

MercyCare EPO Certificate of Coverage

This certificate is a description of health insurance benefits provided to MercyCare Exclusive Provider Option (EPO) Subscribers and their Eligible Dependents.

Every effort has been made to ensure that the information in this Certificate is accurate. Benefits described are subject to the terms and conditions of the Master Schedule of Benefits.

For detailed information about the MercyCare EPO Plan contact the EPO's Customer Service Department at the number listed below.

Office:

MercyCare Insurance Company
3430 Palmer Drive
Janesville, WI 53546

Claims Mailing Address:

MercyCare Insurance Company
P.O. Box 2770
Janesville, WI 53547-2770

Toll-Free Customer Service Number:

1-800-895-2421

Print Date: May 2002

**Mercy EPO
CERTIFICATE OF COVERAGE
MercyCare Health Plan
P.O. Box 2770
Janesville, Wisconsin 53547-2770**

PLAN TYPE:

GROUP NUMBER:

EMPLOYER:

EMPLOYEE:

CERTIFICATE NUMBER:

EFFECTIVE DATE:

MercyCare Insurance Company (referred to in this Certificate of Coverage as "MercyCare") has issued and delivered a policy to your Group, a copy of which is available for your review at your Group's office, to provide you with a health care benefit program. The policy is guaranteed renewable except as stated in the policy's termination provisions.

This is your certificate as long as you are eligible for insurance and you become and remain insured. This certificate explains the terms and conditions of your insurance coverage. Read this certificate carefully. If you have questions, contact your Group's Insurance Administrator or MercyCare at the address shown above. This certificate replaces any previous certificates of coverage that you may have been issued. This certificate is incorporated into and forms a part of the policy issued to your Group. However, if the terms of this certificate differ from the terms of the policy, the policy will govern.

Your name, as an employee insured under the policy, and the names of your dependents who are also insured under the policy, are as set forth in the enrollment form which you completed and which is made part of the policy.

The Group Contract, the Certificate of Coverage, the Schedule of Benefits, and any addenda or endorsements thereto, and the applications of the Group, and the employee, constitute the entire policy.

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UNDERSTANDING THIS CERTIFICATE

What you should know about this Certificate:

It is important that you understand all parts of this Certificate in order to get the most out of the coverage that you have.

Some of the terms that are used in this Certificate have specific meanings. These terms and their meanings can be found in the Glossary section of this Certificate.

How this Certificate is Organized:

This Certificate outlines the coverage that you have under the employer group contract that we have with your employer. This Certificate of Coverage is divided into the following sections:

- Introduction
- Obtaining Services
- Emergency and Urgent Care
- Benefit Provisions
- Coverage Information
- General Provisions
- Coordination of Benefits
- Claim Provisions
- Consent to Release Information
- Complaint Procedures
- Glossary

INTERPRETING THIS CERTIFICATE

MercyCare Insurance Company has the authority to interpret this Certificate of Coverage and all questions that arise under it. If any benefit in this Certificate of Coverage is subject to a determination of medical necessity, we will make that factual determination. MercyCare's determinations in the administration of the Plan, including determinations as to whether services or supplies are covered services or are medically necessary, are final and conclusive as long as MercyCare has not abused its discretion in making those determinations.

QUESTIONS?

If after you read this Certificate of Coverage you have questions, please call the Customer Service Department at: **1-800-895-2421** Any quotation of benefits given by a MercyCare representative is not a guarantee of coverage. Benefit coverage is determined based on the terms and conditions of your certificate and schedule of benefits.

EXCLUSIVE PROVIDER OPTION (EPO)

This EPO has been developed to provide members excellent quality of care that is also affordable. The provider network is primarily made up with Mercy Health System physicians. Please check your provider directory to learn of the entire network. The EPO network listed in the provider directory is color-coded. All other providers listed in the directory do not apply to your EPO network.

For the purposes of this document a participating provider is a provider that belongs to the EPO network. A non-participating provider is a provider that does not belong to the EPO network and authorization must be obtained from MercyCare for coverage of care.

PROVIDER SELECTION

At the time you enrolled in the MercyCare plan, you selected a primary care physician for you and, if you have dependent coverage, your covered dependents. You can change your primary care physician as follows:

- During the open enrollment period or dual choice enrollment period held by your group for the plan; or
- At any other time during the contract year as long as you give MercyCare written notice on a designated MercyCare Change of Status Form. This form must be submitted on or before the 20th day of a month, in order for the change to be effective on the first day of the following month.

The change will be made as long as the new provider you have selected is accepting additional patients. MercyCare reserves the right to modify the list of participating providers at any time.

For newborns, a participating primary care physician should be chosen before delivery so that the chosen provider can be notified upon delivery.

REFERRALS

If you are under the care of a participating provider and specialty services or treatment needed is not available by a participating provider, you must obtain a referral from your treating participating physician and you must obtain authorization from the Plan prior to receiving the service or treatment in order to receive benefits. **To ensure coverage, it is your responsibility to verify with MercyCare that authorization has been given prior to you receiving the service or treatment from a non-participating provider.**

The referring provider and the Medical Department will determine the duration of the referral or the number of visits it authorizes based on what is medically appropriate. A verbal request for a referral will not guarantee that the referral is authorized and approved by MercyCare. If a referral is not approved by the Medical Department, it is not considered valid, and the services are not considered authorized. **It is your responsibility to make sure your doctor submits a referral to the Plan prior to seeking treatment.**

For maternity care, you should notify MercyCare by the sixth month of pregnancy, but no later than 1 month prior to the anticipated delivery date. For emergency care, you should notify MercyCare within 48-hours of emergency admission.

You can visit any participating provider without a referral.

CONTINUITY OF CARE

If, during your last open enrollment period, MercyCare made materials available to you indicating that your primary care physician was or would be a participating provider, that primary care physician will be treated as a participating provider for you during your entire plan year, even if the provider terminates as a participating provider.

If you are undergoing a course of treatment with a provider who terminates as a participating provider, that provider will continue to be treated as a participating provider for you until the earliest of (a) the end of the course of treatment, (b) 90 days from the provider's termination, or (c) the end of your plan year (if the course of treatment involves your pregnancy, and you are in the second or third trimester at the time the provider terminates, the provider will continue to be treated as a participating provider for you through post-partum care). This paragraph does not apply to a provider who is no longer practicing in the service area or who was terminated from the plan for professional misconduct.

COPAYMENTS, COINSURANCE AND DEDUCTIBLES

All covered services are subject to any copayment, coinsurance, and/or deductible limits shown in your Schedule of Benefits.

The single deductible applies to each member each contract year, and the family deductible amount is the most that the employee and his or her dependents must pay each contract year.

OBTAINING SERVICES

You will not receive deductible credit for any amounts paid for services that are not covered by the Plan, including:

- Amounts paid to providers other than participating providers, except when you have an approved referral.
- Any copayments you pay.
- Amounts paid for certain services as marked in your Schedule of Benefits.

Coinsurance payments begin once you meet any applicable deductible amounts. Copayments are not applicable toward the out-of-pocket maximum and will apply even after the out-of-pocket maximum is met.

OUT-OF-POCKET MAXIMUM

The out-of-pocket maximum is the limit, if any, on the amount you will pay for covered services in a contract year. The amount of the out-of-pocket maximum is shown in the Schedule of Benefits. The “single” out-of-pocket maximum applies to each member each contract year and the “family” out-of-pocket maximum is the most that the employee and his or her dependents will pay out-of-pocket each contract year.

You will pay more than the out-of-pocket maximum amount in a contract year if you:

- Receive services that are not covered services;
- Receive services from non-participating providers that are not authorized by the Plan; or
- Receive services that are subject to limitations, and those limits have been exceeded; or
- Receive services that are subject to copayments.

In these circumstances, you may be responsible for charges even if you have met your out-of-pocket maximum for the contract year.

LIFETIME BENEFITS MAXIMUM

In a member’s lifetime, total benefits under this policy and any other MercyCare coverage may be limited by dollar amount. This dollar amount, if any, is shown in your Schedule of Benefits.

STUDENTS OBTAINING SERVICES

Medical/Surgical Benefits:

Eligible dependent children under the age specified in your Schedule of Benefits who are full-time students at an accredited secondary school, vocational, technical, adult education school; or accredited college or university are covered just as other members of the Plan.

All routine, preventive, and follow-up care must be provided by a participating provider. Urgent or emergent care is covered under the Emergency and Urgent Care section of this certificate.

Psychological Disorder and Chemical Dependency Benefits:

Full-time students attending a school other than a secondary school outside the service area, but within the State of Wisconsin, will have coverage for limited outpatient services received from non-participating providers for psychological disorders and/or chemical dependency. This coverage includes a clinical assessment by a non-participating provider. If outpatient services are recommended, coverage will be provided for 5 visits to a non-participating provider. All non-participating outpatient treatment should be provided by facilities or providers located within the State of Wisconsin and in reasonable proximity to the school the student is enrolled.

If the Plan’s psychiatric designee determines that treatment will prevent a student from attending school on a regular basis or the student is no longer enrolled in school, non-participating services will not be covered.

After completing 5 visits, continuing care by the non-participating provider must be approved by the Plan’s psychiatric designee.

The total outpatient benefit for psychological disorders and chemical dependency services is limited according to your Schedule of Benefits.

If you have any questions about full-time students obtaining services, please contact the Customer Service Department at

1-800-895-2421

EMERGENCY AND URGENT CARE

Please refer to your Schedule of Benefits for copayment information on Emergency Care and Urgent Care services.

EMERGENCY CARE

Emergency means a medical condition that manifests itself by acute symptoms of sufficient severity, including severe pain, to lead a prudent layperson with an average knowledge of health and medicine reasonably to conclude that, without immediate medical attention, death or serious injury to your body will likely result.

Examples of emergency care situations are heart attacks, strokes, loss of consciousness, significant blood loss, suffocation, attempted suicide, convulsions, epileptic seizures, acute allergic reactions, acute asthmatic attacks, acute hemorrhages, acute appendicitis, coma, drug overdose, and any condition for which you are admitted to the hospital as an inpatient from the emergency room.

These and other acute conditions are emergencies when these four elements exist:

1. They require immediate medical care for bodily injury or sickness.
2. Symptoms are unexpected and severe enough to cause a person to seek medical help right away.
3. Immediate care is secured.
4. Diagnosis or the symptoms themselves show that immediate care was required.

Call Customer Service at 1-800-895-2421 for all emergency or out-of-state inpatient admissions as soon as possible or within 48 hours.

If you require emergency care, you should seek care from the nearest physician, hospital or clinic. You must contact the Plan within 48 hours of the emergency or as soon as reasonably possible in order to arrange follow-up care. Failure to notify MercyCare may result in denial of payment.

The Plan has the right to transfer you (at no expense to you) to the facility of the Plans choice upon receiving confirmation from your attending physician that you are able to travel.

Follow-up care is only covered when it is received from a participating provider.

URGENT CARE

Urgent care is care for a bodily injury or illness that you need sooner than a routine doctor's visit. Examples of urgent care situations are broken bones, sprains, non-severe bleeding, minor cuts and burns, and drug reactions.

In the Service Area:

Urgent care must be received from a participating provider or at a participating urgent care center.

Outside the Service Area:

If you require urgent care and you are outside the service area and cannot return home without medical harm, you should seek care by the nearest physician, hospital or clinic.

Follow-up care is only covered when it is received from a participating provider.

Members are entitled to these benefit provisions subject to the terms, conditions and exclusions of the policy and this Certificate. MercyCare's determinations in the administration of the Plan, including determinations as to whether services or supplies are covered services or are medically necessary, are final and conclusive as long as MercyCare has not abused its discretion in making those determinations. Covered services and supplies will be covered only if medically necessary. Covered services and supplies performed by a non-participating provider are allowable only when prior authorized by MercyCare. Coverage is subject to any copayment, coinsurance, deductible and/or other limits shown in the Schedule of Benefits.

