MercyCare PPO CERTIFICATE OF COVERAGE

MercyCare Insurance Company
MercyCare HMO, Inc.
P.O. Box 550
Janesville, Wisconsin 53547-0550

PLAN TYPE:

GROUP NUMBER:

EMPLOYER:

EMPLOYEE:

CERTIFICATE NUMBER:

EFFECTIVE DATE:

MercyCare HMO, Inc. and MercyCare Insurance Co. (referred to in this Certificate of Coverage as "MercyCare") have issued and delivered a policy with several liability 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. "Several liability" means that each insurer is responsible only for its own obligations under the policy and is NOT responsible for the other insurer's obligations. MercyCare HMO, Inc. is responsible for benefits received from a participating provider or from a non-participating provider with a referral. MercyCare Insurance Co. is responsible for benefits received from a non-participating provider without a referral. The policy is guaranteed renewable except as stated in the policy's termination provisions.

NOTICE: LIMITED BENEFITS WILL BE PAID WHEN NON-PARTICIPATING PROVIDERS ARE USED. You should be aware that when you elect to utilize the services of a non-participating provider for a covered service, benefit payments to such non-participating providers are not based upon the amount billed. The basis of your benefit payment will be determined according to the usual and customary charge, which is determined by comparing charges for similar services adjusted to the geographical area where the services are performed. YOU RISK PAYING MORE THAN THE COINSURANCE AMOUNT AFTER THE PLAN HAS PAID ITS REQUIRED PORTION. Non-participating providers may bill members for any amount up to the billed charge after the plan has paid its portion of the bill. Participating providers have agreed to accept discounted payment for covered services with no additional billing to the member other than co-payment, coinsurance and deductible amounts. You may obtain further information about

the participating status of health care providers and information on out-of-pocket expenses by calling the toll free number on your identification card.

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

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

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

TABLE OF CONTENTS

TABLE OF CONTENTS

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. As a MercyCare member, you are responsible for understanding the benefits to which you are entitled under the policy, and the rules you must follow to receive those benefits.

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

How this Certificate is organized:

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

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

INTERPRETING THIS CERTIFICATE

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. Any quotation of benefits given by a MercyCare representative is not a guarantee of coverage. Benefit coverage is determined based on the terms and conditions of your Certificate and Schedule of Benefits.

LEVELS OF BENEFITS

As a member of the MercyCare PPO benefit plan, you have two levels of benefits available. In most cases, the benefit level is based on the type of provider you see. If you receive services from a participating provider, you will receive the highest level of benefits. If you receive services from a non-participating provider, a lower level of benefits will apply. Please be aware that certain services are not covered if rendered by a non-participating provider. Refer to your Schedule of Benefits to understand which services are covered at each level.

Level 1 Benefits
MercyCare PPO provides Level 1 benefits for those services rendered by participating providers, or by non-participating providers with an approved referral from MercyCare. The PPO participating providers are distinctly designated in the provider directory, which is available online at www.mercycarehealthplans.com.

Level 2 Benefits
Level 2 benefits are available if services are rendered by any provider other than those that are designated as PPO participating providers.

PRIMARY CARE PHYSICIAN (PCP)

At the time you enrolled in this MercyCare plan, you selected a primary care physician for you and, if you have dependent coverage, your covered dependents. You may select a pediatrician as the primary care physician for a member who is a child. You can change your primary care physician as follows:

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

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

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

REFERRALS AND STANDING REFERRALS FOR LEVEL 1 BENEFITS

Your primary care physician is responsible for your care. You can visit any participating provider without a referral, but your primary care physician is available to assist you in finding the appropriate participating provider. You do not need a referral from your primary care physician to receive covered services from any participating provider, including without limitation obstetrical and gynecological care.

In order to obtain Level 1 Benefits for specialty services and treatment that cannot be obtained from a PPO participating provider, you must obtain:

- A referral from a participating provider, and;
- Prior written approval from the Plan

The referring provider and the Quality Health Management Department will determine the duration of the referral or the number of visits authorized based on what is medically appropriate. If a referral is not approved by the Quality Health Management Department, it is not considered valid and the services are not considered authorized for Level 1 benefits. The Plan reserves the right to direct you to a specialist of its choice. Without an approved referral, services rendered by a non-participating provider will be considered as a Level 2 benefit, except in the case of an emergency.

You can visit any Level 1 provider without a referral. Please be aware that the benefit level reimbursement will be affected by your choice of provider, and that certain services require prior authorization, regardless of provider, in order to be covered at Level 1 or Level 2. The exception is Emergency Care, which is always covered at Level 1.

PRIOR AUTHORIZATION

To assure proper medical management the following services require prior authorization from the Plan before they will be covered services, regardless of whether they are rendered by a participating or non-participating provider. Failure to get prior authorization means the procedure will be denied upon claim submission. If you appeal the denial for services that are state mandated or an essential health benefit and the service is found to be medically necessary, the service will be covered. If the service is not covered, you will be responsible for the payment of such services.

Categories of services and supplies requiring prior authorization are:

Autism Treatment

Biofeedback services
Cardiac Rehabilitation
Congenital Heart Disease Surgeries
Dental/Anesthesia Services - Hospital or Ambulatory
Dental Surgery - Accident Only
Durable Medical Equipment
Genetic testing and counseling
Hearing Exams and Hearing Aids
Home Health Care
Hospice Care
Hospital Services – Inpatient/Outpatient
Insulin pumps
Magnetic Resonance Imaging (MRI)
Maternity services received out of the service area in the last 30 days of pregnancy
Medical Supplies
Non-participating provider services and supplies
Pharmaceuticals administered in provider's office
Prosthesis
Psychological disorder and chemical dependency, inpatient and transitional treatment
Reproductive services, inpatient

Surgical Services – inpatient, outpatient, and free-standing surgical facility
Skilled Nursing Facility Services
Temporomandibular Disorders (TMJ)
Transplants

The method for filing a request for prior authorization, also known as a pre-service claim, is set out in the Claims Provisions section of this certificate.

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

CONTINUITY OF CARE

If, at the time of your enrollment, or most recent renewal, whichever is later, the Plan made materials available to you indicating that your primary care physician was in the provider directory, that primary care physician will be treated as a provider for you during your entire plan year, even if the provider is no longer listed in the Plan's provider directory.

If you are undergoing a course of treatment with a provider who terminates as a participating provider, that coverage will continue to be treated as a Level 1 benefit for you until the earliest of:

a. the end of the course of treatment,
b. 90 days from the provider's termination,
c. the end of your plan year.

