MercyCare Health Plans
Medicare Select Policy

Underwritten by MercyCare HMO, Inc.

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

Guaranteed renewable for life – premium subject to change

If you do not terminate this policy and we do not cancel it, we will automatically renew your policy for each calendar year. Your policy however will be renewed no sooner than the greater of three months after it is issued, the period for which you have paid the premium, or the beginning of the next calendar year. You cannot be cancelled because you have used or overused benefits. You can only be cancelled if you do not pay the premium, if you have given us fraudulent information in your application and for other very limited reasons as described in the Effective Date, Renewal and Termination of Coverage section of this policy. Your premium may increase when it goes up for everyone and when you reach a certain age.

Your rights to return this policy

Please read this policy right away. If you are not satisfied with it for any reason, you may return it to us within thirty (30) days after delivery. Upon return, the policy is no longer valid. If you return the policy within the thirty days, we will refund all premium to the person who paid it.

Your right to cancel this policy midterm

You may cancel this policy midterm, either per your request or in the event of your death.
Upon cancellation **MercyCare** will issue a pro rata refund to you or your estate.

IMPORTANT NOTICE
CONCERNING STATEMENTS IN THE APPLICATION FOR YOUR INSURANCE

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

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P.O. Box 550
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TTY/TDD: **(800) 947-3529**

mercycarehealthplans.com

This Medicare Select Policy issued by MercyCare HMO, Inc. (referred to as "**MercyCare**" in this **policy**) and the separate Outline of Coverage (together referred to as the **"policy"**) describe the terms and conditions under which you will be provided with certain hospital, medical and other services as specified herein. Such services will be provided by **MercyCare** by agreement with physicians, hospitals, and other health care providers.

Coverage under this policy begins as of 12:01 a.m. Central Time on the date on the accompanying schedule page.

This **policy** is issued in consideration of the timely payment by you or on your behalf of the premium in effect for the coverage being provided. Such premium is subject to change by **MercyCare** with advance notice. **MercyCare** reserves the right to cancel coverage under this **policy** if timely payment is not made.

MercyCare may adopt reasonable policies, procedures, rules and interpretations to promote the orderly and efficient administration of this **policy**. You agree to abide by such policies, procedures, rules and interpretations. All services are available to **members** without regard to race, color, handicap, age, sex, creed, national origin, ancestry, or sexual orientation.

TABLE OF CONTENTS

DEFINITIONS

The following are definitions of terms as they are used in this **policy**. Defined terms are printed in bold face type wherever found in this **policy**.

ADVERSE DETERMINATION

Adverse determination means a determination by **MercyCare**, in which all of the following apply:

1. An admission to a healthcare facility, the availability of care, the continued stay or other treatment that is a covered benefit has been reviewed by **MercyCare**;

2. Based on the information provided, the treatment in #1 above does not meet **MercyCare's** requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness;

3. Based on the information provided, **MercyCare** reduced, denied or terminated the treatment under #1 above, or payment for the treatment was denied;

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

APPLICATION FORM

Application form means the form completed by a potential member requesting coverage from **MercyCare**.

BODILY INJURY

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

CLAIM

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

CONFINEMENT/CONFINED

Confinement or **confined** means (a) the period of time between admission as an inpatient or outpatient to a **hospital**, **skilled nursing facility** or licensed ambulatory surgical center, and discharge therefrom; or (b) the time spent receiving **emergency** care for **bodily injury** or **sickness** 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**.

COVERED SERVICE

Covered service means a service or supply specified in this **policy** and the Outline of Coverage, for which benefits will be provided.

CUSTODIAL CARE

Custodial care means provision of room and board, nursing care, personal care or other care designed to assist you in the activities of daily living. **Custodial care** occurs when, in the opinion of a 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 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.

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.

EXPEDITED REVIEW

Expedited review means a review process used when the standard review process would jeopardize the member's life, health or ability to regain maximum function.

EXPERIMENTAL/INVESTIGATIVE

Experimental or investigative means the use of any service, treatment, procedure, facility, equipment, drug, devices or supply for **your bodily injury** or **sickness** that:

1. Requires the approval by the appropriate federal or other governmental agency that has not been granted at the time it is used; or

2. Is not yet recognized as acceptable medical practice to treat that bodily injury or sickness, as determined by **MercyCare** for the **bodily injury** or **sickness**.

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

1. It is commonly performed or used on a widespread geographic basis.

2. It is generally accepted to treat that **bodily injury** or **sickness** by the medical profession in the United States.

3. Its failure rate or side effects are unacceptable.

4. You have exhausted more conventional methods of treating the **bodily injury** or **sickness**.

5. It is recognized for reimbursement by Medicare, Medicaid and other insurers and self-funded plans. For **Medicare eligible** services, **MercyCare** will not be more restrictive than Medicare in determining what is experimental or investigative. **MercyCare** will follow **Medicare's** coverage determinations.

EXPERIMENTAL TREATMENT DETERMINATION

Experimental treatment determination means a determination by **MercyCare** in which all of the following apply:

1. A proposed treatment has been reviewed;

2. Based on the information provided, the proposed treatment is determined to be experimental under the terms of this **policy**;

3. Based on the information provided, **MercyCare** denied the treatment or payment for the treatment.

FREESTANDING SURGICAL FACILITY

Freestanding surgical facility means any accredited public or private establishment that has permanent facilities equipped and operated primarily for performing surgery with continuous physician services and

registered professional nursing services whenever a patient is in the facility. It does not provide services or accommodations for patients to stay overnight.

GRIEVANCE

Grievance means any dissatisfaction that **you** have with **MercyCare** or with a provider of service that has been expressed in writing by **you** or on **your** behalf, including dissatisfaction with the provision of services, our claims practices, or our decision to disenroll you.. See the section on Grievance Procedure in this **policy** for more information.

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:

1. A place for treatment of chemical dependency;

2. A nursing home; or

3. A federal hospital.

IDENTIFICATION CARD

Identification card means the card that **MercyCare** issues to **you** that indicates **your** eligibility to receive **covered services.**

INDEPENDENT REVIEW ORGANIZATION (OR IRO)

Independent review organization means an entity certified by the Office of the Commissioner of Insurance to review **MercyCare's** decisions. Please refer to the Complaint Procedures section for a description of the independent review process.

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 **your** recovery has reached a plateau or non-measurable improvement in **your** condition has slowed or ceased entirely and only minimal rehabilitative gains can be demonstrated. **MercyCare** determines what constitutes **maintenance or long term therapy** after reviewing **your** case history or treatment

plan submitted by a provider.

MEDICALLY NECESSARY

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

1. Consistent with the symptom(s) or diagnosis and treatment of **your bodily injury** or **sickness**;

2. Appropriate under the standards of acceptable medical practice to treat that **bodily injury** or **sickness**;

3. Not solely for **your** convenience or the convenience of **your** 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 **you**; and

5. The most economical manner of accomplishing the desired end result.

For **Medicare eligible** services, **MercyCare** will not be more restrictive than **Medicare** in determining what is **medically necessary**. **MercyCare** will follow **Medicare's** coverage determinations.