AMBULANCE SERVICES

Covered Services:

- Professional ground or air ambulance service is covered in an emergency as described in the Emergency and Urgent Care section of this Certificate.
- Ambulance transportation is also covered from a hospital to the nearest hospital equipped to provide treatment that was not available at the original facility.

Non-Covered Services:

- Ambulance service that is used in situations that are not considered life threatening, as described in the Emergency and Urgent Care section of this Certificate.

BIOFEEDBACK

Covered Services:

- Biofeedback is covered only for treatment of headaches, spastic torticollis, and urinary incontinence.
- Benefit limitations will be determined based on the provider of services.
- Biofeedback services must have prior authorization from the Plan.

CARDIAC REHABILITATION

Covered Services:

- Cardiac Rehabilitation is covered when obtained through a participating provider, when medically necessary, and with prior authorization by the Plan.
- Phase II Cardiac Rehabilitation is subject to prior authorization by the Plan and must be provided in an outpatient department of a hospital, in a medical center or clinic program. This benefit applies only to members with a recent history of:
 - a) a heart attack;
 - b) coronary bypass surgery;

- c) onset of angina pectoris;
- d) heart valve surgery;
- e) onset of decubital angina;
- f) percutaneous transitional angioplasty, or
- g) cardiac transplant.

- Benefits are payable only for members who begin an exercise program immediately, or as soon as medically indicated, following a hospital confinement for one of the conditions above.

Non-Covered Services:

- Maintenance or long term therapy.
- Behavioral or vocational counseling.
- Phase III Cardiac Rehabilitation.

CHIROPRACTIC SERVICES

Covered Services:

- Services must be medically necessary.

Non-Covered Services:

- Maintenance or long term therapy as determined by MercyCare after reviewing an individual's case history or treatment plan submitted by a provider.

COSMETIC and RECONSTRUCTIVE SURGERY

Covered Services:

- Coverage for the treatment of breast cancer includes:
 - a) Reconstruction of the breast on which a mastectomy was performed.
 - b) Surgery and reconstruction of the other breast to produce a symmetrical appearance.
 - c) Prosthesis and physical complications of all stages of mastectomy, including lymphedema.
- Reconstructive surgery which is medically necessary and which is either:
 - a) Incidental to or following surgery necessitated by bodily injury or sickness, or
 - b) Caused by congenital disease or abnormality of a dependent child which results in a functional defect.

Non-Covered Services:

- Procedures, services, counseling and supplies related to sex transformation surgery and sex hormones related to such treatments.
- Plastic or cosmetic surgery which is undertaken solely to improve the member's appearance and which is not medically necessary for the correction of a functional defect caused by a bodily injury or sickness. Psychological reasons do not represent a medical/surgical necessity.

DENTAL SURGERY

Covered Services:

- Oral surgery with prior authorization from the plan for gum or bone tumors and cysts.
- Surgical removal of impacted wisdom teeth (third molars).
- Treatment with prior authorization from the Plan for bodily injury to permanent, sound and natural teeth and bone, but only if:
 - a) the bodily injury occurs while you are a member covered by the Plan; and
 - b) the bodily injury is not caused by chewing or biting; and
 - c) the treatment begins within 90 days of the bodily injury with a maximum of 180 days from the date of injury to complete treatment.
- With required prior authorization, inpatient hospital and free-standing surgical facility services, and anesthetics provided in conjunction with dental care if the member:
 - a) Is under age 5; or
 - b) Has a chronic disability that arises from a mental or physical impairment or combination of mental or physical impairments; and is likely to continue indefinitely; and results in substantial functional limitations in one or more of the following areas of a major life activity: self-care, receptive and expressive language, learning, mobility, capacity of independent living, or economic self-sufficiency; or
 - c) Has a medical condition that requires hospital confinement or general anesthesia for dental care.

Non-Covered Services:

- Oral surgery performed solely for the fitting of dentures or the restoration or corrections of teeth.
- All services performed by a dentist or orthodontist, except those specifically listed in this certificate. These exclusions include, but are not limited to:
 - a) Dental implants.
 - b) Shortening of the mandible or maxillae.
 - c) Correction of malocclusion.
 - d) Treatment for any jaw joint problems, other than temporomandibular disorders, including craniomaxillary, craniomandibular disorder, or
 - e) Other conditions of the joint linking the jaw bone and skull.
 - f) Hospital costs for any of these services except as specifically described in the certificate.
- Oral surgery except as specifically described in this certificate.
- All periodontic procedures.

DIABETES SERVICES

All equipment and supplies must be purchased from a participating durable medical supplier and/or a participating pharmacy.

Covered Services:

- Self-management education programs and diabetic equipment and supplies.
- Diabetic equipment if considered medically necessary by the Plan.
- Insulin pumps are covered if prior authorized and meet the medical criteria established by the Plan.
- Diabetic supplies.
- Insulin.

DURABLE MEDICAL EQUIPMENT

Durable medical equipment is defined as:

- a) Able to withstand repeated use, and
- b) Primarily and customarily used to serve a medical purpose, and
- c) Not generally useful except for the treatment of a bodily injury or sickness, and
- d) Is appropriate for use in the home.

Covered Services:

- Durable medical equipment (DME) is covered only when:
 - a) Prior authorized by the plan, and
 - b) Determined to be medically necessary, and
 - c) Purchased at a participating provider or other provider authorized by the Plan, and
 - d) Ordered or prescribed by a participating provider, or a non-participating provider with an active referral authorized by the Plan.
- Orthotics are covered for acute conditions only.
- Foot Orthotics are covered only when all the preceding conditions are met and the following conditions are met:
 - a) Are a prescription orthotic, and
 - b) The member has a documented diagnosis of diabetes with neuropathy or peripheral vascular disease.
- Orthopedic shoes that are an integral part of a brace.

Non-Covered Services:

- Durable medical equipment required for athletic performance and/or participation.
- Garments and/or other equipment and supplies that are not medically necessary to treat a covered bodily injury or sickness.

BENEFIT PROVISIONS

- Repairs and replacement of durable medical equipment without prior authorization from the Plan.
- Durable medical equipment for comfort, personal hygiene, and convenience items including but not limited to: air conditioners, air cleaners, humidifiers, physical fitness equipment, physician equipment, alternative communication devices, and self-help devices not medical in nature.
- Home testing and monitoring equipment except those used in connection with the treatment of diabetes, infant apnea, or premature labor.
- Equipment, models, or devices which have features over and above those which are medically necessary for the member. Coverage is limited to the standard model as determined by the Plan.
- Oxygen therapy and other inhalation therapy and related items for home use except as authorized by the Plan.
- Motorized vehicles, other than a motorized wheel chair when medically necessary.

**In order to verify whether a specific DME item is covered, please contact the Customer Service Department at:
1-800-895-2421**

EMERGENCY CARE

Please refer to the Emergency and Urgent Care section of this Certificate.

FAMILY PLANNING

Covered Services

- Covered services include consultation, tubal ligation, diaphragms, intrauterine devices (IUD), Depo provera shots, and vasectomy.
- Implanted birth control devices are covered once every 5 years.

Non-Covered Services:

- Revision of scarring caused by implanted birth control devices.
- Elective abortions.

HEARING EXAMS AND HEARING AIDS

Covered Services:

- Hearing aids and hearing exams are covered when obtained through a participating provider.
- The reconditioning and repair of existing aids is covered when considered medically necessary.

- New hearing aids are covered once per ear in a 36-month period.
- Benefit is subject to the limitations specified in your schedule of benefits.

Non-Covered Services:

- Hearing aids if more than one per ear in any 36-month period.
- Cochlear implants.

HOME HEALTH CARE

Covered Services:

- Home health care benefits are covered up to 40 visits per contract year with prior authorization, when the attending physician certifies that:
 - a) Confinement in a hospital or skilled nursing facility would be necessary if home care were not provided.
 - b) Necessary care and treatment is not available from the member's immediate family, or others living with the member without undue hardship.
 - c) The home health care services are provided and coordinated by a state licensed or Medicare certified home health agency or certified rehabilitation agency.
- It is necessary that the attending physician establish a home health care plan, approve it in writing and review this plan at least every 2 months, unless the attending physician determines that less frequent reviews are sufficient.
- Home health care means one or more of the following:
 - a) Home nursing care that is provided from time to time or on a part-time basis. It must be provided or supervised by a registered nurse;
 - b) Home health aide services which are medically necessary as part of the home care plan, must consist solely of caring for the patient. A registered nurse or medical social worker must supervise the care.
 - c) Physical, respiratory, occupational and speech therapy;
 - d) Medical supplies, drugs and medicines prescribed by a physician, and lab services by or for a hospital. These services are covered to the same extent such items would be covered under the policy if you were confined to a hospital;
 - e) Nutritional counseling under the supervision of a registered or certified dietitian if considered medically necessary as part of the home care plan;

BENEFIT PROVISIONS

- f) The evaluation of the need for home care when approved or requested by the attending physician.
- If you were hospitalized immediately before the home health care services began, the physician who was the primary provider of care during the hospital confinement must approve an initial home care plan.
- Each visit by a qualified person providing services under a home care plan or evaluating the need for or developing a plan is considered one home care visit.
- Up to 4 consecutive hours in a 24 hour period of home health service are considered one home care visit. The maximum weekly benefit for such coverage may not exceed the usual and customary weekly cost for care in a skilled nursing facility.

Non-Covered Services:

- Custodial care.

HOSPICE CARE

Covered Services:

- Hospice care services are covered with prior authorization and approval from the Plan if a member's life expectancy is six months or less.
- The care is available on an intermittent basis with on-call services available on a 24-hour basis. It includes services provided in order to ease pain and make the member as comfortable as possible.
- Hospice care must be provided through a licensed hospice care provider approved by the Plan.

Non-Covered Services:

- Hospice care provided outside the member's home.

HOSPITAL SERVICES

Covered Services:

- Inpatient and outpatient hospital services are covered when rendered by a hospital or freestanding surgical facility.
- Inpatient hospital services require prior authorization and include the following:
 - a) Inpatient hospital confinement days are covered with prior authorization as medically necessary.
 - b) Daily room and board in a semi-private, ward, intensive care or coronary care room, including general nursing care if medically necessary. A private room will be covered if approved by the Plan.
 - c) Hospital services and supplies determined to be medically necessary furnished for your treatment during confinement, including drugs administered to you as an inpatient.

- Outpatient hospital services include services and supplies, including drugs, when incurred for the following:

- a) Emergency room treatment provided in accordance with the Emergency Care section of this Certificate.
- b) Surgical day care.
- c) Regularly scheduled treatment such as chemotherapy, inhalation therapy, and radiation therapy.
- d) Diagnostic testing which includes laboratory, x-ray, and other diagnostic testing.

Non-Covered Services:

- Inpatient hospital services for days that are NOT certified by the Plan as being medically necessary by a participating or non-participating provider with whom you have an active referral authorized by the Plan.
- Continued hospital stay(s), if the participating provider has documented that care could effectively be provided in a less acute care setting.
- Take-home drugs dispensed prior to your release from confinement, whether billed directly or separately by the hospital.
- Inpatient and outpatient hospital services for non-covered treatment.
- Durable medical equipment is not covered under the Hospital services benefit. Please see the Durable Medical Equipment and Disposable Medical Supplies benefit in this section.

KIDNEY DISEASE TREATMENT

Covered Services:

Kidney disease treatment is limited to all inpatient and outpatient services provided. This benefit is limited to all services and supplies directly related to kidney disease, including but not limited to, dialysis, transplantation, donor-related services, and related physician charges. These services are limited to \$30,000 in benefits each contract year.

MEDICAL SUPPLIES

A medical supply is a disposable, consumable, expendable, or non-durable, medically necessary item which usually has a one time or limited time use and is discarded.

Covered Services:

- Disposable medical supplies are covered when: prior authorized by the Plan, determined to be medically necessary, and ordered or prescribed by a provider.
- Compression stockings are limited by compression weight (greater than 30 mmhg) and to two pair per contract year.