If 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 Level 1 for you through post-partum care.

This coverage 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.

CO-PAYMENTS, DEDUCTIBLE, AND COINSURANCE

You must pay a deductible, copayment and/or coinsurance for most covered services as shown in your Schedule of Benefits. These payments are due at the time of service or when billed by the provider.

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

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

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

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

Coinsurance payments begin once you meet any applicable deductible amounts.

PER HOSPITAL ADMISSION COPAY

Each hospital admission is subject to a "Per Hospital Admission Co-pay," if this provision is indicated in your schedule of benefits. However, if two or more family members are admitted to the hospital through the emergency room for the same emergency incident, the per hospital admission co-pay is limited to a dollar amount equal to two family members' co-pay for that stay.

OUT-OF-POCKET MAXIMUM

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

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

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

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

STUDENTS OBTAINING SERVICES

Medical/Surgical Benefits:
Eligible dependent children who are full-time students are covered just as other members of the Plan.

For students living outside the service area, all medical care will be covered as a Level 2 benefit. Urgent or emergency care is covered as a Level 2 benefit.

Psychological Disorder and Chemical Dependency Benefits:
A full time student attending a school beyond high school in Wisconsin and outside the service area will have coverage for limited outpatient services received from Level 2 providers for psychological disorders and/or chemical dependency at a Level 1 benefit in accordance with Wisconsin Statute section 609.655.

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

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

1-800-895-2421

EMERGENCY CARE

Services required stabilizing or initiating treatment in an emergency. Emergency Health Services must be received on an outpatient basis at a Hospital or Alternative Facility. Emergency Care does not require prior authorization, and is covered for services provided by participating and non-participating providers. Services are covered at the in-network level of benefits

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

If you require emergency care, you should seek care from the nearest physician, hospital or clinic. You must contact your primary care physician within 48 hours of the emergency or as soon as reasonably possible in order to arrange follow-up care.

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

Benefits under this section include the facility charge, supplies and all professional services required to stabilize your condition and/or initiate treatment. This includes placement in an observation bed for the purpose of monitoring your condition (rather than being admitted to a Hospital for an Inpatient Stay).

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

URGENT CARE

Covered Health Services received at an Urgent Care Center. Examples of urgent care situations are broken bones, sprains, non-severe bleeding, minor cuts and burns, and drug reactions.

Coverage is determined by the provider/benefit level you choose.

Members are entitled to these benefit provisions subject to the terms, conditions and exclusions of the policy and this Certificate. Urgent Care services and supplies will be covered services only if medically necessary. Coverage is subject to any coinsurance, copayment, deductible and/or other limits shown in the Schedule of Benefits.

ACUPUNCTURE SERVICES

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

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

Non-Covered Services:
- Acupuncture services provided by non-participating providers.
- Acupuncture services provided by non-certified or non-licensed providers.

AMBULANCE SERVICES

Covered Services:
- Professional ground or air ambulance service is covered in an emergency as described in the Emergency and Urgent Care section of this Certificate.
- Non-Emergency ambulance transportation (either ground or air ambulance, as we determine appropriate) is also covered between facilities when the transport is any of the following:
- From a non-participating provider to a participating provider
- From a hospital to the nearest hospital equipped to provide treatment that was not available at the original facility.
- To a more cost-effective acute care facility
- From an acute facility to a sub-acute setting.

Non-Covered Services:
- Ambulance service that is used in situations that are not considered life threatening.

AUTISM TREATMENT

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

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

Covered Services:
- Diagnostic testing and evaluation by a provider approved by MercyCare.
- Intensive-level services for up to 4 cumulative years for members between the age of 2 and 9 years;
- Nonintensive-level services that are provided:
  a) after the completion of intensive-level services treatment, or
  b) to a member who has not and will not receive intensive-level services, but for whom nonintensive-level services will improve the member's condition.
- Nonintensive-level services that include direct or consultative services when provided by qualified providers, qualified supervising providers, qualified professionals, qualified paraprofessionals or qualified therapists.

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

Non-Covered Services
- Any services that do not have prior authorization from the Plan.
- Custodial or respite care.
- Travel time for qualified providers, supervising providers, professionals, therapists, or paraprofessionals.
- Animal-based therapy, including hippo-therapy.
- Auditory integration training.
- Chelation therapy.
- Child care fees.
- Cranial sacral therapy.
- Hyperbaric oxygen therapy.
- Special diets or supplements.
- Treatment provided by parents or legal guardian.

- Autism therapy, treatment or services provided to a member who is residing in a residential treatment center, inpatient treatment or day treatment facility.
- The cost for the facility or location when treatment, therapy or services are provided outside a member's home.

BIOFEEDBACK

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

CARDIAC REHABILITATION

Covered Services:
- Cardiac Rehabilitation is covered when obtained through a participating provider, when medically necessary, and with prior authorization by the Plan.
- Phase II Cardiac Rehabilitation is subject to prior authorization by the Plan and must be provided in an outpatient department of a hospital, in a medical center or in a clinic program. This benefit applies only to members with a recent history of:
  a) a heart attack;
  b) coronary bypass surgery;
  c) onset of angina pectoris;
  d) heart valve surgery;
  e) onset of decubital angina;
  f) percutaneous 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 performed by a participating chiropractor are covered without a referral. Services must be medically necessary.

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

CONGENITAL HEART DISEASE SURGERIES

Covered Services:
- With prior authorization, congenital heart disease (CHD) surgeries which are ordered by a physician to treat conditions such as coarctation of the aorta, aortic stenosis, tetralogy of fallot, transposition of the great vessels and hypoplastic left or right heart syndrome.
- Benefits under this section include the facility charge and the charge for supplies and equipment. Benefits for Physician services are described under Physician Services.
- Surgery may be performed as open or closed surgical procedures or may be performed through interventional cardiac catheterization.

COSMETIC AND RECONSTRUCTIVE SURGERY

Covered Services:
- Coverage for the treatment of breast cancer includes:
  a) Reconstruction of the breast on which a mastectomy was performed.
  b) Surgery and reconstruction of the other breast to produce a symmetrical appearance.
  c) Prosthesis and physical complications of all stages of mastectomy, including lymphedemas.

- Reconstructive surgery which is medically necessary and which is either:
  a) Incidental to or following surgery necessitated by bodily injury or sickness, or
  b) Caused by congenital disease or abnormality of a dependent child, which results in a functional defect.