MEDICAID

Medicaid means the 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 amended.

MEDICARE ALLOWABLE

The **Medicare allowable** amount is the maximum amount that Medicare allows for a service. This amount may be less than the originally billed amount.

MEDICARE ELIGIBLE

Medicare eligible means health care services or expenses that are covered by **Medicare**. **Medicare** must recognize them as **medically necessary** and reasonable. The services or expenses may or may not be fully reimbursed by **Medicare**.

MEDICARE PART D

Medicare Part D means the **Medicare** outpatient prescription drug coverage.

MEMBER

Member means an individual who is eligible for and covered by **Medicare**; has completed an **application form** and had it accepted by **MercyCare**; and has paid the correct initial premium.

MERCYCARE

MercyCare means MercyCare HMO, Inc.

NON-PARTICIPATING PROVIDER

Non-participating provider means a provider other than a **participating provider**.

PARTICIPATING PROVIDER

A **participating provider** is a provider listed in **MercyCare's** most current provider directory.

PHYSICIAN CHANGE FORM

A **physician change form** is available through **MercyCare's** Customer Service Department that enables you to change **your primary care physician**. Refer to the Provider Selection provision in the Obtaining Services section of this **policy** for more information.

POLICY

Policy means this policy which has been issued to **you** which sets forth the terms, conditions, and limitations of **your** coverage with **MercyCare**. **Policy** includes this policy, the Outline of Coverage, and **your application form**.

PRESCRIPTION DRUG

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

PRIMARY CARE PHYSICIAN

Primary care physician means a physician practicing family medicine, internal medicine, OB/GYN, osteopathic medicine or pediatrics who has accepted primary responsibility for **your** health care. You must name your primary care physician on your application form or on a later **physician change form**.

Your primary care physician:

1. Provides entry into **MercyCare's** health care system;

2. Evaluates your total health care needs;

3. Provides personal medical care in one or more medical fields; and

4. Is in charge of coordinating other health services and referring you 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 **policy**. To obtain **prior authorization**, contact **MercyCare** at the address on the first page of this **policy** or at the telephone number printed on **your identification card**.

PROVIDER OF HEALTH CARE

Providers of health care include:

1. Medical or osteopathic physicians, hospitals, and clinics.

2. 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**.

3. Nurses licensed by the State of Wisconsin and certified as a nurse anesthetist to provide **covered services**.

4. Nurse midwives licensed by the State in which they practice to provide **covered services**.

REFERRAL and STANDING REFERRAL

Referral means a form prepared in writing by a **participating** physician if he or she feels that **you** require specialty care beyond that available from **participating providers**. A **referral** may authorize one or more visits to a **participating** or **non-participating provider**, and must be submitted to and approved by **MercyCare's** Quality Health Management Department before such services occur. A **standing referral** may authorize ongoing treatment if medically appropriate. The referring provider and the Quality Health Management Department will determine the duration of the **referral** or the number of visits it authorizes based on what is medically appropriate.

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 **your** 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**.

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 as such by the State of Wisconsin or other applicable jurisdiction.

YOU/YOUR

You or **your** means the **member** under this **policy**.

OBTAINING SERVICES

PRIMARY CARE PHYSICIAN

At the time that **you** enrolled **you** selected a **primary care physician** to provide health care for **you**. **You** can change to another **primary care physician** after **you** are enrolled. **You** can make a change at any time as long as **you** give **MercyCare** written notice on a **physician change form**. **You** must give notice on or before the twentieth (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 physician is accepting additional patients.

REFERRALS

Your primary care physician is responsible for **your** care. If specialty care is needed, **your primary care physician** may give you a **referral** or a **standing referral** to an appropriate **participating provider**. No referral is required to see a **participating** physician or nurse practitioner who specializes in obstetrics and gynecology (OB/GYN).

If **your participating** physician feels that **you** require specialty care beyond that available from **participating providers**, he or she may complete a **referral** form. A **referral** may authorize one or more visits to a **participating** or **non-participating provider**, and must be submitted to and approved by **MercyCare's** Quality Health Management Department before such services occur. The referring provider and the Quality Health Management Department will determine the duration of the **referral** or the number of visits it authorizes based on what is medically appropriate. A verbal request for a **referral** will not guarantee that the **referral** is authorized and approved by **MercyCare**. The Quality Health Management Department must determine whether the request for services should be approved. If a **referral** is not approved by the Quality Health Management Department, it is not considered valid, and the services are not considered authorized. If an authorized **referral** is not obtained for service from a **non-participating provider**, **MercyCare** will not cover any claims associated with that service. If an authorized **referral** is not obtained for a service from a participating provider, **MercyCare** will not cover any claims associated with that service and you will not have responsibility to pay for these services. It is your responsibility to make sure your doctor submits a **referral** to **MercyCare** prior to seeking treatment.

MercyCare covers the difference between **Medicare eligible** charges and actual charges for authorized services by **referral**.

CONTINUITY OF CARE

MercyCare reserves the right to modify the list of **participating providers** at any time. However, if at the time of **your** enrollment, or most recent renewal, whichever is later, **MercyCare** made materials available to you indicating that your **primary care physician** was or would be a **participating provider**, that **primary care physician** will be treated as a **participating provider** for **you** during the entire year, even if the provider terminates as a **participating provider**. If **you** are undergoing a course of treatment with a provider who terminates as a **participating provider**, that provider will continue to be treated as a **participating provider** for **you** as follows:

1. If receiving services from a **primary care physician**, until the end of the year.

2. If receiving services from a provider who is not a **primary care physician**, 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 the year

If the course of treatment involves your pregnancy, and **you** are in the second or third trimester at the time the provider terminates, the provider will continue to be treated as a **participating provider** for **you** through post-partum care). This paragraph does not apply to a provider who is no longer practicing in the **service area** or who was terminated from **MercyCare** for professional misconduct.

NON-EMERGENCY CARE

Except in the event of an **emergency**, all services described in this **policy** must be obtained directly from:

1. Your **primary care physician**;

2. A participating specialist; or

3. A **non-participating provider** authorized by **MercyCare**.

Otherwise, the services are NOT covered and the **member** is responsible for payment.

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 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.

Other acute conditions are **emergencies** when these four elements exist:

1. They require immediate medical care for **bodily injury** or **sickness**.

2. Symptoms are unexpected and severe enough to cause a person to seek medical help right away.

3. Immediate care is secured.

4. Diagnosis or the symptoms themselves show that immediate care was required.

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

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

If you think **you** need acute **emergency** care **you** should go to the nearest Emergency Room or call 911.