Non-Covered Services:

- Garments, and other supplies, that are not medically necessary to treat a covered bodily injury, or sickness.
- Garments and other supplies for a non-covered bodily injury or sickness.
- Replacement of supplies without prior authorization from the Plan.
- Medical supplies for comfort or personal hygiene and convenience items, such as, but not limited to: diapers, disposable bed pads, home exercise supplies, and self help devices not medical in nature.
- Any food, liquid or nutritional supplement.
- Home testing and monitoring supplies except those used in connection with the treatment of diabetes, infant apnea, or premature labor.
- Oxygen therapy and other inhalation therapy and related items except for those authorized by the Plan.

**In order to verify whether a specific Medical Supply is covered, please contact the Customer Service Department at:
1-800-895-2421**

NEWBORN BENEFITS

Covered Services:

- Nursery room, board, and care.
- Routine or preventative exam and other routine or preventative professional services when received by the newborn child before release from the hospital.
- Circumcisions when rendered prior to discharge from the hospital.
- Plastic surgery, in order to reconstruct or restore function to a body part with a functional defect present at birth.

- Well-Child Care rendered after release from the hospital.
- A primary care physician should be chosen for the newborn before delivery so that the chosen physician can be notified upon delivery.

PHYSICAL THERAPY, SPEECH THERAPY, AND/OR OCCUPATIONAL THERAPY

Covered Services:

- Outpatient physical therapy, speech therapy, and/or occupational therapy are covered services as shown in the Schedule of Benefits.
- Services must be medically necessary due to bodily injury or sickness. The care must be for restoration of a function or ability that was present and has been lost due to bodily injury or sickness. Therapy must be necessitated by a medical condition and not be primarily educational in nature.
- Provider must be a registered physical, occupational, or speech therapist and must not live in the patients home or be a family member.

Non-Covered Services:

- Any form of therapy or treatment for learning or developmental disabilities, including:
 - a) Hearing and speech therapy for a learning disability and communication delay.
 - b) Therapy for perceptual disorders, mental retardation and related conditions.
 - c) Evaluation and therapy for behavior disorders and learning disabilities.
 - d) Special evaluation and treatment of multiple handicaps, hyperactivity, or sensory deficit and motor dysfunction.
 - e) Developmental and neuro-educational testing or treatment.
 - f) Other special therapy except as specifically listed in this Certificate.
- Vocational testing and counseling, including evaluation and treatment and work hardening programs.
- Speech and hearing screening examinations are limited to the routine or preventive screening tests performed for determining the need for correction.
- Services rendered by a masseuse.
- Maintenance or long term therapy as determined by the Plan after reviewing an individual's case history and treatment plan submitted by a provider.
- Biofeedback, except that provided by a physical therapist for treatment of headaches, spastic torticollis and urinary incontinence.

PHYSICIAN SERVICES

Covered Services:

- Physician services include in office services, routine or preventive physicals, inpatient/outpatient visits, and home visits.

Non-Covered Services:

- Any services and/or supplies given primarily at the request of, for the protection of, or to meet the requirements of a party other than the member when such services and/or supplies are state-mandated.

Excluded services and supplies include physical exams, disease immunizations, services and supplies for employment, licensing, marriage, adoption, insurance, camp, school, sports, and travel.

PODIATRY SERVICES

Covered Services:

- Routine or preventive exams when medically necessary.

Non-Covered Services:

- Services rendered a) in the examination, treatment or removal of all or part of corns, calluses, hypertrophy or hyperplasia of the skin or subcutaneous tissues of the feet; b) in the cutting, trimming or other nonoperative partial removal of toenails; c) treatment of flexible flat feet; d) in connection with any of these except when prescribed by a participating provider who is treating a member for a metabolic or peripheral disease.

PREGNANCY BENEFITS

Covered Services:

- Treatment of pregnancy is covered for an employee, an employee's covered dependent spouse, or an employee's covered dependent child.
- Pregnancy benefits include coverage for inpatient hospital care and pre- and post-natal care received from a participating provider.
- Please refer to the Continuity of Care section of this Certificate.

Non-Covered Services:

- Surrogate mother services.
- Elective abortions.
- Maternity services received out of the service area in the last 30 days of pregnancy without prior authorization from the Plan except in an emergency. Prior authorization is based on medical necessity.
- Amniocentesis or chorionic villi sampling (CVS) solely for sex determination.

PRESCRIPTION DRUGS

Please see your Prescription Drug Rider if applicable.

PROSTHESIS

Covered Services:

- Replacement of natural or artificial limbs and eyes no longer functional due to physiological change or malfunction beyond repair, if medically necessary.
- Prosthetic devices must be approved in advance by the Plan.

Non-Covered Services:

- Equipment, models, or devices which have features over and above those which are medically necessary for the member. Coverage is limited to the standard model as determined by the Plan.

PSYCHOLOGICAL DISORDER AND CHEMICAL DEPENDENCY

Covered services include the following treatment for psychological disorder and chemical dependency:

Covered Services:

- Outpatient Treatment – Treatment received while not confined to a hospital or qualified treatment facility or participating in transitional treatment is covered up to the benefit maximums specified in the Schedule of Benefits.
- Transitional Treatment- Treatment received in an outpatient setting that is more intensive than traditional outpatient care but less restrictive than traditional inpatient care is covered up to the benefit maximum specified in the Schedule of Benefits.

Transitional treatment is limited to intensive outpatient programs certified by the American Society of Addictive Medicine for the treatment of psychoactive substance abuse disorders; and the following programs certified by the Department of Health and Family Services: mental health services and treatment for alcoholism and other drug problems in day treatment programs; services for chronic mental illness in community support programs; services for alcohol or drug dependent members in certified residential treatment programs.

- Inpatient Treatment – Treatment received while confined as a registered bed patient in a hospital or qualified treatment facility is covered up to the benefit maximum specified in the Schedule of Benefits.
- Prescription Drugs used for the treatment of mental health, alcohol and drug abuse are covered regardless of whether this certificate includes the Prescription Drug Rider, but will be subject to any

such rider if one exists. The charges for such drugs will not be applied to the maximum benefit available for any mental health, alcohol or drug abuse services.

Coverage Provisions:

- Outpatient, inpatient and transitional treatment of psychological disorders and/or chemical dependency each have specific benefit limits stated in the Schedule of Benefits.
- The services must be considered medically necessary.
- Court ordered mental health services are covered, subject to the benefit maximums described above, if provided by a participating provider, or a provider to whom the Plan has issued a referral.
- Services rendered pursuant to an emergency detention situation are covered, subject to the benefit maximums described in the Schedule of Benefits, when rendered by any provider as long as the Plan has been notified within 72 hours so that continuing care may be arranged. Emergency detention services by a participating or non-participating provider are not covered after the Plan has arranged for services by a participating provider.
- Family therapy is covered only if the diagnosed member is present at the family therapy session.

Non-Covered Services:

- Maintenance or long term therapy.
- Biofeedback, except that provided by a physical therapist for treatment of headaches and spastic torticollis and urinary incontinence.
- Hypnotherapy, marriage counseling, or residential care except for the treatment of alcohol or drug dependency.
- In-home treatment services.
- Halfway houses.
- Covered services under this provision do not include treatment of nicotine habit or addiction, or the treatment of being overweight or obese.
- Methadone maintenance therapy.
- Respite Care.

REPRODUCTIVE SERVICES

Covered Services:

- Diagnostic testing and treatment for fertility/infertility is subject to the limitations specified in the member's Schedule of Benefits. All services provided after the maximum amount payable has been reached are the member's responsibility.
- Artificial insemination benefits are limited to the physician's charge for the procedure.

Non-Covered Services:

- Any other artificial means to achieve pregnancy, consultations for, or any procedures in connection with, but not limited to in vitro fertilization, gamete intra fallopian transfer (GIFT), embryo transplant, or any other assistive reproductive technique.
- Reversal of voluntarily induced sterilization procedures.
- Donor sperm.
- Charges for donor, laboratory or biological fees directly related to the insemination procedure.
- Surrogate mother services.

SKILLED NURSING FACILITY

Covered Services:

- Charges for daily room and board and general nursing services provided during a skilled nursing facility confinement are covered if you entered the facility within 24 hours after discharge from a covered hospital confinement for continued treatment of the same condition. Confinement in a swing bed in a hospital is considered the same as a skilled nursing facility.
- Coverage is provided for physical therapy; occupational therapy; speech therapy; and durable medical equipment if medically necessary and provided by a participating provider.
- Your primary care physician must certify that your skilled nursing facility confinement is medically necessary for care or treatment of the bodily injury or sickness that caused the hospital confinement.
- Skilled nursing facility services require a prior authorization from the Plan and the Plan must consider the services to be at a skilled level of care and medically necessary.

Non-Covered Services:

- Custodial care.
- Skilled nursing facility days in excess of the number specified in the Schedule of Benefits per confinement.

STAY HEALTHY PROGRAM

Covered Services:

- Health education or physical fitness programs are covered (up to the maximum specified in the

Schedule of Benefits) for an employee and his or her covered dependents age 18 and over.

Examples of covered classes include adult physical fitness, wellness, and lifestyle programs such as smoking cessation, Lamaze classes or weight loss. This benefit can also apply to a health club membership. Proof of fee payment must be submitted to the Plan with the appropriate forms, available from the Customer Service Department.

**In order to determine if a specific program or course is a covered service, please contact the Customer Service Department at:
1-800-895-2421**

Non-Covered Services:

- Entrance fees for competitive sports.
- Purchases of home exercise equipment or supplies.
- Any food, liquid, and/or nutritional supplements and any weight loss program that incorporates these items.

TEMPOROMANDIBULAR DISORDERS

Covered Services:

- Diagnostic procedures and medically necessary surgical and non-surgical treatment for the correction of temporomandibular disorders (TMD) are covered if all of the following apply:
 - a) The condition is caused by congenital, developmental or acquired deformity, sickness or bodily injury.
 - b) Under the accepted standards of the profession of the health care provider rendering the service, the procedure or device is reasonable and appropriate for the diagnosis or treatment of this condition.
 - c) The purpose of the procedure or device is to control or eliminate infection, pain, disease or dysfunction.
- This includes coverage for prescribed intraoral splint therapy devices.

Non-Covered Services:

- Cosmetic or elective orthodontic care, periodontic care or general dental care.

TRANSPLANTS

Covered Services:

Coverage is limited to those procedures that are considered by the Plan to be non-experimental, medically necessary, and effective. The Plan requires that all transplant-related services, including evaluation, be authorized prior to the member's receipt of any such services. Services must be performed at a facility approved by the Plan. Organ transplant benefits are subject to the lifetime limit per member stated in the schedule of benefits.

Except for kidney transplants, there is no coverage for transplants for the first 12 months after the member's enrollment date if the need for a transplant arises from a preexisting condition. A preexisting condition is one for which medical advice, diagnosis, care or treatment was recommended or received within 6 months prior to the member's enrollment date. This paragraph does not apply to a dependent child who is enrolled within 60 days of birth, adoption, or placement for adoption as described in the Enrollment and Effective Date provision of the Coverage Information section of the certificate. Also, the 12-month exclusion is reduced by the member's period of creditable coverage that ended less than 63 days before the member's enrollment date. Creditable coverage means a group health plan; health insurance; Medicare, Medicaid; a medical care program of the armed forces of the United States, the federal Indian health service, or an American Indian tribal organization; a state health benefits risk pool; a health insurance program for federal government employees and their dependents; a public health plan as defined by the federal department of health and human services; and the health coverage plan for Peace Corps volunteers. Creditable coverage does not include the limited or special purpose coverage excluded by law, such as accident-only, disability income, workers compensation, auto medical payment, credit-only, dental or vision benefits offered separately, specified illness, hospital or other fixed indemnity, and Medicare supplement. A member's enrollment date is the member's effective date of coverage under this certificate, if earlier, or the first day of the waiting period for such effective date.