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

NOTICE REGARDING PEDIATRIC DENTAL SERVICES

This policy does not include pediatric dental services as required under the federal Patient Protection and Affordable Care Act. This coverage is available in the insurance market and can be purchased as a stand-alone product. Please contact MercyCare's Customer Service Department at: 1-800-895-2421, your agent, or the *American Health Benefits Exchange,* also called the *Health Insurance Marketplace,* if you wish to purchase pediatric dental coverage or a stand-alone dental services product.

DENTAL/ANESTHESIA SERVICES – HOSPITAL OR AMBULATORY SURGERY SERVICES

Covered Services:

With required prior authorization and if medically necessary, inpatient hospital and free-standing surgical facility services. and anesthetics provided in conjunction with dental care in a hospital or free-standing surgical facility, if the member:

a) 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

b) Has a medical condition that requires hospital confinement or general anesthesia for dental care.

DENTAL SURGERY – ACCIDENT ONLY

Covered Services:

- Treatment with prior authorization from the Plan for bodily injury to permanent, sound and natural teeth and bone, but only if:
  1. the bodily injury occurs while you are a member covered by the Plan; and
  2. the bodily injury is not caused by chewing or biting; and
  3. the treatment is received from a doctor of dental surgery or doctor of medical dentistry; and
  4. the dental damage is severe enough that initial contact with a physician or dentist occurred within 72 hours of the accident. (You may request an extension of this time-period, provided that you do so within 60 days of the injury and if extenuating circumstances exist due to the severity of the injury.); and
  5. the treatment begins within 3 months of the accident; and
  6. Treatment is completed within 12 months from the date of injury to complete treatment.

Benefits for treatment of accidental injury are limited to the following:

- Emergency examination.
- Necessary diagnostic X-rays.
- Endodontic (root canal) treatment. Temporary splinting of teeth.
- Prefabricated post and core.
- Simple minimal restorative procedures (fillings). Extractions.
- Post-traumatic crowns if such are the only clinically acceptable treatment.
- Replacement of lost teeth due to the Injury by implant, dentures, or bridges
- Oral surgery with prior authorization from the Plan for gum or bone tumors and cysts.
- Surgical removal of impacted wisdom teeth (third molars).

Non-Covered Services:

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

DIABETES SERVICES

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

Covered Services:

- Outpatient self-management education programs for the treatment of diabetes, education and medical nutrition therapy services that are ordered by a physician and provided by appropriately licensed or registered healthcare professionals.

- Medical eye examinations (dilated retinal examinations) and preventive foot care for Covered Persons with diabetes.
- Diabetic equipment, if considered medically necessary by the Plan.
- Insulin pumps with prior authorization and meeting the medical criteria established by the Plan.
- Diabetic supplies.
- Insulin.

DURABLE MEDICAL EQUIPMENT AND MEDICAL SUPPLIES

Durable medical equipment is defined as:

1. Able to withstand repeated use, and
2. Is not disposable, and
3. Primarily and customarily used to serve a medical purpose, and
4. Not generally useful except for the treatment of a bodily injury or sickness, and
5. Is appropriate for use in the home, and
6. In not implantable in the body, and
7. provides therapeutic benefits or enables the patient to perform certain tasks that he or she would be unable to perform or otherwise undertake due to certain covered medical conditions or illnesses.

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

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

Covered Services:
Durable medical equipment (DME) is covered only:

1. With prior authorized by the Plan, and when
2. Determined to be medically necessary, and
3. Purchased at a participating DME provider or other provider authorized by the Plan, and
4. Ordered or prescribed by a participating provider, or a non-participating provider with an active referral authorized by the Plan and
5. Not generally available over the counter (OTC).

If more than one piece of DME can meet your functional needs, Benefits are available only for the equipment that meets the minimum specifications for your needs. If you rent or purchase a piece of DME that exceeds this guideline, you will be responsible for any cost difference between the piece you rent or purchase and the piece we have determined is the most cost-effective.

Examples of DME include:

- Equipment to assist mobility, such as a standard wheelchair.
- A standard Hospital-type bed.
- Oxygen and the rental of equipment to administer oxygen (including tubing, connectors and masks).
- Delivery pumps for tube feedings (including tubing and connectors).
- Braces, including necessary adjustments to shoes to accommodate braces. Braces that stabilize an injured body part and braces to treat curvature of the spine are considered DME and are a Covered Health Service. Braces that straighten or change the shape of a body part are orthotic devices, and are excluded from coverage. Dental braces are also excluded from coverage.
- Breast pump and breastfeeding supplies in conjunction with each birth for the duration of breastfeeding.
- Prescription foot orthotics when the member has a documented diagnosis of diabetes with neuropathy or peripheral vascular disease.
- Mechanical equipment necessary for the treatment of chronic or acute respiratory failure (except that air-conditioners, humidifiers, dehumidifiers, air purifiers and filters, and personal comfort items are excluded from coverage).
- Burn garments.
- Insulin pumps and all related necessary supplies as described under Diabetes Services.
- External cochlear devices and systems. Benefits for cochlear implantation are provided under the applicable medical/surgical Benefit categories in this Certificate, as required by Wisconsin insurance law.

Benefits under this section also include speech aid devices and tracheo-esophageal voice devices required for treatment of severe speech impediment or lack of speech directly attributed to a sickness or injury. Benefits for the purchase of speech aid devices and tracheo-esophageal voice devices are available only after completing a required three-month rental period. Benefits are limited as stated in the Schedule of Benefits.

Benefits under this section do not include any device, appliance, pump (excluding an insulin pump), machine, stimulator, or monitor that is fully implanted into the body.

We will decide if the equipment should be purchased or rented. Benefits are available for repairs and replacement, except that:

- Benefits for repair and replacement do not apply to damage due to misuse, malicious breakage or gross neglect.

- Benefits are not available to replace lost or stolen items.

