Doctor of Podiatric Medicine (D.P.M.);
(c) Doctor of Chiropractic (D.C.);
(d) Doctor of Optometry (O.D.);
(e) Optician;
(f) Registered Physical Therapist (R.P.T.);
(g) Psychologist (Ph.D.; Ed.D.; Psy.D.);
(h) Speech Therapist;
(i) Occupational Therapist;
(j) Registered Respiratory Therapist;
(k) Anesthesiologist;
(l) Osteopath (D.O.);

(m) Doctor of Dental Surgery (D.D.S.) or Doctor of Dental Medicine (D.M.D.);
(n) Certified Nurse Midwife (C.N.M.);
(o) Certified Registered Nurse Anesthetist (C.R.N.A.);
(p) Licensed Clinical Social Worker (L.C.S.W.);
(q) Master of Social Work (M.S.W.);
(r) Physician's Assistant (PA-C);
(s) Nutritionist;
(t) Dietitian;
(u) Nurse Practitioner (N.P.); or
(v) Audiologist.

33. **Provider's Services** means services rendered by a Provider and billed, if at all, by the Provider rendering and regularly charging for such services.

34. **Premium** means the amount of money currently charged by GHC-SCW, and payable to GHC-SCW by the Subscriber for services and Benefits made available to Subscribers under this Subscriber Policy. Premium is payable whether or not any such services or Benefits are actually required by or received by the Subscriber in any month.

35. **Primary Care Provider (PCP)** means an In-Network Medical Doctor, Nurse Practitioner, or Physician's Assistant, employed, contracted or engaged by GHC-SCW and selected by the Subscriber to provide Provider's Services without Prior Authorization.

36. **Prior Authorization** means the advance authorization, with appropriate documentation, by the GHC-SCW Medical Director or his/her designee for specific medical services or treatment. Services requiring Prior Authorization are specified in Articles III and IV of the Policy and Outline of Coverage. Failure to obtain Prior Authorization when required may result in the Subscriber receiving a lesser or no Benefit.

37. **Prosthetic Appliance** means an artificial device to replace all or part of an external body part.

38. **Reasonable and Customary Fees and Charges** 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 due 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.

39. **Service Area** means Dane County, Jefferson County, Green County, Lafayette County, Rock County, Columbia County, Dodge County, Iowa County, Sauk County, Adams County, Juneau County, or Grant County in Wisconsin.

40. **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);
    (d) Maintains a daily medical record of each patient.

    The term excludes facilities providing services primarily for domiciliary or Custodial Care.

41. **Subscriber** means an Eligible Person: who has applied for enrollment hereunder; whose Subscriber Application has been received and accepted by GHC-SCW; to whom a Subscriber Policy has been issued by GHC-SCW; and whose coverage hereunder is in force by the terms of the Subscriber Policy. Must reside in the Service Area for at least 75% of the days in any 12-month period.

42. **Subscriber Application** means the application for enrollment under this Subscriber Policy. It must be completed by the Subscriber upon a form prescribed by GHC-SCW.

43. **Subscriber Policy** means this Policy, issued to the Subscriber by GHC-SCW. It sets forth the Benefits and services available to Subscribers. It explains essential terms and conditions affecting eligibility, coverage conditions, and termination of coverage.

44. **Surgical Services** means the performance of surgical procedures by a Provider.

45. **Urgent Condition** means the rapid onset of symptoms of an illness or injury which requires medical care but is not life-threatening. Within the Service Area, treatment for an Urgent Condition must be obtained from an In-Network Provider. When outside the Service Area, and care cannot be safely delayed until returning to the Service Area, treatment for an Urgent Condition should be obtained from the nearest medical facility. Claims for such care should be submitted to GHC-SCW. GHC-SCW must be notified prior to receiving Out-of-Area Care for an Urgent Condition.

    If you have an Urgent Condition you should: First CONTACT YOUR PRIMARY CARE CLINIC to see if you can make an appointment with your PCP. If your PCP Is not available, your primary care clinic will instruct you to go to a specified urgent care clinic. Clinic phone lines are answered anytime, day or night. If you are instructed by your PCP to seek services from an Out-of-Network Provider for urgent care, you should contact the GHC-SCW Care Management Department within 48 hours to report that you received services from an Out-of-Network Provider. GHC-SCW will determine benefits at the time of claim.

ARTICLE II

EFFECTIVE DATE, TERMINATION OF COVERAGE AND CONVERSION RIGHTS

A. Open Enrollment Period

The six-month period beginning with the first month during which a person enrolls in Medicare Part B or, the beginning of the month in which a person turns age 65. During the Open Enrollment Period, a person will not be required to complete a health statement, submit to a physical exam, or be subject to underwriting.

B. Effective Date of Coverage

1. An Eligible Person, who has applied for coverage under this Subscriber Policy, and who has paid the appropriate Premium, shall have coverage under this Subscriber Policy effective at 12:00 midnight on the first day of the Coverage Month for which Premium is paid to GHC-SCW by the Subscriber.

2. Coverage under this Subscriber Policy begins on the Individual Effective Date; there are no limitations, exclusions or waiting periods for coverage of a pre-existing condition.

C. Disenrollment by GHC-SCW

1. The coverage of the Subscriber shall terminate at 11:59 p.m. on the last day of the Coverage Month. Disenrollment may occur under any of the following reasons:

   (a) The Subscriber has failed to pay required Premiums by the end of the 31-day grace period.
   (b) A Subscriber has knowingly provided fraudulent information in applying for coverage that is discovered by GHC-SCW within two years.
   (c) The Subscriber has committed acts of physical or verbal abuse which pose a threat to providers or members of the organization.
   (d) The Subscriber has allowed a non-Subscriber to use the GHC-SCW identification card to obtain services or has knowingly provided fraudulent information in applying for coverage.
   (e) The Subscriber establishes primary, permanent residence outside of the Service Area. The Subscriber is required to notify GHC-SCW if he/she moves out of the Service Area.

2. Extension of Benefits. If, for any reason, a Subscriber's coverage terminates while he or she is confined in a Hospital, the Subscriber shall be entitled to have Hospital Benefits continue until he or she is discharged from the Hospital or until total disability ends. This extension of benefits provision is in no way affected by a Subscriber's coverage under Medicare Part D.