COVERED SERVICES

You are entitled to **covered services** subject to the terms and conditions of this **policy**. Services and supplies will be covered only if **medically necessary** and if rendered by or at the direction of **your participating** physician, or **non-participating provider** if a **referral** to the **non-participating provider** is authorized by **MercyCare**. **MercyCare** will follow **Medicare's** coverage determinations for **Medicare eligible** expenses.

AMBULANCE SERVICES

Medicare eligible local professional ambulance service is covered to the extent not covered by **Medicare**. Service must be rendered in accordance with the Emergency Care provision of the Obtaining Services section of this **policy**.

BLOOD

Medicare eligible blood is covered to the extent not covered by **Medicare**.

CHIROPRACTIC SERVICES

Chiropractic services are covered without a **referral** if services are rendered by a **participating** chiropractor. Services must be **medically necessary** as determined by a **participating** chiropractor.

Benefits are NOT available for **maintenance or long term therapy**.

DENTAL SURGERY

To the extent not covered by **Medicare**, **covered services** include inpatient **hospital** and **freestanding surgical facility** services, and anesthetics provided therein, in conjunction with dental care if **you**:

1. Are under age 5; or

2. Have a chronic disability that is attributable to 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 for independent living, or economic self-sufficiency; or

3. Have a medical condition that requires **hospital confinement** or general anesthesia for dental care.

DIABETES SERVICES

To the extent not covered by **Medicare**, **covered services** include:

Diabetic self-management education programs and non-prescription diabetic equipment and supplies. Diabetic equipment may include non-prescription Accuchecks and glucometers as well as the installation and use of an insulin infusion pump. Insulin infusion pump coverage is limited to the purchase of one pump per year. The pump must be in use for 30 days before purchase. Diabetic supplies may include non-prescription insulin, syringes, chem-strips and lancets obtained from a **participating provider**.

DURABLE MEDICAL EQUIPMENT

Medically necessary Medicare eligible durable medical equipment is covered to the extent not covered by **Medicare**. It must be purchased at a **participating provider** or other provider authorized by **MercyCare**. It must be ordered or prescribed by a **participating provider**; a **participating** physician to whom **you** have an active **referral**; or a **non-participating** physician authorized by **MercyCare**.

To be considered durable medical equipment, the equipment must be:

1. Able to withstand repeated use; and

2. Primarily and customarily used to serve a medical purpose; and

3. Not generally useful except for the treatment of **bodily injury** or **sickness**; and

4. Appropriate for use in the home.

Examples include crutches; wheelchairs; hospital beds; customized braces; equipment used in the administration of oxygen; and initial acquisition of artificial limbs or eyes. Other than orthopedic shoes that are an integral part of a brace, orthotics are not covered. Durable medical equipment required for athletic performance and/or participation is not covered.

FOREIGN TRAVEL COVERAGE

Charges for **emergency hospital**, physician and medical care **you** receive while traveling outside of the United States are covered, subject to the following limitations:

1. Coverage is subject to a lifetime limit of $50,000, which applies across all policies issued by **MercyCare** that cover **you**.

2. The care must begin within the first 60 consecutive days of each trip outside the United States.

3. Coverage is limited to care that would be **Medicare eligible** if provided in the United States, and to care that is not covered by **Medicare**.

HEARING EXAMS

Hearing exams to determine need for hearing correction are covered when obtained through a **participating provider**.

HOME HEALTH CARE

Home health care is a **covered service** to the extent not covered by **Medicare**, up to 365 visits per **policy year** when the attending physician certifies that:

1. **Confinement** in a **skilled nursing facility** or **hospital** would otherwise be required if home health care were not provided; and

2. Necessary care and treatment is not available from **your** dependents, parents, brothers, sisters or their spouses, or other persons residing with **you**, without causing undue hardship; and

3. The home health care services are to be provided or coordinated by a state-licensed or **Medicare**-certified home health agency or certified rehabilitation agency.

The attending physician must 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:

1. The evaluation of the need for home care when approved or requested by the attending physician.

2. 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.

3. **Medically necessary** home health aide services that are provided from time to time or on a part-time basis as part of the home care plan. The services must consist solely of caring for the patient. A registered nurse or medical social worker must supervise the care.

4. Physical, respiratory, occupational, or speech therapy.

5. Medical supplies, drugs and medicines prescribed by a physician, and lab services by or from a **hospital**. These services are covered to the same extent they would be covered under the **policy** if **you** were **confined** to a **hospital**.

6. Nutrition counseling provided by or under the supervision of a registered or certified dietitian if **medically necessary** as part of the home care plan.

If **you** were hospitalized immediately before the home health care services began, the physician who was the primary provider of care during the **hospital confinement** must approve an initial home care plan.

Each visit by a qualified person providing services under a home care plan or evaluating the need for or developing a plan is considered one home care visit. Up to 4 consecutive hours in a 24-hour period of home health service are considered one home care visit.

Any other **Medicare eligible** home health care is also a **covered service** to the extent not covered by **Medicare**.

HOSPITAL SERVICES

Medicare eligible inpatient and outpatient **hospital** services are covered, when rendered by a **hospital** or **freestanding surgical facility**, to the extent not covered by **Medicare** and to the extent the **hospital** or **freestanding surgical facility** is permitted to charge by federal law and regulation and subject to the **Medicare** reimbursement rate.

Inpatient **hospital** services include the following:

1. Daily room and board in a semi-private, ward, intensive care or coronary care room, including general nursing care if **medically necessary**. A private room will be covered if determined by **MercyCare** to be **medically necessary**.

2. **Hospital** services and supplies determined to be **medically necessary** furnished for **your** treatment during **confinement**, including drugs administered to **you** as an inpatient. Take-home drugs dispensed prior to **your** release from **confinement**, whether billed directly or separately by the **hospital** are NOT covered.

3. Inpatient **confinement** days are covered when care is being directed by a provider.

Inpatient psychiatric care is limited to 175 days of **Medicare eligible** services during **your** lifetime, which applies across all policies issued by **MercyCare** that cover **you**, after **you** have exhausted **Medicare** coverage for such services.

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

1. Emergency room treatment provided in accordance with the Emergency Care provision of the Obtaining Services section of this **policy**.

2. Surgical day care.

3. Regularly scheduled treatment such as chemotherapy, inhalation therapy, and radiation therapy.

4. Diagnostic testing which includes laboratory, x-ray, and other diagnostic testing.

KIDNEY DISEASE

Up to $30,000 per calendar year for kidney dialysis and transplant services, including the donor's expenses, are covered when rendered by a **participating provider**, to the extent not otherwise covered by **Medicare** or under this **policy**.

MEDICAL SERVICES UNDER PART B

Medicare eligible medical services and other health services rendered by a **participating provider** are covered to the extent not otherwise covered by **Medicare** or under this **policy**, after you have satisfied the Part B deductible as specified in the Outline of Coverage. This includes physician services; services and supplies incident to physician services; diagnostic tests; certified registered nurse anesthetist services; and services of physician assistants and nurse practitioners.

