MercyCare Select
Certificate of Coverage

This certificate is a description of health insurance benefits provided to MercyCare Select Subscribers and their Eligible Dependents.

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

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

Office:

MercyCare Insurance Company
3430 Palmer Drive
Janesville, WI 53546

Claims Mailing Address:

MercyCare Insurance Company
P.O. Box 550
Janesville, WI 53547-0550

Toll-Free Customer Service Number:

1-800-895-2421

Print Date: May 2002

MCPOSOCT1998

MERCYCARE SELECT CERTIFICATE OF COVERAGE
MercyCare Health Plan
P.O. Box 550
Janesville, Wisconsin 53547-0550

PLAN TYPE:

GROUP NUMBER:

EMPLOYER:

EMPLOYEE:

CERTIFICATE NUMBER:

EFFECTIVE DATE:

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

This 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 Obtaining Services section of this Certificate and the definition of “usual and customary charge” for a more detailed explanation.

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

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

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GLOSSARY

SOUND AND NATURAL TEETH
Sound and natural teeth means teeth that would not have required restoration in the absence of a member's traumatic bodily injury, or teeth with restoration limited to composite or amalgam fillings. It does not mean teeth with a crown or root canal therapy.

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

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

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

URGENT CARE
Urgent care is care for 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.

WE
We means MercyCare Insurance Company

YOU/YOUR
You/your means any member enrolled in the plan.

GLOSSARY

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

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

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

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

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

PROVIDER NETWORK
A provider network is a group of providers contracted with the Plan to provide services for members within a specific geographic location. 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 of Wisconsin to provide covered services.

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

REFERRAL
Referral refers to the form prepared in writing by a network provider. If your MercyCare network provider feels that you require specialty care beyond that available from MercyCare network providers, he/she may complete a referral form. However, such referrals must be submitted to MercyCare's Medical Services Department for consideration before any recommended treatment or services are obtained. The Medical Services Department must determine whether the request for services should be approved. Such referrals are not valid without the Medical Service Department's approval.

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 coverages 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 NURSING FACILITY
Skilled nursing facility means an institution which is licensed by the State of Wisconsin, or other applicable jurisdiction, that maintains and provides all of the following:

1. Permanent and full-time bed care facilities for resident patients;
2. A physician's services available at all times;
3. A registered nurse or physician in charge and on full-time duty and one or more registered nurses or licensed vocational or practical nurses on full-time duty;
4. A daily record for each patient; and
5. Continuous skilled nursing care for sick or injured persons during convalescence.

A skilled nursing facility is not, except by coincidence, a rest home; a home for care of the aged to support activities of daily living; or a facility engaged in the care and treatment of alcoholics, drug addicts, or persons with mental disorders.

IMPORTANT INFORMATION

UNDERSTANDING THIS CERTIFICATE

What you should know about this Certificate:

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

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

How this Certificate is Organized:

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

- Important Information
- Obtaining Services
- Emergency and Urgent Care
- Benefit Provisions
- Coverage Information
- General Provisions
- Coordination of Benefits
- Claim Provisions
- Consent to Release Information
- Complaint, Appeal, and Grievance Procedures
- Glossary
- Index

INTERPRETING THIS CERTIFICATE

MercyCare Insurance Company has the authority to interpret this Certificate of Coverage and all questions that arise under it. If any benefit in this Certificate of Coverage is subject to a determination of medical necessity, we will make that factual determination.

QUESTIONS?

If after you read this Certificate of Coverage you have questions, please call the Customer Service Department at: **1-800-895-2421**

LEVELS OF BENEFITS

As a member of the MercyCare Select benefit plan, you are entitled to 3 levels of benefits.

Level 1: Primary Benefits – MercyCare Select provides the highest level of benefits whenever you obtain health care services through a network provider, or with a referral to a participating or non-participating provider. As always, you should obtain services through your chosen primary care physician whenever possible. This highest level of benefits is described in the Level 1 Benefits column of the Schedule of Benefits section of this certificate, and it applies only when you obtained prior authorization where required.

Level 2: Self-Referral Benefits – MercyCare Select provides a second level of benefits if you choose to use a participating or non-participating provider without a referral. When you use this level of benefits, you pay a greater share of the cost of health care services you receive, such as higher annual deductible, and most routine and preventive care is not covered. In addition, when you use a non-participating provider, only the usual and customary charge is covered. This level of benefits is described in the Level 2 Benefits column of the Schedule of Benefits section of this certificate, and it applies only when you have obtained prior authorization where required.

Level 3: Non-Participating Provider Benefits Without Prior Authorization – MercyCare Select provides a third level of benefits when you use a non-participating provider and you do not obtain prior authorization when it is required. Again, when you use this level of benefits you pay a greater share of the cost of health care services you receive; only the usual and customary charge is covered; and most routine and preventive care is not covered. This level of benefits is described in the Level 3 Benefits column of the Schedule of Benefits section of this certificate.

PRIOR AUTHORIZATION AND NON-PARTICIPATING PROVIDERS

Prior authorization means obtaining MercyCare's approval before you receive a service or supply. Any prior authorization requirement will be stated in this certificate or in the Schedule of Benefits, or both. In order to qualify for maximum benefits from non-participating providers, you must obtain prior authorization where it is required. It is your responsibility to verify that MercyCare has given prior authorization when required for maximum benefits from non-participating providers.