3. The Subscriber has the right to appeal disenrollment by filing a Grievance in accordance with the Grievance procedures outlined in *Article VII – Complaint Resolution/Grievance Process.* In certain circumstances, the Subscriber may be eligible for guarantee issue.

D. Reinstatement Provision

Reinstatement is subject to GHC-SCW's right to change or terminate this policy. If a Subscriber ends this policy by not paying the Premium, he or she may apply for it to be reinstated. The following rules apply:

1. Coverage must have lapsed due to non-payment of Premium;

2. The Subscriber must apply for reinstatement within one year of the lapse date; and

3. The Subscriber wants to reinstate the same coverage he or she had.

4. GHC-SCW must approve a Subscriber's application to reinstate. GHC-SCW can either approve or decline it.

5. If GHC-SCW agrees to reinstate coverage charges and/or losses resulting from services and/or injuries occurring during the lapse of coverage period will not be covered.

6. If approved, the new policy will be effective on the first day of the month following approval, providing the required Premium has been paid.

7. GHC-SCW will not accept monthly payments for reinstatement applications when terminated due to non-payment of Premium. The Subscriber must pay Premiums for the new policy quarterly.

8. If the policy is reinstated after December 31, 2005, coverage for Outpatient prescription drugs will not be included.

E. Suspension of Coverage for Medical Assistance Entitlement

1. This Subscriber Policy may be suspended at the request of the Subscriber for a period not to exceed 24 months when the Subscriber is entitled to Medical Assistance under Title XIX of the Social Security Act. The Subscriber must notify GHC-SCW within 90 days after the medical assistance entitlement is effective.

2. If the Subscriber loses medical assistance entitlement and notifies GHC-SCW within 90 days of its termination, this Subscriber Policy shall be reinstituted effective on the date of loss of medical assistance entitlement. The Subscriber must pay Premium attributable to this period. If the Subscriber Policy is reinstituted after December 31, 2005, coverage for Outpatient prescription drugs will not be included.

F. Suspension of Coverage for Group Health Coverage Entitlement

1. This Subscriber Policy may be suspended at the request of the Subscriber for a period not to exceed 24 months when the Subscriber is entitled to Benefits under section 226(b) of the Social Security Act and is covered under a group health plan. The Subscriber must notify GHC-SCW within 90 days after the group health coverage entitlement is effective.

2. If the Subscriber loses coverage under the group health plan and notifies GHC-SCW within 90 days of its termination, this Subscriber Policy shall be reinstituted effective on the date of loss of group health coverage entitlement. The Subscriber must pay Premium attributable to this period. If the Subscriber Policy is reinstituted after December 31, 2005, coverage for Outpatient prescription drugs will not be included.

G. Clerical Errors

1. No clerical error made by GHC-SCW shall:

   (a) Invalidate the coverage of a Subscriber otherwise validly in force; nor
   (b) Continue coverage otherwise validly terminated.

H. Cancellation

If this Subscriber Policy cancels midterm, either by the Subscriber's request or the death of the Subscriber, GHC-SCW shall not issue a refund of the Premium for the month in which the cancellation occurred. Premiums paid for coverage beyond the cancellation date will be refunded on a pro-rated basis to the Subscriber or the Subscriber's estate.

I. Benefit Changes

Benefits under this Subscriber Policy will change automatically to coincide with any changes in the applicable Medicare deductible amount and co-payment percentage factors.

J. Premium Rate Change

If there is a Premium change, GHC-SCW will notify Subscribers at least 30 days before the start of the period for which the Premium changed. If the Premium increase is 25% or more, or if there is a change in Benefits, GHC-SCW will provide a 60-day notice.

K. Guarantee Issue

GHC-SCW guarantees to issue this Subscriber Policy to Eligible Persons having guarantee issue rights. GHC-SCW will not discriminate in the pricing of the Subscriber Policy because of health status, claims experience, receipt of health care, medical condition or age, and will not impose a pre-existing condition exclusion. If a Subscriber loses health care coverage under certain circumstances, he/she is guaranteed the right to purchase certain Medicare Supplement or Medicare Select policies. Please contact GHC-SCW for more information about your rights under this provision.

The guarantee issue provisions discussed here are added to the six-month open enrollment period that Medicare enrollees have when they first enroll in Medicare Part B.

ARTICLE III

HOSPITAL AND RELATED SERVICES

This Subscriber Policy will cover the Medicare Part A deductible and supplemental Benefits for Medicare-Eligible Expenses under Medicare Parts A and B. Benefits not covered by Medicare will not be covered by this Subscriber Policy except for the Benefits listed in Article III and Article IV.

A. On or after the Individual Effective Date, the Subscriber is entitled to coverage of Inpatient Hospital Services that are Medicare-Eligible Expenses.

   Coverage for Inpatient Hospital Services is limited to the following:

   - Medicare Part A Deductible (first 60 days) for each Benefit Period.
   - Medicare Part A Co-insurance from the 61st to the 90th day for each Benefit Period.
   - Medicare Part A Co-insurance for lifetime reserve days.
   - Medicare-Eligible Expenses upon exhaustion of Medicare Hospital inpatient coverage and lifetime reserve days.

   1. Inpatient Hospital Service in accommodations as provided in paragraph five below. Beneficiaries are only entitled to these Benefits for admissions on the order or concurrence of an In-Network Provider; or, in Emergency Conditions, by any other Provider. Benefits are subject to the Exclusions and Limitations, and the provisions below.

   2. Outpatient Services for an Emergency Condition without Prior Authorization

   3. Out-of-Area Service in a Hospital, including care while traveling in foreign countries, limited to:

      (a) Inpatient Hospital Services for an Emergency or Urgent Condition; and
      (b) Outpatient Hospital Services for an Emergency or Urgent Condition.

   4. Inpatient Hospital Services and Outpatient Care for the treatment of kidney disease including dialysis, transplantation and donor-related services.

   5. A bed in a room regularly containing two beds, if such is available when the Subscriber applies for Hospital admission. If not, the Subscriber is entitled to accommodations in a room containing three or four beds. A bed in a room with two to four beds may not be available when the Subscriber applies for Hospital admission. If not, he or she shall be entitled to a different class of accommodations until such a bed becomes available. If a Subscriber occupies a private room without the order or concurrence of an In-Network Provider, GHC-SCW will only pay the amount of the Hospital's most common semi-private room charge; any additional private room charges are the Subscriber's responsibility.