Kidney: See "Treatment of Kidney Disease" in this section of your Certificate.

Benefits related to the procurement of transplant organs, including surgical removal procedures, storage, and transportation of the procured organ, will be available in the amount not to exceed the amount per organ stated in the Schedule of Benefits.

Procurement costs will be applied towards the lifetime limit on organ transplant benefits.

BENEFIT PROVISIONS

Non-Covered Services:

- Procedures involving non-human and artificial organs.
- Lodging expenses.
- Transportation expenses except for medically necessary ambulance services.
- Any prescription drug copayment.
- Transplant services from providers and/or facilities not approved by the Plan.
- Transplants and all related expenses that have not been prior authorized by MercyCare.
- Organ transplant expenses of donor if the recipient is not an eligible Plan member (except for kidney transplants).
- Retransplantation. (except for kidney transplants).
- Purchase price of bone marrow, organ, or tissue that is sold rather than donated.
- All separately billed donor-related services (except for kidney transplants).

URGENT CARE

- Please refer to the Emergency and Urgent Care section

VISION CARE

Covered Services:

- Medical eye examinations provided as part of the treatment for pathological conditions.
- Routine or preventive eye exams are covered.
- Initial eyeglasses or contact lenses are covered after cataract surgery.

Non-Covered Services:

- Eyeglass frames, lenses, or contact lenses except for initial eyeglasses or contact lenses after cataract surgery.
- Tints, polishing or other lens treatments done for cosmetic purposes only.
- Vision therapy, or orthoptics treatment.
- Keratorefractive eye surgery, including tangential or radial keratotomy.

X-RAY, LABORATORY AND DIAGNOSTIC TESTING

Covered Services:

- Inpatient and outpatient diagnostic x-ray, laboratory and diagnostic tests are covered services.
- The Plan covers mammograms for members as follows:
 - a) Age 35-39: 1 baseline mammogram;
 - b) Age 40 and over, annually.

- The Plan covers any mammography examinations for members of any age if such exams are deemed medically appropriate.
- Blood lead tests for members under age 6 conducted in accordance with rules of the Wisconsin Department of Health and Family Services are covered services.

OTHER MEDICAL SERVICES

Covered Services:

- The administration of blood and blood products including blood extracts or derivatives and autologous donations (self to self).
- Cancer therapy.
- Registered dietitian services at a hospital or participating provider's office.
- Allergy injections and disease immunizations.
- Infusion therapy.
- A second opinion from a participating provider regarding covered services.

GENERAL EXCLUSIONS AND LIMITATIONS

- Treatment for a bodily injury or sickness arising from or sustained in the course of any occupation or employment for compensation, profit or gain if:
 - a) Benefits are provided or payable, or would have been provided or payable if you had applied for coverage, under any Worker's Compensation or Occupational Disease Act or Law; or
 - b) You fail to obtain coverage or file a claim for benefits for which you are eligible under any Worker's Compensation or any Occupational Disease Act or Law.

This exclusion does not apply to an employee who is not required to have coverage under a Worker's Compensation or Occupational Disease Act or Law, AND who discloses the lack of such coverage on the group application.

- Any loss caused or contributed by:
 - a) War or any act of war declared or not; or
 - b) Any act of international armed conflict or any conflict involving armed forces of any international authority.
- Services and supplies that are, in the Plan's judgment, experimental or investigative. These services include any that are not recognized as conforming to commonly accepted medical practice within the service area or any for which the required approval of a government agency has not been granted at the time the services and supplies are

BENEFIT PROVISIONS

provided, except that coverage shall be provided for any covered drug with the following criteria:

- a) Is prescribed for the treatment of HIV infection or an illness or medical condition arising from or related to HIV infections; an
 - b) Is approved by the Federal Food and Drug Administration, including phase-3 investigational drugs; and
 - c) If the drug is an investigational new drug, is prescribed and administered in accordance with the treatment protocol approved by the Federal Food and Drug Administration for the investigational new drug.
- Any service rendered AFTER the date your coverage under the policy terminates or AFTER you are disenrolled from the Plan, except as provided in the Extension of Benefits provision of this certificate or any service rendered BEFORE the member's effective date in the Plan.
 - Medical expense due to your commission or attempted commission of a civil or criminal battery or felony.
 - Charges for any treatment related to a non-covered service.
 - Any treatment or services rendered by or at the direction of:
 - a) A person residing in your household; or
 - b) A family member (such as your lawful spouse, child, parent, grandparent, brother, sister, or any person related in the same way to your covered dependent).
 - Services and supplies not medically necessary for diagnosis and treatment of a covered bodily injury or sickness.
 - Services and supplies for which no charge is made or for which you would not have to pay without this coverage.
 - The amount of any copayment, coinsurance, and/or deductible that you must pay as shown in the Schedule of Benefits and/or in any rider attached to this certificate.
 - All services not specifically covered in the Benefit Provisions section of this certificate or by any Rider attached to the policy and any service not provided or received in accordance with the terms and conditions of this certificate and policy.
 - Ancillary medical services (including hospital facility charges, anesthesia charges, lab and x-ray charges) provided during the course of a non-covered bodily injury or sickness. This exclusion does not apply to benefits for Dental Surgery as described in the Benefit Provisions section.
 - Expenses for medical reports, including preparation and presentation.
 - Services to the extent the member is eligible for Medicare benefits, regardless of whether or not the member is actually enrolled in Medicare.
 - Treatment, services, and supplies furnished by the U.S. Veterans Administration, except when the Plan is the primary payor under applicable federal law.
 - Services for holistic medicine, including homeopathic medicine, or other programs with an objective to provide complete personal fulfillment.
 - Charges for missed appointments.
 - Coma stimulation/recovery programs.
 - Treatment, services and supplies provided while held, detained or imprisoned in a local, state or federal penal or correctional institution, or while in the custody of law enforcement officials. Persons on work release are exempt from this exclusion.
 - Any surgical treatment for morbid obesity, including ileal bypass, gastric bypass, or stapling.
 - Skin tag removal.
 - Services of a blood donor.
 - Sublingual (under the tongue) allergy testing and/or treatment.
 - Work or education related preventive treatment.
 - Sexual counseling services is limited to those techniques commonly used by participating providers for conditions producing significant physical and mental symptoms.
 - Genetic counseling.
 - Acupuncture.

COVERAGE INFORMATION

ELIGIBILITY

Employees and their dependents become eligible under the Plan as follows:

Employee:

- The date the employee qualifies for health coverage under the Plan, specified by the Group and MercyCare. However, if the employee is not in active status on this date, coverage for the employee and his or her dependents will not become effective until he or she returns to active status.

Dependents:

- The date the employee becomes eligible for coverage as defined above, for the employee's dependents on that date; or
- The date of the employee's marriage for any dependent (spouse or stepchild(ren)) acquired on that date; or
- The date of birth of the employee's natural-born child(ren); or
- The date a child is placed in the employee's home for adoption, or the date that a court issues a final order granting adoption of the child to the employee, whichever occurs first; or
- The date of a change of status that makes a dependent newly eligible; or
- A newborn child of an employee, an employee's covered dependent spouse, or covered dependent child under the age of 18 is eligible for covered services. Coverage terminates for the child of a covered dependent child at the end of the month the employee's covered dependent child reaches 18 years of age.

Except in cases of coverage continuation or conversion, an employee's dependent is eligible ONLY if the employee is covered. No dependent's effective date will be prior to the employee's effective date of coverage. If an employee's dependent child is also an eligible employee in the employee's group, the dependent child is not eligible as a dependent and must apply as an employee.

Except for dependent children, a member must reside or work in the service area. MercyCare considers a member's "residence" to be in the location in which he or she spends at least 9 months out of a 12 month contract year.

ENROLLMENT AND EFFECTIVE DATES

Enrollment Periods:

An eligible employee may enroll in the plan by submitting a completed enrollment form available from the group

during an open enrollment period or dual choice enrollment period. At the same time, the employee may enroll his or her eligible dependents with the enrollment form. The effective date of coverage for the employee and any enrolled dependents is indicated on the first page of this certificate inserted after the front cover.

Newly Eligible Employee or Dependent Enrollment:

An eligible employee may enroll himself or herself and/or his or her eligible dependents in the Plan by submitting a completed enrollment form or change form available from the Group, as follows:

- a) An employee who becomes newly eligible for coverage after the first enrollment period, and his or her eligible dependents may enroll within 30 days from the date he or she is eligible, as specified by the group contract. The effective date of coverage for the employee and any enrolled dependents is indicated on the first page of this Certificate inserted after the front cover.
- b) If dependent coverage is in effect, the employee should enroll a newborn dependent as soon as possible and coverage for the dependent will be effective on the date of birth, if enrolled within one year from the date of birth. If dependent coverage is not in effect, the employee has 60 consecutive days from the date of birth to enroll a newborn dependent effective on the date of birth. If the employee does not enroll a newborn dependent within this 60 day period, the newborn child will have no coverage unless, within one year after birth of the child the employee pays all past due premiums plus interest on these premiums at the rate of 5 ½% per year.
- c) The employee has 60 consecutive days from the date a child is placed in the employee's home for adoption or from the date that a court issues a final order granting adoption of the child to the employee, whichever occurs first, to enroll a dependent who is adopted or placed for adoption. The dependent child is covered on the date he or she is placed in the employee's home for adoption or the date that a court issues a final order granting adoption of the child to the employee, whichever occurs first.
- d) An employee member may enroll the employee's new spouse and stepchildren, effective on the date of marriage, by providing MercyCare with a completed change form within 30 days after the date of marriage.
- e) An employee member may enroll the employee's newly eligible dependent, other than as described above, by providing MercyCare with a completed change form. If the change form is received by MercyCare BEFORE the dependent's eligibility date, coverage is effective on the dependent's eligibility date. If the change form is received AFTER the dependent's eligibility date, but within 30 days of that date, coverage is effective on the date MercyCare specifies.

COVERAGE INFORMATION

Enrollment Upon Loss of Other Coverage:

An eligible employee may enroll himself or herself and his or her eligible dependents in the Plan, effective on the first day of the month following MercyCare's receipt of a completed enrollment form, if:

- a) They declined to enroll in the plan during an open enrollment period or dual choice enrollment period; and
- b) They were covered under a group health plan or had health insurance coverage during such an enrollment period; and
- c) The employee stated in writing, if required by MercyCare, that enrollment was declined due to the coverage under another group health plan or health insurance; and
- d) Their coverage under the group health plan or health insurance is exhausted or terminated; and
- e) They submit a completed enrollment form, which is available from the group, within 30 days after their coverage under the group health plan or health insurance is exhausted or terminated.

Enrollment When Employee Declined Coverage:

An employee who declined to enroll in the Plan during an open enrollment period or dual choice enrollment period may enroll in the Plan if a person becomes a dependent of the employee through marriage, birth, adoption or placement for adoption. The dependent may also enroll in the Plan. The employee must submit a completed enrollment form, which is available from the Group, within 30 days after the date of the marriage, birth, adoption or placement for adoption. The effective date of enrollment is the date of the marriage, birth, adoption or placement for adoption.

Late Enrollment for Spouse of Employee Member:

The spouse of an employee member may enroll in the Plan if a child becomes a dependent of the employee through birth, adoption or placement for adoption. The employee must submit a completed change form, which is available from the Group, within 30 days after the date of the birth, adoption or placement for adoption. The effective date of enrollment is the date of the birth, adoption or placement for adoption.

Other Late Enrollment:

An eligible employee may enroll himself or herself and an employee member may enroll his or her eligible dependents in the Plan, other than as described above, by submitting a completed enrollment form or change form available from the Group, as follows:

- a) An employee may enroll within 30 days after requesting coverage and receiving notice of the right to enroll. Coverage is effective on the first of

the month after approval of the employee's application or 18 months from the date of the application, whichever occurs first.

