

CERTIFICATE OF COVERAGE
MercyCare Health Plans
P.O. Box 2770
Janesville, Wisconsin 53547-2770

PLAN TYPE:

GROUP NUMBER:

GROUP:

EMPLOYEE:

CERTIFICATE NUMBER:

EFFECTIVE DATE:

MercyCare HMO, Inc. (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.

This certificate limits benefits received from a non-participating provider to the usual and customary charge. This amount may be less than the billed charges. See the Emergency Care section of this certificate and the definition of “usual and customary charge” for a more detailed explanation.

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, this 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 group contract that we have with your Group. 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
- Index

INTERPRETING THIS CERTIFICATE

MercyCare HMO, Inc. has the authority to interpret this Certificate of Coverage and all questions that arise under it. Benefits under this Certificate of Coverage will be paid only if MercyCare decides in its discretion that the member is entitled to them. For example 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.

PROVIDER SELECTION

At the time you enrolled in this 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 any 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

Your primary care physician is responsible for your care. You can visit any participating provider without a referral, but your primary care physician is available to assist you in finding the appropriate participating provider.

If your primary care physician or another participating provider feels that you need specialty care beyond that available from participating providers, he or she must complete a referral form. A referral may authorize coverage for one or more visits to a non-participating provider, and must be submitted to and approved by MercyCare's Quality Health Management Department before such services occur. The referring provider and the Quality Health Management Department will determine the duration of the referral or the number of visits for which it authorizes coverage based on what is medically appropriate. A verbal request for a referral will not guarantee that the referral is authorized and approved by MercyCare. The Quality Health Management Department must determine whether the referral should be approved. If a referral is not approved by the Quality Health Management Department, it is not considered valid, and coverage for the services is not considered authorized. If an authorized referral is not obtained for services from a non participating provider MercyCare will not cover any claims associated with those services.

For service to be covered it is your responsibility to make sure your doctor submits a referral to the Plan prior to seeking treatment.

PRIOR AUTHORIZATION

To assure proper medical management, the following services require prior authorization from the Plan before they will be covered services, regardless of whether they are rendered by a participating or non-participating provider. Failure to get prior authorization means the services are not covered, so you will be responsible for the payment of such services.

Categories of services and supplies requiring prior authorization are:

Autism Treatment
Biofeedback services
Cardiac rehabilitation
Dental surgery
Durable medical equipment
Genetic testing and counseling
Home health care
Hospice care
Hospital services, inpatient and outpatient
Insulin pumps
Magnetic Resonance Imaging (MRI)
Maternity services received out of the service area in the last 30 days of pregnancy
Medical supplies
Non-participating provider services and supplies
Pharmaceuticals administered in provider's office
Positron emission tomography (PET) imaging
Prosthesis
Psychological disorder and chemical dependency, inpatient and transitional treatment
Reproductive services, inpatient
Surgical services, inpatient, outpatient, and at a free-standing surgical facility
Skilled nursing facility services
Temporomandibular disorders (TMJ)
Transplants

For questions about the prior authorization process, please call our Customer Service Department at 1-800-895-2421.

CONTINUITY OF CARE

If, at the time of your enrollment or most recent renewal, 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.

NON-EMERGENCY CARE

Except in the event of an emergency or urgent care situation, all services described in this certificate must be obtained directly from:

- Your primary care physician.
- Another participating provider.
- A non-participating provider with a referral authorized by the Plan.

COPAYMENTS, COINSURANCE, AND DEDUCTIBLES

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

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

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.
- Amounts paid for certain services as marked in your Schedule of Benefits.
- Any copayments you pay.

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

OUT-OF-POCKET MAXIMUM

The out-of-pocket maximum is the most you will pay in co-insurance for your covered services in a contract year. The out-of-pocket maximum may or may not include any deductibles that apply, depending on your schedule of benefits. The amount of the out-of-pocket maximum is shown in the Schedule of Benefits. The "single" out-of-pocket maximum is the most that each member will pay out-of-pocket each contract year.

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 may 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
- Receive services that are subject to copayments.
- Receive services that require prior authorization that were not authorized by the Plan (see Prior Authorization section of this Certificate); or
- Receive services that require a referral and prior approval was not given by the Plan.

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. The lifetime maximum applies across all policies issued by MercyCare and covering the member.

STUDENTS OBTAINING SERVICES

Medical/Surgical Benefits:

Eligible dependent children who are full-time students are covered just as other members of the Plan.

All routine, preventive, and follow-up care must be provided by a participating provider or with a referral authorized by the Plan. Urgent or Emergency 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 beyond high school in Wisconsin and outside the service area, 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 in which 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 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 a lack of immediate medical attention will likely result in death or serious injury to your body. Examples of emergency care situations include but are not limited to 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, and drug overdose.

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 your primary care physician within 48 hours of the emergency or as soon as reasonably possible in order to arrange follow-up care.

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

In addition to the emergency room copay, emergency treatment provided by non-participating providers may be subject to usual and customary charges.

To be covered, non-emergency or follow-up care must be provided by 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:

To be covered, 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.

To be covered, non-emergency or follow-up care must be provided by a participating provider.

Members are entitled to these benefit provisions subject to the terms, conditions and exclusions of the policy and this Certificate. Benefits under this Certificate will be paid only if MercyCare decides in its discretion that the member is entitled to them. 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. Services and supplies will be covered services only if medically necessary and if rendered by a participating provider. Coverage is subject to any coinsurance copayment, deductible and/or other limits shown in the Schedule of Benefits.

Services and supplies from non-participating providers are covered services only with prior authorization from the Plan.

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

ACUPUNCTURE SERVICES

Your schedule of benefits will indicate whether or not you have coverage for acupuncture. Participating acupuncturists can be found in your provider directory.

Covered Services:

- Acupuncture services performed by a certified or licensed participating acupuncturist are covered without a referral.
- Services are subject to the coinsurance, copayments, and other terms as specified in your Schedule of Benefits.

Non-Covered Services:

- Acupuncture services provided by non-participating providers.
- Acupuncture services provided by non-certified or non-licensed providers.

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.

AUTISM TREATMENT

Your schedule of benefits will indicate the effective date and limitations of this coverage. Refer to the glossary for definitions of terms used in this section.