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

Non-Covered Services:

- Durable medical equipment required for athletic performance and/or participation.
- Garments and/or other equipment and supplies that are not medically necessary to treat a covered bodily injury or sickness.
- Replacement for damaged, lost or stolen items.
- Physician equipment, home testing and monitoring equipment, including but not limited to blood pressure equipment, stethoscopes, otoscopes, equipment that tests for blood levels other than glucose, oxygen level monitoring equipment and equipment that may monitor other types of measures or values.
- Exercise or physical fitness equipment (examples: treadmills, exercise bikes, bicycles, foam roller, etc.)
- Any food, liquid or nutritional supplements including those prescribed by a physician.
- Motorized vehicles or power operated vehicles, including but not limited to motorized scooters, except for motorized wheel chair when medically necessary.
- Durable medical equipment for comfort, personal hygiene, and convenience items including but not limited to: air conditioners; air cleaners, purifiers, humidifiers, or dehumidifiers; alternative communication devices; self-help devices not medical in nature; automobile modifications or lifts; baskets for wheelchairs and walkers; bath benches, or chairs; bath systems or lifts; car seats; cervical pillows; dressing sticks or aids; diapers; disposable gloves; disposable undergarments; eating utensils; eggcrate mattress pads; electric patient lifts; ergonomic chairs; orthotic socks; oral hygiene products; oral nutritional supplements and infant formula available over the counter; pillows; portable care or travel nebulizers; raised toilet seats; reachers; safety equipment such as gait belts, helmets, knee and elbow pads, or safety glasses; shower chairs; strollers; feeding aids; grab bars; grooming aids; heating pads; home bathtub spas; home massage equipment; lamb's wool sheepskin padding; lap trays not used for trunk support; lumbar rolls or cushion; massagers or Theracane; occipital release boards; stroller or wheelchair canopies; toileting systems or lifts; tongue depressors; vaporizers; vehicle travel or safety tie down restraints; wheelchair attendant controls; wheelchair backpacks or clips; wheelchair swing-aways; wheelchair or removable hardware when not needed for slide transfers; wheelchair work or cut-out trays; wigs; alcohol wipes; band-aids; over the counter (OTC) antibiotic ointments; OTC dressing supplies (examples: 4X4 gauze, tape, betadine, etc.); and home remodeling or modifications.
  Prescribed or non-prescribed medical supplies and disposable supplies. Examples include: elastic stockings, ace bandages, gauze and dressings, and urinary catheters. This exclusion does not apply to:
  a) Disposable supplies necessary for the effective use of DME for which Benefits are provided in this Section.
  b) Diabetic supplies for which Benefits are provided as described under Diabetes Services.
  c) Ostomy supplies for which Benefits are provided as described under Ostomy Supplies.
- Tubings and masks except when used with DME as described under this section.

EMERGENCY CARE

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

GENETIC TESTING AND COUNSELING

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

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

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

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

Non-Covered Services:

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

HEARING EXAMS and HEARING AIDS

Covered Services:

- Hearing aids, hearing exams and hearing aid procedures are covered when obtained through a Level 1 provider, and with prior authorization from the Plan.
- The reconditioning and repair of existing aids is covered when considered medically necessary.
- Post-cochlear implant aural therapy.
- New hearing aids are covered once per ear in a 36-month period.
- Benefit is subject to the limitations specified in your Schedule of Benefits.
- Cochlear implants are covered for children under the age of 19 with prior authorization from the Plan.
- Cochlear implants for those over age 19 may be covered if there is evidence based justification that a cochlear implant is medically necessary and effective for the member.
- Implantable bone conduction hearing aid, also called bone-anchored hearing aid (Baha®) is covered for patients with conductive hearing losses (unilateral or bilateral), or mixed hearing losses, if the patient has a bone conduction pure tone average up to 45 dBHL and a speech discrimination score better than 60% (in the indicated ear) who additionally has any one or more of the following conditions:
  a) Congenital or surgically induced malformations of the external ear canal and/or middle ear (example: atresia) or
  b) Tumors of the external ear canal and/or tympanic cavity, or
  c) Severe chronic external otitis or otitis media, or
  d) Otosclerosis in those who are not suitable candidates for stapedectomy, or
  e) Dermatitis of the external ear canal, including reactions from ear molds used for typical air conduction hearing aids, or
  f) Other conditions in which an air conduction hearing aid is contraindicated (example: relapsing polychondritis).
- Implantable bone conduction hearing aid, also called bone-anchored hearing aid (Baha®) is covered for the treatment of unilateral sensorineural hearing loss (single sided deafness) when there is normal hearing in the opposite ear (defined as a 20 dBHL air conduction pure tone average).
- The procedure and related services to implant a bone conduction hearing aid are covered as medical/surgical benefits; the device itself (bone anchored aid) is covered under the hearing aid benefit portion of your Plan. See your schedule of benefits for coverage limits.

Non-Covered Services:

- Hearing aids if more than one per ear in any 36-month period.
- Coverage for services in excess of the limits stated in your schedule of benefits.

HOME HEALTH CARE

Covered Services:

- Home health care benefits are covered up to the limits stated in the Schedule of Benefits with prior authorization, when the attending physician certifies that:
  1. Confinement in a hospital or skilled nursing facility would be necessary if home care were not provided.
  2. Necessary care and treatment is not available from the member's immediate family, or others living with the member without undue hardship.
  3. The home health care services are provided and coordinated by a state licensed or Medicare certified home health agency or certified rehabilitation agency.
- It is necessary that the attending physician establish a home health care plan, approve it in writing and review this plan at least every 2 months, unless the attending physician determines that less frequent reviews are sufficient.
- Home health care means one or more of the following:
  a) The evaluation of the need for home care when approved or requested by the attending physician.
  b) Home nursing care that is provided from time to time or on a part-time basis. It must be provided or supervised by a registered nurse;
  c) Home health aide services that are medically necessary as part of the home care plan must consist solely of caring for the patient. A registered nurse or medical social worker must supervise the care.
  d) Physical, respiratory, occupational and speech therapy;
  e) Medical supplies, drugs and medicines prescribed by a physician, and lab services by or from a hospital. These services are covered to the same extent such items would be covered under the policy if you were confined to a hospital;
  f) Nutritional counseling under the supervision of a registered or certified dietitian if considered medically necessary as part of the home care plan;
- If you were hospitalized immediately before the home health care services began, the physician who was the primary provider of care during the hospital confinement must approve an initial home care plan.
- Each visit by a qualified person providing services under a home care plan or evaluating the need for or developing a plan is considered one home care visit.
- Up to 4 consecutive hours in a 24-hour period of home health service are considered one home care visit. The maximum weekly benefit for such coverage may not exceed the usual and customary weekly cost for care in a skilled nursing facility.

Non-Covered Services:
- Custodial care.

HOSPICE CARE

Covered Services:
- Hospice Care services are covered with prior authorization from the plan and if a member is terminally ill, and the care is available on an intermittent basis with on-call services available on a 24-hour basis. It includes services provided in order to ease pain and make the member as comfortable as possible.
- Hospice care must be provided through a licensed hospice care provider approved by the Plan.

Non-Covered Services:
- Hospice room and board expenses.

HOSPITAL SERVICES

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

- 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.
  e) Physician/surgical services as described under Physician Services.