- b) An employee member may enroll the employee's newly eligible dependent, other than as described above, by providing MercyCare with a completed enrollment form. If the enrollment form is received more than 30 days after a dependent's eligibility date, the dependent may enroll within 30 days after requesting change and receiving notice of the right to enroll. Coverage is effective on the first of the month after approval of the dependent's application or 18 months from the date of the application, whichever occurs first.

CHANGES TO ENROLLMENT FORM

Changes to the original enrollment form, other than physician or address changes, must be made by completing a change form, which will be made available by the Plan to the Group for distribution to its employees.

BENEFIT CHANGES

An increase in benefits will become effective on the date of change in benefits if the employee is in active status. Otherwise, the change will be effective on the day following the date that the employee returns to active status. If dependent coverage is in effect, an increase in benefits will be delayed for covered dependents if the dependent is confined in an institution operated for the care of mentally or physically sick, injured or disabled persons. An increase in the dependent's coverage will be effective on the day after discharge from confinement. Discharge from confinement must be certified by a medical physician.

A decrease in benefits will become effective on the date of change of benefits.

TERMINATION OF COVERAGE

Coverage terminates for employees and covered dependents on the date when one of the following happens:

1. The policy terminates; or
2. A covered service is no longer covered by the policy, except that termination then relates only to that covered service.

Your group has the authority to terminate, amend or modify the coverage described in this certificate. If this coverage is terminated, you will not receive benefits. If it is amended or modified, you may not receive the same benefits.

COVERAGE INFORMATION

Coverage also terminates for employees and covered dependents for any of the reasons listed below. The termination date for these reasons may be on the date the event happens, or it may be at the end of the month after it happens, depending on which date the group chooses on the group application. (You may consult the Group to determine which date applies to you.)

- The employee's employment terminates; or
- The employee ceases to meet eligibility requirements under the policy; or
- The member requests voluntary disenrollment; or
- The employee retires, or;
- The dependent no longer qualifies as an eligible dependent.

EXTENSION OF BENEFITS

Termination of Group Policy:

If you are validly covered and totally disabled as a result of a covered bodily injury or sickness existing on the date the policy terminates, the Plan will continue to provide medical benefits until the earliest of the following:

- The date your primary care physician certifies that you are no longer totally disabled; or
- The date the maximum benefit is paid; or
- The end of 12 consecutive months immediately following the date of termination of coverage; or
- The date similar coverage is provided under another group policy, other than temporary coverage, for the condition or conditions causing the total disability.

Termination of Member's Coverage:

If on the date your coverage terminates under this policy you are confined in the hospital, the Plan will continue to cover the charges for covered expenses incurred for the inpatient hospital services provided to you during the hospital confinement. Benefits for these hospital services will continue until the earliest of the following:

- The date on which your hospital confinement ends;
- The date the maximum benefit is paid; or
- The date on which 90 consecutive days pass since your coverage ended under this policy.

This Extension of Benefits provision applies only to covered services relating to the condition(s) which existed on the date your coverage terminated.

RIGHTS TO CONTINUE GROUP MEDICAL COVERAGE

If your coverage ends for certain of the reasons listed in the Termination of Coverage section, you may be

eligible to continue coverage under federal and/or state laws, as stated below. While a member is entitled to all of the benefits under the federal or state laws that apply, the member is not entitled to a duplication of those benefits.

State Continuation:

You may apply for an extension of group coverage only if you have been covered under the plan for at least 3 consecutive months. You may elect this option if:

1. Your eligibility for group coverage terminates due to the employee's loss of eligibility other than for misconduct on the job; or
2. You are the former spouse of an employee and the marriage ended due to divorce or annulment while dependent coverage was in effect; or
3. You are the surviving dependent spouse or child of an employee who dies while dependent coverage was in effect.

Your employer is required to provide you with a written notice of these rights. You must receive the notice within 5 days after the date your employer knows that your eligibility for coverage will terminate.

You have 30 days from the date of the notice to elect the continuation option and pay the premium due to your employer. Your employer will tell you when and how much is due, and will send payment to the Plan. You must complete a new enrollment form if you are a former spouse or a surviving dependent spouse or child. Coverage under the Plan continues under this option until the earliest of the following:

1. The end of 18 consecutive months from the date you elected this option if the Plan requires you to convert to individual coverage; or
2. The date you are eligible for similar coverage under another group medical plan; or
3. The end of the last month for which premium was paid by you when due; or
4. The date you are no longer a resident of the service area; or
5. If you are the former spouse of an employee, the date the employee is no longer covered by the Plan or replacement group policy; or
6. The date on which your employer terminates coverage under the policy.

Federal Continuation:

The Federal Consolidated Omnibus Budget Reconciliation Act (COBRA) applies to employers with 20 or more employees. COBRA entitles you to a continuation of coverage under the policy if:

1. You are a surviving dependent spouse or child of an employee who dies while dependent coverage was in effect; or

COVERAGE INFORMATION

2. Your eligibility for group coverage ends because your employment terminates for reasons other than gross misconduct, or because your work hours are reduced; or
3. You are the former spouse of an employee and the marriage ended due to divorce or legal separation while dependent coverage was in effect; or
4. Your eligibility for group coverage ends because the employee becomes eligible for Medicare; or
5. You are a dependent child who is no longer considered eligible for coverage; or
6. The employee is retired and your eligibility for group coverage ends because the employer files bankruptcy under federal law.

You, or your dependents, are responsible for informing the employer of dissolution of marriage, legal separation or a child losing dependent status. If you should lose coverage for any of these reasons, and you wish to elect continuation coverage, you must complete an election form and submit it to the employer within 60 days of the later of the date:

- You are no longer covered; or
- You are notified of the right to elect COBRA continuation of coverage.

You will be responsible for paying any premiums to the employer for the continuation of coverage.

Depending on how you qualify, you may continue coverage for up to 18 or 36 months. If it is determined that you are disabled under the Social Security Act at the time of the qualifying event, you may be eligible to continue coverage for up to 29 months. You must provide notice of the disability determination to the employer within 60 days after the determination.

COBRA coverage ends at the earliest of one of these events:

1. The date of the 18, 29, or 36 month maximum coverage period, whichever is applicable;
2. The first day (including grace periods, if applicable) on which timely payment is not made;
3. The date on which the employer ceases to maintain any group health plan (including successor plans);
4. The first day on which you are actually covered by any other group health plan; however, if the new group health plan contains an exclusion or limitation relating to any preexisting condition that you may have, then coverage will end on the earlier of the satisfaction of the waiting period for preexisting conditions contained in the new group health plan or upon the occurrence of any one of the other events stated in this section.

CONVERSION COVERAGE

If you do not elect continuation of coverage, if you elected continuation of coverage and it terminates, or if the policy terminates, a conversion policy may be available without medical examination. You qualify for a conversion policy if you were covered under the Plan for at least 3 consecutive months and:

1. Your eligibility for group coverage terminates due to the employee's loss of eligibility other than for misconduct on the job; or
2. You are the former spouse of an employee and the marriage ended due to divorce or annulment while dependent coverage was in effect; or
3. You have been a covered dependent child but no longer meet the definition of "dependent" under the policy.

The employer is required to provide you with a written notice of these rights. You must receive the notice within 5 days after the date the employer knows that the member's eligibility for coverage will terminate.

You have 30 days after the date coverage terminates to make application to the Plan and pay the required premium for a conversion policy. The premium must be paid in advance and quarterly. You may obtain an application form from the Plan. The conversion policy will be effective on the day after your group coverage ends, provided you enroll and pay the first premium within 30 days after the date coverage terminates.

Benefits provided under the conversion policy may differ from the benefits provided under the Plan.

MercyCare may refuse to issue a conversion policy if it has determined that you have other similar coverage. The conversion policy will not be available if it would result in overinsurance or duplication of benefits. MercyCare will use the standards for overinsurance filed with the Wisconsin Office of the Commissioner of Insurance.

DISENROLLMENT

“Disenrollment” means that a member’s coverage under the Plan is revoked. MercyCare can disenroll a member only for the reasons listed below:

1. Required premiums are not paid by the end of the grace period; or
2. The member commits acts of physical or verbal abuse that pose a threat to providers or to other members of the Plan; or
3. A member allows a non-member to use the member’s identification card to obtain services; or
4. A member has provided fraudulent information in applying for coverage; or
5. The member no longer lives or works in the service area; or
6. The member is unable to establish or maintain a satisfactory physician-patient relationship with a participating primary care physician. (If a member refuses to follow the recommended treatment of his/her primary care physician, this may constitute an unsatisfactory physician-patient relationship.) Disenrollment for this reason is permitted only if MercyCare can demonstrate that it has provided the member an opportunity to select another participating primary care physician; made a reasonable effort to assist the member in establishing a satisfactory physician-patient relationship; and properly communicated the complaint, appeal, and grievance procedures to the member. See the Complaint, Appeal, and Grievance Procedures section in this certificate for more information.

Except for non-payment of required premiums, the Plan will arrange to provide similar alternative medical coverage for any terminated member until the member finds his/her own coverage or until the next opportunity to change insurers, whichever occurs first.

ADVANCE DIRECTIVES

If you are over the age of 18 and of sound mind, you may execute a living will or durable power of attorney for health care. The documents tell others what your wishes are if you are physically and mentally unable to express your wishes in the future. If you do have an advance directive, a copy should be given to your primary care physician. Also, please notify us in writing, as we are required, by law, to advise your primary care provider and the clinic, that you have an advance directive. You are not required to send the forms to the Plan.

CASE MANAGEMENT / ALTERNATIVE TREATMENT

Case management is a program the Plan offers to members. The Plan employs a professional staff to provide case management services. As part of this case management, the Plan reserves the right to direct treatment to the most effective option available.

CLERICAL ERRORS

No clerical errors made by the Plan or the Group will invalidate coverage that is otherwise validly in force or continue coverage otherwise validly terminated, provided that the error is corrected promptly and in no event more than 60 days after the error is made.

CONFORMITY WITH STATE STATUTES

Any provisions which, on the policy effective date, conflict with the laws of the state in which the policy is issued are amended to conform to the minimum requirements of those laws.

INCONTESTABILITY

After you are insured for 2 years, the Plan cannot contest the validity of coverage on the basis of any statement that you made regarding your insurability except for fraudulent misrepresentation. No statement made by you can be contested unless it is in written form signed by you. A copy of the form must then be given to you and becomes a part of this certificate.

LIMITATIONS ON SUITS

No action can be brought against the Plan to pay benefits until the earliest of: 1) 60 days after the Plan has received or waived proof of loss; or 2) the date that the Plan has denied full payment. This delay will not prejudice you. No action can be brought more than 3 years after the time the Plan required written proof of loss.

PHYSICAL EXAMINATION

The Plan has the right to request a member to receive a physical examination to determine eligibility for claimed services or benefits. The Plan will pay for the expense of the physical examination. By completing the application for coverage, you have consented to such an examination.

PROOF OF COVERAGE

As a member, it is your responsibility to show your MercyCare identification card each time you receive services.

SUBROGATION AND REIMBURSEMENT

Except as otherwise provided in the Coordination of Benefits section of this certificate, in the event the Plan makes payment on your behalf for covered services, the Plan shall be subrogated to all of your rights of recovery against any person or organization for such payments. In addition, the Plan is granted the right of reimbursement for such payments from the proceeds of any settlement, judgment or other payment that you obtain. The Plan's rights of subrogation and reimbursement apply to any recoveries that you make.

By making payment for covered services, the Plan is granted a lien on the proceeds of any settlement, judgment or other payment, which you receive, and you consent to said lien. You agree to take whatever steps are necessary to help the Plan secure said lien and to execute and deliver all instruments and papers and do whatever else is necessary to secure the Plan's rights of subrogation and reimbursement. You agree to cooperate with the Plan representatives in completing such forms and in giving such information surrounding any sickness or bodily injury as the Plan or its representatives deem necessary.