Autism Spectrum Disorder Treatment means treatment for members who have a primary verified diagnosis of autism spectrum disorder when made by a provider skilled in testing and in the use of empirically validated tools specific for autism spectrum disorders. MercyCare reserves the right to require a second opinion in establishing the diagnosis of autism.

Covered Services:

- Diagnostic testing and evaluation by a provider approved by MercyCare.
- Intensive-level services for up to 4 cumulative years for members between the age of 2 and 9 years;
- Nonintensive-level services that are provided:
 1. after the completion of intensive-level services treatment, or

2. to a member who has not and will not receive intensive-level services, but for whom nonintensive-level services will improve the member's condition.
- Nonintensive-level services that include direct or consultative services when provided by qualified providers, qualified supervising providers, qualified professionals, qualified paraprofessionals or qualified therapists.

Coverage Provisions:

- To be covered, intensive-level services must:
 1. Have prior authorization from the Plan, and
 2. Be provided by one of these participating providers: qualified provider, qualified supervising provider, qualified professional, qualified paraprofessional or qualified therapist, and
 3. Be deemed to be evidence-based and efficacious, and
 4. Be part of the member's treatment plan that was subject to prior authorization, and
 5. Be provided when the parent or guardian is present the majority of the time.
- To be covered, nonintensive-level services must:
 1. Have prior authorization from the Plan, and
 2. Be provided by one of these participating providers: qualified provider, qualified supervising provider, qualified professional, qualified paraprofessional or qualified therapist, and
 3. Be part of the member's treatment plan that was subject to prior authorization, and
 4. Be deemed to be evidence-based and efficacious.

Non-Covered Services

- Any services that do not have prior authorization from the Plan.
- Custodial or respite care.
- Travel time for qualified providers, supervising providers, professionals, therapists, or paraprofessionals.
- Animal-based therapy, including hippotherapy.
- Auditory integration training.
- Chelation therapy.
- Child care fees.
- Cranial sacral therapy.
- Hyperbaric oxygen therapy.
- Special diets or supplements.
- Treatment provided by parents or legal guardians.
- Autism therapy, treatment or services provided to a member who is residing in a residential treatment center, inpatient treatment or day treatment facility.
- The cost for the facility or location when treatment, therapy or services are provided outside a member's home.

BIOFEEDBACK

Covered Services:

- Biofeedback is covered only for treatment of headaches, spastic torticollis, urinary incontinence, and post traumatic stress disorder.
- 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 in a 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 transluminal 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:

- Chiropractic services performed by a participating chiropractor are covered without a referral. 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 lymphedemas.
- 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 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:

- 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 in a hospital or free-standing surgical facility, 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

BENEFIT PROVISIONS

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.

- Oral surgery with prior authorization from the Plan for gum or bone tumors and cysts.
- Surgical removal of impacted wisdom teeth (third molars).

Non-Covered Services:

- Oral surgery performed solely for the fitting of dentures or the restoration or correction 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 other conditions of the joint linking the jaw bone and skull.
- e) Hospital costs for any of these services except as specifically described in the certificate.
- f) Any treatment for Bruxism-including splint devices.

- 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 with prior authorization and meeting the medical criteria established by the Plan.
- Diabetic supplies.
- Insulin.

DURABLE MEDICAL EQUIPMENT AND MEDICAL SUPPLIES

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, and
- e) provides therapeutic benefits or enables the patient to perform certain tasks that he or she would be unable to perform or otherwise undertake due to certain covered medical conditions or illnesses.

Coverage for durable medical equipment is subject to the limitations specified in the member's Schedule of Benefits.

Medical Supply is defined as a disposable, consumable, medically necessary item which usually has a one time or limited time use and is then discarded.

Covered Services:

- Durable medical equipment (DME) is covered only:
 - a) With prior authorization by the Plan and when:
 - b) Determined to be medically necessary, and
 - c) Purchased at a participating DME 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 and
 - e) Not generally available over the counter (OTC).
- 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 covered brace.
- Home monitoring equipment for the treatment of diabetes, infant apnea, or premature labor.
- Compression stockings, when ordered by a participating provider, are limited by compression weight (greater than 30 mmhg) and to two pairs per contract year.
- Injectable medication given in an office or outpatient setting.
- Rental of cervical and/or lumbar traction devices is limited to a three month rental.
- Mechanical Devices used to treat sleep apnea require a three month rental to establish that there is a regular and consistent use, and a medical benefit prior to purchase.
- Oxygen therapy and other inhalation therapy and related items for home use.

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

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.
- Replacement of supplies without prior authorization from the Plan.
- Replacement for damaged, lost or stolen items.
- Repairs and replacement of durable medical equipment without prior authorization from the Plan.
- Physician equipment, home testing and monitoring equipment, including but not limited to blood pressure equipment, stethoscopes, otoscopes, equipment that tests for blood levels other than glucose, oxygen level monitoring equipment and equipment that may monitor other types of measures or values.
- Exercise or Physical fitness equipment (examples: treadmills, exercise bikes, bicycles, foam roller, etc.)
- 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.
- Any food, liquid or nutritional supplements including those prescribed by a physician.
- Motorized vehicles, or power operated vehicles, including but not limited to motorized scooters, except for motorized wheel chair when medically necessary.
- Durable medical equipment for comfort, personal hygiene, and convenience items including but not limited to: air conditioners; air cleaners, purifiers, humidifiers, or dehumidifiers; alternative communication devices; self-help devices not medical in nature; automobile modifications or lifts; baskets for wheelchairs and walkers; bath benches, or chairs; bath systems or lifts; car seats; cervical pillows; dressing sticks or aids; diapers; disposable gloves; disposable undergarments; eating utensils; eggcrate mattress pads; electric patient lifts; ergonomic chairs; orthotic socks; oral hygiene products; oral nutritional supplements and infant formula available over the counter; pillows; portable care or travel nebulizers; raised toilet seats; reachers; safety equipment such as gait belts, helmets, knee and elbow pads, or safety glasses; shower chairs; strollers; feeding aids; grab bars; grooming aids; heating pads; home bathtub spas; home massage equipment; lambs wool sheepskin padding; lap trays not used for trunk support; lumbar rolls or cushion; massagers or Theracane; occipital

release boards; stroller or wheelchair canopies; toileting systems or lifts; tongue depressors; vaporizers; vehicle travel or safety tie down restraints; wheelchair attendant controls; wheelchair backpacks or clips; wheelchair swing-aways; wheelchair or removable hardware when not needed for slide transfers; wheelchair work or cut-out trays; wigs; alcohol wipes; band-aids; over the counter (OTC) antibiotic ointments; OTC dressing supplies (examples: 4X4 gauze, tape, betadine, etc.); and home remodeling or modifications.