If you fail to obtain prior authorization when it is required for a non-participating provider, the usual and customary charge for benefits will be payable as outlined in the Level 3 Benefits column of the Schedule of Benefits section of this certificate. The amount that you pay for these services under the Level 3 Benefits column will not apply toward satisfaction of any out-of-pocket expense limits.

To obtain prior authorization for services from a non-participating provider, you must notify MercyCare as soon as possible but no later than 7 days before health care services requiring prior authorization are received. (For maternity care, you should notify MercyCare by the sixth month of pregnancy, but no later than 1 month prior to the anticipated delivery date. For emergency care, you should notify MercyCare within 24-hours of emergency admission.)

The number to call for prior authorization is specified on your MercyCare Select identification card.

PROVIDER SELECTION

At the time you enrolled in the MercyCare plan, you selected a primary care physician for you and, if you have dependent coverage, your covered dependents. The primary care physician you selected directly determined the provider network in which you will be associated. You can change your primary care physician as follows:

- During the open enrollment period or dual choice enrollment period held by your group for the plan; or
- At any other time during the contract year as long as you give MercyCare written notice on a designated MercyCare Change 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.

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

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

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

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

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

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

MERCYCARE
MercyCare means MercyCare Insurance Company.

NETWORK PROVIDER
Network provider means any provider in the same provider network as your primary care physician. You can visit any network provider without a referral. In order to determined if a provider is one of your network providers, please review your Provider Directory.

NON-EXPERIMENTAL
Non-experimental means:

a) Any discrete and identifiable technology; regimen or modality regularly and customarily used to diagnose or treat bodily injury or sickness; and

b) For which there is conclusive, generally accepted evidence that such technology, regimen or modality is safe, efficient and effective as determined by MercyCare.

NON-PARTICIPATING PROVIDER
Non-participating provider means a provider of health care that has not signed an agreement with MercyCare to provide covered services to members.

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

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

PARTICIPATING PROVIDER
Participating provider refers to any provider of health care that has signed an agreement with the plan and is not a provider within a member's chosen provider network. For a listing of participating providers, please review your 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 Insurance Company as described in this certificate.

POLICY
Policy means the agreement between the Group and MercyCare setting forth the contractual rights and obligations of the parties and wherein MercyCare agrees to provide a health benefit program to eligible employees and dependents of the Group. The policy includes this certificate, the group application form, and enrollment forms.

POLICYHOLDER
Policyholder means the Group.

PRESCRIPTION DRUG
Prescription drug refers to any substance recognized as a drug in the Official U.S. Pharmacopoeia and National Formulary or Official Homeopathic Pharmacopoeia of the United States or any supplement to either of them.

GLOSSARY

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

EXPERIMENTAL/INVESTIGATIVE
Experimental or investigative means the use of any service, treatment, procedure, facility, equipment, drug, devices or supply for a member's bodily injury or sickness that:

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

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

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

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.

GRIEVANCE
Grievance means any dissatisfaction that you have with MercyCare or with a network, participating, or non-participating provider that has been expressed in writing by you or on your behalf. See the Complaint, Appeal and Grievance Procedures section in this certificate for more information.

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

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

HOSPITAL
Hospital means an institution that:

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

2. a. Qualifies as a psychiatric or tuberculosis hospital;
   b. Is a Medicare provider; and
   c. Is accredited as a hospital by the Joint Commission on Accreditation of Healthcare Organizations.

Hospital does not mean an institution that is chiefly:

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

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

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.

MAXIMUM FAMILY DEDUCTIBLE
Maximum family deductible means the total deductible applied to all members in one family in a contract year. The maximum is stated on the Schedule of Benefits.

OBTAINING SERVICES

the course of treatment involves your pregnancy, and you are in your second or third trimester at the time the provider terminates, the provider will continue to be treated as a network or 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.

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

REFERRALS

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

If your primary care physician or another network provider feel that you need specialty care beyond that available from MercyCare network providers, he or she may complete a referral form. These referrals must be submitted to and approved by MercyCare's Medical Services Department before receiving services from a participating or non-participating provider. A verbal request for a referral will not guarantee that the referral is authorized and approved by MercyCare. Once the decision on the referral has been made, a copy of the referral with the decision is sent to you, the requesting provider, and the non-participating provider.

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 network provider.
- A participating or non-participating provider with a referral authorized by the Plan.

If you visit a participating or non-participating provider without a referral, and prior authorization is not required, the services will be covered at Level 2 as outlined in the Schedule of Benefits section of this certificate. If you visit a non-participating provider without a referral, and prior authorization is required but not obtained, services will be covered at Level 3 as outlined in the Schedule of Benefits section of this certificate.

COPAYMENTS, COINSURANCE AND DEDUCTIBLES

All covered services are subject to any copayment, coinsurance, and/or deductible limits shown in your Schedule of Benefits. This level of copayments, coinsurance and/or deductible limits that will apply to charges for covered services depends on whether or not you use a network provider and, if you use other providers of health care, whether you obtain a referral or prior authorization.

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

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

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

OUT-OF-POCKET MAXIMUM

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

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

- Receive services that are not covered services;
- Receive services that are subject to limitations; or
- Receive services that are subject to copayments.