OUTPATIENT REHABILITATION SERVICES

Medicare eligible outpatient rehabilitation services obtained through a **participating provider** are covered to the extent not covered by **Medicare**. **Maintenance or long term therapy** is not covered.

PHYSICAL THERAPY, SPEECH THERAPY, AND/OR OCCUPATIONAL THERAPY

Medicare eligible outpatient physical therapy, speech therapy, and/or occupational therapy are **covered services**, to the extent not covered by **Medicare**, when rendered by a **participating provider**. 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. Therapy may not be primarily educational in nature.

The provider must be a registered physical, occupational or speech therapist and must not live in **your** home or be **your** family member.

PREVENTIVE HEALTH SERVICES

Routine or preventive health care services obtained through a **participating provider**, as determined to be medically appropriate by an attending physician, are covered to the extent not covered by **Medicare**.

SECOND OPINION

A second opinion is covered when the opinion is provided by a **participating provider**.

PROSTHESIS

Medicare eligible replacement of natural or artificial limbs and eyes is covered if they are no longer functional due to physiological change or malfunction beyond repair; if **medically necessary**; and only to the extent not covered by **Medicare**. Prosthetic devices require **prior authorization** from **MercyCare**.

SKILLED NURSING FACILITY

Medicare eligible care during the 21st through 100th days in a **participating skilled nursing facility** is covered to the extent not covered by **Medicare**.

If your stay is not covered by Medicare because you did not have a Medicare "qualifying hospital stay," charges for daily room and board and general nursing services provided during a **skilled nursing facility confinement** in a licensed participating facility is covered for up to an additional 30 days as long as it is **medical necessary**.

Coverage is provided for physical therapy; occupational therapy; and speech therapy if **medically necessary** and provided by a **participating provider**. **MercyCare** must consider the services to be at a skilled level of care and **medically necessary**. There is no coverage for **custodial care**.

Confinement in a swing bed in a **hospital** is considered the same as a **skilled nursing facility**.

SPECIALTY CARE SERVICES

Medicare eligible specialty care services (such as surgery, surgery with an assistant surgeon if necessary, oncology, cardiology, or anesthesiology) are covered, to the extent not covered by **Medicare**, if the care is rendered by a **participating provider**. **Covered services** include breast reconstruction of the affected tissue incident to a mastectomy. If specialty care is not available from **MercyCare's participating providers**, **an** authorized **referral** from **MercyCare** is required to see a **non-participating provider**.

STAY HEALTHY PROGRAM

Health education or physical fitness programs are covered up to a maximum of $25 per year. Examples of covered classes include adult physical fitness; wellness; and lifestyle programs such as smoking cessation or weight loss. Covered programs do NOT include entrance fees for competitive or contact sports or equipment purchases. This benefit can also apply to a health club membership. Proof of fee payment must be submitted to **MercyCare** with the appropriate forms, available from the Customer Service Department. In order to determine if a specific program or course is a **covered service**, please contact the **MercyCare** Customer Service Department at 1-800-895-2421.

TRANSPLANTS

Medicare eligible transplants are covered, to the extent not covered by **Medicare**. Transplant-related services, including evaluation, provided by a **non-participating provider** are not covered unless you obtain an authorized **referral** from **MercyCare**.

URGENT CARE

Covered services include **Medicare eligible** care for a **bodily injury** or **sickness** 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 drug reactions.

In the service area:

Urgent care should always be received from a **participating provider**, including 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 from the nearest physician, **hospital** or clinic. **Follow up care is not covered when it is received from a non-participating provider.**

VISION CARE

Covered services include medical eye examinations provided as part of the treatment for pathological conditions and **routine or preventive** eye exams.

The cost of frames, lenses, and contact lenses is NOT covered except for initial eyeglasses or contact lenses after cataract surgery. Eyeglasses or contact lenses must be obtained through a **participating provider** contracted with **MercyCare** to provide these services, if one is available.

X-RAY AND LABORATORY TESTS

Medicare eligible x-ray, mammography, laboratory and other diagnostic tests are **covered services** to the extent not covered by **Medicare**.

RESTRICTIONS, LIMITATIONS, AND EXCLUSIONS FOR COVERED SERVICES

RESTRICTIONS

The **policy** restricts availability of **covered services** as follows:

1. **Emergency** and urgent care may not be covered if **you** fail to follow the rules which are explained under Emergency Care in the Obtaining Services section and the Urgent Care provision of the Covered Services section of this **policy**.

2. If, due to circumstances not reasonably within **MercyCare's** control (such as complete or partial destruction of facilities; war; riot; civil insurrection; disability of significant part of a **participating provider's** personnel or health professionals; major disaster or epidemic; or similar causes), the rendition of medical or hospital services by **MercyCare** or **participating providers** is delayed or rendered impractical, neither **MercyCare** nor any **participating provider** has any liability or obligation on account of such delay or for such failure to provide services. However, **MercyCare** and **participating providers** shall make a good faith effort to render medical and **hospital** services insofar as practical, according to their best judgment, within the limitation of such facilities and personnel as are then available.

LIMITATIONS

Benefits are limited as stated in this **policy**, including:

1. Nursing home care is limited to the care in a **skilled nursing facility** that is **Medicare eligible**, and up to 30 days of **medically necessary skilled nursing facility** care if you do not have a **Medicare** "qualifying hospital stay."

2. **Home health care** is limited to the 365 visits per year and **Medicare eligible** care that is specifically covered by this **policy**.

3. Care received during foreign travel that is otherwise **Medicare eligible** must begin within the first 60 days of a trip, and is subject to a $50,000 lifetime limit.

4. Inpatient psychiatric care is limited to 175 days per lifetime.

5. Kidney dialysis and transplant services are limited to $30,000 per calendar year.

6. Dental surgery is limited to facility services for certain **members**.

7. Speech and hearing screening examinations are limited to **routine or preventive** exams to determine the need for correction.

8. Sexual counseling services are limited to those techniques commonly used by **participating providers** or for conditions not producing significant physical and mental symptoms.

EXCLUSIONS

Covered services under this **policy** do NOT include:

1. The following surgical services:

    a. Procedures; services; counseling; and supplies related to sex transformation surgery and sex hormones related to such treatments, unless **Medicare eligible**.

b. Reversal of voluntary sterilization and related procedures.

c. Plastic or cosmetic surgery which is undertaken solely to improve **your** 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.

d. Any surgical treatment for morbid obesity, including ileal bypass, gastric bypass, or stapling, unless **Medicare eligible.**

e. Cochlear implants, unless **Medicare eligible**.

f. Keratorefractive eye surgery, including tangential or radial keratotomy.

g. Skin tag removal.