You agree to do nothing to prejudice the Plan's rights under this provision. You agree not to make any settlement that specifically excludes or attempts to exclude the benefits paid by the Plan. You agree to notify the Plan of any claim made on your behalf in connection with a bodily injury or sickness and shall include the amount of the benefits paid by the Plan on your behalf in any claim made against any other person.

The Plan has no right to recover from you under this provision if you are not made whole, after taking into consideration your comparative negligence. If there is a dispute as to whether you have been made whole, the Plan may obtain a judicial determination of the issue.

WORKERS COMPENSATION

The policy is not issued in lieu of nor does it affect any requirement for coverage by Workers' Compensation. If you are eligible for Workers' Compensation coverage for a bodily injury or sickness sustained in the course of any occupation or employment, that bodily injury or sickness is not covered under this policy, whether or not you actually obtained such coverage or receive benefits under any coverage you obtain. If the Plan covered treatment for such bodily injury or sickness, and the Plan determines that you also received Worker's Compensation benefits for the same incident, the Plan has the right to recover as described under the Right to Recovery provision of the Coordination of Benefits section of this certificate. The Plan will exercise the right to recover against you.

The recovery rights will be applied even though:

1. The Workers' Compensation benefits are in dispute or are made by means of settlement or compromise; or
2. No final determination is made that the bodily injury or sickness was sustained in the course of or resulted from your employment;
3. The amount of Workers' Compensation due to medical or health care is not agreed upon or defined by you or the Workers' Compensation carrier; or
4. The medical or health care benefits are specifically excluded from the Workers' Compensation settlement or compromise.

In the event that Workers' Compensation benefits are in dispute or when the amount of Workers' Compensation due to medical or health care is not agreed upon, claims processing will be suspended. The involved parties will be notified as to the reason for the delay in processing. Upon resolution of such questions or problems, claims processing will be resumed and recovery rights will be applied.

In the event that Workers' Compensation denies a claim, the Plan will cover the resulting charges only if you have followed the guidelines outlined in this certificate. The Plan is not obligated to cover charges incurred to a non-participating provider and/or facility without a valid referral.

You hereby agree that, in consideration for the coverage provided by the policy, you will notify the Plan of any Workers' Compensation claim you make, and that you agree to reimburse the Plan as described above.

This provision will also apply to coverage that you may receive under any Occupational Disease Act or Law.

The Coordination of Benefits provision applies when you have health care coverage under more than one health plan. The following rules in this section determine which plan will be primary and which plan will be secondary.

DEFINITIONS

Allowable Expense means any necessary, reasonable, and customary health care item or expense that is covered, even partially, under one or more plans. The difference between the cost of a private hospital room and a semi-private hospital room is not considered an allowable expense unless it is determined that the patient's stay in a private hospital room is medically necessary.

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 benefit paid.

Allowable expenses under any other plan include the benefits that would have been payable if (a) a claim had been duly made; or (b) the member had complied with all plan provisions, such as pre-certification of admissions and referrals. MercyCare will not reduce benefits because the member has elected a level of benefits under another plan that is lower than he or she could have elected.

Claim Determination Period means a contract year. However, it does not include any part of a year that a person is not covered under this plan, or any part of a year before this or a similar Coordination of Benefit provision became effective.

Plan means any of the following that provides benefits or services for medical or dental care:

1. Group insurance or group-type coverage, whether insured or uninsured, that includes continuous 24-hour coverage. This includes pre-payment, group practice or individual practice coverage. It also includes coverage other than school accident-type coverage.
2. Coverage under a governmental plan or coverage that is required or provided by law. This does not include a state plan under Medicaid. It also does not include any plan whose benefits, by law, are in excess to those of any private insurance program or other non-governmental program.

Primary Plan/Secondary Plan is determined by the Order of Benefit Determination rules. When the plan is considered **Primary**, benefits will be paid for covered services as if no other coverage were involved. When the plan is considered **Secondary**, benefits will be paid based on what was already paid by the primary plan.

This Plan means the group health plan offered by MercyCare and described in this certificate.

ORDER OF BENEFIT DETERMINATION

The rules outlined below establish the order of benefit determination as to which plan is primary and which plan is secondary.

1. **No coordination of benefits provision:** If the other plan does not have a coordination of benefits provision, that plan will be considered primary.
2. **Non-dependent/Dependent:** The plan that covers a person as an employee, member or subscriber, other than a dependent, is considered primary. The plan that covers a person as a dependent of an employee, member or subscriber is considered secondary.
3. **Dependent Children:** When a dependent child has coverage under both parents' plans, the Birthday Rule is used to determine which plan will be considered primary.

Birthday Rule: The plan of the parent whose birth date occurs first in a calendar year is considered primary. If both parents have the same birth date, the plan that has covered the parent for a longer period of time will be considered primary. If the other plan does not use the Birthday Rule to determine the coordination of benefits, the other plan's rule will determine the order of benefits.

4. **Dependent Children with Divorced or Separated Parents:** When a dependent child has coverage under both parent's plans and a court order awards custody of the child to one parent, benefits for the child are determined in this order:
 - a. First, the plan of the parent with custody of the child;
 - b. Then, the plan of the spouse of the parent who has custody of the child; and
 - c. Finally, the plan of the parent who does not have custody of the child.

COORDINATION OF BENEFITS

If the specific terms of a court decree state that both parents share joint custody and do not specify which parent is responsible for health care expenses, the order of benefits will be determined by the Birthday Rule.

If a court decree orders that one parent be responsible for health care expenses, the plan of that parent will be considered primary.

The rules and the coordination of benefits for dependent children of divorced or separated parents will only apply when we have been informed of the court ordered terms. Retroactive coordination will not be allowed.

5. **Active/Inactive Employee:** The plan that covers an employee who is actively at work or as that employee's dependent is considered primary over the plan that covers an employee who is either laid off or retired or as that employee's dependent. If the other plan does not have this rule, and the plans do not agree, this rule will not apply.
6. **Continuation of Coverage:** The plan that covers a member as an actively at work employee or as that employee's dependent is considered primary over any continuation of coverage plan. If the other plan does not have this rule, and the plans do not agree, this rule will not apply.
7. **Longer/Shorter Length of Coverage:** If none of the above rules apply to the covered member, the plan that has covered the person for a longer period of time will be considered primary.

EFFECT ON BENEFITS WHEN THIS PLAN IS SECONDARY

MercyCare will apply these provisions when it is determined that this Plan be considered secondary under the Order of Benefit Interpretation rules. The benefits of this Plan will be reduced when the sum of the following exceeds the allowable expenses in a claim determination period:

1. The benefits that would be payable for the Allowable Expenses under This Plan in the absence of this Coordination of Benefits provision; and
2. The benefits that would be payable for the allowable expenses under the other plans, in the absence of provisions with a purpose like that of this Coordination of Benefits provision, whether or not a claim is made.

Under this provision, the benefits of This Plan will be reduced so that they and the benefits payable under the other plans do not total more than those Allowable Expenses.

MERCYCARE'S RIGHTS UNDER THE COORDINATION OF BENEFITS PROVISION

Right to Necessary Information:

In order to apply and coordinate benefits appropriately, MercyCare may require certain information. MercyCare has the right to decide what information we need in order to determine our payment, and to obtain that information from any organization or person. MercyCare may obtain the information without your consent, but will do so only as it is needed to apply the coordination of benefits rules. We also have the right to give necessary information to another organization or person in order to coordinate benefits. Medical records remain confidential as required by state law.

Facility of Payment:

MercyCare will adjust payments made under any other plan that should have been made by MercyCare. If we make such a payment on behalf of a member, it will be considered a benefit payment for that member's policy, and we will not be responsible to pay that amount again.

Right to Recovery:

Payments made by MercyCare that exceed the amount that we should have paid may be recovered by MercyCare. MercyCare may recover the excess from any person or organization to whom, or on whose behalf, the payment was made.

COORDINATION OF BENEFITS WITH MEDICARE

In all cases, coordination of benefits with Medicare will conform to Federal Statutes and Regulations. If you are eligible for Medicare benefits, but not necessarily enrolled, your benefits under this plan will be coordinated to the extent benefits otherwise would have been paid under Medicare as allowed by Federal Statutes and Regulations. Except as required by Federal Statutes and Regulations, this Plan will be considered secondary to Medicare.

1. The Plan will pay participating providers directly for covered services you receive, and you will not have to submit a claim. However, if you use an approved non-participating provider and receive a bill, a claim must be submitted within 60 days after the services are received, or as soon as possible. If the Plan does not receive the claim as soon as reasonably possible and within 12 months after the date it was otherwise required, the Plan may deny coverage of the claim.

To submit a claim, send an itemized bill from the physician, hospital, or other provider to the following address:

**MercyCare Insurance Company
Claims Department
P.O. Box 2770
Janesville, WI 53547-2770**

Be sure to include your name and identification card number.

If the services were received outside the United States, please be sure to indicate the appropriate exchange rate at the time the services were received.

2. You agree to provide to the Plan any additional information regarding the occurrence and extent of the event for which the claim is made which the Plan shall reasonably require in order to process the claim.
3. The Plan may pay all or a portion of any benefits provided for health care services to the provider or to the employee if so directed in writing at the time the claim is filed.
4. Benefits accrued on your behalf upon death shall be paid, at the Plan's option, to any one of more of the following:
 - a. your spouse; or
 - b. your dependent children, including legally adopted children; or
 - c. your parents; or
 - d. your brothers and sisters; or
 - e. your estate.

Any payment made by the Plan in good faith will fully discharge the Plan to the extent of such payment.

5. In the event of a question or dispute concerning the provision of health care services or payment for such services under the policy, the Plan may require that you be examined, at the expense of the Plan, by a participating provider designated by the Plan.

CONSENT TO RELEASE INFORMATION

CONSENT AND AUTHORIZATION

A member consents to the release of medical and/or legal information to the Plan for himself or herself and for his/her covered dependents when he/she signs the enrollment form and when his/her identification card is used to receive health care services. If a member will not consent to release information regarding health care services or supplies to the plan, the plan has the right to deny coverage for such services or supplies.

Each member authorizes and directs any person or institution that has examined or treated the member to furnish to the Plan at any reasonable time, upon its request, any and all information and records or copies of records relating to the examination or treatment rendered to the member and for which the member seeks coverage under the plan. The Plan agrees that such information and records will be considered confidential to the extent required by law. The Plan shall have the right to submit any and all records concerning health care services rendered to members to appropriate medical review personnel. Expenses incurred to obtain such records for the Plan will be the responsibility of the member.

The Plan also has the right to review any employment records, including those maintained by the group, to make certain that the group and members are entitled to coverage from the Plan.

PHYSICIAN AND HOSPITAL REPORTS

Physicians and hospitals must give the Plan reports to help the Plan determine contract benefits due to you. You agree to cooperate with the Plan to execute releases that authorize physicians, hospitals, and other providers of health care to release all records to the Plan regarding services you receive. It is also a condition of the Plan paying benefits. All information must be furnished to the extent the Plan deems it necessary in a particular situation and as allowed by pertinent statutes.

RIGHT TO COLLECT NEEDED INFORMATION

You must cooperate with the plan when seeking coverage under the plan, and when asked will assist the plan by:

1. Authorizing the release of medical information including the names of all providers from whom you received medical attention; and
2. Providing information regarding the circumstances of your bodily injury or sickness; and
3. Providing legal and other information needed to administer the plan, including information about

other health care and insurance coverage and benefits.

COMPLAINT PROCEDURES

MercyCare is committed to ensuring that all member concerns are handled in an appropriate and timely manner. We ensure that every member has the opportunity to express dissatisfaction with any aspect of the Plan.

VERBAL COMPLAINT

If you have a complaint regarding a decision made by the Plan or with any other aspect of the Plan, you may contact our Customer Service Department via the telephone.

If the Customer Service Department is unable to resolve your complaint initially, they will contact you by phone with the outcome within 10 working days of the receipt of the complaint.

If you are not satisfied with the resolution of the complaints you may verbally request an appeal or you may submit a written request for a grievance hearing.