   6. Inpatient psychiatric Hospital care for mental illness, limited to 175 days per lifetime, after exhaustion of Medicare benefits.

   7. Blood and blood components received while a Hospital patient.

   8. Organ Transplants – Inpatient Hospital Services and Outpatient Care for organ transplants that are Medicare-Eligible Expenses. Transplant coverage includes necessary tests, labs, and exams before surgery for the Subscriber and the organ donor, follow-up care for the Subscriber and a live donor, and procurement of organs and tissues.

B. The Subscriber may be hospitalized under Emergency Conditions without Prior Authorization or the order or concurrence of an In-Network Provider. If so, he or she must notify GHC-SCW of the hospitalization within 48 hours of the onset of the Emergency Condition or as soon as reasonably possible. He or she must also cooperate in his or her transfer, as soon as medically permissible, to a Hospital where In-Network Providers have staff affiliation, for treatment by an In-Network Provider, as provided in Article IV.

C. As long as this Subscriber Policy is in effect, services under this Article III will be available to the Subscriber for an unlimited time, except as provided in this Subscriber Policy. But, the In-Network Provider or other attending Provider (when admission is for Emergency Conditions or Urgent Conditions by an out-of-network Provider) shall determine the duration of any Hospital confinement. No Inpatient Hospital Services will be provided under this Article III beyond the date a Subscriber's release is ordered or authorized by the In-Network Provider or attending Provider.

D. GHC-SCW will pay for Medically Necessary ground ambulance transportation for a Subscriber when other forms of transportation would endanger the Subscriber's health. Except in an Emergency Condition, all ambulance service must be pre-authorized by GHC-SCW Care Management.

   GHC-SCW will cover ambulance transportation which has been pre-authorized by GHC-SCW Care Management as follows: from a scene of an accident to a Hospital; from the home to a Hospital or Skilled Nursing Facility; between Hospitals and Skilled Nursing Facilities; or from a Hospital or Skilled Nursing Facility to the home. If the Subscriber is an inpatient in a Hospital or Skilled Nursing Facility which cannot provide a Medically Necessary service, GHC-SCW will cover round trip ambulance transportation to the nearest appropriate facility.

   GHC-SCW will not cover ambulance transportation from the Subscriber's home to a GHC-SCW Clinic or doctor's office.

   Air ambulance will be covered only under the following circumstances:

   1. Medically Necessary transportation, due to illness or injury, from remote locations inaccessible by ground ambulance; or

   2. When, in the GHC-SCW Medical Director's professional judgment, medical circumstances are such that ground ambulance transportation would further endanger the Subscriber's health.

E. GHC-SCW will provide Inpatient Hospital Services of a special duty nurse (Registered Nurse or Licensed Practical Nurse) when deemed Medically Necessary by the Subscriber's attending In-Network Provider or, in Emergency Conditions, by the attending out-of-network Provider.

F. Upon Prior Authorization of GHC-SCW Care Management, GHC-SCW will provide Home Health Care services for a condition of a Subscriber which, in the attending In-Network Provider's opinion, does not require Hospitalization but which cannot satisfactorily be treated on an ambulatory basis at a GHC-SCW Clinic. An In-Network Provider must: (1) establish this plan; (2) approve it in writing; and (3) review it at least every two months, unless the Provider decides less frequent reviews are adequate. Coverage is provided for up to 365 Home Health Care visits per calendar year for each Subscriber, including those paid for by Medicare. The maximum weekly Benefit for home care will not be more than the usual and customary cost of care in a Skilled Nursing Facility.

G. Skilled Nursing Facility Care

   1. The Subscriber shall be entitled to skilled nursing care in a Medicare-approved Skilled Nursing Facility as approved by the GHC-SCW Medical Director, for a condition which, in the GHC-SCW Medical Director's opinion: a. does not require Hospital confinement; but b. cannot be treated satisfactorily under a Home Health Care program or at a GHC-SCW Clinic on an ambulatory basis. The maximum Benefit is 100 days per Benefit Period. The following conditions must be met:

(a) The Subscriber must be admitted to the Skilled Nursing Facility within 30 days of discharge following a Hospital stay of at least three days
(b) An In-Network Provider certifies that skilled nursing or skilled rehabilitation services are needed and provided on a daily basis; and
(c) The Skilled Nursing Facility's Utilization Review Committee or a Peer Review Organization does not disapprove the stay.

2. Skilled Nursing Facility Care that does not qualify for coverage under Medicare is provided for 30 days per calendar year if an In-Network Provider certifies that skilled nursing or skilled rehabilitation is needed and provided on a daily basis. This coverage is provided in addition to skilled nursing care in a Medicare-approved Skilled Nursing Facility as described above.

H. Hospice care is available as long an In-Network Provider certifies a Subscriber is terminally ill, and the Subscriber elects to receive the services.

I. Upon Prior Authorization of GHC-SCW Care Management, any routine patient care that is covered under this Policy is also covered when administered to a Subscriber in a Cancer Clinical Trial.

This coverage is subject to all the terms, conditions, restrictions, exclusions and limitations that apply to this Policy, including the treatment coverage provided under the Plan, or contract of services performed by In-Network Providers and Out-of-Network Providers.

GHC-SCW will not cover non-routine patient care costs for the Cancer Clinical Trial, which includes, but is not limited to:

(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.

GHC-SCW will not cover expenses for preventive Cancer Clinical Trials.

GHC-SCW will not cover items and services provided by the research sponsors free of charge for any individual enrolled in the Cancer Clinical Trial.

ARTICLE IV

PROFESSIONAL AND OTHER SERVICES

This policy will cover the Medicare Part A deductible and supplemental Benefits for Medicare-Eligible Expenses under Medicare Parts A and B. Benefits not covered by Medicare will not be covered by this Subscriber Policy except for the Benefits listed in Article III and Article IV.

A. Basic Services

A Subscriber is entitled to the following services on or after the Individual Effective Date. They must be received from or by the order of an In-Network Provider or the appropriate auxiliary health personnel working under an In-Network Provider's supervision. The services must be Medicare-Eligible Expenses and are subject to the Exclusions and Limitations in Article V.

1. **Provider's Services** limited to the following:

   (a) **Medical diagnosis, care and treatment** by one or more Providers: (1) At a Hospital or Skilled Nursing Facility in which the Subscriber is confined on the order or concurrence of an In-Network Provider; (2) At a GHC-SCW Clinic; or (3) At any other location deemed necessary by an In-Network Provider.