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

LIFETIME BENEFITS MAXIMUM

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

OBTAINING SERVICES

STUDENTS OBTAINING SERVICES

Medical/Surgical Benefits:

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

All routine, preventive, and follow-up care must be provided by a network provider or with a referral in order to be covered as Level 1 Benefits. Otherwise, the services will be covered as Level 2 Benefits as outlined in the Schedule of Benefits section of this certificate if the student has obtained prior authorization where it is required and, if not, services received from a non-participating provider will be covered at Level 3 as outlined in the Schedule of Benefits section of this certificate.

Psychological Disorder and Chemical Dependency Benefits:

A full-time student attending a school other than a secondary school outside the service area will have coverage for services received from non-participating providers for psychological disorders and/or chemical dependency. Coverage will be provided at Level 2 or Level 3, as appropriate, for inpatient, transitional and outpatient care.

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

1-800-895-2421

GLOSSARY

the end of the month in which the dependent child turns age 18.

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

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

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

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

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

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

   by a network 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.

DUAL CHOICE ENROLLMENT PERIOD

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

EMERGENCY

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

Some examples of emergency care are:

- Acute allergic reactions.
- Acute asthmatic attacks.
- Convulsions.
- Epileptic seizures.
- Acute hemorrhage.
- Acute appendicitis.
- Coma.
- Heart attack.
- Attempted suicide.
- Suffocation.
- Stroke.
- Drug overdose.
- Loss of consciousness.
- Any condition for which you are admitted to the hospital as an inpatient from the emergency room.

EMPLOYEE

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

GLOSSARY

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

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

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 FORM
Change 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 forms are provided by MercyCare and are available from the Group.

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

COINSURANCE
Coinsurance means a charge, expressed as a percentage of the fee for covered services, that you are required to pay for certain covered services provided under the policy. You are responsible for the payment of any coinsurance charge directly to the network or participating or non-participating provider when covered services are received.

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 care for an emergency in a hospital. Hospital swing bed confinement is considered the same as confinement in a skilled nursing facility. If you are transferred to another facility for continued treatment of the same or related condition, it is considered one confinement.

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

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

COPAYMENT
Copayment means a charge, expressed as a fixed dollar amount, that you are required to pay for certain covered services provided under the policy. You are responsible for the payment of any copayment directly to the network, participating, or non-participating provider when covered services are received. Copayments are not applicable toward the contract year out-of-pocket maximum.

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 is provided when, in the opinion of a network 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 network 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. Only charges for covered services may be used to satisfy the deductible. The amount of the deductible, if any, is stated in the Schedule of Benefits.

DEPENDENT
Dependent means the following:

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

EMERGENCY AND URGENT CARE

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

URGENT CARE

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

In the Service Area:
Urgent care should always be received by either a network or 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.

The usual and customary charge for urgent care, other than care received from a network provider or with a referral, is covered under the Level 2 Benefits column of the Schedule of Benefits section of this certificate or, if prior authorization is required but not obtained, under the Level 3 Benefits column.

Follow up care is subject to the limitations in the Schedule of Benefits.

EMERGENCY CARE

Emergency means a medical condition that manifests itself by acute symptoms of sufficient severity, including severe pain, to lead a prudent layperson with an average knowledge of health and medicine reasonably to conclude that, without immediate medical attention, death or serious injury to your body will likely result. Examples of emergency care situations are heart attacks, strokes, loss of consciousness, significant blood loss, suffocation, attempted suicide, convulsions, epileptic seizures, acute allergic reactions, acute asthmatic attacks, acute hemorrhages, acute appendicitis, coma, and drug overdose.

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.

Charges for emergency care that is obtained from a network provider will be covered under the Level 1 Benefits column of the Schedule of Benefits section of this certificate. The usual and customary charge for emergency care that is obtained from other providers of health care will be covered under the Level 2 Benefits column of the Schedule of Benefits section of this certificate.

Follow up care is subject to the limitations in the Schedule of Benefits.

BENEFIT PROVISIONS

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

AMBULANCE SERVICES

Covered Services:

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

Non-Covered Services:

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

CARDIAC REHABILITATION

Covered Services:

- Cardiac Rehabilitation is covered when medically necessary.
- Phase II Cardiac Rehabilitation services require prior authorization and must be provided in an outpatient department of a hospital, in a medical center or clinic program. This benefit applies only to members with a recent history of:

  a) a heart attack;
  b) coronary bypass surgery;
  c) onset of angina pectoris;
  d) heart valve surgery;
  e) onset of decubital angina;
  f) percutaneous transitional angioplasty, or
  g) cardiac transplant.

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

Non-Covered Services:

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

CHIROPRACTIC SERVICES

Covered Services:

- Chiropractic services are covered if they are considered medically necessary.

Non-Covered Services:

- Maintenance or long term therapy.

DENTAL SURGERY

Covered Services:

- Treatment with prior authorization from the Plan for bodily injury to permanent, sound and natural teeth or to the soft tissue structures surrounding the 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.

- Oral surgery with prior authorization from the Plan for gum or bone tumors and cysts.
- With required prior authorization, inpatient hospital and free-standing surgical facility services, and anesthetics provided in conjunction with dental care if the member:

  a) Is under age 5; or
  b) Has a chronic disability that arises from a mental or physical impairment or combination of mental or physical impairments; and is likely to continue indefinitely; and results in substantial functional limitations in one or more of the following areas of a major life activity: self-care, receptive and expressive language, learning, mobility, capacity of independent living, or economic self-sufficiency; or
  c) Has a medical condition that requires hospital confinement or general anesthesia for dental care.