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

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

KIDNEY DISEASE TREATMENT

Covered Services:
Services and supplies directly related to the treatment of kidney disease, including but not limited to, inpatient, outpatient, dialysis, transplantation, donor-related services, and related physician charges.

NEWBORN BENEFITS

Covered Sevices:
- 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.
  f) Preventive care and screening as described under Preventive Care.

A primary care physician should be chosen for the newborn before delivery so that the chosen physician can be notified upon delivery. Reimbursement for newborn expenses is dependent on the facility at which the child is born and the physician you choose to be present at the time of birth. As a result, the benefit levels may differ between mother and newborn.

OSTOMY SUPPLIES

Covered Services:

Benefits for ostomy supplies are limited to the following:

- Pouches, face plates and belts.
- Irrigation sleeves, bags and ostomy irrigation catheters.
- Skin barriers.

Non-covered Services:
Benefits are not available for deodorants, filters, lubricants, tape, appliance cleaners, adhesive, adhesive remover, or other items not listed above.

PHYSICAL THERAPY, SPEECH THERAPY OCCUPATIONAL THERAPY, AND/OR PULMONARY THERAPY

Covered Services:
- Both habilitative and rehabilitative outpatient physical therapy, speech therapy and/or occupational therapy and pulmonary rehabilitation are covered services as shown in the Schedule of Benefits when rendered by a participating provider.
- Services must be medically necessary for restoration of a function or ability that was present and has been lost due to bodily injury or sickness in the case of rehabilitative services, or necessary to help a member keep, learn or improve skills and functioning for daily living in the case of habilitative services.
- Therapy must be necessitated by a medical condition and not be primarily educational in nature.
- Provider must be a registered physical, occupational or speech therapist and must not live in the patient's home or be a family member.
- For speech and occupational therapy services for the treatment of autism, please refer to the Autism Treatment section of this certificate.

Non-Covered Services:
- Vocational testing and counseling, including evaluation and treatment and work hardening programs.
- Speech and hearing screening examinations are limited to the routine or preventive screening tests performed by a participating provider for determining the need for correction.
- Services rendered by a masseuse.
- Maintenance or long term therapy and any maintenance or therapy program that consists of activities that preserve the patient's present level of function and prevent regression of that function.

PHYSICIAN SERVICES

Covered Services:
- In office services unless otherwise excluded by this certificate or Schedule of Benefits.
- Routine or preventive physicals
- Inpatient/outpatient visits
- Home visits
- Surgical services with prior authorization by the Plan

Non-Covered Services:
Any services and/or supplies given primarily at the request of, for the protection of, or to meet the requirements of, a party other than the member when such services and/or supplies are not otherwise medically necessary or appropriate, unless the services and/or supplies are state-mandated. Excluded services and supplies include physical exams, disease immunizations, services and supplies for employment (including travel for employment), licensing, marriage, adoption, insurance, camp, school, sports, and travel.

PODIATRY SERVICES

Covered Services:
- Routine or preventive exams when medically necessary and provided by a participating provider.
- Routine foot care for members who are diabetic or have documented diagnosis of peripheral vascular disease.

Non-Covered Services:
- The following services are non-covered except when prescribed by a participating provider who is treating a member for metabolic or peripheral vascular disease:
  a) Services rendered in the examination, treatment or removal of all or part of corns, calluses, hypertrophy or hyperplasia of the skin or subcutaneous tissues of the feet.
  b) Services related to the cutting, trimming or other non-operative partial removal of toenails.
  c) Treatment of flexible flat feet.

PREGNANCY BENEFITS

Covered Services:
- Only services and supplies for the pregnancy of an employee, an employee's covered dependent spouse, or an employee's covered dependent child are covered.
- Pregnancy benefits include coverage for inpatient hospital care and pre- and post-natal care received from a participating provider.
- Please refer to the Continuity of Care section of this Certificate.
- Breast pump and breastfeeding supplies in conjunction with each birth for the duration of breastfeeding.

Non-Covered Services:
- Elective abortions.
- Treatment, services or supplies required as the result of a written or unwritten agreement for the

benefit of a party other than the member, or as a volunteer for such a party.
- Maternity services received out of the service area in the last 30 days of pregnancy without prior authorization from the Plan except in an emergency. Prior authorization is based on medical necessity.
- Amniocentesis or chorionic villi sampling (CVS) solely for sex determination.

PRESCRIPTION DRUGS

Please see your Prescription Drug Rider. If your Group's health benefit package includes a MercyCare prescription drug rider, you must satisfy the deductibles and pay copayment and coinsurance under both the prescription drug rider and this Certificate.

PREVENTIVE CARE

Covered Services:
Preventive care services are covered as listed below:

1. Preventive care services that have a rating of 'A' or 'B' in the current recommendations of the United States Preventive Services Task Force.
2. Immunizations that are recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved.
3. For infants, children and adolescents, evidence-informed preventive care and screenings recommended in the comprehensive guidelines supported by the Health Resources and Services Administration.
4. For women, additional preventive care and screenings recommended in comprehensive guidelines supported by the Health Resources and Services Administration.

Please see your Schedule of Benefits for the specific preventive care benefits covered under the Plan.

In addition, for dependents under age 7 and dependents who did not receive the age-appropriate immunizations while under age 7, preventive care services will also include immunizations for Diphtheria, Measles, Hepatitis B, Polio, Pertussis, Mumps, Varicella, Tetanus, Rubella, and Homophilus Influenza B.

Coverage for preventive care services is not subject to copayments, coinsurance or deductibles for services provided at Level 1.

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.
- Breast prosthesis as required by the Women's Health and Cancer Rights Act of 1998, including mastectomy bras and lymphedema stockings for the arm.
- With prior authorization by the Plan and when obtained from a participating provider.

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

PSYCHOLOGICAL DISORDER AND CHEMICAL DEPENDENCY

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

  Transitional treatment is limited to intensive outpatient programs certified by the American Society of Addiction Medicine for the treatment of psychoactive substance abuse disorders, and the following programs certified by the Department of Health Services: mental health services and treatment for alcoholism and other drug problems in day treatment programs; services for chronic mental illness in community support programs; services for alcohol or drug dependent members in certified residential treatment programs; and programs to provide coordinated emergency mental health services for members who are experiencing a mental health crisis or who are in asituation likely to turn into a mental health crisis if support is not provided for the period of time the member is experiencing a mental health crisis until the member is stabilized or referred to other providers for stabilization. Programs providing coordinated emergency mental health services for members must provide timely notice to MercyCare to facilitate coordination of such services.
- Inpatient Treatment – Treatment received while confined as a registered bed patient in a hospital or qualified treatment facility up to the benefit maximum specified in the Schedule of Benefits.