   (b) **Surgical Services,** as well as preoperative and postoperative care; required services of operative assistants; and administration of anesthesia. Oral surgical procedures are limited to Medicare-Eligible Expenses.

   (c) **Mental Health Care** by a psychiatrist or other mental health personnel. Actual charges will be paid for Outpatient mental health care

   (d) **Preventive Care Services** covered by Medicare and preventive care services *not* covered by Medicare, including but not limited to periodic health examinations as deemed appropriate by In-Network Providers with respect to the age, gender, and health status of the Subscriber.

   Preventive care services covers hearing aids, including the initial evaluation and fitting of the hearing aid. This Benefit is limited to one hearing aid per ear every 36 months. Coverage is limited to 50% of $2,000 in eligible charges, for a maximum payment by GHC-SCW of $1,000 per hearing aid. Hearing aids must be purchased through an In-Network Provider to be eligible for coverage.

   Eye examinations to determine the need for corrective eyeglass lenses and the written prescription for corrective eyeglass lenses by a GHC-SCW Provider, or an ophthalmologist to whom the Subscriber has been referred by a GHC-SCW Provider. Contact lens services, which include the exam and prescription for and fitting for contact lenses, will be provided at an appropriate fee.

2. **Diagnostic Tests**, including: X-ray; laboratory; mammograms, electrocardiograms and electroencephalograms when ordered or prescribed by an In-Network Provider .

3. **Injected Medications and Immunizations,** administered by an In-Network Provider . Provided immunizations include, but are not limited to: polio, tetanus, measles, mumps, rubella, varicella (chicken pox), hepatitis B, influenza, pertussis and diphtheria.

4. **Outpatient Speech/Physical/Occupational/Cardiac Rehabilitation Therapy Services.** Actual charges will be paid when these services are obtained with Prior Authorization from GHC-SCW Care Management.

5. **Alcohol and Drug Addiction Services** when medically required in the professional judgment of GHC-SCW Care Management. Services include: diagnosis; medical treatment; and referral services provided on an Outpatient basis by a Provider or other health care personnel. Services are covered under mental health care and actual charges will be paid.

6. **Emergency Outpatient Care** without Prior Authorization

   (a) At a GHC-SCW Clinic or at the emergency room of a GHC-SCW designated Hospital. This care is for Emergency Conditions, which occur within the Service Area. It includes necessary related diagnostic and therapeutic services.

   (b) GHC-SCW will pay the actual charges, subject to Medicare-Eligible Expenses: a) for the services to which the Subscriber would otherwise have been entitled under this Subscriber Policy; and b) when performed under Emergency Conditions for a Subscriber, without the Prior Authorization of GHC-SCW Care Management.

7. **Ear Examinations** to determine the need for hearing correction.

8. **Prosthetic Appliances.** GHC-SCW will provide payment of actual charges for Prosthetic Appliances obtained with the Prior Authorization of GHC-SCW Care Management.

9. **Durable Medical Equipment** provided at the GHC-SCW Clinic or upon the order of an In-Network Provider. GHC-SCW will decide whether to rent or purchase. GHC-SCW will pay the actual rental or purchase charge.

10. **Oral Surgical Procedures** when related to surgery of the jaw and setting fractures.

11. **Treatment of Kidney Disease** including Inpatient Hospital Services, dialysis, insulin, transplantation, and donor-related services. GHC-SCW will not duplicate any Medicare payments for treatment of kidney disease.

12. **Equipment and Supplies for the Treatment of Diabetes** including expenses related to the installation and use of an insulin infusion pump and coverage for non-prescription equipment and supplies used in the treatment of diabetes. Diabetic self-management and education programs are covered. Replacement of the insulin infusion pump, durable medical equipment, or prosthetic appliances is available if, in the judgment of the GHC-SCW Medical Director, the equipment is no longer adequate to meet Medical Necessity and has exceeded its warranty, or the Subscriber's condition has significantly changed so as to make the original equipment inappropriate. Coverage is not provided for any prescription drugs covered by Medicare Part D, including but not limited to insulin and medical supplies associated with the injection of insulin such as syringes, needles, alcohol swabs and gauze.

13. **Chiropractic Services** when provided by a chiropractor approved by GHC-SCW.

14. **Blood** and blood components received on an Outpatient basis.

15. **Prescription Drugs**. This policy covers only prescription drugs covered by Medicare Part A and Medicare Part B that are Medicare-Eligible Expenses.

16. **Breast reconstruction following mastectomy.** Coverage includes reconstruction of both breasts to produce a symmetrical appearance, prostheses, and treatment of physical complications at all stages, including lymphedemas.

17. **Dental-related Hospital and anesthetic services** for those with a chronic disability or a medical condition that requires hospitalization or general anesthesia for dental care.

18. **Glaucoma Screenings** provided annually for persons at high risk for glaucoma, individuals with a family history of glaucoma, and individuals with diabetes.

19. **Medical Nutrition Therapy for Beneficiaries with Diabetes or Renal Disease.** Actual charges will be paid when these services are obtained with Prior Authorization from GHC-SCW Care Management.

20. **Cochlear Implants,** when recommended by a GHC-SCW contracted Provider and authorized by GHC-SCW Care Management.

21. **Organ Transplants** – Provider's Services for organ transplants that are Medicare-Eligible Expenses.

22. **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. Coverage required for diagnostic procedures and Medically Necessary non-surgical treatment may not exceed $1,250 annually. A physical therapy evaluation is required before an intraoral splint is considered as a treatment option. Services require Prior Authorization. Members must consult their Primary Care Provider prior to beginning treatment for TMJ.

23. **Complementary Medicine**, Complementary Medicine professional services, are provided by a GHC-SCW Complementary Medicine Provider at a GHC-SCW owned and operated facility, and is subject to copayments, with no annual limit.

B. Out-of-Area Services

A GHC-SCW Subscriber is entitled to Out-of-Area Services including emergency or urgent care when traveling within the United States or a foreign country.

Benefits are limited to services for Emergency and Urgent Conditions, or services with Prior Authorization from GHC-SCW. If a Subscriber receives non-authorized Out-of-Area Services, Medicare will still pay its share of approved charges if the services are Medicare-Eligible Expenses.