Non-Covered Services:

- Oral surgery performed solely for the fitting of dentures or the restoration or corrections of teeth.

COMPLAINT, APPEAL, AND GRIEVANCE PROCEDURES

MercyCare is committed to ensuring that all member complaints 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. MercyCare provides 3 levels of complaint handling. First, you may file a complaint. Second, if your complaint was not handled to your satisfaction, you may file an appeal. Third, you may file a grievance with the Plan.

COMPLAINT

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

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

If the complaint is urgent or involves an urgent clinical situation, you will be notified by phone of the outcome within 3 working days of the receipt of the complaint.

If you are not satisfied with the resolution of the complaint, you may request an appeal.

APPEAL

To file an appeal, contact the Customer Service Department. You will receive a letter from the Customer Service Department giving a brief description of the appeal process.

Within 10 working days of the Appeals Committee Meeting, the Customer Service Department will send a letter to you with the disposition of the appeal and a description of your right to file a grievance if applicable.

All appeals will be decided within 20 working days of the receipt of appeal, unless there are extenuating circumstances.

GRIEVANCE

You are entitled to use the Grievance procedure at any point in your complaint process. To file a grievance, contact the Customer Service Department.

The Customer Service Department will send you a letter acknowledging receipt of the request for a grievance hearing within 10 days of receipt. You will be notified with the necessary information about the date, time, and location of the scheduled hearing at least 7 days before the hearing is scheduled.

The Grievance Committee will review the substance of the grievance and review all relevant documents pertaining to the grievance.

At the grievance hearing, you and/or a representative you have chosen to act on your behalf, may present information relevant to the grievance. If you choose, you may participate in the hearing through a conference call.

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

Within 5 working days of the grievance hearing, the Customer Service Department will send a letter to you with the resolution of the grievance and provide you with information on your right to file a complaint with the State Commissioner of Insurance if applicable.

All grievances will be decided within 30 days of the receipt of the grievance. In urgent cases, grievances will be expedited. The Plan will make every effort to address these issues immediately and resolve the grievance within 3 working days.

MercyCare Insurance Company
Customer Service Department
P.O. Box 550
Janesville, WI 53547-0550
1-800-895-2421

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 mail or by phone at the address and phone number below:

Office of the Commissioner of Insurance
P.O. Box 7873
Madison, WI 53707-7873
1-800-236-8617 or 266-0103 in Madison

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 any health care services or refuse to pay 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.

BENEFIT PROVISIONS

- 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.

- Oral surgery except as specifically described in this certificate.
- All periodontic procedures.

DIABETES SERVICES

Covered Services:

- Self-management education programs and diabetic equipment and supplies.
- Diabetic equipment may include: accuchecks and glucometers, as well as the installation and use of an insulin infusion pump, if considered medically necessary by the Plan. Insulin infusion pump coverage is limited to the purchase of one pump per contract year. The insulin pump must be in use for 30 days before purchase.
- Diabetic supplies may include: insulin, syringes, chem strips and lancets obtained from a participating provider.

DURABLE MEDICAL EQUIPMENT AND DISPOSABLE MEDICAL SUPPLIES

Covered Services:

- Durable medical equipment (DME) and disposable medical supplies are covered with prior authorization.
- To be considered durable medical equipment, the equipment must be:

  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 bodily injury or sickness; and
  d) appropriate for use in the home.

  Examples include: accuchecks, glucometers, crutches, wheelchairs, hospital beds, customized braces, and initial acquisition of artificial limbs or eyes.

- Orthopedic shoes that are an integral part of a brace are covered with prior authorization from the Plan.
- A disposable medical supply is different from durable medical equipment in that it is intended for one-time use and is discarded.

  Examples include: syringes, lancets, ostomy supplies, and compression support hose, e.g. JOBST. Coverage for compression support hose is limited to 2 pairs per contract year.

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

Non-Covered Services:

- Other than orthopedic shoes that are an integral part of a brace, orthotic appliances are not covered.
- Durable medical equipment required for athletic performance and/or participation.
- Garments and/or other equipment and supplies that are not medially necessary to treat a covered bodily injury or sickness.
- Repairs and replacement of durable medical equipment/supplies without prior authorization from the Plan.
- Medical supplies and durable medical equipment for comfort, personal hygiene and convenience items such as air conditioners, air cleaners, humidifiers, physical fitness equipment, physician equipment, alternative communication devices, and self-help devices not medical in nature.
- Home testing and monitoring supplies and related equipment except those used in connection with the treatment of diabetes, infant apnea, or premature labor.
- Equipment, models, or devices which have features over and above those which are medically necessary for the member. Coverage is limited to the standard model as determined by the Plan.
- Oxygen therapy and other inhalation therapy and related items for home use except as authorized by the Plan.
- Motor vehicles or customization of vehicles, lifts for wheelchairs and scooters, and stair lifts.

BENEFIT PROVISIONS

EMERGENCY CARE

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

FAMILY PLANNING / REPRODUCTIVE SERVICES

Covered Services:

- Covered services include consultation, tubal ligations, diaphragms, intrauterine devices (IUDs) and vasectomy.
- Diagnostic testing and treatment for fertility/infertility is subject to the limitations specified in the Schedule of Benefits.
- Artificial insemination benefits are limited to the referral physician's charges for the insemination procedure.
- Implantable birth control devices are covered one every 5 years.