EMERGENCY CARE

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

GENETIC TESTING AND COUNSELING

Covered Services:

With prior authorization from the Plan, genetic testing is covered when:

- The test is not considered experimental or investigational, and
- The test is medically necessary, and
- The results will affect the course of medically necessary treatment.

With prior authorization from the Plan, genetic counseling is covered when:

- It is associated with a covered and approved test, or
- It is for the purpose of determining if a specific genetic test is appropriate.

Non-Covered Services:

- Direct-to-consumer genetic testing.
- Paternity testing.
- Fetal sex determination.
- Genetic testing of a non-plan member.
- Genetic counseling that is associated with non-covered genetic tests.
- Genetic testing when the results do not provide direct medical benefit to the Plan member.

HEARING EXAMS AND HEARING AIDS

Covered Services:

- Hearing aids, hearing exams and hearing aid procedures are covered when obtained through a participating provider, and with prior authorization from the Plan.
- 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 PROVISIONS

- Benefit is subject to the limitations specified in your Schedule of Benefits.
- Cochlear implants are covered for children under the age of 18 with prior authorization from the Plan.
- Implantable bone conduction hearing aid, also called bone-anchored hearing aid (Baha®) is covered for patients with conductive hearing losses (unilateral or bilateral), or mixed hearing losses, if the patient has a bone conduction pure tone average up to 45 dBHL and a speech discrimination score better than 60% (in the indicated ear) who additionally has any one or more of the following conditions:
 - a) Congenital or surgically induced malformations of the external ear canal and/or middle ear (example: atresia) or
 - b) Tumors of the external ear canal and/or tympanic cavity, or
 - c) Severe chronic external otitis or otitis media, or
 - d) Otosclerosis in those who are not suitable candidates for stapedectomy, or
 - e) Dermatitis of the external ear canal, including reactions from ear molds used for typical air conduction hearing aids, or
 - f) Other conditions in which an air conduction hearing aid is contraindicated (example: relapsing polychondritis).
- Implantable bone conduction hearing aid, also called bone-anchored hearing aid (Baha®) is covered for the treatment of unilateral sensorineural hearing loss (single sided deafness) when there is normal hearing in the opposite ear (defined as a 20 dBHL air conduction pure tone average).
- The procedure and related services to implant a bone conduction hearing aid are covered as medical/surgical benefits; the device itself (bone anchored aid) is covered under the hearing aid benefit portion of your Plan. See your schedule of benefits for coverage limits.
- 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) The evaluation of the need for home care when approved or requested by the attending physician.
 - b) 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;
 - c) Home health aide services that 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.
 - d) Physical, respiratory, occupational and speech therapy;
 - e) Medical supplies, drugs and medicines prescribed by a physician, and lab services by or from 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;
 - f) Nutritional counseling under the supervision of a registered or certified dietitian if considered medically necessary as part of the home care plan;
- 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:

- Hearing aids if more than one per ear in any 36-month period.
- Cochlear implants for members age 18 and older.
- Coverage for services in excess of the limits stated in your schedule of benefits.

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.

Non-Covered Services:

- Custodial care.

HOSPICE CARE

Covered Services:

- Hospice Care services are covered with prior authorization from the Plan and if a member's life expectancy is six months or less, and 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 room and board expenses.

HOSPITAL SERVICES

Covered Services:

- Inpatient and outpatient hospital services are covered with prior authorization by the Plan when rendered by a hospital or freestanding surgical facility.
- Inpatient hospital services include the following:
 - a) 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 determined by the Plan to be medically necessary.
 - b) Hospital services and supplies determined to be medically necessary and furnished for your treatment during confinement, including drugs administered to you as an inpatient.
 - c) Inpatient participating hospital confinement days are covered when care is being directed by a participating provider and with authorization from the Plan.
- 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.

- 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 Medical Supplies section of this Certificate of Coverage. For discharge equipment and supplies, refer to the Durable Medical Equipment and Medical Supplies section of this Certificate of Coverage.

KIDNEY DISEASE TREATMENT

Covered Services:

Services and supplies directly related to the treatment of kidney disease, including but not limited to, inpatient, outpatient, dialysis, transplantation, donor-related services, and related physician charges. These services are limited - please see the Schedule of Benefits for benefit maximums.

NEWBORN BENEFITS

Covered Services:

- Newborn benefits include the following services:
 - a) Nursery room, board, and care.
 - b) Routine or preventative exam and other routine or preventative professional services when received by the newborn child before release from the hospital.
 - c) Circumcisions when rendered prior to discharge from the hospital.
 - d) Plastic surgery, in order to reconstruct or restore function to a body part with a functional defect present at birth.
 - e) 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 when rendered by a participating provider.
- Services must be medically necessary due to bodily injury or sickness.

BENEFIT PROVISIONS

- 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 patient's home or be a family member.
- For speech and occupational therapy services for the treatment of autism, please refer to the Autism Treatment section of this certificate.

Non-Covered Services:

- Any form of therapy or treatment for learning or developmental disabilities, including: hearing therapy for a learning disability and communication delay; therapy for perceptual disorders, mental retardation and related conditions; evaluation and therapy for behavior disorders; special evaluation and treatment of multiple handicaps, hyperactivity, or sensory deficit and motor dysfunction; developmental and neuro-educational testing or treatment; and 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 by a participating provider for determining the need for correction.
- Services rendered by a masseuse.
- Maintenance or long term therapy and any maintenance or therapy program that consists of activities that preserve the patient's present level of function and prevent regression of that function.