Payment of actual charges will be made for services to which the Subscriber is entitled under this Subscriber Policy, limited to: (a) Inpatient and Outpatient care for an Emergency Condition; and (b) Inpatient and Outpatient care for an Urgent Condition. Claims should include full particulars of the illness, injury, or condition. They should be submitted as soon as possible to Group Health Cooperative of South Central Wisconsin Claims Department, P.O. Box 44971, Madison, WI 53744-4971.

C. Upon Prior Authorization of GHC-SCW Care Management, any routine patient care that is covered under this Policy is also covered when administered to a Subscriber in a Cancer Clinical Trial.

This coverage is subject to all the terms, conditions, restrictions, exclusions and limitations that apply to this Policy, including the treatment coverage provided under the Plan, or contract of services performed by In-Network Providers and Out-of-Network Providers.

GHC-SCW will not cover non-routine patient care costs for the Cancer Clinical Trial, which includes, but is not limited to:

(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.

GHC-SCW will not cover expenses for preventive Cancer Clinical Trials.

GHC-SCW will not cover items and services provided by the research sponsors free of charge for any individual enrolled in the Cancer Clinical Trial.

ARTICLE V

EXCLUSIONS AND LIMITATIONS

A. Exclusions

1. GHC-SCW will not pay for or provide items or services under this Subscriber Policy which:

   (a) Are for treatment, services and/or supplies that Medicare does not cover, except as specifically provided by this Subscriber Policy.

   (b) Are not reasonable and necessary for: the diagnosis or treatment of an illness; or to improve functioning of a malformed body member; or for maintenance of health of the Subscriber; however no items or services determined to be eligible by Medicare will be denied;

   (c) Require Prior Authorization, and are provided by anyone without Prior Authorization of GHC-SCW Care Management, except for out-of-area Emergency Conditions or Urgent Conditions;

   (d) Are required as a result of: any act of war, declared or undeclared; enemy action; or action of the armed forces of the United States, any state of the United States, or its allies; insurrection; riot; acts of terrorism, or while serving on active duty in the armed forces of any country or state;

   (e) Constitute personal comfort items or services. This includes, but is not limited to, television, telephone, and newspapers, if a charge is made for them;

   (f) Are dental services of any kind; including but not limited to: diagnostic dental x-rays; laboratory tests; dental Prosthetic Appliances; or treatment of periodontal disease. The only dental services provided are Medicare-Eligible Expenses limited to oral surgical procedures specified in Article IV, A.8.

   (g) Are for Custodial Care;

   (h) Are for intermediate nursing home care;

   (i) Excluded from coverage: Reconstructive surgery and/or cosmetic treatment, repair of accidental injury (unless representing a medical/surgical necessity) except as indicated in this policy. This also includes any cosmetic services or surgical procedures performed for psychological reasons. Examples include but are not limited to: blepharoplasty, breast surgeries (except as noted in Article IV, breast reconstruction following mastectomy), 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, skin tags and lipomas;

   (j) Are extra charges for a private room in a Hospital or Skilled Nursing Facility, when a semi-private or shared room is available, unless it is determined to be Medically Necessary and approved by GHC-SCW Care Management;

   (k) Are private-duty nursing services provided outside a Hospital;

   (l) Are incident to an injury or condition covered by any workers' compensation law or occupational disease law of a state or of the United States. This is regardless of whether the Subscriber's right to compensation under such law or laws has been waived, compromised or not yet been asserted;

(m) Are eyeglasses; contact lenses; contact lens prescriptions; or contact lens fittings; or contact lens services; except that eyeglass lenses and/or contact lenses are covered when a Subscriber has had cataract surgery;

(n) Are provided after the Subscriber's condition ceases to require such items or services. The furnishing by GHC-SCW of a portion of such items or services, or payment for them, shall not be construed to require GHC-SCW to continue to furnish or pay for such items or services;

(o) Are provided in any Hospital or other institution operated by or for any agency of the government of the United States or of a State, or by any subdivision of such as agency, and where the Subscriber has no legal obligation to pay for such items or services;

(p) Are for or in connection with: a. Experimental surgery or treatment, such as certain organ transplants; or b. which are Experimental Prosthetic Appliances or Durable Medical Equipment; unless such surgery, treatment, appliance, or equipment is expressly approved in advance by the GHC-SCW Medical Director and is a Medicare-Eligible Expense. Coverage is provided for non-Experimental transplants, such as kidney transplants and related donor expenses as provided for in Articles III and IV;

(q) Are for inpatient mental health care in a psychiatric Hospital beyond 175 days per lifetime or are provided in a facility that is not a Medicare approved psychiatric Hospital;

(r) Are for any outpatient prescription drugs covered by Medicare Part D;

(s) Are for transportation of the Subscriber to or from any location for treatment by an In-Network Provider, other than Medically Necessary ambulance service, as provided for in Article III, D;

(t) Are for special examinations to provide information to any third party, such as an insurance company or prospective or present employer;

(u) Are expenses associated with replacement, repair or maintenance of abused Prosthetic Appliances or Durable Medical Equipment;

(v) Are for the replacement of Prosthetic Appliances and Durable Medical Equipment; however, GHC-SCW may replace an item if, in the Medical Director's judgment: (1) The item is no longer useful and has exceeded its reasonable lifetime under normal use; or (2) The Subscriber's condition has changed enough to make the original inappropriate. Replacement of an insulin infusion pump is limited to one pump per calendar year when deemed Medically Necessary. Replacement of a lost or stolen item will be covered if such item is Medically Necessary;

(w) Are: (1) For equipment which is not primarily medical in nature or is for the Subscriber's comfort and convenience; (2) In the nature of Provider's equipment; (3) For replacement or repair of equipment which is covered by a homeowners or similar policy; or (4) For deluxe equipment except where the deluxe features are necessary for the effective treatment of a patient's condition in order for the patient to operate the equipment him or herself;

(x) Are for non-durable medical supplies. This includes, but is not limited to: support hose or sleeves; corrective shoes; arch supports; adhesive tape; antiseptics; or other first-aid supplies. GHC-SCW will only pay for the following prescribed non-durable medical items: Oxygen, ostomy supplies, catheters, and surgical dressings obtained with Prior Authorization of GHC-SCW Care Management;

(y) Are for care beyond 30 days in a Skilled Nursing Facility not covered by Medicare;

(z) Are for any part of services paid by Medicare, that duplicate Medicare benefits, or are expenses for which the Subscriber is compensated by Medicare;

(aa) Are for the treatment of tongue thrust;

(bb) Complications, consultations, services and procedures related to a non-covered procedure;

(cc) Drug screening for illicit or illegal drugs/substances is excluded, except for Subscribers in active treatment for AODA or for a disease that requires abstinence from a specific drug or if the drug screening is a Medicare-Eligible Expense;

(dd) Corrective shoes or foot orthotics except for Medicare-Eligible Expenses, including diabetic patients or patients with rheumatoid arthritis with a history of foot complications

(ee) Are for Home Health Care services provided by a Subscriber's immediate family or residents in the Subscriber's home.