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

Coverage Provisions:
- Outpatient, inpatient and transitional treatment of psychological disorders and/or chemical dependency each have specific benefit limits stated in the Schedule of Benefits.
- Inpatient and transitional treatment services require prior authorization by the Plan. The services must be considered medically necessary.
- Court ordered mental health services are covered, subject to the benefit maximums described above, if provided by a participating provider, or a nonparticipating provider with prior authorization from the Plan.
- Services rendered pursuant to an emergency detention situation are covered, subject to the benefit maximums described in the Schedule of Benefits, when rendered by any provider as long as the Plan has been notified within 72-hours so that continuing care may be arranged. Emergency detention services provided by a non-participating provider after the 72-hour hold are not covered after the Plan has arranged for services by a participating provider in a more appropriate setting.
- Family therapy is covered only if the diagnosed member is present at the family therapy session.
- For behavioral health services related to the treatment of autism spectrum disorder, see the Autism Treatment section of this certificate.

Non-Covered Services:
- Maintenance or long term therapy.
- Biofeedback, except that provided by a licensed healthcare provider for treatment of headaches, spastic torticollis and urinary incontinence, or by a behavioral health practitioner for the treatment of post-traumatic stress disorder.
- Hypnotherapy,
- Marriage counseling.
- Halfway houses.
- Treatment of nicotine habit or addiction.
- Treatment of being overweight or obese.
- Methadone maintenance therapy.
- Custodial or Respite Care.
- Travel time for qualified providers, supervising providers, professionals, therapists or paraprofessionals.
- Animal-based therapy, including hypnotherapy.
- Auditory integration training.
- Chelation therapy.
- Child care fees.
- Cranial sacral therapy.
- Hyperbaric oxygen therapy.
- Special diets or supplements.
- Treatment provided by parents or legal guardians.

REPRODUCTIVE SERVICES

Covered Services:
- Covered services include all contraceptive methods for women currently identified by the FDA, including consultation, tubal ligation, diaphragms, intrauterine devices (IUD), Depo Provera shots, implantable birth control devices and vasectomy for men. NOTE: those methods available through the pharmacy are covered under the prescription drug benefit; see your drug rider for more information.
- Services required to treat or correct underlying causes of infertility.

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

SCOPIC PROCEDURES - OUTPATIENT DIAGNOSTIC AND THERAPEUTIC

Covered Services:
Diagnostic and therapeutic scopic procedures and related services received on an outpatient basis at a participating provider. Diagnostic scopic procedures are those for visualization, biopsy and polyp removal.

Examples of diagnostic scopic procedures include colonoscopy, sigmoidoscopy, and endoscopy. Benefits include:

- The facility charge and the charge for supplies and equipment, including anesthesia.
- Physician services for anesthesiologists, pathologists, and radiologists.

When these services are performed for preventive screening purposes, benefits are described under Preventive Care.

SKILLED NURSING FACILITY/INPATIENT HABILITATIVE AND REHABILITATIVE SERVICES

Covered Services:

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

Non-Covered Services:

- Custodial care.
- Days in excess of the number specified in the Schedule of Benefits per confinement.

STAY HEALTHY PROGRAM

Covered Services:

- Health education or physical fitness programs are covered (up to the maximum specified in the Schedule of Benefits) for an employee and his or her covered dependents age 18 and over.

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

Non-Covered Services:

- Entrance fees for competitive sports.
- Purchases of home exercise equipment or supplies.

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

TEMPOROMANDIBULAR DISORDERS

Covered Services:

- Diagnostic procedures and medically necessary surgical and non-surgical treatment for the correction of temporomandibular disorders (TMJ) are covered if all of the following apply:
  1. You have prior authorization from the Plan for all temporomandibular-related evaluation and other services, and for the facilities where services are performed.
  2. The condition is caused by congenital, developmental or acquired deformity, sickness or bodily injury.
  3. 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.
  4. 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 except as described in this certificate.
- Any treatment or supplies for Bruxism.

TRANSPLANTS

Covered Services:

Coverage is limited to those organ transplant procedures that are considered by the Plan to be non-experimental, medically necessary, and effective. “Organ” includes bone marrow and stem cells. All transplant-related services, including evaluation, and the facilities where the services are performed, require prior authorization by the Plan.

Benefits related to the procurement of transplant organs, including surgical removal procedures, storage, and transportation of the procured organ.

Kidney: See "Kidney Disease Treatment" in this section of the certificate.

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 without prior authorization by the Plan.
- Organ transplant expenses of donor if the recipient is not an eligible Plan member (except for kidney transplants).
- Retransplantation. (except for kidney transplants).
- Purchase price of bone marrow, organ, or tissue that is sold rather than donated.
- All separately billed donor-related services (except for kidney transplants).
- Storage and collection fees for cord blood and stem cells for possible and/or indefinite or undetermined need for transplant.

URGENT CARE

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

VISION CARE

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

For Children under the age of 19, the following services as limited by the Schedule of Benefits.
- Routine or preventive eye exams are covered when rendered by a participating ophthalmologist or optometrist.
- Prescription glasses (including lenses and frames) or contact lenses.

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

X-RAY, LABORATORY and DIAGNOSTIC TESTING

Covered Services:
- Inpatient and outpatient diagnostic x-ray, laboratory and diagnostic tests are covered services when rendered by and at the direction of a participating provider..
- CT scans, PET scans, MRI, MRA, nuclear medicine, and major diagnostic services rendered by and at the direction of a participating provider.
- The Plan covers mammograms in accordance with the recommendations described in the "Preventive Care" provision of this certificate and in accordance with Wisconsin state law. Please see your Schedule of Benefits for additional details.
- Blood lead tests for members conducted in accordance with rules of the Wisconsin Department of Health Services are covered services.

OTHER MEDICAL SERVICES

Covered Services:
- The administration of blood and blood products including blood extracts or derivatives and autologous donations (self to self).
- Cancer therapy except when experimental or investigational. The exception for experimental or investigational cancer therapy does not apply to routine patient care that is administered to a member in a- qualified clinical trial and that is otherwise a covered service.
- Registered dietitian services at a hospital or a participating provider's office.
- Allergy injections and disease immunizations.
- Infusion therapy.
- A second opinion from a participating provider regarding covered services.