VERBAL APPEAL

To file an appeal, you may contact the Customer Service Department by telephone. You will receive a letter from the Customer Service Department advising that your appeal is being reviewed by an internal committee.

You will receive notice of the outcome of your appeal within 20 working days of the receipt of your request. If there are extenuating circumstances that will cause a delay in the decision, you will be notified of the reason for the delay.

Upon completion of your appeal you will be notified of the outcome. You will also be given notice of your right to file a grievance in case you are not satisfied with the outcome of your appeal.

GRIEVANCE

You have the right to request a grievance hearing at any time you are dissatisfied with a decision made by MercyCare, or with any other aspect of the plan by submitting your concern to MercyCare in writing, or by verbally requesting a grievance hearing following an unsatisfactory outcome of a verbal appeal.

The Customer Service Department will send notification, acknowledging the receipt of your grievance request within 5 days. You will then be contacted via the telephone (if available) by a Customer Service

Representative who will explain the grievance process and advise you of the next available date for a grievance hearing. You will receive a written confirmation of your hearing date a minimum of 7 days before the hearing is scheduled.

The Grievance Committee will review the substance of your concern and review all relevant documents pertaining to the grievance. The Grievance Committee will not include the person who made the initial determination. There will be at least one member of the Committee who is a MercyCare insured and who is not employed by MercyCare, if possible.

At your grievance hearing, you and/or a representative you have chosen to act on your behalf have the right to be present and present information relevant to the grievance. If you choose not to be present, you may also participate in the hearing through a conference call.

The Grievance Committee will then make a decision on the resolution of the grievance.

Within five (5) working days of the grievance hearing, the Customer Service Department will send a letter to you with the resolution of the grievance and if applicable any corrective action that will be taken.

All grievances will be decided within thirty calendar days, unless there are extenuating circumstances. In such cases, customer service will notify the member of the reason for the delay before the 30th day and resolve the case within forty-five working days from the receipt of the grievance request. The grievance standards begin on the date in which all required information is received by MercyCare.

To ensure your privacy, MercyCare requests that you sign a written authorization allowing us to share all information pertinent to your case with the Grievance Committee members. The Authorization to Release Information form will be sent to you along with the letter confirming your hearing date. If the release is not received, your grievance hearing will be delayed until such time as the release is received.

An expedited review may be obtained if a delay of service could seriously jeopardize your life or health or your ability to regain maximum function, or if a reviewing physician advises us that you would be subject to severe pain that cannot be adequately managed without the care or treatment that is the subject of the grievance, or that the grievance should be expedited. You will be notified by phone of the outcome within 72 hours of the receipt of the complaint.

You will also be notified of any additional rights that you have in case the results are not to your satisfaction.

INDEPENDENT REVIEW

You have the right to request and obtain an independent review of an adverse determination or an experimental treatment determination, if you are dissatisfied with MercyCare's decision, and the determination meets one of the applicable definitions, as follows:

- (a) "Adverse Determination" means a determination by MercyCare, in which all of the following apply:
1. An admission to a health care facility, the availability of care, the continued stay or other treatment that is a covered benefit has been reviewed by the Plan.
 2. Based on the information provided, the treatment in #1 above does not meet MercyCare's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness.
 3. Based on the information provided, MercyCare reduced, denied or terminated coverage for the treatment under #1 above.
 4. The amount of the reduced, denied or terminated coverage exceeds, or will exceed during the course of the treatment, \$250.

This definition includes the denial of a request for a referral for out-of-network services when you request health care services from a provider that does not participate in MercyCare's provider network because the clinical expertise of the provider may be medically necessary for the treatment of your medical condition and that expertise is not available in MercyCare's provider network.

- (b) "Experimental treatment determination" means a determination by MercyCare in which all of the following apply:
1. A proposed treatment has been reviewed.
 2. Based on the information provided, the proposed treatment is determined to be experimental under the terms of the Plan.
 3. Based on the information provided, MercyCare denied coverage for the treatment.
 4. The cost or expected cost of the denied coverage exceeds, or will exceed during the course of the treatment, \$250.

Each time MercyCare makes an adverse determination or an experimental treatment determination, you will receive a notice explaining your right to request an independent review, and how to go about obtaining an independent review. Your request for independent

review must be made within 4 months from the date of the adverse determination or experimental treatment determination, or from the date of receipt of notice of the grievance panel decision, whichever is later. The request for independent review must be made in writing, contain the name of the selected Independent Review Organization, and be accompanied by a \$25 fee, payable to the independent review organization. The \$25 fee is refundable by MercyCare if the Independent Review decision is made in favor of the member.

In order to be eligible for independent review, you must exhaust MercyCare's internal grievance procedure. You need not exhaust the internal grievance procedure if either of the following conditions are met:

- a) Both MercyCare and you, or your authorized representative, agree that the appeal should proceed directly to independent review.
- b) The independent review organization determines that an expedited review is appropriate upon receiving a request from you or your authorized representative that is simultaneously sent to MercyCare.

MercyCare will acknowledge your request for independent review within 2 business days of receipt of the request. MercyCare will forward the case to the independent review organization within 5 business days after receiving written notice of the request for independent review. If a case is identified as being expedited, MercyCare will forward the case to the independent review organization within 1 day after receiving notice of request for review.

The independent review organization will make a decision within 30 business days after receiving all pertinent information required to make the decision. If the independent review organization is working with an expedited case, the decision will be made within 72 hours after receipt of all pertinent information required to make the decision. In the case of an expedited review, the Independent Review Organization will notify you and MercyCare of its decision within 1 hour of making the decision, or as soon as possible.

The independent review organization decision is binding.

OFFICE OF THE COMMISSIONER OF INSURANCE

You may resolve your problem by taking the steps outlined above. You may also contact the Office of the Commissioner of Insurance to file a complaint. The Office of the Commissioner of Insurance is a state agency that enforces Wisconsin's insurance laws. To request a complaint form, you can contact the Office of the Commissioner of Insurance by one of the following:

Office of the Commissioner of Insurance

P.O. Box 7873

Madison, WI 53707-7873

(800) 236-8517

(608) 266-3585

Fax: (608) 264-8115

(800) 947-3529 (TDD)

(ask for 608/266-3586)

Email: complaints@oci.state.wi.us

Website: oci.wi.gov

The following are definitions of terms as they are used in this Certificate.

ACTIVE STATUS

Active status means performing your job on a regular, full-time basis as defined in the group application. Each day of a regular paid vacation and any regular non-working holiday shall be deemed active status if you were in an active status on your last regular working day.

ACUTE ILLNESS/INJURY

Illness or injuries that are of rapid onset with an expected short-term duration.

BODILY INJURY

Bodily injury means an injury resulting from an accident, independent of all other causes.

CERTIFICATE

Certificate means this Certificate of Coverage which has been issued to you and which summarizes the terms, conditions, and limitations of your health care coverage.

CHANGE OF STATUS FORM

Change of Status form means the form you must complete if you wish to add or delete dependents or change the information contained on your enrollment form. Change of Status forms are provided by MercyCare and are available from the Group.

CHRONIC ILLNESS/CONDITION

Illness or conditions that are of long duration and show little change, or a slow progression, of the symptoms or condition. Treatment is supportive in nature and not curative.

CLAIM

Claim means a demand for payment due in exchange for health care services rendered.

COINSURANCE

Coinsurance means the member's portion, expressed as a percentage of the fee for covered services that you are required to pay for certain covered services provided under the policy.

CONFINEMENT/CONFINED

Confinement or confined means (a) the period of time between admission as an inpatient or outpatient to a hospital, alcohol and other drug abuse (AODA) residential treatment center, skilled nursing facility or licensed ambulatory surgical center, and discharge therefrom; or (b) the time spent receiving emergency care for sickness or bodily injury in a hospital. Hospital swing bed confinement is considered the same as confinement in a skilled nursing facility. If you are transferred to another facility for continued treatment of the same or related condition, it is considered one confinement.

CONGENITAL

Congenital means a condition which exists at birth but is not hereditary.

CONTRACT YEAR

Contract year means the 12-month period beginning on the effective date of the group's policy.

COPAYMENT

Copayment means the member's portion, expressed as a fixed dollar amount, that you are required to pay for certain covered services provided under the policy.

COVERED SERVICE

Covered service means a service or supply specified in this certificate and the Schedule of Benefits for which benefits will be provided.

CUSTODIAL CARE

Custodial care means provision of room and board, nursing care, personal care or other care designed to assist you in the activities of daily living. Custodial care occurs when, in the opinion of a participating provider, you have reached the maximum level of recovery. If you are institutionalized, custodial care also includes room and board, nursing care, or other care when, in the opinion of a participating provider, medical or surgical treatment cannot reasonably be expected to enable you to live outside an institution. Custodial care also includes rest cures, respite care, and home care provided by family members.

DEDUCTIBLE

Deductible means a pre-determined amount of money that an individual member may have to pay before benefits are payable by MercyCare. The single deductible applies to each member each contract year, and the family deductible amount is the most that the employee and his or her dependents must pay each contract year.

DEPENDENT

Dependent means the following:

1. An employee's lawful spouse; and/or
2. An employee's unmarried and natural blood-related child, stepchild, legally adopted child or child placed in the custody of the employee for adoption (as provided for in section 632.896 of the Wisconsin Statutes) whose age is less than the limiting age stated in the schedule of benefits. Adopted children become dependents when placed in the custody of the parent; and/or Grandchildren if the parent is a dependent child. The dependent grandchild will be covered until the end of the month in which the dependent child turns age 18.
- 3.

If the employee is the father of a child born outside of marriage, the child does not qualify as a dependent unless there is a court order declaring paternity or acknowledgment of paternity is filed with the Wisconsin Department of Health and Family Services or the equivalent agency if the birth was outside of the state of Wisconsin. Upon qualification, coverage for the child will be effective according to the Eligibility and Effective Date of Coverage section.

A spouse and stepchildren cease to be dependents at the end of the month in which a divorce decree is granted, and may be terminated subject to Continuation and Conversion privileges. Other children cease to be dependents at the end of the calendar year in which they reach the limiting age stated in the Schedule of Benefits or at the end of the month in which they marry, whichever occurs first, except that:

1. Children over the limiting age who are full-time students, if otherwise eligible, cease to be dependents at the end of the calendar year in which they cease to be full-time students or in which they turn the age specified in the Schedule of Benefits for full-time students, whichever occurs first.

Full-time student means the child is in regular full-time attendance at an accredited secondary school; accredited vocational, technical, or adult education school, or an accredited college or university which provides a schedule of courses or classes and whose principal activity is the provision of an education. Proof of attendance is required upon request from MercyCare. Full-time student status is to be defined by the institution in which the student is enrolled. Student status includes any intervening vacation period if the child continues to be a full-time student.

2. A covered dependent child who attains the limiting age while insured under the policy shall remain eligible for benefits if he or she is incapable of self-sustaining employment because of mental retardation or physical handicap which existed before the dependent attained the limiting age. The dependent must continue to be chiefly dependent on the employee for support and maintenance.

Written proof of incapacity and dependency must be provided to MercyCare in a form satisfactory to MercyCare within 31 days after the dependent's attainment of the limiting age. MercyCare, at its sole discretion, may require the dependent to be examined from time to time by a participating provider for the purpose of determining the existence of the incapacity prior

to granting continued coverage. Such examinations may occur at reasonable intervals during the first two years after continuation under this section is granted and annually thereafter. The employee must notify MercyCare immediately of a cessation of incapacity or dependency.

3. A child who is considered a dependent ceases to be a dependent on the date the child becomes insured as an eligible employee.

DEVELOPMENTAL DISABILITY

Developmental disability means mental retardation or a related condition such as cerebral palsy, epilepsy or autism, but excluding mental illness and infirmities of aging, which is:

- a) Manifested before the individual reaches age 22,
- b) Likely to continue indefinitely, and
- c) Results in substantial functional limitations in 3 or more of the following areas of major life activity:
 1. Self-care.
 2. Understanding and use of language.
 3. Learning.
 4. Mobility.
 5. Self-direction.
 6. Capacity for independent living.
 7. Economic self-sufficiency.