PHYSICIAN SERVICES

Covered Services:

- In office services unless otherwise excluded by this Certificate or the Schedule of Benefits.
- Routine or preventive physicals
- Inpatient and outpatient visits
- Home Visits
- Surgical services with prior authorization by the Plan

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 not otherwise medically necessary or appropriate, unless the services and/or supplies are state-mandated. Excluded services and supplies include physical exams, disease immunizations, services and supplies for employment (including travel for employment), licensing, marriage, adoption, insurance, camp, school, sports, and travel.

PODIATRY SERVICES

Covered Services:

- Routine or preventive exams when medically necessary and provided by a participating provider.

Non-Covered Services:

- The following services are non-covered except when prescribed by a participating provider who is treating a member for metabolic or peripheral vascular disease:
 - a) Services rendered 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) Services related to the cutting, trimming or other non-operative partial removal of toenails.
 - c) Treatment of flexible flat feet.

PREGNANCY BENEFITS

Covered Services:

- Only services and supplies for the pregnancy of an employee, an employee's covered dependent spouse, or an employee's covered dependent child are covered.
- 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:

- Elective abortions.
- Treatment, services or supplies required as the result of a written or unwritten agreement for the benefit of a party other than the member, or as a volunteer for such a party.
- 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. If your Group's health benefit package includes a MercyCare prescription drug rider, you must satisfy the deductibles and pay copayment and coinsurance under both the prescription drug rider and this Certificate.

PREVENTIVE CARE

Covered Services:

- Well child care.

BENEFIT PROVISIONS

- Annual routine or preventive physicals, including the following tests performed on a preventive basis ONLY: Colonoscopy, sigmoidoscopy, mammogram, Pap Smear.

Preventive care services may or may not be subject to the deductible. Your Schedule of Benefits will indicate whether or not you have this benefit.

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
- With prior authorization by the Plan and when obtained from a participating provider.

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:

- 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 Addiction 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; and programs to provide coordinated emergency mental health services for members who are experiencing a mental health crisis or who are in a situation likely to turn into a mental health crisis if support is not provided for the period of time the member is experiencing a mental health crisis until the member is stabilized or referred to other providers for stabilization. Programs providing

coordinated emergency mental health services for members must provide timely notice to MercyCare to facilitate coordination of such services.

- 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 a 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.
- Outpatient, inpatient and transitional treatment services require prior authorization by the Plan. 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 nonparticipating provider with prior authorization from the Plan
- 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 provided by a non-participating provider are not covered after the Plan has arranged for services by a participating provider in a more appropriate setting.
- Family therapy is covered only if the diagnosed member is present at the family therapy session.
- For behavioral health services related to the treatment of autism spectrum disorder, see the Autism Treatment section of this Certificate.

Non-Covered Services:

- Maintenance or long term therapy.
- Biofeedback, except that provided by a licensed healthcare provider for treatment of headaches, spastic torticollis and urinary incontinence, or by a behavioral health practitioner for the treatment of post traumatic stress disorder.
- Hypnotherapy, or residential care except for the treatment of alcohol or drug dependency.
- In-home treatment services, except those for treatment of autism with prior authorization.

BENEFIT PROVISIONS

- Halfway houses.
- Treatment of nicotine habit or addiction.
- Treatment of being overweight or obese.
- Methadone maintenance therapy.
- Custodial or Respite Care.
- Travel time for qualified providers, supervising providers, professionals, therapists or paraprofessionals.
- Animal-based therapy, including hippotherapy.
- Auditory integration training.
- Chelation therapy.
- Child care fees.
- Cranial sacral therapy.
- Hyperbaric oxygen therapy.
- Special diets or supplements.
- Treatment provided by parents or legal guardians.

REPRODUCTIVE SERVICES

Covered Services:

- Covered services include consultation, tubal ligation, diaphragms, intrauterine devices (IUD), Depo provera shots, implantable birth control devices and vasectomy.
- 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.
- Services subject to the limitations specified in the Schedule of Benefits include but are not limited to related hospital, professional and diagnostic services, and medications that are incidental to such insemination or fertilization methods.
- Artificial insemination benefits are limited to the physician's charge for the procedure.

Non-Covered Services:

- Any artificial means to achieve pregnancy other than the physician's charge for artificial insemination, including but not limited to consultations for, or any procedures in connection with, in vitro fertilization, gamete intra fallopian transfer (GIFT), embryo transplant, or any other assistive reproductive technique.
- Infertility services which are not for the treatment of illness or injury (i.e., treatment needed to achieve pregnancy). The diagnosis of infertility alone does not constitute an illness.
- Reversal of voluntarily induced sterilization procedures.
- Donor sperm.
- Storage and collection fees for sperm and ovum.
- Charges for donor, laboratory or biological fees directly related to an artificial insemination procedure.
- Revision of scarring caused by implantable birth control devices.

- Elective abortions.
- Treatment, services or supplies required as the result of a written or unwritten agreement for the benefit of a party other than the member, or as a volunteer for such a party.

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 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 (TMJ) are covered if all of the following apply:
 - a) You have prior authorization from the Plan for all temporomandibular-related evaluation and other services, and for the facilities where services are performed.
 - b) The condition is caused by congenital, developmental or acquired deformity, sickness or bodily injury.
 - c) 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.
 - d) 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.

These services are limited, please see the Schedule of Benefits for benefit maximums.

Non-Covered Services:

- Cosmetic or elective orthodontic care, periodontic care or general dental care.
- Any treatment or supplies for bruxism.

TRANSPLANTS

Covered Services:

Coverage is limited to those organ transplant procedures that are considered by the Plan to be non-experimental, medically necessary, and effective. "Organ" includes bone marrow and stem cells. All transplant-related services, including evaluation, and the facilities where the services are performed, require prior authorization 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 Dates 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 "Kidney Disease Treatment" in this section of the 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.

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.

BENEFIT PROVISIONS

- Transplants and all related expenses without prior authorization by the Plan.
- 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).
- Storage and collection fees for cord blood and stem cells for possible and/or indefinite or undetermined need for transplant.

URGENT CARE

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

VISION CARE

Covered Services:

- Medical eye examinations provided as part of the treatment for pathological conditions when rendered by or at the direction of a participating physician.
- Routine or preventive eye exams are covered when rendered by a participating ophthalmologist or optometrist.
- Initial eyeglasses or contact lenses are covered after cataract surgery if purchased from a participating provider.