2. The following medical services:

a. Any services and/or supplies given primarily at the request of; for the protection of; or to meet the requirements of, someone other than **you** 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 other preventive services and supplies for employment; licensing; marriage; adoption; insurance; camp; school; or travel.

b. Expenses for medical reports, including preparation and presentation.

c. Services rendered i) 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; ii) in the cutting, trimming or other nonoperative partial removal of toenails; iii) treatment of flexible flat feet; iv) in connection with any of these except when prescribed by a **participating provider** who is treating **you** for a metabolic or peripheral disease.

d. Any food, liquid, and/or nutritional supplements and any weight loss program that incorporates these.

e. Any artificial means to achieve pregnancy; donor sperm; or surrogate mother services. A "surrogate mother" is a woman who, through in vitro fertilization or any other means of fertilization, gives birth to a child which she may or may not have a genetic relationship to, or an individual who provides a uterus for the gestation of a fertilized ovum obtained from a donor when the child will be parented by someone other than the woman whom gives birth.

f. Implantable birth control items; services related to scarring due to the removal of implantable birth control items (e.g., Norplant); or elective abortions.

g. Sublingual (under the tongue) allergy testing and/or treatment.

h. Treatment for viral warts, except plantar warts.

i. Physician charges beyond the charge approved by **Medicare**.

3. The following ambulance services:

a. Ambulance service other than ground ambulance, unless such service meets **Medicare** requiremements or is **prior authorized** by **MercyCare**.

b. Any amounts over the amounts allowed by **Medicare** if the ambulance service does not accept **Medicare** assignment.

4. The following therapy services:

a. Vocational rehabilitation, testing, and counseling, including evaluation and treatment and work hardening programs.

b. **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.

c. Recreational or educational therapy or physical fitness or health education programs except as specifically stated. Home exercise equipment or supplies are not covered.

d. Hypnotherapy, marriage counseling, residential care, or biofeedback (except for treatment of headaches and spastic torticollis).

e. 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 any that are **Medicare eligible**).

f. Vision therapy or orthoptics treatment (eye exercises).

g. Coma stimulation programs.

5. The following dental services:

a. All services performed by dentist and other dental, care, treatment, or services, including all orthodontic services, except any that are **Medicare eligible** or covered under the benefits for dental surgery. This includes but is not limited to dental implants; shortening of the mandible or maxillae; correction of malocclusion; treatment for any jaw joint problems, including temporomandibular joint disorder (including bite splint therapy), craniomaxillary, craniomandibular disorder, or other conditions of the joint linking the jaw bone and skull; and **hospital** costs except as described in this **policy**.

b. Oral surgery, except any that is **Medicare eligible** or is covered under the benefits for dental surgery.

c. All periodontic procedures, except any that are **Medicare eligible**.

6. The following hospital and inpatient services:

a. Inpatient **hospital** services for days that are NOT certified to **MercyCare** as being **medically necessary** by **your primary care physician**, a **participating provider** to whom **you** have an active **referral** (if one is required), or a **non-participating provider** with **prior authorization**, including a continued **hospital** stay if the provider has documented that care could effectively be provided in a less acute care setting (e.g. **skilled nursing facility**).

b. Take home drugs and supplies dispensed at the time of **hospital** discharge which can reasonably be purchased on an outpatient basis, whether billed directly or separately by the **hospital**.

7. The following transplant services:

   a. Transplant procedures, including non-human and artificial organ transplant procedures, except any that are **Medicare eligible** with **prior authorization**.

   b. Organ transplant expenses of a donor and separately billed donor-related services (except for kidney transplants).

   c. Retransplantation. Only one transplant per organ is covered during **your** lifetime, which applies across all policies issued by **MercyCare** that cover **you**, except as required for treatment of kidney disease.

   d. Purchase price of bone marrow, organ, or tissue that is sold rather than donated.

8. The following medication:

   a. Any **prescription drugs**.

   b. Over-the-counter drugs and medications unless otherwise stated in this **policy**.

9. The following durable medical equipment and supplies:

   a. Any durable medical equipment purchase or rental exceeding $300 per month without **prior authorization**.
   b. Repairs and replacement of durable medical equipment or supplies without **prior authorization**.

   c. Supplies and equipment that are not **medically necessary** to treat a covered **bodily injury** or **sickness**, including for comfort or personal hygiene and convenience items such as: garments, air conditioners; air cleaners; humidifiers; physical fitness equipment; physician equipment; alternative communication devices; and self-help devices not medical in nature.

   d. Disposable supplies, except non-prescription test strips and lancets and used in connection with the treatment of diabetes.

   e. Home testing and monitoring supplies and related equipment except those non-prescription items used in connection with the treatment of diabetes.

   f. Equipment, models, or devices which have features over and above those which are **medically necessary** for **you**. Coverage is limited to the standard model as determined by **MercyCare**.

   g. Oxygen therapy and other inhalation therapy and related items for home use except with **prior authorization**.

   h. Elastic support stockings, such as TEDS, JOBST, etc.

   i. Orthotic appliances other than orthopedic shoes that are an integral part of a brace.

   j. Hearing aids.

k. Motor vehicles or customization of vehicles; lifts for wheelchairs and scooters; and stair lifts.

10. The following general items:

a. For **Emergency** care received from a **non-participating provider**, any amounts over the amounts allowed by **Medicare** if the **non-participating provider** does not accept **Medicare** assignment.

b. Services for holistic medicine, including homeopathic medicine, or other programs with an objective to provide complete personal fulfillment.

c. **Custodial care**.

d. Personal comfort or convenience items, such as television, telephone, or a private room in the **hospital**, housekeeping and homemaker services, a masseuse, and meal services as part of home health care.

e. Any service rendered AFTER the date **your** coverage under the **policy** terminates or AFTER **you** are disenrolled; also, any service rendered BEFORE **your policy** effective date.

f. Eyeglass frames and lenses or contact lenses; or fitting of contact lenses, except the lens of the affected eye after cataract surgery.

g. Services and supplies that are not reasonable or **medically necessary** for diagnosis and treatment of a covered **bodily injury** or **sickness**, or not required in accordance with accepted standards of medical, surgical, or psychiatric practice.

h. Charges for missed appointments.

i. Services and supplies that are, in **MercyCare's** judgment, **experimental** or **investigative**. These include any that are not recognized as conforming to commonly accepted medical practice within the **service area**; and any for which the required approval of a government agency has not been granted at the time the services and supplies are provided; However, coverage is provided for any covered drug which meets the following criteria:

i. is prescribed for the treatment of HIV infection or a **sickness** arising from or related to HIV infections; and

ii. is approved by the Federal Food and Drug Administration, including phase-3 investigational drugs; and

iii. 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.

j. Any treatment or services rendered by or at the direction of a person residing in **your** household; or **your** family member (such as **your** lawful spouse; child; parent; grandparent; brother; or sister).

k. Services by any **non-participating provider**, except i) with **prior authorization**; ii) in an **emergency** in the **service area** when a **participating provider**; and iii) in an **emergency** outside the **service area**.