DUAL CHOICE ENROLLMENT PERIOD

Dual choice enrollment period means a period each year when the group and MercyCare agree to allow members who are currently enrolled in any of the group's other benefit plans to enroll for coverage under MercyCare's plan.

EMERGENCY

Emergency means a medical condition that manifests itself by acute symptoms of sufficient severity, including severe pain, to lead a prudent layperson with an average knowledge of health and medicine reasonably to conclude that, without immediate attention, could likely result in death or serious injury to your body.

EMPLOYEE

Employee means an individual whose employment or other status, except for family dependency, is the basis for eligibility for enrollment under the policy.

ENROLLMENT FORM

Enrollment form means the form completed by a potential member requesting coverage from MercyCare and listing all dependents to be covered on the effective date of coverage.

EXPERIMENTAL/INVESTIGATIVE

Experimental or investigative means the use of any service, treatment, procedure, facility, equipment, drug,

devices or supply for a member's bodily injury or sickness that:

- a. Requires the approval by the appropriate federal or other governmental agency that has not been granted at the time it is used; or
- b. Is not yet recognized as acceptable medical practice to treat that bodily injury or sickness, as determined by MercyCare for a member's bodily injury or sickness.

The criteria that MercyCare's Medical Services Department uses for determining whether a service, treatment, procedure, facility, equipment, drug, device or supply is considered to be experimental or investigative include whether:

- a. It is commonly performed or used on a widespread geographic basis.
- b. It is generally accepted to treat that bodily injury or sickness by the medical profession in the United States.
- c. Its failure rate or side effects are unacceptable.
- d. The member has exhausted more conventional methods of treating the bodily injury or sickness.
- e. It is recognized for reimbursement by Medicare, Medicaid and other insurers and self-funded plans.

FREESTANDING SURGICAL FACILITY

Freestanding surgical facility means any accredited public or private establishment that has permanent facilities equipped and operated primarily for performing surgery with continuous physician services and registered professional nursing services whenever a patient is in the facility. It does not provide services or accommodations for patients to stay overnight.

FULL PROVIDER AGREEMENT

Full provider agreement means a general agreement to provide covered services to members, and does not include limited provider agreements such as those for referral or unusual services only.

GRIEVANCE

Grievance means any dissatisfaction with MercyCare's provision of services, claims practices, or administration of the plan that is expressed in writing to MercyCare by or on behalf of a member. See the Complaint Procedures section in this certificate for more information.

GROUP

Group means the employer, union, trust or association to which the policy is issued and through which eligible employees and dependents become entitled to coverage described in this certificate.

GROUP APPLICATION

Group application means the form completed by a Group requesting coverage from MercyCare for individuals in their Group.

HOSPITAL

Hospital means an institution that:

1.
 - a. Is licensed and run according to Wisconsin laws, or other applicable jurisdictions, that apply to hospitals;
 - b. Maintains at its location all the facilities needed to provide diagnosis of, and medical and surgical care for, bodily injury or sickness;
 - c. Provides this care for fees;
 - d. Provides such care on an inpatient basis; and
 - e. Provides continuous 24-hour nursing services by registered graduate nurses; or
2.
 - a. Qualifies as a psychiatric or tuberculosis hospital;
 - b. Is a Medicare provider; and
 - c. Is accredited as a hospital by the Joint Commission on Accreditation of Healthcare Organizations.

Hospital does not mean an institution that is chiefly:

- a. A place for treatment of chemical dependency;
- b. A nursing home; or
- c. A federal hospital.

IDENTIFICATION CARD

Identification card means the card that MercyCare issues to you that indicates your entitlement to receive covered services from participating providers.

LEARNING DISABILITY

Learning Disability means an inability or defect in the ability to learn. It occurs in children and is manifested by difficulty in learning basic skills such as writing, reading and mathematics.

MAINTENANCE OR LONG TERM THERAPY

Maintenance or long term therapy means ongoing therapy delivered after the acute phase of a sickness has passed. It begins when a patient's recovery has reached a plateau or non-measurable improvement if his/her condition has slowed or ceased entirely and only minimal rehabilitative gains can be demonstrated. The determination of what constitutes maintenance or long term therapy is made by MercyCare after reviewing an individual's case history or treatment plan submitted by a provider.

MEDICALLY NECESSARY

Medically necessary means a service, treatment, procedure, equipment, drug, device, or supply provided by a hospital, physician, or other provider of health care that is required to identify or treat a member's bodily injury or sickness and which is determined by MercyCare to be:

1. Consistent with the symptom(s) or diagnosis and treatment of the member's bodily injury or sickness;
2. Appropriate under the standards of acceptable medical practice to treat that bodily injury or sickness;
3. Not solely for the convenience of the member, physician, hospital or other provider of health care;
4. The most appropriate service, treatment, procedure, equipment, drug, device or supply which can be safely provided to the member; and
5. The most economical manner of accomplishing the desired end result.

MEDICAID

Medicaid means a program instituted pursuant to Title XIX (Grants to States for Medical Assistance Programs) of the United States Social Security Act, as added by the Social Security Amendments of 1965 as now or hereafter amended.

MEDICARE

Medicare means Title XVIII (Health Insurance Act for the Aged) of the United States Social Security Act, as added by the Social Security Amendments of 1965 as now or hereafter amended.

MEMBER

Member means the employee and his/her dependents who have been enrolled and are entitled to benefits under the policy.

MERCYCARE

MercyCare means MercyCare Insurance Company.

NON-EXPERIMENTAL

Non-experimental means:

- a) Any discrete and identifiable technology; regimen or modality regularly and customarily used to diagnose or treat bodily injury or sickness; and
- b) For which there is conclusive, generally accepted evidence that such technology, regimen or modality is safe, efficient and effective as determined by MercyCare.

NON-PARTICIPATING PROVIDER

Non-participating provider means a provider that is not listed in your provider directory as participating in the EPO network.

OPEN ENROLLMENT PERIOD

Open enrollment period means a period (each year) when the Group and MercyCare agree to allow potential members to enroll for coverage, regardless of whether they are currently enrolled in any of the Group's other medical benefit plans.

OUT-OF-POCKET EXPENSES

Out-of-pocket expenses means the portion of covered charges for which the member is responsible because of applicable coinsurance and/or deductible provisions, or non-covered charges.

PARTICIPATING PROVIDER

Participating provider means a provider that is listed in your provider directory as a participating provider in the EPO network. EPO providers are color coded in blue in your directory.

PHYSICIAN CHANGE FORM

Physician change form refers to the form available through MercyCare's Customer Service Department that enables a member to change his or her selection of primary care physician. Refer to the provision entitled Provider Selection in the Obtaining Services section of this certificate for more information.

PLAN

Plan means the group health plan offered by MercyCare Insurance Company as described in this certificate.

POLICY

Policy means the agreement between the Group and MercyCare setting forth the contractual rights and obligations of the parties and wherein MercyCare agrees to provide a health benefit program to eligible employees and dependents of the Group. The Group Contract, the Certificate of Coverage, the Schedule of Benefits, and any addenda or endorsements thereto, and the applications of the Group and the employee, constitute the entire policy.

POLICYHOLDER

Policyholder means the Group.

PRESCRIPTION DRUG

Prescription drug means any medicinal substance, the label of which, under the Federal Food, Drug and Cosmetic Act, is required to bear the legend: "Caution: Federal Law prohibits dispensing without prescription."

PRIMARY CARE PHYSICIAN

Primary care physician means a physician practicing family medicine, internal medicine, or pediatrics who has accepted primary responsibility for the MercyCare member's health care.

You must name your primary care physician on your enrollment form or on a later physician change form.

Each family member may have a different primary care physician. A member's primary care physician:

- Provides entry into MercyCare's health care system.
- Evaluates a member's total health care needs.
- Provides personal medical care in one or more medical fields.
- Is in charge of coordinating other health services and referring the member to other providers of health care when appropriate.

PRIOR AUTHORIZATION

Prior authorization means obtaining MercyCare's approval before you receive a service or supply. Any prior authorization requirement will be stated in this certificate or in the schedule of benefits. To obtain prior authorization, contact MercyCare at the address on the first page of this certificate or at the telephone number printed on your identification card.

PROVIDER NETWORK

A provider network is a group of providers contracted with the Plan to provide services for members within a specific geographic location and are part of the EPO network as color coded in your provider directory.

PROVIDERS OF HEALTH CARE

Providers of health care include:

- a) Medical or osteopathic physicians, hospitals, and clinics.
- b) Podiatrists, physical therapists, physician's assistants, psychologists, chiropractors, nurse practitioners, and dentists licensed by the State of Wisconsin, or other applicable jurisdiction to provide covered services.
- c) Nurses licensed by the State of Wisconsin and certified as a nurse anesthetist to provide covered services.
- d) Nurse midwives licensed by the State of Wisconsin to provide covered services.

QUALIFIED TREATMENT FACILITY

Qualified treatment facility means a facility, institution, or clinic duly licensed to provide mental health or substance abuse treatment; primarily established for that purpose; and operating within the scope of its license.

REFERRAL

A referral is the process by which any service that requires prior authorization will be reviewed by MercyCare's medical services department. Your doctor will complete a referral form, which will function as a request for authorization for any services that require prior authorization (for example, visits to a non-participating provider). This form is submitted to MercyCare, where the Medical Department will determine whether or not the requested services will be approved. See page 2 for referral process requirements.

ROUTINE OR PREVENTIVE

Routine or preventive care means any physical exam or evaluation done in accordance with medically appropriate guidelines for age and sex, in consideration of a member's personal and/or family medical history, when an exam is otherwise not indicated for the treatment of an existing or known bodily injury or sickness.

SCHEDULE OF BENEFITS

Schedule of Benefits means a summary of coverage and limitations provided under the policy.

SERVICE AREA

Service area means the geographical area in which MercyCare is authorized to offer a health plan.

SICKNESS

Sickness means any condition or disease that causes loss of, or affects, normal body function other than those resulting from bodily injury.

SKILLED CARE

Skilled care means medical services that are ordered by a participating provider and given by or under the direct supervision of a registered nurse, licensed practical nurse, licensed physical, occupational or speech therapist. Skilled care is usually necessary for only a limited period of time. It does not include maintenance or long term care. Daily care such as assistance with getting out of bed, bathing, dressing, eating, maintenance of bowel and bladder function, preparing special diets, assisting patients with taking their medicines, or 24 hour supervision for potentially unsafe behavior, do not require skilled care and are considered custodial care.

SKILLED NURSING FACILITY

Skilled nursing facility means an institution, which is licensed by the State of Wisconsin, or other applicable jurisdiction.

SOUND AND NATURAL TEETH

Sound and natural teeth means teeth that would not have required restoration in the absence of a member's traumatic bodily injury, or teeth with restoration limited to

composite or amalgam fillings. It does not mean teeth with a crown or root canal therapy.

TOTAL DISABILITY OR TOTALLY DISABLED

Total disability or totally disabled means, for an employee or his or her employed covered spouse, that the person is at all times prevented from engaging in any job or occupation for wage or profit for which he or she is reasonably qualified by education, training, or experience. Total disability also means the person cannot engage in any job or occupation for wage or profit.

For a covered spouse who is not employed and a covered dependent child, total disability means a disability preventing the person from engaging in substantially all of the usual and customary activities of a person in good health and of the same age and sex.

Total disability will be determined based upon the medical opinion of MercyCare's Medical Director and other appropriate sources.

URGENT CARE

Urgent care is care for an accident or illness that you need sooner than a routine doctor's visit. Examples of urgent care situations are broken bones, sprains, non-severe bleeding, minor cuts and burns, and drug reactions.

WE

We means MercyCare Insurance Company.

YOU/YOUR

You/your means any member enrolled in the plan.

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