Non-Covered Services:

- Any artificial means to achieve pregnancy and the reversal of voluntarily induced sterilization procedures.
- No benefits are available to donor, laboratory, or biological fees directly related to the insemination procedure itself.
- Donor sperm.
- Implantable birth control devices, except for once every 5 years.
- Early removal (within 5 years of insertion) of implantable birth control items is not covered unless due to medical complications.
- Services related to scarring due to the removal of implantable birth control items.

HEARING EXAMS AND HEARING AIDS

Covered Services:

- Hearing aids and hearing exams are covered when obtained through a network provider.
- The reconditioning and repair of existing aids is covered when considered medically necessary.
- New hearing aids are covered once per ear in a 36 month period.

Non-Covered Services:

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

HOME HEALTH CARE

Covered Services:

- Home health care benefits are covered up to 40 visits per contract year with prior authorization, when the attending physician certifies that:

  a) Confinement in a hospital or skilled nursing facility would be necessary if home care were not provided.
  b) Necessary care and treatment is not available from the member's immediate family, or others living with the member without undue hardship.
  c) The home health care services are provided and coordinated by a state licensed or Medicare certified home health agency or certified rehabilitation agency.

- It is necessary that the attending physician establish a home health care plan, approve it in writing and review this plan at least every 2 months, unless the attending physician determines that less frequent reviews are sufficient.
- Home health care means one or more of the following:

  a) Home nursing care that is provided from time to time or on a part-time basis. It must be provided or supervised by a registered nurse;
  b) Home health aide services that are provided from time to time or on a part-time basis. A registered nurse or medical social worker must supervise the care. The home health aide services must be medically necessary as part of the home care plan and they must consist solely of caring for the patient;
  c) Physical, respiratory, occupational and speech therapy;
  d) Medical supplies, drugs and medicines prescribed by a physician, and lab services by or for a hospital. They are covered to the same extent such items would be covered under the policy if you were confined to a hospital;
  e) Nutritional counseling under the supervision of a registered or certified dietitian if considered medically necessary as part of the home care plan;
  f) The evaluation of the need for home care when approved or requested by the attending physician.

- If you were hospitalized immediately before the home health care services began, the physician who was the primary provider of care during the hospital confinement must approve an initial home care plan.
- Each visit by a qualified person providing services under a home care plan or evaluating the need for or developing a plan is considered one home care visit.

CLAIM PROVISIONS

1. The Plan will pay participating and network 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 Insurance Company
   Claims Department
   P.O. Box 550
   Janesville, WI 53547-0550

   Be sure to include your name and identification card number.

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

2. You agree to provide to the Plan any additional information regarding the occurrence and extent of the event for which the claim is made which the Plan shall reasonably require in order to process the claim.

3. The Plan may pay all or a portion of any benefits provided for health care services to the provider or to the employee if so directed in writing at the time the claim is filed.

4. Benefits accrued on your behalf upon death shall be paid, at the Plan's option, to any one of more of the following:

   a. your spouse; or
   b. your dependent children, including legally adopted children; or
   c. your parents; or
   d. your brothers and sisters; or
   e. your estate.

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

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

specify which parent is responsible for health care expenses, the order of benefits will be determined by the Birthday Rule.

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

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

5. ***Active/Inactive Employee:*** The plan that covers an employee who is actively at work or as that employee's dependent is considered primary over the plan that covers an employee who is either laid off or retired or as that employee's dependent. If the other plan does not have this rule, and the plans do not agree, this rule will not apply.

6. ***Continuation of Coverage:*** The plan that covers a member as an actively at work employee or as that employee's dependent is considered primary over any continuation of coverage plan. If the other plan does not have this rule, and the plans do not agree, this rule will not apply.

7. ***Longer/Shorter Length of Coverage:*** If none of the above rules apply to the covered member, the plan that has covered the person for a longer period of time will be considered primary.

EFFECT ON BENEFITS WHEN THIS PLAN IS SECONDARY

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

1. The benefits that would be payable for the Allowable Expenses under This Plan in the absence of this Coordination of Benefits provision; and

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

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

MERCYCARE'S RIGHTS UNDER THE COORDINATION OF BENEFITS PROVISION

Right to Necessary Information:

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

Facility of Payment:

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

Right to Recovery:

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

COORDINATION OF BENEFITS WITH MEDICARE

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

- Up to 4 consecutive hours in a 24 hour period of home health aide service are considered one home care visit. The maximum weekly benefit for such coverage may not exceed the usual and customary weekly cost for care in a skilled nursing facility.

Non-Covered Services:

- Custodial care.

HOSPICE CARE

Covered Services:

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

Non-Covered Services:

- Hospice care provided outside the member's home.

HOSPITAL SERVICES

Covered Services:

- Inpatient and outpatient hospital services are covered when rendered by a hospital or freestanding surgical facility.
- Inpatient hospital services require prior authorization and include the following:

  a) 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 certified to be medically necessary.
  b) Hospital services and supplies determined to be medically necessary furnished for your treatment during confinement, including drugs administered to you as an inpatient.
  c) Inpatient hospital confinement days are covered.

- 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 to the Plan as being medically necessary by the admitting provider.
- Continued hospital stay(s), if a network 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 items.
- Durable medical equipment is not covered under the Hospital services benefit, please see the Durable Medical Equipment and Disposable Medical Supplies benefit in this section.

KIDNEY DISEASE TREATMENT

Covered Services:

- Up to $30,000 per contract year, including dialysis and kidney transplantation and donor-related services are covered.