l. Services not specifically covered in the Covered Services section of this **policy** or by rider to the **policy**; services not provided or received in accordance with the terms and conditions of this **policy**; and

treatment related to a non-**covered service**, except benefits for dental surgery as described in the Covered Services section.

m. Health care services or expenses that are payable by **Medicare**; or that would have been paid by **Medicare** if **you** enrolled in **Medicare**; or that are not **Medicare eligible** unless they are specifically listed as **covered services** in this policy; or that are beyond those required to satisfy **Medicare** copayments or deductibles, or both, for the following benefits: ambulance services; blood, durable medical equipment; inpatient **hospital** services through 150 days; outpatient **hospital** services; medical services under Part B; outpatient rehabilitation services; physical therapy; speech therapy; occupational therapy; prosthesis; **Medicare eligible** days in a **skilled nursing facility**; specialty care services; transplants (other than kidney transplants); and x-ray and lab tests.

n. 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 benefits are provided or are payable under any Workers' Compensation or Occupation Disease Act or Law, even if **you** fail to file a **claim** for such benefits.

o. Any loss caused or contributed to by war or any act of war declared or not; or any act of international armed conflict; or any conflict involving armed forces of any international authority.

p. Any loss caused or contributed to by **your** commission or attempted commission of a civil or criminal battery or felony.

q. Services and supplies for which no charge is made; or for which **you** would not have to pay without this coverage; or for which another party has the obligation to pay, including any other insurance and any government program (except **Medicaid**) and the U.S. Veterans Administration (except when **MercyCare** is the primary payer under applicable federal law).

r. Ancillary medical services (including but not limited to **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 Covered Services section.

s. Services of a blood donor.

t. 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, except persons on work release.

EFFECTIVE DATE, RENEWAL AND TERMINATION OF COVERAGE

EFFECTIVE DATE OF COVERAGE

Coverage for an individual who is eligible for and covered by **Medicare**; has completed an **application form** and had it accepted by **MercyCare**; and has paid the correct initial premium is effective at 12:01 a.m. on the date stated on the schedule page accompanying this **policy**.

TERM AND RENEWAL

This **policy** will be in effect for one year from the effective date. If **you** do not terminate this **policy** and **MercyCare** does not disenroll **you**, **MercyCare** will automatically renew **your policy** for each calendar year. **You** cannot be disenrolled because **you** have used or overused benefits.

DISENROLLMENT

"Disenrollment" means that **your** coverage under this **policy** is revoked. **MercyCare** can disenroll **you** only for the reasons listed below:

1. **You** do not pay required premiums by the end of the grace period; or

2. **You** allow a non-**member** to use **your identification card** to obtain services; or

3. **You** provided fraudulent information in applying for coverage; or

4. **You** no longer live or work in the **service area**.

Your coverage terminates at 11:59 p.m. on the day stated in **your** notice of disenrollment. Except for non-payment of premiums, **MercyCare** will arrange to provide similar alternative medical coverage if **you** are disenrolled. This coverage is provided until the anniversary of the **policy** or for one year, whichever is earlier.

REINSTATMENT

If **you** are disenrolled because **you** did not pay required premiums by the end of the grace period, **your policy** will be reinstated if:

1. **You** submit a completed **application form**, and

2. **MercyCare** approves **your** application, and

3. **You** have paid the required premium.

If **your policy** is reinstated, the new **policy** will be effective on the first day of the month following approval.

However, if within one year after **you** were disenrolled we accept **your** premium and do not deliver or mail to **you** a written statement of our reservations within 45 days after we receive **your** premium, **your policy** will be reinstated as of the date we accepted **your** premium.

If reinstated, the **policy** will cover only loss that results from a **bodily injury** or **sickness** that occurs after the date of reinstatement.

TOTAL DISABILITY UPON TERMINATION

If, for any reason, **your** coverage terminates while **you** are totally disabled, **you** are entitled to benefits for

any continuous loss commencing while this **policy** was in force. Such benefits continue only so long as the appropriate premium is paid; while **you** remain totally disabled; and until payment of any maximum benefits. Receipt of **Medicare Part D** benefits is not considered in determining a continuous loss. **You** are "totally disabled" if **you** are at all times prevented from engaging in any job or occupation for wage or profit for which **you** are reasonably qualified by education, training, or experience. If **you** are not normally employed, "totally disabled" means **you** are prevented from engaging in substantially all of the usual and customary activities of a person in good health and of the same age and sex. Whether **you** are totally disabled will be determined based upon the medical opinion of **MercyCare's** Medical Director or other appropriate sources.

CANCELLATION

If **you** cancel this **policy** or die midterm, **MercyCare** will issue a pro rata refund of **policy** premium to **you** or **your** estate.

SUSPENSION DUE TO MEDICAID ENTITLEMENT

This **policy** may be suspended for up to 24 months at **your** request if **you** become entitled to **Medicaid**. **You** must notify **MercyCare** within 90 days after **you** become entitled to **Medicaid**.

If **you** lose **Medicaid** during the 24 month suspension period and notify **MercyCare** within 90 days after its termination, this **policy** or, if it is no longer available, a substantially equivalent policy, will be reinstituted effective on the date **you** lose **Medicaid**. **You** must pay premium for the reinstituted policy beginning with the date **you** lose **Medicaid**.

SUSPENSION AVAILABLE WHILE COVERED UNDER A GROUP HEALTH PLAN

This policy may be suspended for any period determined by federal regulation at **your** request if **you** become entitled to benefits under section 226 (b) of the Social Security Act and **you** have group health coverage. If **you** lose group health coverage during the suspension period and notify **MercyCare** within 90 days after its termination, this policy or, if it is no longer available, a substantially equivalent policy, will be reinstituted effective on the date **you** lose group health coverage. **You** must pay premium for the reinstituted policy beginning with the date **you** lose group health coverage.

CONTINUATION OF COVERAGE

In the event the secretary of the United States Department of Health and Human Services ceases to permit the sale of Medicare Select policies, such as this **policy**, **MercyCare** will give **you** the opportunity to purchase a comparable policy.

PREMIUM AND BENEFIT CHANGES

PREMIUM PAYMENTS

MercyCare will send **you** a notice when **your** premium is due. **You** should pay this premium by the due date stated in the notice. To keep this **policy** in effect, **you** must pay the premium within the 31 day grace period after the first day of the period for which the premium is due. Coverage under this **policy** remains in effect during the grace period, and we may deduct the premium due for this coverage from any benefits received before **you** have properly cancelled the **policy**.

PREMIUM CHANGES

Your premium rate may change when **MercyCare** changes premiums for all **MercyCare** Senior Policies and when you turn a certain age. If you reach an age that places you into the next premium tier, the rate change will take effect at the next policy renewal date, which is January 1st of each year. **MercyCare** will notify **you** of any premium changes. If the premium will increase more than 25%, **MercyCare** will notify **you** at least 60 days before **your policy** renews. You can find more information about the premium rates in the Outline of Coverage that was issued with this policy, or in a subsequent update.