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 when rendered by and at the direction of a participating provider.
- 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 by a participating provider.
- 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 except when experimental or investigational. The exception for experimental or investigational cancer therapy does not apply to routine patient care that is administered to a member in a cancer clinical trial and that is otherwise a covered service. Routine patient care does not include the health care service, item, or investigational drug that is the subject of the cancer clinical trial; any health care service, item, or drug provided solely to satisfy data collection and analysis needs that are not used in the direct clinical management of the member; an investigational drug or device that has not been approved for market by the federal Food and Drug Administration; transportation, lodging, food, or other expenses for the member or the family or companion of the member that are associated with travel to or from a facility providing the cancer clinical trial; any services, items, or drugs provided by the cancer clinical trial sponsors free of charge for any patient; or any services, items, or drugs that are eligible for reimbursement other than under the Plan, including by the sponsor of the cancer clinical trial. To qualify as a cancer clinical trial under this provision, it must satisfy all of the following:
 - a) A purpose of the trial is to test whether the intervention potentially improves the member's health outcomes.
 - b) The treatment provided as part of the trial is given with the intention of improving the member's health outcomes.
 - c) The trial has therapeutic intent and is not designed exclusively to test toxicity or disease pathophysiology.
 - d) The trial (i) tests how to administer a health care service, item, or drug for the treatment of cancer; (ii) tests responses to a health care service, item, or drug for the treatment of cancer; (iii) compares the effectiveness of health care services, items, or drugs for the treatment of cancer with that of other health care services, items, or drugs for the treatment of cancer; or

- (iv) studies new uses of health care services, items, or drugs for the treatment of cancer.
 - e) The trial is approved by (i) a National Institute of Health, or one of its cooperative groups or centers, under the federal Department of Health and Human Services; (ii) the federal Food and Drug Administration; (iii) the federal Department of Defense; or (iv) the federal Department of Veterans Affairs.
- 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 except when such occupation or employment is as a domestic servant; employee of a farmer or other employer that is not required to have Worker's Compensation coverage; volunteer; or partner in or sole proprietor or LLC member of a business on a substantially part-time basis. This exclusion applies whether or not you have Worker's Compensation coverage, or file a claim or receive benefits under any coverage you have.
 - Treatment, services and supplies for any bodily injury or sickness as the result of war, declared or undeclared, enemy action of armed forces of the United States, or any state of the United States, or any of its allies, or while serving in the armed forces of any country.
 - 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 provided, except that coverage shall be provided for any covered drug with the following criteria:
 - a) It is prescribed for the treatment of HIV infection or an illness or medical condition arising from or related to HIV infections; and
 - b) It is approved by the federal Food and Drug Administration, including phase-3 investigational drugs; and
 - c) If the drug is an investigational new drug, it 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, except, to the extent required by law, routine patient care that is administered to a member in a cancer clinical trial that would be covered under this Certificate if the member were not enrolled in a cancer clinical trial.
 - 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 are limited to those techniques commonly used by participating providers for conditions producing significant physical and mental symptoms.
- Any treatment or devices used to obtain, treat, or enhance sexual performance and/or function. This includes dysfunction caused by organic diseases.
- Genetic counseling, except as specifically covered in this Certificate.
- Acupuncture, unless the group policy covers it.
- The removal by any method of common warts and plane flat warts.
- Prophylactic procedures to prevent or diagnose a sickness that has not yet occurred.
- Any service and/or supply 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 not otherwise medically necessary or appropriate, unless the services and/or supplies are state mandated. Excluded services and supplies include physical exams, disease immunizations, and services and supplies for employment (including travel for employment), licensing, marriage, adoption, insurance, camp, school, sports or travel.

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, if later,
- 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.
- 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, 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 the location in which he or she spends at least 9 months out of a 12 month contract year.

Please refer to the glossary for the definition of dependent.

There may be adverse tax consequences if you enroll a dependent child who does not satisfy the support test under the federal Working Families Tax Relief Act of 2004. Generally, the support test requires that you provide more than one-half of the child's support. In some cases, however, the support test requires that the child has not provided more than half of his or her own

support. If you enroll a dependent child who does not satisfy the support test, the value of that dependent coverage in excess of any premiums you pay toward that coverage will be included in your wages for purposes of employment taxes and income taxes and will be reported on Form W-2. Also, any premiums required of you in connection with such dependent coverage must be paid on an after tax basis.

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 the initial enrollment period or any 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, or in other enrollment materials you received from your Group or the Plan.

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 of status 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 policy. 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, or in other enrollment materials you received from your Group or the Plan.
- 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

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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 of status 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 of status form. If MercyCare receives the change of status form BEFORE the dependent's eligibility date, coverage is effective on the dependent's eligibility date. If the change of status form is received AFTER the dependent's eligibility date, but within 30 days of that date, coverage is effective on the date MercyCare specifies.

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 the initial enrollment period or any 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 the initial enrollment period or any 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 of status 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 of status 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 of status 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 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 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 Group is required to provide you with a written notice of these rights. You must receive the notice within 5 days after the date your Group 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 Group. Your Group 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

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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 Group terminates coverage under the policy.

Federal COBRA 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
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 Group 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.

Federal USERRA Continuation:

The federal Uniformed Services Employment and Reemployment Rights Act (USERRA) applies to an employee who is absent from employment due to service in the military. Such employees and their dependents are entitled to continue coverage for the lesser of:

1. 24 months from the beginning of the employee's absence from employment; and
2. the day after the date on which the employee fails to apply for or return to employment.

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 Group is required to provide you with a written notice of these rights. You must receive the notice within 5 days after the date the Group 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 Procedures section in this Certificate of Coverage 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.

RIGHTS OF RECOVERY: 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. The Plan's subrogation and reimbursement rights apply to full and partial settlements, judgments, or other recoveries paid or payable to your or your representative, no matter how those proceeds are captioned or characterized.

The Plan's rights of subrogation and reimbursement apply to any recoveries that you make including benefits or payments for underinsured or uninsured motorist protection, no-fault or traditional auto insurance, medical payment coverage (auto, homeowners or otherwise), worker's compensation coverage or third party administrators.