NEWBORN BENEFITS

Covered Services:

- A newborn child of an employee, an employee's covered dependent spouse, and/or covered dependent child under the age of 18 is eligible for 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.

BENEFIT PROVISIONS

PHYSICAL THERAPY, SPEECH THERAPY, AND/OR OCCUPATIONAL THERAPY

Covered Services:

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

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 network 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.
- Biofeedback, except that provided by a physical therapist for treatment of headaches and spastic torticollis.

PHYSICIAN SERVICES

Covered Services:

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

Non-Covered Services:

- Routine or preventive physicals when they are primarily at the request of, for the protection of, or to meet the requirements of, a party other than the member.

PODIATRY SERVICES

Covered Services:

- Routine or preventive exams when medically necessary.

Non-Covered Services:

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

PREGNANCY BENEFITS

Covered Services:

- Treatment of pregnancy is covered for an employee, an employee's covered dependent spouse, or an employee's covered dependent child.
- Pregnancy benefits include coverage for inpatient hospital care and pre- and post-natal care.
- Except in an emergency, maternity services received out of the service area in the last 30 days of pregnancy without prior authorization from the Plan are payable as outlined in the Level 3 Benefits column of the Schedule of Benefits section of this certificate. Prior authorization is based on medical necessity.

Non-Covered Services:

- Surrogate mother services.
- Elective abortions.
- Amniocentesis or chronic villi sampling (CVS) solely for sex determination.

PRESCRIPTION DRUGS

Please see your Prescription Drug Rider if applicable.

COORDINATION OF BENEFITS

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

DEFINITIONS

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

When a plan provides benefits in the form of services, the reasonable cash value of each service rendered shall be considered both an allowable expense and benefit paid.

Allowable expenses under any other plan include the benefits that would have been payable if (a) a claim had been duly made; or (b) the member had complied with all plan provisions, such as 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

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

WORKERS COMPENSATION

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

The recovery rights will be applied even though:

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

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

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

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

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

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.

PSYCHOLOGICAL DISORDER AND CHEMICAL DEPENDENCY

In order to receive the maximum level of benefits, prior authorization is required. Covered services include the following treatment for psychological disorder and chemical dependency:

Covered 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.

- Transitional Treatment- Treatment received in an outpatient setting that is more intensive than traditional outpatient care but less restrictive than traditional inpatient care is covered up to the benefit maximum specified in the Schedule of Benefits.

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

- Outpatient Treatment- Treatment received while not confined to a hospital or qualified treatment facility or participating in transitional treatment is covered in full up to the benefit maximums specified in the Schedule of Benefits.

- Prescription drugs used for the treatment of mental health, alcohol and drug abuse are covered regardless of whether this certificate includes the Prescription Drug Rider, but will be subject to any such rider. The charges for such drugs will not be applied to the maximum benefit available for any mental health, alcohol or drug abuse services.

  Outpatient, inpatient and transitional treatment of psychological disorders and/or chemical dependency each have specific benefit limits stated in the Schedule of Benefits. There is also a total benefit limit for all treatment of psychological disorders and/or chemical dependency as stated in the schedule of benefits.

  Court ordered mental health services are covered under the Level 3 benefits column if provided by a network provider or with a referral. Services rendered pursuant to an emergency detention situation are covered at this level of benefits when rendered by any provider as long as MercyCare has been notified within 72 hours so that continuing care may be arranged. Follow-up care, except by a network provider, or with a referral, is covered at Level 3 as outlined in the Schedule of Benefits section of this certificate.

Non-Covered Services:

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

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.
- Your attending physician must certify that your skilled nursing facility confinement is medically necessary for care or treatment of the bodily injury or sickness that caused the hospital confinement.
- Skilled nursing facility services require a prior authorization from the Plan and the Plan must consider the services to be medically necessary.

Non-Covered Services:

- Custodial care.

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

SPECIALTY CARE SERVICES

Covered Services:

- Specialty care services (such as surgery, surgery with an assistant surgeon if necessary, oncology, cardiology, or anesthesiology) are covered.
- Covered services include breast reconstruction of the affected tissue incident to a mastectomy.
- Inpatient or outpatient surgery requires prior authorization.

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.

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

Non-Covered Services:

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

TEMPOROMANDIBULAR DISORDERS

Covered Services:

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

- This includes coverage for prescribed intraoral splint therapy devices.

Non-Covered Services:

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

TRANSPLANTS

Covered Services:

Coverage is limited to those procedures that are considered by the Plan to be non-experimental, medically necessary, and effective. Organ transplant benefits are subject to the lifetime limit per member stated in the schedule of benefits.

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

ADVANCE DIRECTIVES

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

CASE MANAGEMENT / ALTERNATIVE TREATMENT

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

CLERICAL ERRORS

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

CONFORMITY WITH STATE STATUTES

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

INCONTESTABILITY

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

LIMITATIONS ON SUITS

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

PHYSICAL EXAMINATION

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

PROOF OF COVERAGE

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

SUBROGATION AND REIMBURSEMENT

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

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

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

DISENROLLMENT

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

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

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

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.

- The following transplants are covered; however you must have prior authorization from the Plan for all services:

  Heart: For the treatment of congestive cardiomyopathy, end-stage ischemic heart disease, hypertrophic cardiomyopathy, terminal valvular disease, congenital heart disease (upon individual consideration), cardiac tumors (upon individual consideration), myocarditis, coronary embolization, post-traumatic aneurysm.