BENEFIT CHANGES

Benefits under this **policy** will change automatically to coincide with any changes in the applicable **Medicare** deductibles, copayments, and/or coinsurance. Premiums may be modified with such a change in benefits.

COMPLAINT PROCEDURES

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

VERBAL COMPLAINT

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

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 **you** are not satisfied with the resolution of the complaint, **you** may submit a written request for a **grievance** hearing.

GRIEVANCE

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

The Customer Service Department will send notification acknowledging receipt of **your grievance** request within 5 days. **You** will then be contacted via the telephone (if available) by a Customer Service Representative who will explain the **grievance** process and advise you of the next available date for a **grievance** hearing. **You** will receive a written confirmation of **your** hearing date a minimum of 7 days before the hearing is scheduled.

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

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

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

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

All **grievances** will be decided within 30 calendar days after receipt of the **grievance**, unless there are extenuating circumstances. In such cases, Customer Service will notify **you** in writing before the 30th day that the **grievance** has not been decided, the reason for the delay, and when a decision on the **grievance** may be expected. **MercyCare** will resolve the case within 30 calendar days after giving this notice.

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

INDEPENDENT REVIEW

You have the right to request and obtain an independent review. An "independent review" is a review of an **adverse determination** and an **experimental treatment determination**. An **independent review organization** or IRO will perform this review.

After **MercyCare** makes an **adverse determination** or an **experimental treatment determination**, you will receive a notice explaining your right to request an independent review, and how to go about obtaining an independent review. Your request for independent review must be made within 4 months from the date of the **adverse determination** or **experimental treatment determination**, or from the date of receipt of notice of the grievance panel decision, whichever is later. The request for independent review must be made in writing and sent to **MercyCare**, Customer Service Department, Independent Review, P.O. Box 550, Janesville, Wisconsin 53547-0550. The request should contain the following:

1. Your name, address, and phone number

2. An explanation of your disagreement with **MercyCare's** determination, including any documentation that supports your position.

3. A statement authorizing your representative to pursue independent review on your behalf if you are using such a representative to pursue independent review.

4. The name of the **independent review organization** you select. A list of certified IROs will be sent to you in response to your internal grievance; or you may obtain a list of certified **independent review organizations** from the Customer Service Department at 1-800-895-2421 or from the website of the Office of the Commissioner of Insurance noted at the end of this Complaint Procedures section.

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

1. Both **MercyCare** and you, or your authorized representative, agree that the appeal should proceed directly to independent review.

2. The **independent review organization** grants a request that you made to both the IRO and **MercyCare** to treat your appeal as an **expedited review**.

Within 2 days of receipt of your request for independent review, **MercyCare** will acknowledge your request and immediately notify the IRO you selected. If the IRO determines your case should be expedited, **MercyCare** will forward the case to the IRO within 1 day after receipt of your request for independent review. In all other cases, **MercyCare** will forward the case to the IRO within 5 business days after receipt of your request for independent review.

An IRO decision regarding an adverse benefit determination must be consistent with the terms of the plan. An IRO decision regarding an **experimental treatment determination** is limited to a determination of whether or not the proposed treatment is experimental.

The IRO will make a decision within 30 business days after receiving all pertinent information required to complete the case review. If the case requires an **expedited review**, the IRO will make a decision as quickly as your health condition requires, but not more than 72 hours after receiving all pertinent information required to complete the case review. In the case of an **expedited review**, the IRO will notify you and **MercyCare** of its decision within 1 hour of making the decision, or as soon as possible.

The IRO decision will be in writing, signed on behalf of the **independent review organization**, and served by personal delivery or by mailing a copy to you or your authorized representative and to **MercyCare**. The IRO decision is binding on you and on **MercyCare**.

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

MercyCare Health Plans
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 file a complaint online or to print a complaint form, visit OCI's website at www.oci.wi.gov, or contact OCI at:

Office of the Commissioner of Insurance
Complaints Department
P.O. Box 7873
Madison, WI 53707-7873
(800) 236-8517
(608) 266-0103
Website: http://oci.wi.gov

CONSENT TO RELEASE INFORMATION

CONSENT AND AUTHORIZATION

You consent to the release of **your** medical and/or legal information to **MercyCare** when **you** sign the **application form** and when **your identification card** is used to receive health care services. **MercyCare** has the right to deny coverage for the health services of any **member** who will not consent to release information to **MercyCare**.

You authorize and direct any person or institution that has examined or treated **you** to furnish to **MercyCare** at any reasonable time, upon its request, any and all information and records or copies of records relating to **your** examination or treatment. **MercyCare** agrees that such information and records will be considered confidential to the extent required by law. **MercyCare** shall have the right to submit any and all records concerning **your** health care services to appropriate medical review personnel. Expenses incurred to obtain such records for **MercyCare** will be **your** responsibility.

MercyCare also has the right to review any other records to make certain that **you** are entitled to coverage from **MercyCare**.

PHYSICIAN AND HOSPITAL REPORTS

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

RIGHT TO COLLECT NEEDED INFORMATION

You must cooperate with **MercyCare** and when asked will assist **MercyCare** 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.

CLAIM PROVISIONS

1. **MercyCare** will pay **participating providers** directly for **covered services you** receive, and **you** will not have to submit a **claim**. However, if **you** use a **non-participating provider** or receive a bill for some other reason, a **claim** must be submitted within 60 days after the services are received, or as soon as possible. If **MercyCare** does not receive the **claim** as soon as reasonably possible and within 12 months after the date it was otherwise required, **MercyCare** 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 Health Plans
   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 **MercyCare** any additional information regarding the occurrence and extent of the event for which the **claim** is made which **MercyCare** shall reasonably require in order to process the **claim**.

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

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

   a. **your** spouse; or

   b. **your** dependent children, including legally adopted children; or

   c. **your** parents; or

   d. **your** brothers and sisters; or

   e. **your** estate.

   Any payment made by **MercyCare** in good faith will fully discharge **MercyCare** 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**, **MercyCare** may require that **you** be examined, at the expense of **MercyCare**, by a **participating provider** designated by **MercyCare**.

6. If **your claim** is denied by **MercyCare**, **you** may file a **grievance** in accordance with the Grievance Procedure section of this **policy**.

GENERAL PROVISIONS

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 or 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 **MercyCare** in writing as **MercyCare** is required, by law, to advise **your primary care physician** and the clinic that **you** have an advance directive. **You** are not required to send the forms to **MercyCare**.

CASE MANAGEMENT/ALTERNATIVE TREATMENT

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

CLERICAL ERRORS

No clerical errors made by **MercyCare** 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 under this **policy**, **MercyCare** 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 **policy**.