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. The Plan is not required to help you pursue your claim for damages or personal injuries and no amount of associated costs, including attorney's fees, shall be deducted from our recovery without the Plan's express written consent. No so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall defeat this right unless applicable state law provides otherwise. 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's representatives in completing such forms and in giving such information surrounding any sickness or bodily injury as 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 may not accept any settlement that does not fully reimburse the Plan, without its written approval. 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 persons. If you receive any payment from any party as a result of Sickness or Injury, and we allege some or all of those funds are due to us, you shall hold those funds in trust, either in a separate bank account in your name or in your attorney's trust account. You agree that you will serve as a trustee over those funds to the extent of the benefits the Plan has paid.

The Plan has a first priority right to recover up to 100% of the benefits paid by the Plan out of the proceeds of any settlement, judgment, or other payment before you receive any proceeds unless applicable law provides that you must be made whole before the Plan can recover. You agree you are made whole if a claim results in payment to you, by way of settlement, compromise, judgment or other payment, of an amount less than the combined total of any available third party payments. If there is a dispute as to whether you have been made whole, the Plan may obtain a judicial determination of the issue.

In the case of your wrongful death or survival claims, the provisions of this section apply to your estate, the personal representative of your estate, and your heirs or beneficiaries. Neither you, your personal representative, any representative of your estate, your heirs or your beneficiaries, may allocate recovery among wrongful death and survivorship claims, whether by settlement or otherwise, in a manner that does not reimburse the Plan 100% of its interest without written consent from the Plan or its representative.

WORKERS COMPENSATION

The policy is not issued in lieu of nor does it affect any requirement for coverage by Workers' Compensation. Treatment for a bodily injury or sickness arising from or sustained in the course of any occupation or employment for compensation, profit or gain, is not covered under this policy, except when such occupation or employment is as a domestic servant; employee of a farmer or other employer that is not required to have Worker's Compensation coverage; volunteer; or sole proprietor, partner in or sole proprietor or LLC member of a business on a substantially part-time basis. This

exclusion applies whether or not you actually have Worker's Compensation coverage, or file a claim or receive benefits under any coverage you have. If the Plan paid for the treatment of any such bodily injury or sickness, the Plan has the right to recover such payments as described under the Right to Recovery provision of the Coordination of Benefits section of this Certificate unless the bodily injury or sickness arose from or was sustained in the course of occupation or employment as a domestic servant; employee of a farmer or other employer that is not required to have Worker's Compensation coverage; volunteer; or sole proprietor, partner in or sole proprietor of LLC member of a business on a substantially part-time basis.. You must reimburse the Plan, and the Plan will exercise the right to recover against you.

The recovery rights will be applied even though:

1. Any 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 arose from or was sustained in the course of any occupation or employment for compensation, profit or gain; or
3. The amount of any Workers' Compensation due for medical or health care is not agreed upon or defined by you or Workers' Compensation carrier; or
4. The medical or health care benefits are specifically excluded from any Workers' Compensation settlement or compromise.

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

COORDINATION OF BENEFITS

The Coordination of Benefits provision applies when you have health care coverage under more than one health plan.

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 precertification 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.

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.

COORDINATION OF BENEFITS

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 and federal 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 a non-participating provider or receive a bill for some other reason, 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 HMO, Inc.
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 or 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. The Plan has the right to deny coverage for the health services of any member who will not consent to release information to the Plan.

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. 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 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 information about other health care and insurance coverage and benefits.

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 complaint you may submit a written request for a grievance hearing.

GRIEVANCE

You have the right to request a grievance hearing at any time you are dissatisfied with a decision made by the Plan, or with any other aspect of the Plan by submitting your concern to the Plan in writing.

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/or a representative you have chosen to act on your behalf may 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 after receipt of the grievance, unless there are extenuating circumstances. In such cases, Customer Service will notify the member in writing before the 30th day that the grievance has not been decided, the reason for the delay, and when a decision on the grievance may be expected. MercyCare will resolve the case within thirty calendar days after giving this notice.

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 as quickly as your health condition requires, but not more than 72 hours after receipt of the grievance.

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

INDEPENDENT REVIEW

You have the right to request and obtain an independent review. An "independent review" is a review of an adverse determination and an experimental treatment determination, as defined below, by an independent review organization. An "independent review" will also include a review of a preexisting condition exclusion denial determination, as defined below, or a rescission of a policy or certificate as soon as the Commissioner of Insurance certifies an independent review organization able to effectively provide an independent review. An "independent review organization" is a neutral expert certified by the Commissioner of Insurance.

(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 the treatment under #1 above, or payment for the treatment was denied.
4. The amount of the reduction or the cost or expected cost of the denied or terminated

COMPLAINT PROCEDURES

treatment or payment exceeds, or will exceed during the course of the treatment, \$292 in 2010 (as adjusted by the Commissioner of Insurance for inflation in future years).

This definition includes the denial of a request for a referral for out-of-plan 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 the treatment or payment for the treatment.
4. The cost or expected cost of the denied treatment or payment exceeds, or will exceed during the course of the treatment, \$292 in 2010 (as adjusted by the Commissioner of Insurance for inflation in future years).

(c) "Preexisting condition exclusion denial determination" means a determination by or on behalf of an insurer that issues a health benefit plan denying or terminating treatment or payment for treatment on the basis of a preexisting condition exclusion.

After 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 and sent to MercyCare, Customer Service Department, Independent Review, P.O. Box 2770, Janesville, Wisconsin 53547-2770. The request should contain the following:

- a. Your name, address, and phone number.
- b. An explanation of your disagreement with MercyCare's determination, including any documentation that supports your position.
- c. A statement authorizing your representative to pursue independent review on your behalf if you

are using such a representative to pursue independent review.

- d. The name of the independent review organization you select. You can obtain a list of certified independent review organizations from the Customer Service Department at [1-800-895-2421] or from the web site of the Office of the Commissioner of Insurance noted at the end of this Complaint Procedures section.

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 bypassing the grievance procedure is appropriate upon receiving a request from you or your authorized representative that is simultaneously sent to MercyCare. Bypassing the grievance procedure is appropriate if your health condition is such that requiring you to use the internal grievance procedure before proceeding to independent review would jeopardize your life or health or your ability to regain maximum function.