  Liver: For the treatment of extrahepatic biliary atresia, inborn error of metabolism (alpha-1-antitrypsin deficiency, Wilson's disease, glycogen storage disease, tryrosinemia, hemochromatosis), primary biliary cirrhosis, hepatic vein thrombosis, sclerosing cholangitis, post-necrotic cirrhosis or chronic active hepatitis (HBe Ag negative), alcoholic cirrhosis (if patient has abstained from alcohol consumption for 12 or more months), epithelioid hemangioepithelioma, poisoning, polycystic disease.

  Autologous (self to self) and allogenic (donor to self) bone marrow: Only for the treatment of aplastic anemia, acute leukemia, severe combined immunodeficiency (adenosine deaminase deficiency and idiopathic deficiencies), Wiskott-Aldrich syndrome, infantile malignant osteopetrosis (Albers-Schoenberg disease or marble bone disease), Hodgkin's and non-Hodgkin's lymphoma, combined immunodeficiency, chronic myelogenous leukemia, pediatric tumors based upon individual consideration, neuroblastoma.

  Corneal: For treatment of corneal opacity, keratoconus or any abnormality resulting in an irregular refractive surface not correctable with a contact lens or in a member who cannot wear a contact lens, corneal ulcer, repair of severe lacerations.

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

  Other Covered Transplants: Parathyroid transplants, musculoskeletal transplants intended to improve the function and appearance of any body area which has been altered by disease; trauma; congenital anomalies; or previous therapeutic processes, kidney/pancreas, heart/lung, and lung transplants as determined to be medically necessary by the Plan.

- Donor services are covered only if the recipient is a member of the Plan, except in the case of a kidney transplant.
- 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.
- Transplants and all related expenses, except those outlined in this Certificate.
- Organ transplant expenses of donor if the recipient is not an eligible Plan member (except for kidney transplants).
- Retransplantation. (except for kidney transplants).
- Purchase price of bone marrow, organ, or tissue that is sold rather than donated.
- All separately billed donor-related services (except for kidney transplants).

URGENT CARE

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

VISION CARE

Covered Services:

- Medical eye examinations provided as part of the treatment for pathological conditions.
- Routine or preventive eye exams are covered when rendered by a network 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 AND LABORATORY TESTS

Covered Services:

- Inpatient and outpatient diagnostic x-ray, mammography or laboratory tests are covered services.
- The Plan covers mammograms for female members as follows:

  a) Age 35-39: 1 baseline mammogram;
  b) Age 40 –49: Every 1 to 2 years;
  c) Age 50 and over: Annually.

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

OTHER MEDICAL SERVICES

Covered Services:

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

Non-Covered Services:

- 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 and network providers and for conditions producing significant physical and mental symptoms.
- Procedures, services, counseling and supplies related to sex transformation surgery and sex hormones related to such treatments.
- Genetic counseling.
- Acupuncture.

GENERAL EXCLUSIONS AND LIMITATIONS

- Treatment for a bodily injury or sickness arising from or sustained in the course of any occupation or employment for compensation, profit or gain if:

  a) Benefits are provided or are payable under any Worker's Compensation or Occupational Disease Act or Law; or
  b) You fail to file a claim for benefits for which you are eligible under any Worker's Compensation or any Occupational Disease Act or Law.

- Any loss caused or contributed by:

  a) War or any act of war declared or not; or
  b) Any act of international armed conflict or any conflict involving armed forces of any international authority.

- Services and supplies that are, in the Plan's judgment, experimental or investigative. These services include any that are not recognized as conforming to commonly accepted medical practice within the service area or any for which the required approval of a government agency has not been granted at the time the services and supplies are provided, except that coverage shall be provided for any covered drug with the following criteria:

  a) Is prescribed for the treatment of HIV infection or an illness or medical condition arising from or related to HIV infections; an
  b) Is approved by the Federal Food and Drug Administration, including phase-3 investigational drugs; and
  c) If the drug is an investigational new drug, is prescribed and administered in accordance with the treatment protocol approved by the Federal Food and Drug Administration for the investigational new drug.

- Any 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 or court-ordered. Excluded services and supplies include physical exams, disease immunizations and services and supplies for

Federal Continuation:

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

1. You are a surviving dependent spouse or child of an employee who dies while dependent coverage was in effect; or
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 a dissolution of marriage, legal separation or a child losing dependent status. If you should lose coverage for any of these reasons, and you wish to elect continuation coverage, you must complete an election form and submit it to the employer within 60 days of the later of the date:

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

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

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

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

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

CONVERSION COVERAGE

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

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

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

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

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

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

COVERAGE INFORMATION

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

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

EXTENSION OF BENEFITS

Termination of Group Policy:

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

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

Termination of Member's Coverage:

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

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

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

RIGHTS TO CONTINUE GROUP MEDICAL COVERAGE

If your coverage ends for certain of the reasons as 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 a continuation of group coverage only if the member has been covered under the plan for at least 3 consecutive months. You may elect this option if:

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

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

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

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

BENEFIT PROVISIONS

employment, licensing, marriage, adoption, insurance, camp, school, and travel.