(ff) Are for Out-of-Area Services, except for Emergency Conditions or Urgent Conditions, or services with Prior Authorization from GHC-SCW. If a Subscriber receives non-authorized services out of the Service Area, Medicare will still pay its share of approved charges if the services are Medicare-Eligible Expenses.

(gg) Surgical Services. Surgical Services not deemed Medically Necessary.

(hh) Complementary Medicine services that are not within the scope of a GHC-SCW's Complementary Medicine provider's professional license, and services not provided at a GHC-SCW owned and operated facility, by a GHC-SCW Provider. The Complementary Medicine Services available do not represent the full spectrum of services that are available to the public. Non-formulary medications and devices will not be covered.

B. Limitations

1. The selection of a Primary Care Provider is limited to Providers employed, contracted or engaged by GHC-SCW to provide primary medical care.

2. A Subscriber may change GHC-SCW delivery systems by notifying GHC-SCW of the desired change in writing. The change will take place the first day of the month following 60 days from the date GHC-SCW receives the change notice. A Subscriber may change Primary Care Providers within a delivery system without notice to GHC-SCW.

3. Specialty medical care is provided by a panel of Providers under contract with GHC-SCW. Prior Authorization for specialty care is limited to this panel of contracted Providers.

4. In the event of any major disaster, epidemic, or war, GHC-SCW will remain obligated for Benefits and services provided under this Subscriber Policy; but only to the extent of the available GHC-SCW facilities and staff. If the disaster, epidemic or war causes a lack of available Providers, which in turn causes a delay or failure to provide services or Benefits; then neither GHC-SCW nor any In-Network Provider nor group of In-Network Providers, will be liable for such delay or failure.

5. GHC-SCW will have no liability for a delay or failure to provide services due to circumstances not reasonably within its control. Neither will any In-Network Provider or group of In-Network Providers be so liable. Such circumstances might include the following: the inability of an In-Network Provider to arrange admission of a Subscriber to a Hospital; complete or partial destruction of facilities; civil insurrection; labor dispute; disability of a significant number of GHC-SCW medical personnel; riot; war; or other similar causes.

6. GHC-SCW will be responsible for payment or reimbursement of claims only if they are presented to GHC-SCW within one year of the date of service.

ARTICLE VI

GENERAL PROVISIONS

A. 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 Subscriber and provided, arranged or paid by GHC-SCW, computed on the basis of usual, customary and reasonable fees charged by health care providers of such services. If any Subscriber 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 Subscriber against the Third Party for such Expenses.

GHC-SCW shall have the right to subrogate against a Third Party or seek reimbursement from a Subscriber for the full amount of usual, customary and reasonable Expenses necessarily incurred by the Subscriber and related to injuries caused by a Third Party, less any percentage of causal negligence reasonably attributable to the Subscriber. In paying Expenses for the Subscriber, 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 Subscriber. Regardless of any such arrangement, when GHC-SCW pays such Expenses it is subrogated to the Subscriber'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 Subscriber of GHC-SCW and/or accepting benefits or the provision of health care services by GHC-SCW, including payment for Expenses, each Subscriber 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 Subscriber.

These Subrogation and Reimbursement rights granted to GHC-SCW shall not apply until such time as the Subscriber has been "made whole". The Subscriber is made whole if a claim results in payment to the Subscriber, 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 Subscriber is made whole when a claim results in payment for less than the total available Third Party proceeds after reducing the Subscriber's total damages to account for any contributory negligence attributable to the Subscriber. GHC-SCW and the Subscriber 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 Subscriber.

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

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

Each Subscriber shall execute such forms as GHC-SCW deems necessary or appropriate, to permit GHC-SCW to enforce these Subrogation and Reimbursement rights. The Subscriber, his/her 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 Subscriber 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 Subscriber 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 Subscriber 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 Subscriber's attorneys' fees or court costs, regardless of whether or not a lawsuit is filed, and regardless in whether or not the Subscriber prevails. GHC-SCW and the Subscriber 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 Subscriber without payment.

By becoming a Subscriber of GHC-SCW and/or accepting medical Benefits from GHC-SCW, the Subscriber 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 Subscriber may receive, and the Subscriber 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 Subscriber shall be held in trust by the Subscriber and/or his/her 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 a necessary, reasonable and customary item of expense 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.

   The difference between the cost of a private Hospital room and the cost of a semi-private Hospital room is not considered an Allowable Expense unless the Subscriber's stay in a private Hospital room is Medically Necessary either in terms of generally accepted medical practice or as specifically defined by the plan.

   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 calendar 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 overinsurance exists and how much each plan will pay or provide.

2. **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 Subscriber Policy.

3. **Where Other Plan Does Have Provision.** Benefits to which a Subscriber is entitled under this Subscriber Policy 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 Subscriber 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 Subscriber other than as a dependent will be determined before the benefits of the plan which cover such Subscriber as a dependent;

(b) For Subscribers who are dependent children of parents who are not legally separated or divorced:

(1) except as provided in subparagraph (b)(2) below, the benefits of the plan which covers such Subscriber 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 Subscriber, as a dependent child of a parent whose date of birth occurs later in a calendar year;

(2) 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;

(3) if the other plan does not have the rules described in subparagraphs (b)(1) and (b)(2) 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 Subscriber Policy;

(4) however, if the other plan does not have the rules described in subparagraphs (b)(1) and (b)(2) 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.

(b) For Subscribers who are dependent children of parents who are legally separated or divorced:

(1) 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;

(2) 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. 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)(1) and (c)(2) 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.