GENERAL EXCLUSIONS and LIMITATIONS

- Treatment for a bodily injury or sickness arising from or sustained in the course of any occupation or employment for compensation, profit or gain except when such occupation or employment is as a domestic servant; employee of a farmer or other employer that is not required to have Worker's Compensation coverage; volunteer; or partner in or sole proprietor or LLC member of a business on a substantially part-time basis. This exclusion applies whether or not you have Worker's Compensation

coverage, or file a claim or receive benefits under any coverage you have.

- Treatment, services and supplies for any bodily injury or illness as the result of war, declared or undeclared, enemy action of armed forces of the United States, or any state of the United States, or any of its allies, or while serving in the Armed forces of any country.
- Services and supplies that are, in the Plan's judgment, experimental or investigative. These services include any that are not recognized as conforming to commonly accepted medical practice within the service area or any for which the required approval of a government agency has not been granted at the time the services and supplies are provided, except that coverage shall be provided for any covered drug with the following criteria:
  1. It is prescribed for the treatment of HIV infection or an illness or medical condition arising from or related to HIV infections; and
  2. It is approved by the federal Food and Drug Administration, including phase-3 investigational drugs; and
  3. If the drug is an investigational new drug, it is prescribed and administered in accordance with the treatment protocol approved by the federal Food and Drug Administration for the investigational new drug.

- Any service rendered AFTER the date your coverage under the policy terminates or AFTER you are disenrolled from the Plan, except as provided in the Extension of Benefits provision of this Certificate or any service rendered BEFORE the member's effective date in the Plan.
- Medical expense due to your commission or attempted commission of a civil or criminal battery or felony.
- Charges for any treatment related to a non-covered service, except, to the extent required by law, routine patient care that is administered to a member in a cancer clinical trial that would be covered under this Certificate if the member were not enrolled in a cancer clinical trial..
- Any treatment or services rendered by or at the direction of:
  a) A person residing in your household; or
  b) A family member (such as your lawful spouse, child, parent, grandparent, brother, sister, or any person related in the same way to your covered dependent).

- Services and supplies not medically necessary for diagnosis and treatment of a covered bodily injury or sickness.
- Services and supplies for which no charge is made or for which you would not have to pay without this coverage.
- The amount of any co-payment, coinsurance, and/or deductible that you must pay as shown in the Schedule of Benefits and/or in any rider attached to this Certificate.
- All services not specifically covered in the Benefit Provisions section of this Certificate or by any rider attached to the policy and any service not provided or received in accordance with the terms and conditions of this Certificate and Policy.
- Ancillary medical services (including hospital facility charges, anesthesia charges, lab and x-ray charges) provided during the course of a non-covered bodily injury or sickness. This exclusion does not apply to benefits for Dental Surgery as described in the Benefit Provisions section.
- Expenses for medical reports, including preparation and presentation.
- Services to the extent the member is eligible for Medicare benefits, regardless of whether or not the member is actually enrolled in Medicare.
- Treatment, services, and supplies furnished by the U.S. Veterans Administration, except when the Plan is the primary payor under applicable federal law.
- Services for holistic medicine, including homeopathic medicine, or other programs with an objective to provide complete personal fulfillment.
- Charges for missed appointments.
- Coma stimulation/recovery programs.
- Treatment, services and supplies provided while held, detained or imprisoned in a local, state or federal penal or correctional institution, or while in the custody of law enforcement officials. Persons on work release are exempt from this exclusion.
- Any surgical treatment for morbid obesity, including ileal bypass, gastric bypass, or stapling.
- Skin tag removal.
- Services of a blood donor.
- Sublingual (under the tongue) allergy testing and/or treatment.
- Work or education related preventive treatment.
- Sexual counseling services are limited to those techniques commonly used by providers for conditions producing significant physical and mental symptoms.
- Any treatment or devices used to obtain, treat, or enhance sexual performance and/or function. This includes dysfunction caused by organic diseases.
- Genetic counseling except as specifically covered in this Certificate of benefits..
- The removal by any method of common warts and plane flat warts.
- Prophylactic procedures to prevent or diagnose a sickness that has not yet occurred.
- Any service and/or supply given primarily at the request of, for the protection of, or to meet the requirements of a party other than the member when such services and/or supplies are not otherwise medically necessary or appropriate, unless the services and/or supplies are state mandated.

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

- Weight loss programs. Including dietary and nutritional treatment in conjunction with obesity.
- Private duty nursing, defined as the provision of individual and continuous care (in contrast to part-time or intermittent care) of 4 or more hours provided according to an individual plan of care, including shift care by a registered or licensed practical nurse or a certified nursing assistant.

ELIGIBILITY

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

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

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

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

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

Please refer to the glossary for the definition of dependent.

There may be adverse tax consequences if you enroll a dependent child who does not satisfy the support test under the federal Working Families Tax Relief Act of 2004. Generally, the support test requires that you provide more than one-half of the child's support. In some cases, however, the support test requires that the child has not provided more than half of his or her own support. If you enroll a dependent child who does not satisfy the support test, the value of that dependent coverage in excess of any premiums you pay toward that coverage will be included in your wages for purposes of employment taxes and income taxes and will be reported on Form W-2. Also, any premiums required of you in connection with such dependent coverage must be paid on an after tax basis.

ENROLLMENT AND EFFECTIVE DATES

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

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

a) An employee who becomes newly eligible for coverage after the first enrollment period and his or her eligible dependents may enroll within 30 days from the date he or she is eligible, as specified by the policy. The effective date of coverage for the employee and any enrolled dependents is indicated on the first page of this Certificate inserted after the front cover.

b) If dependent coverage is in effect, the employee should enroll a newborn dependent as soon as possible and coverage for the dependent will be effective on the date of birth, if enrolled within one year from the date of birth. If dependent coverage is not in effect, the employee has 60 consecutive days from the date of birth to enroll a newborn dependent effective on the date of birth. If the employee does not enroll a newborn dependent within this 60 day period, the newborn child will have no coverage unless, within one year after birth of the child the employee pays all past due premiums plus interest on these premiums at the rate of 5 ½% per year.

c) The employee has 60 consecutive days from the date a child is placed in the employee's home for adoption or from the date that a court issues a final order granting adoption of the child to the employee, whichever occurs first, to enroll a dependent who is adopted or placed for adoption. The dependent child is covered on the date he or she is placed in the employee's home for adoption or the date that a court issues a final order granting adoption of the child to the employee, whichever occurs first.

d) An employee member may enroll the employee's new spouse and stepchildren, effective on the date of marriage, by providing MercyCare with a completed change of status form within 30 days after the date of marriage.
e) An employee member may enroll the employee's newly eligible dependent, other than as described above, by providing MercyCare with a completed change of status form. If MercyCare receives the change of status form BEFORE the dependent's eligibility date, coverage is effective on the dependent's eligibility date. If the change of status form is received AFTER the dependent's eligibility date, but within 30 days of that date, coverage is effective on the date MercyCare specifies.