LIMITATIONS ON SUITS

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

OTHER COVERAGE

If **you** have another policy or plan that provides benefits or services for medical care or treatment, **MercyCare** will reduce benefits under this **policy** by the benefits or services **you** received or could have received under the other policy or plan. The total benefits and services available under all such policies and plans will not exceed the actual expense for **your** medical care and treatment. If **you** receive a direct or indirect payment under another policy or plan for services provided under this **policy**, **MercyCare** has the right to recover the payment from **you**.

PHYSICAL EXAMINATION

MercyCare has the right to require **you** to receive a physical examination to determine **your** eligibility for claimed services or benefits under this **policy** (including issues relating to subrogation). The Plan will pay for the physical examination. By completing the application for coverage under the **policy**, **you** are deemed to have consented to such an examination.

PROOF OF COVERAGE

It is your responsibility to show **your MercyCare identification card** each time **you** receive **covered services**.

QUALITY ASSURANCE

MercyCare's Medical Management Program is designed to ensure that quality medical care is accessible and appropriate to **your** needs, and to identify problems with care and correct those problems. There are many elements to this Program, including a process for choosing and deciding whether to retain **participating providers**; guidelines and education for providers regarding medical management and quality of care; review of medical data to monitor provision of care and treatment results; and consideration of **member** complaints and **grievances** to detect problems in provision of care. If **you** have any questions about this Program, please contact the **MercyCare** Customer Service Department.

RIGHTS OF RECOVERY: SUBROGATION AND REIMBURSEMENT

If **you** are injured and a third party is contractually responsible or otherwise liable for the expenses incurred because of such injury, **MercyCare** will be subrogated to, and may enforce these rights of recovery against **you** or the third party(ies) for such expenses. A "third party" is the person who injured **you** or someone on that person's behalf, including but not limited to medical, health and accident, workers compensation, motor vehicle or premises medical expense coverage and liability, uninsured or underinsured motorist, school or no fault insurer(s).

When used in this section the term "expenses" shall mean the costs of all medical, surgical and hospital care furnished to **you** and covered by **MercyCare**. Expenses are computed on the basis of **Medicare allowable** fees charged by **providers of health care** for such services. When expenses incurred by **MercyCare** have been subject to contractual discounts or capitation agreements, **MercyCare** shall be entitled to reimbursement on the basis of the **Medicare allowable** fees charged by **providers of health care** for such services, without regard to contractual discount or capitation agreements. **MercyCare** has the right to subrogate or seek reimbursement from **you** for the full amount of **Medicare allowable** expenses necessarily incurred by **you**, and related to injuries caused by another person, less any percentage of causal negligence reasonably attributable to **you**.

In addition to and notwithstanding the recovery rights granted to **MercyCare**, by accepting benefits from **MercyCare**, **you** assign to **MercyCare** all rights and claims against third party(ies) for expenses. This assignment includes the right to compromise claims independently, and to recover in actions brought in **MercyCare's** name or in **your** name. These recovery rights granted to **MercyCare** shall not apply until such time as **you** have been "made whole." **You** agree that **you** are made whole if a claim results in payment to **you**, by way of settlement, compromise or judgment, of an amount less than the combined total of any available third party payments. In the event of the settlement or compromise of a disputed claim, **you** agree that **you** are made whole if a claim results in payment to **you** of **your** total damages after reduction to account for any contributory negligence attributable to **you**. **MercyCare** and **you** each have the right to a hearing by a trial judge if there is a dispute as to the amount of contributory negligence reasonably attributable to **you**.

You shall execute such forms as **MercyCare** deems necessary or appropriate to permit **MercyCare** to enforce the subrogation and assignment rights granted under this section. If **MercyCare** compromises a claim for expenses against a third party, then **you** shall be deemed to have released any claim **you** may have against the third party(ies) for the expenses. **You** are not to settle, compromise, or release a claim for expenses without **MercyCare's** consent and **you** are not to settle a claim against a third party, unless:

1. The rights of **MercyCare** are expressly reserved in the settlement, compromise or release;

2. The claim of **MercyCare** is paid in full; or

3. **MercyCare** has given a written waiver of the claim after being provided written notice of the claim.

You shall notify **MercyCare** in writing within thirty-one (31) days after the commencement of any legal proceeding against a third party liable for the payment of the expenses. **MercyCare** shall have the right to participate or intervene in any such proceeding. **You** will join **MercyCare** as a party in such proceeding, as **MercyCare** may elect, in order for **MercyCare** to pursue its rights of subrogation and reimbursement. **MercyCare** and **you** shall each have the right to be represented by their own counsel in any lawsuit or to enforce any claim with regard to the expenses. The expenses due **MercyCare** shall not be reduced in order to pay **your** attorney fees or court costs, regardless of whether or not a lawsuit is filed. **You** agree to grant **MercyCare** a first lien and security interest up to the amount of the expenses upon any award, settlement or judgment you receive. **You** will assign any award, settlement or judgment to **MercyCare** up to the amount of the expenses. Any funds received by **you** shall be held in trust by **you** and/or **your** attorney and paid to **MercyCare** without any deductions for attorney fees or other costs. The amount of any third party recovery shall be applied to reimburse **MercyCare** for the expenses, regardless of whether the award, settlement, judgment, or other recovery is one of general damages, specific damages or punitive damages. For example, if **you** do not sue for the expenses but recover general damages, **MercyCare** shall be reimbursed out of any recovery of general damages.

WORKERS COMPENSATION

This **policy** is not issued in lieu of nor does it affect any requirement for coverage by Workers' Compensation. If **you** are eligible for Workers' Compensation coverage for a **bodily injury** or **sickness** arising from or sustained in the course of any occupation or employment for compensation, profit or gain, that **bodily injury** or **sickness** is not covered under this **policy**, whether or not you actually obtained such coverage or received benefits under any coverage you obtained. If **MercyCare** paid for the treatment of any such **bodily injury** or **sickness**, and **MercyCare** determines that **you** also received Workers' Compensation benefits for the same incident, **MercyCare** has the right to recover such payments as described under the Right to Recovery provision above. You must reimburse **MercyCare**, and **MercyCare** 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** arose from, or 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 for 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 any recovery rights will be applied.

In the event that Workers' Compensation denies a claim, **MercyCare** will cover the resulting charges only if **you** have obtained any available independent review of that denial. For example, **you** must appeal the denial to the state agency that reviews Workers' Compensation claims, if such an appeal is available. No benefits are available from **MercyCare** unless the denial is upheld on appeal. Also note that, as with any other claim, no

benefits are available from **MercyCare** for a claim denied by Workers' Compensation unless coverage is provided under the guidelines outlined in this **policy**. For example, **MercyCare** is not obligated to cover treatment by 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 **MercyCare** of any Workers' Compensation claim **you** make, and that **you** agree to reimburse **MercyCare** as described above.

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