- Any service rendered AFTER the date your coverage under the policy terminates or AFTER you are disenrolled from the Plan, except as provided in the Extension of Benefits provision of this certificate or any service rendered BEFORE the member's effective date in the Plan.
- Medical expense due to your commission or attempted commission of a civil or criminal battery or felony.
- Charges for any treatment related to a non-covered service.
- Any treatment or services rendered by or at the direction of:

  a) A person residing in your household; or
  b) A family member (such as your lawful spouse, child, parent, grandparent, brother, sister, or any person related in the same way to your covered dependent).

- Services and supplies not medically necessary for diagnosis and treatment of a covered bodily injury or sickness.
- Services and supplies for which no charge is made or for which you would not have to pay without this coverage.
- The amount of any copayment, coinsurance, and/or deductible that you must pay as shown in the Schedule of Benefits and/or in any rider attached to this certificate.
- All services not specifically covered in the Benefit Provisions section of this certificate or by any Rider attached to the policy and any service not provided or received in accordance with the terms and conditions of this certificate and policy.
- Ancillary medical services (including hospital facility charges, anesthesia charges, lab and x-ray charges) provided during the course of a non-covered bodily injury or sickness. This exclusion does not apply to benefits for Dental Surgery as described in the Benefit Provisions section.
- Expenses for medical reports, including preparation and presentation.
- Services to the extent the member is eligible for Medicare benefits, regardless of whether or not the member is actually enrolled in Medicare.
- Treatment, services, and supplies furnished by the U.S. Veterans Administration, except when the Plan is the primary payor under applicable federal law.
- Services for holistic medicine, including homeopathic medicine, or other programs with an objective to provide complete personal fulfillment.
- Charges for missed appointments.
- Coma stimulation/recovery programs.
- Treatment, services and supplies provided while held, detained or imprisoned in a local, state or federal penal or correctional institution, or while in the custody of law enforcement officials. Persons on work release are exempt from this exclusion.
- Plastic or cosmetic surgery which is undertaken solely to improve the member's appearance and which is not medically necessary for the correction of a functional defect caused by a bodily injury or sickness. This exclusion does not apply to breast reconstruction of the affected tissue incident to a mastectomy.
- Any surgical treatment for morbid obesity, including ileal bypass, gastric bypass, or stapling.

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. 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, for the employee's dependents on that date; or
- The date of the employee's marriage for any dependent (spouse or stepchild) acquired on that date; or
- The date of birth of the employee's natural-born child; or
- The date a child is placed in the employee's home for adoption, or the date that a court issues a final order granting adoption of the child to the employee, whichever occurs first; or
- The date of a change of status that makes a dependent newly eligible; or
- The date of birth of a child born to the employee's covered dependent child who is under the age of 18. Coverage terminates for the child of a covered dependent child at the end of the month the employee's covered dependent child reaches 19 years of age.

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

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

ENROLLMENT AND EFFECTIVE DATES

Enrollment Periods:

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

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

a) An employee who becomes newly eligible for coverage after the first enrollment period, and his or her eligible dependents may enroll within 30 days from the date he or she is notified of the opportunity to enroll. The effective date of coverage for the employee and any enrolled dependents is indicated on the first page of this certificate inserted after the front cover.
b) If dependent coverage is in effect, the employee should enroll a newborn dependent as soon as possible and coverage for the dependent will be effective on the date of birth. If dependent coverage is not in effect, the employee has 60 consecutive days from the date of birth to enroll a newborn dependent effective on the date of birth. If the employee does not enroll a newborn dependent within this 60 day period, the newborn child will have no coverage unless, within one year after birth of the child the employee pays all past due premiums plus interest on these premiums at the rate of 5 ½% per year.
c) The employee has 60 consecutive days from the date a child is placed in the employee's home for adoption or from the date that a court issues a final order granting adoption of the child to the employee, whichever occurs first, to enroll a dependent who is adopted or placed for adoption. The dependent child is covered on the date he or she is placed in the employee's home for adoption or the date that a court issues a final order granting adoption of the child to the employee, whichever occurs first.
d) An employee member may enroll the employee's new spouse and stepchildren, effective on the date of marriage, by providing MercyCare with a completed change form within 30 days after the date of marriage.
e) An employee member may enroll the employee's newly eligible dependent, other than as described above, by providing MercyCare with a completed change form. If the change form is received by MercyCare BEFORE the dependent's eligibility date, coverage is effective on the dependent's eligibility date. If the change form is received AFTER the dependent's eligibility date, but within 31 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 an open enrollment period or dual choice enrollment period; and
b) They were covered under a group health plan or had health insurance coverage during such an enrollment period; and
c) The employee stated in writing, if required by MercyCare, that enrollment was declined due to the coverage under the group health plan or health insurance; and
d) Their coverage under the group health plan or health insurance is exhausted or terminated; and
e) They submit a completed enrollment form, which is available from the group, within 30 days after their coverage under the group health plan or health insurance is exhausted or terminated.

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

Late Enrollment for Spouse of Employee Member:

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

Other Late Enrollment:

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

a) An employee may enroll within 30 days after requesting coverage and receiving notice of the right to enroll. Coverage is effective on the first of the month after approval of the employee's application or 18 months from the date of the application, whichever occurs first.
b) An employee member may enroll the employee's newly eligible dependent, other than as described above, by providing MercyCare with a completed enrollment form. If the enrollment form is received more than 31 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 changes, must be made by completing a change form, which will be made available by the Plan to the Group for distribution to its employees.

BENEFIT CHANGES

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

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

TERMINATION OF COVERAGE

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

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

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