MercyCare will acknowledge your request for independent review within 2 days of receipt of the request and immediately notify the independent review organization you selected. If the independent review organization determines that your case should be expedited (because following the normal procedure would jeopardize your life or health or your ability to regain maximum function), MercyCare will forward the case to the independent review organization within 1 day after receiving the request for review. Otherwise, MercyCare will forward the case to the independent review organization within 5 business days after receiving the request for independent review.

In addition to the information provided by you and MercyCare, the independent review organization may consider any typed or printed, verifiable medical or scientific evidence that the independent review organization determines is relevant, regardless of whether the evidence has been submitted for consideration at any time previously. Any information you or MercyCare submit to the independent review organization must also be submitted to the other party. If, on the basis of any additional information, MercyCare reconsiders your case and determines that the treatment should be covered, the independent review is terminated. An independent review does not include appearances by you or your authorized representative,

any person representing MercyCare, or any witness on behalf of either you or MercyCare.

A decision of an independent review organization regarding an adverse determination must be consistent with the terms of the plan. A decision of an independent review organization regarding an experimental treatment determination is limited to a determination of whether the proposed treatment is experimental. The independent review organization will determine that the treatment is not experimental and find in your favor only if the independent review organization finds all of the following:

- a. The treatment has been approved by the Food and Drug Administration (FDA), if the treatment is subject to the approval of the FDA.
- b. Medically and scientifically accepted evidence clearly demonstrates that the treatment is proven safe, can be expected to produce greater benefits than the standard treatment without posing a greater adverse risk to you, and meets the coverage terms of the plan and is not specifically excluded under the terms of the plan.

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, it will make its decision as quickly as your health condition requires, but not more than 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 will be in writing, signed on behalf of the independent review organization, and served by personal delivery or by mailing a copy to you or your authorized representative and to MercyCare. The decision is binding on you and MercyCare.

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

Email: marketreg@oci.state.wi.us

Website: www.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. On your first day of coverage, you are deemed to be in active status even if you were absent from work (a) on a regular paid vacation or any regular non-working holiday if you were in an active status on your last regular working day, or (b) due to a health factor.

ACUTE ILLNESS/INJURY

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

AUTISM SPECTRUM DISORDER

Autism spectrum disorder means autism disorder, Asperger's syndrome, or pervasive developmental disorder not otherwise specified.

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 that exists at birth but is not hereditary.

CONTRACT YEAR (Policy Year)

Contract year, or policy 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 this 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 (ren), stepchild (ren), legally adopted child (ren)

or child (ren) 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; and/or

3. Grandchildren if the parent is a dependent child under the age of 18.
4. A child (ren) who is a full-time student who was called to federal active duty before the child's 27th birthday in the national guard or in a reserve component of the U.S. armed forces while such child (ren) was a full-time student at an institution of higher education is eligible for covered services, regardless of age, until the child (ren) marries, or until the child (ren) becomes eligible for coverage under a group health benefit plan that is offered by the child (ren)'s employer where the amount of the premium contribution is less than or the same as the premium amount for the child (ren)'s coverage under this Plan.

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 stepchild (ren) cease to be dependents on the date in which a divorce decree is granted, and may be terminated subject to Continuation and Conversion privileges. All child (ren) also cease to be dependents when they reach the limiting age as stated in the Schedule of Benefits or on the date of their marriage, whichever occurs first, except that:

1. A child (ren) who is a full-time student, if otherwise eligible, ceases to be a dependent when they cease to be full-time student .

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. Full-time student status includes any intervening vacation period if the child continues to be a full-time student.

Full-time student status also includes a medically necessary leave of absence during which the child

ceases to be a full-time student. MercyCare may require the child to submit documentation and certification of the medical necessity of the leave of absence from the child's attending physician. Full-time student status due to a medically necessary leave of absence ends when any of the following occurs:

- a. The child advises MercyCare that he or she does not intend to return to school full time.
 - b. The child becomes employed full time.
 - c. The child obtains other health care coverage.
 - d. The child marries and is eligible for coverage under his or her spouse's health care coverage.
 - e. Coverage of the employee is discontinued or not renewed.
 - f. One year has elapsed since the child ceased to be a full-time student due to the medically necessary leave of absence, and the child has not returned to school full-time.
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.

EFFICACIOUS TREATMENT OR STRATEGY

Efficacious treatment means treatment or strategies designed to address cognitive, social or behavioral conditions associated with autism spectrum disorders; to sustain and maximize gains made during intensive-level services; or to improve the condition of an individual with autism spectrum disorder.

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, a lack of immediate medical attention will 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.

EVIDENCE-BASED THERAPY

Evidence-based therapy means therapy that is based upon medical and scientific evidence; is determined to be an efficacious treatment or strategy; has been approved by the federal food and drug administration (FDA), if the treatment is subject to the approval of the FDA; and medically and scientifically accepted evidence clearly demonstrates that the treatment is proven safe.

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 Quality Health Management 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.

FREE-STANDING SURGICAL FACILITY

Free-standing 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.

GENETIC COUNSELING

Genetic counseling means the process in which a genetic counselor educates families or individuals about their risk of passing on a genetic predisposition for certain disorders to future generations or of having an inherited disorder themselves. This process integrates the following:

- Helping people understand and adapt to the medical, psychological and familial implications of genetic contributions.
- Interpretation of family and medical histories to assess the chance of disease occurrence or recurrence.
- Education about inheritance, testing, management, prevention, resources and research.
- Counseling to promote informed choices and adaptation to the risk or condition.

GENETIC TESTING

A genetic test is a test using deoxyribonucleic acid (DNA) extracted from an individual's cells in order to

determine the presence of a genetic disease or disorder or the individual's predisposition for a particular genetic disease or disorder.

GRIEVANCE

Grievance means any dissatisfaction that you have with MercyCare or with a participating or non-participating provider that has been expressed in writing by you or on your behalf. 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 eligibility to receive covered services from participating providers.