(c) The benefits of the plan covering the Subscriber who is laid-off or a retired employee or enrolled dependent of such Subscriber, shall be determined after the benefits of any other plan covering the person as an active employee, or dependent of such person.

(d) The benefits of a plan covering the Subscriber or enrolled dependent of a Subscriber under continuation shall be determined after the benefits of a plan covering the Subscriber as an active employee or dependent of such person.

(e) 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 Subscriber for the longer period of time shall be determined first.

(f) Benefits under this Subscriber Policy will be reduced when the sum of:

(1) the Benefits that would be payable for the Allowable Expenses under the Subscriber Policy in the absence of this Article VI. B., and

(2) 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 VI. B., whether or not claim is made, exceeds those Allowable Expenses in a Claim Determination Period. In that case, the Benefits under this Subscriber Policy 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 Subscriber Policy are reduced as described above, each Benefit is reduced in proportion. It is then charged against any applicable Benefit limitation under this Subscriber Policy.

4. **No Barrier To Receipt of Services.** None of the above rules as to coordination of benefits will serve as a barrier to the Subscriber first receiving from GHC-SCW Benefits which are covered under this Subscriber Policy.

5. **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.

6. **Right to Recover**. In the event it is determined that Benefits under this Subscriber Policy 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 Payor 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 Wisconsin 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 Subscriber an amount equal to the difference if the Noncomplying Plan reduces its benefits so that the Subscriber receives less in benefits than he or she 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 Subscriber 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 Subscriber claiming Benefits under this Subscriber Policy must furnish to GHC-SCW all information deemed necessary by it to implement the provisions of this Article VI.B. GHC-SCW may require a Subscriber 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 VI.B.6., above.

C. Medicare

Benefits provided under this Subscriber Policy for Subscribers entitled to Medicare payments are not designed to duplicate any benefit to which they are entitled under the Medicare Act. All sums payable for Benefits provided pursuant to this Subscriber Policy shall be payable to and retained by GHC-SCW. Each Subscriber shall complete and submit such consents, releases, assignments and other documents reasonably requested by GHC-SCW in order to obtain or assure Medicare reimbursement.

D. **Workers' Compensation**

This Subscriber Policy 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 Subscriber 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 (Article III, Section A). As a condition of receiving benefits on a contested work or occupational claim, the Subscriber 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 Subscriber 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 Subscriber or the Workers' Compensation carrier; or

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

A Subscriber 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 Subscriber except in reimbursement for payments made by the Subscriber to a Provider or other provider of service for which the Subscriber had express authorization by GHC-SCW, and for which GHC-SCW was liable at the time of payment.

F. **Any Subscriber making claim for cash reimbursement for the cost of Benefits** provided under Articles III and IV shall furnish, as soon as possible, to GHC-SCW affirmative proof of the Benefits received and the charges thereof. Proof 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.

G. **Stipulations of Legal Action**. No action at law or suit in equity shall be commenced to recover under this Subscriber Policy 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 also covered under an employer group policy, the employer group policy is primary and this Medicare Select Subscriber Policy is secondary.

I. **GHC-SCW may adopt reasonable policies, procedures, rules and interpretations to promote the orderly and efficient administration of this Subscriber Policy.** Subscribers agree to abide by the terms and conditions of such policies, procedures, rules and interpretations.

J. **No interest in this Subscriber Policy may be transferred or assigned.**

K. **No person other than a Subscriber Policy is entitled to any Benefit under this Subscriber Policy.** This Subscriber Policy shall not be transferable and shall be forfeited if any Subscriber attempts to transfer it or aids, or attempts to aid, any other person in obtaining any Benefit under it.

L. **Prior Authorization Services.** Benefits for covered services must be coordinated by a Subscriber's Primary Care Provider, except in the case of Emergency Conditions, mental health care, alcohol and drug addiction services, eye examinations and chiropractic services, as described in Articles III and IV. Subscribers must obtain an authorization letter from GHC-SCW before rendering services from a Consulting Provider.

Additional services recommended by Consulting Providers after the rendering of the services authorized by the original authorization are covered only if a new authorization is issued by a Subscriber's Primary Care Provider prior to the rendering of the Consulting Provider's services.

Under certain circumstances, it may be possible to obtain a standing Prior Authorization to a Consulting Provider for services. Standing Prior Authorizations may be obtained for a certain length of time and must be authorized in writing in advance by a Subscriber's Primary Care Provider. Subscribers should contact their Primary Care Provider in order to obtain a standing Prior Authorization.

All covered Benefits for services identified in this Subscriber Policy are subject to all of the terms, conditions, exclusions and limitations of the Subscriber Policy, even if a Prior Authorization is obtained by a Primary Care Provider.

M. **Second opinions** are a covered Benefit when provided by another In-Network Provider. Subscribers should contact GHC-SCW Care Management for a Prior Authorization for a second opinion.

N. **Continuity of Care.** With respect to covered Benefits, coverage shall be provided to a Subscriber for the services of a Provider whose participation with the plan terminates under the following circumstances and for the following lengths of time:

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

2. Subscribers 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 plan year, whichever is shortest; or

3. If maternity care is the course of treatment and the Subscriber 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 woman and infant.

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

O. **In-Network Provider Contract Discounts.** GHC-SCW delivers most care through contracted arrangements with Providers. Co-insurance amounts are typically applied to the GHC-SCW contracted fee. In limited situations, a Provider may calculate co-insurance 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 co-insurance calculations based on these amounts.

P. **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 Subscriber's eligibility or Benefits under his or her health plan. GHC-SCW makes Benefit determinations in accordance with all the terms, conditions, limitations and exclusions of the Subscriber Policy. 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 Subscriber in writing.

Q. **Right to Exchange Information**

Each Subscriber agrees that GHC-SCW may obtain all information (including medical records) with respect to that Subscriber 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 Subscriber agrees to give and authorize others to give GHC-SCW medical information and records relating to the Subscriber. This includes test results and records of care for mental illness/substance abuse. By acceptance of coverage under the policy, each Subscriber shall be deemed to have waived any claim of privilege or confidentiality to such information when released or obtained for these purposes.

R. **Physical Examination**

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

S. **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 Subscriber Policy 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 Subscriber Policy, whether or not the circumstances are the same. The unenforceability or invalidity of any provision or provisions of this Subscriber Policy 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 Subscriber Policy invalid or unenforceable.

T. **Benefit Determination and Subscriber Policy Interpretation.**

GHC-SCW has the discretionary authority to determine eligibility for Benefits and to construe the terms of this Subscriber Policy. Any such determination or construction shall be final and binding for all parties unless arbitrary and capricious.

U. **Notices**

All notices required by this Subscriber Policy must be in writing. They shall be deemed sufficient if sent by U.S. Mail, postage prepaid. Notices to a beneficiary may be sent to the last known address of the beneficiary. Notices to GHC-SCW shall be sent to: GHC-SCW, P.O. Box 44971, Madison, WI 53744-4971. All notices shall be effective at the time of posting, unless otherwise stated.

V. **Periods of Coverage**

Coverage under this Subscriber Policy begins on the Individual Effective Date; there are no limitations, exclusions or waiting periods for coverage of a pre-existing condition.

W. **Entire Agreement**

The entire agreement and contract between GHC-SCW and the Subscriber is made up of: this written Subscriber Policy; and endorsements; any riders; and any amendments. No agent, representative, or employee of GHC-SCW, other than the Executive Director, is authorized to change or waive any of the provisions of this Subscriber Policy.

ARTICLE VII

COMPLAINT RESOLUTION/GRIEVANCE PROCESS

A. Complaint Resolution Process

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

1. Interview the Subscriber 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 Subscriber, including facilitating the processing and resolution of the Complaint.

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

B. Grievance Process

1. Member Appeals Committee

A Subscriber, or authorized representative on behalf of the Subscriber, may file a written expression of dissatisfaction (a Grievance) with the administration, 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 Section B.3.) 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 Subscriber will be notified of the date and time in case the Subscriber would like to present his or her Grievance in person. GHC-SCW will provide the Subscriber 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. **Independent Review**

If the Subscriber does not accept GHC-SCW's Adverse Determination of the Grievance based on Medical Necessity and/or Experimental, Investigational, or Unproven Services issues, the Subscriber, or the authorized representative on behalf of the Subscriber, may request an appeal to an Independent Review Organization (IRO). Denials based on a Benefit exclusion or limitation in this policy is not eligible for consideration by an Independent Review.

GHC-SCW will notify the Subscriber of his or her right to Independent Review and outline the process for filing a request for Independent Review. To request an Independent Review, the Subscriber, or his or her authorized representative, shall provide a written request for an Independent Review, and the name of the IRO selected, to GHC-SCW. The Subscriber may choose an IRO from a list of IROs certified by the Commissioner of Insurance. Subscribers should contact the Office of the Commissioner of Insurance at (800) 236-8517 or visit http://oci.wi.gov or contact GHC-SCW Member Services for a current list of certified IROs.

The written request for Independent Review should be mailed to:

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

The Subscriber must complete GHC-SCW's Internal Grievance process before submitting a request for Independent Review.

A Subscriber may proceed directly to the Independent Review only if:

(a) GHC-SCW and the Subscriber jointly agree to proceed directly to the Independent Review; or
(b) The Subscriber submits a written request to GHC-SCW and the selected IRO asking to bypass GHC-SCW's Internal Grievance process and the IRO determines that the Subscriber's health condition is such that requiring completing of the Grievance process before proceeding to the Independent Review would jeopardize the life or health of the Subscriber or the Subscriber's ability to regain maximum function.

A request for an Independent Review must be made within four months after the Subscriber receives notice of the disposition of his or her Grievance and any corrective action taken on the Grievance.

The decision of the IRO is binding on GHC-SCW and the Subscriber except for the decision of the IRO for rescission of the policy.

3. **Expedited Appeal**
A Subscriber, or the authorized representative on behalf of the Subscriber, 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 Subscriber'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.

4. **Commissioner of Insurance**

A Subscriber may resolve his or her problem by taking the steps outlined in the above Complaint Resolution/Grievance Process. A Subscriber may also contact the OFFICE OF THE COMMISSIONER OF INSURANCE, a state agency which enforces Wisconsin's insurance laws, and file a complaint. A Subscriber 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 VIII

MEMBER RIGHTS AND RESPONSIBILITIES RIGHTS

GHC-SCW members are entitled to the following rights:

1. Receive information about GHC-SCW, its services, its Providers and providers. Further, members have the right to receive information regarding member's rights and responsibilities.
2. Be treated with respect and recognition of your dignity and right to privacy.
3. Participate with Providers in making decisions regarding your health care.
4. A candid discussion of appropriate or medically necessary treatment options for your conditions, regardless of cost or benefit coverage.
5. Voice complaints or appeals about GHC-SCW or the care provided. Members have a right to appeal decisions made by GHC-SCW.
6. Select a personal Provider. Members have the right to change Providers without having to state a reason.
7. Receive a full explanation of any charges that may be billed to you as a result of care.
8. Participate in the governance of the organization. Each member who is at least 18 years old is a voting member of the Cooperative and is encouraged to be an active participant in its operation.
9. Make recommendations regarding the organization members' rights and responsibilities policies.
10. Give informed consent, as required by law, prior to procedures or treatments. To the extent permitted by law, you have the right to refuse the recommended treatment and to be informed of the consequences of that decision.
11. Receive confidential treatment of all communications and records concerning your care, except as otherwise provided by law. Upon submitting proper authorization for the disclosure of information, you have the right, except as otherwise limited by law, to
    a. view those health care records generated by GHC-SCW pertaining to you at any time during regular business hours, upon reasonable notice;
    b. receive a copy of your health care records, upon payment of GHC-SCW's fee and upon reasonable notice; and
    c. receive a copy of GHC-SCW's X-ray reports pertaining to you, or have the X-rays referred to another health care provider upon payment of GHC-SCW's costs and upon reasonable notice.

RESPONSIBILITIES

GHC-SCW members have the following responsibilities:

1. Be considerate of others, observe safety and smoking regulations in all GHC-SCW facilities, treat GHC-SCW personnel with consideration and respect, and supply accurate and complete medical history information.
2. Provide, to the extent possible, information that GHC-SCW and their providers need in order to care for you.
3. Use facilities and equipment appropriately, and fulfill any financial obligation you may incur.
4. Be on time for appointments and inform the clinic when an appointment cannot be kept so someone else may be seen.
5. Read and understand your coverage.
6. Follow GHC-SCW's instructions for care agreed upon with your Providers.
7. Understand your health problems and participate in developing mutually agreed-upon treatment goals to the degree possible.