INFERTILITY

A member is considered infertile if he or she is unable to conceive or produce conception after one year of frequent, unprotected heterosexual sexual intercourse, or six months of frequent unprotected heterosexual

intercourse if the female partner is over age 35 years. Alternatively, a woman without a male partner may be considered infertile if she is unable to conceive or produce conception after at least twelve (12) cycles of donor insemination (six cycles for women age 35 or older). The diagnosis of infertility alone does not constitute an illness.

INTENSIVE-LEVEL SERVICES

Intensive-level services means 1) evidence-based behavioral therapy that is designed to help an individual with autism spectrum disorder overcome the cognitive, social, and behavioral deficits associated with that disorder, and 2) therapies that are directly based on, and related to, a member's therapeutic goals and skills as prescribed by a physician familiar with the member.

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;
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 HMO, Inc.

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-INTENSIVE LEVEL SERVICES

Non-intensive level services means evidence-based therapy that occurs after the completion of treatment with intensive level services and that is designed to sustain and maximize gains made during treatment with intensive level services, or, for an individual who has not and will not receive intensive level services, evidence-based therapy that will improve the individual's condition.

NON-PARTICIPATING PROVIDER

Non-participating provider means a provider not listed in the most current provider directory.

ORTHOTIC

Orthotic means an externally applied device used to modify the structural and functional characteristics of the neuromuscular and skeletal systems.

OUT-OF-POCKET MAXIMUM

The out-of-pocket maximum is the most you will pay in coinsurance for your covered services in a contract year. The out-of-pocket maximum may or may not include any deductibles that apply, depending on your Schedule of Benefits. The amount of the out-of-pocket maximum is shown in the Schedule of Benefits.

PARTICIPATING PROVIDER

Participating provider refers to any provider listed in the most current provider 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 HMO, Inc. 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 their 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 that 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 the Plan'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. The primary care physician you select directly determines the provider network with which you will be associated.

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 in which they practice to provide covered services.

QUALIFIED PARAPROFESSIONAL

Qualified paraprofessional means an individual working under the active supervision of a qualified supervising provider and who complies with all of the following:

1. Attains at least 18 years of age.
2. Obtains a high school diploma.
3. Completes a criminal background check.
4. Obtains at least 20 hours of training that includes subjects related to autism, evidence-based treatment methods, communication, teaching techniques, problem behavior issues, ethics, special topics, natural environment, and first aid.
5. Obtains at least 10 hours of training in the use of behavioral evidence-based therapy including the direct application of training techniques with an individual who has autism spectrum disorder present.
6. Receives regular, scheduled oversight by a qualified provider in implementing the treatment plan for the member.

QUALIFIED PROFESSIONAL

Qualified professional means an individual working under the supervision of an outpatient mental health clinic who is a licensed treatment professional as defined in s. DHS 35.03 (9g), and who has completed at least 2080 hours including all of the following:

1. 1500 hours supervised training involving direct 1:1 work with individuals with autism spectrum disorders using evidence-based, efficacious therapy models.
2. Supervised experience with all of the following:

- a. Working with families as part of a treatment team and ensuring treatment compliance.
- b. Treating individuals with autism spectrum disorders who function at a variety of cognitive levels and exhibit a variety of skill deficits and strengths.
- c. Treating individuals with autism spectrum disorders with a variety of behavioral challenges.
- d. Treating individuals with autism spectrum disorders who have shown improvement to the average range in cognitive functioning, language ability, adaptive and social interaction skills.

3. Academic coursework from a regionally accredited higher education institution with demonstrated coursework in the application of evidence-based therapy models consistent with best practice and research on effectiveness for individuals with autism spectrum disorders.

QUALIFIED PROVIDER

Qualified provider means an individual acting within the scope of a currently valid state-issued license for psychiatry or psychology or a social worker licensed or certified to practice psychotherapy and who has completed at least 2080 hours that includes all of the following:

1. Fifteen hundred hours supervised training involving direct one on one work with individuals with autism spectrum disorders using evidence-based, efficacious therapy models.
2. Supervised experience with all of the following:
 - a. Working with families as the primary provider and ensuring treatment compliance.
 - b. Treating individuals with autism spectrum disorders who function at a variety of cognitive levels and exhibit a variety of skill deficits and strengths.
 - c. Treating individuals with autism spectrum disorders with a variety of behavioral challenges.
 - d. Treating individuals with autism spectrum disorders who have shown improvement to the average range in cognitive functioning, language ability, adaptive and social interaction skills.
 - e. Designing and implementing progressive treatment programs for individuals with autism spectrum disorders.

3. Academic coursework from a regionally accredited higher education institution with demonstrated coursework in the application of evidence-based

therapy models consistent with best practice and research on effectiveness for individuals with autism spectrum disorders.

QUALIFIED SUPERVISING PROVIDER

Qualified supervising provider means a qualified provider that is a currently valid state-licensed psychiatrist, psychologist or a social worker licensed or certified as a psychotherapist and the qualified provider has completed at least 4160 hours of experience as a supervisor of less experienced providers, professionals and paraprofessionals.

QUALIFIED THERAPIST

Qualified therapist means a speech-language pathologist or occupational therapist acting within the scope of a currently valid state issued license and who has completed at least 1200 hours of training including all of the following:

1. Seven hundred fifty (750) hours supervised training involving direct 1:1 work with individuals, including pediatric individuals, with autism spectrum disorders using evidence-based, efficacious therapy models.
2. Supervised experience with all of the following:
 - a. Working with families as the direct speech or occupational therapist and ensuring treatment compliance.
 - b. Treating individuals with autism spectrum disorders who function at a variety of cognitive levels and exhibit a variety of skill deficits and strengths.
 - c. Treating individuals with autism spectrum disorders with a variety of behavioral challenges.
 - d. Treating individuals with autism spectrum disorders who have shown improvement to the average range in language ability and adaptive and social interaction skills.

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 Quality Health Management 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 Quality Health Management 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.

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.

USUAL AND CUSTOMARY CHARGE

Usual and customary charge is the dollar amount for a treatment, service, or supply provided by a health care provider that is reasonable, as determined by the Plan, when taking into consideration among other factors, determined by MercyCare, amounts charged by health care providers for similar treatment, services, and supplies when provided in the same geographic area under similar or comparable circumstances.

WE

We means MercyCare HMO, Inc.

YOU/YOUR

You/your means any member enrolled in the Plan.

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