Enrollment Upon Loss of Other Coverage:
An eligible employee may enroll himself or herself and his or her eligible dependents in the Plan, effective on the first day of the month following MercyCare's receipt of a completed enrollment form, if:
a) They declined to enroll in the Plan during the initial enrollment period or any dual choice enrollment period; and
b) They were covered under a group health plan or had health insurance coverage during such an enrollment period; and
c) The employee stated in writing, if required by MercyCare, that enrollment was declined due to the coverage under another group health plan or health insurance; and
d) Their coverage under the group health plan or health insurance is exhausted or terminated; and
e) They submit a completed enrollment form, which is available from the Group, within 30 days after their coverage under the group health plan or health insurance is exhausted or terminated.

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

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

Other Late Enrollment:
An eligible employee may enroll himself or herself and an employee member may enroll his or her eligible dependents in the Plan, other than as described above, by submitting a completed enrollment form or change of status form available from the Group, as follows:
a) An employee may enroll within 30 days after requesting coverage and receiving notice of the right to enroll. Coverage is effective on the first of the month after approval of the employee's application or 18 months from the date of the application, whichever occurs first.
b) An employee member may enroll the employee's newly eligible dependent, other than as described above, by providing MercyCare with a completed enrollment form. If the enrollment form is received more than 30 days after a dependent's eligibility date, the dependent may enroll within 30 days after requesting change and receiving notice of the right to enroll. Coverage is effective on the first of the month after approval of the dependent's application or 18 months from the date of the application, whichever occurs first.

CHANGES TO ENROLLMENT FORM

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

BENEFIT CHANGES

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

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

TERMINATION OF COVERAGE

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

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

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

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

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

EXTENSION OF BENEFITS

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

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

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

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

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

RIGHTS TO CONTINUE GROUP MEDICAL COVERAGE

If your coverage ends for certain reasons listed in the Termination of Coverage section, you may be eligible to continue coverage under federal and/or state laws, as stated below. While a member is entitled to all of the benefits under the federal or state laws that apply, the member is not entitled to a duplication of those benefits.

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

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

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

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

1. The end of 18 consecutive months from the date you elected this option if the Plan requires you to convert to individual coverage; or
2. The date you are eligible for similar coverage under another group medical plan; or
3. The end of the last month for which premium was paid by you when due; or
4. The date you are no longer a resident of the service area; or
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 the Group terminates coverage under the policy.

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

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

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

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

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

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

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

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

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. If a member performs an act, practice or omission that constitutes fraud, or makes an intentional misrepresentation of material fact in the application; or
3. The member commits acts of physical or verbal abuse that pose a threat to providers or to other members of the Plan; or
4. A member allows a non-member to use the member's identification card to obtain services; or
5. The member no longer lives or works in the service area.
6. The member is unable to establish or maintain a satisfactory physician-patient relationship with a participating primary care physician. (If a member refuses to follow the recommended treatment of his/her primary care physician, this may constitute an unsatisfactory physician-patient relationship.) Disenrollment for this reason is permitted only if MercyCare can demonstrate that it has provided the member an opportunity to select another participating primary care physician; made a reasonable effort to assist the member in establishing a satisfactory physician-patient relationship; and properly communicated the complaint, appeal, and grievance procedures to the member. See the Complaint Procedures section in this Certificate of Coverage for more information.

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

ADVANCE DIRECTIVES

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

CASE MANAGEMENT / ALTERNATIVE TREATMENT

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

CLERICAL ERRORS

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

CONFIDENTIALITY OF INFORMATION

MercyCare is required by law to maintain the privacy of your personal health and financial information.
We limit the collection of this information to that which is necessary to administer our business and provide quality services.

We administer electronic, physical, and procedural safeguards that comply with federal regulations to safeguard your information and review these safeguards to protect your privacy. We limit the use of oral, written, and electronic personal information about you and ensure that only an authorized workforce with the need to know have access to it.

A Notice of Privacy Practices is available to you describing how MercyCare may use and disclose this information and how you can access this information. The Notice is available at www.mercycarehealthplans.com.

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.

QUALITY INITIATIVES

MercyCare Health Plans has many initiatives to insure our members take full advantage of our preventative benefits and to assist our members in managing their chronic medical problems.

Examples include reminders to members to get screening mammograms and indicated vaccinations for their children. Members with diabetes or asthma can access our disease management registered nurses for assistance in monitoring and controlling these conditions.

For details go to MercyCare's website: www.mercycarehealhtplans.com.

RESCISSION

Rescission means to void your coverage retroactively back to your enrollment in the plan. MercyCare will not void your coverage in this plan, except in the event of fraud or intentional misrepresentation of material fact.

RIGHTS OF RECOVERY: SUBROGATION AND REIMBURSEMENT

Except as otherwise provided in the Coordination of Benefits section of this certificate, in the event the Plan makes payment on your behalf for covered services, the Plan shall be subrogated to all of your rights of recovery against any person or organization for such payments. The Plan's subrogation and reimbursement rights apply to full and partial settlements, judgments, or other recoveries paid or payable to your or your representative, no matter how those proceeds are captioned or characterized.

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

By making payment for covered services, the Plan is granted a lien on the proceeds of any settlement, judgment, or other payment, which you receive, and you consent to said lien. The Plan is not required to help you pursue your claim for damages or personal injuries and no amount of associated costs, including attorney's fees, shall be deducted from our recovery without the Plan's express written consent. No so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall defeat this right unless applicable state law provides otherwise. You agree to take whatever steps are necessary to help the Plan secure said lien and to execute and deliver all instruments and papers and do whatever else is necessary to secure the Plan's rights of subrogation and reimbursement. You agree to cooperate with the Plan's representatives in completing such forms and in giving such information surrounding any sickness or bodily injury as its representatives deem necessary.

You agree to do nothing to prejudice the Plan's rights under this provision. You agree not to make any settlement that specifically excludes or attempts to exclude the benefits paid by the Plan. You may not accept any settlement that does not fully reimburse the Plan, without its written approval. You agree to notify the Plan of any claim made on your behalf in connection with a bodily injury or sickness and shall include the amount of the benefits paid by the Plan on your behalf in any claim made against any other persons. If you receive any payment from any party as a result of Sickness or Injury, and we allege some or all of those funds are due to us, you shall hold those funds in trust, either in a separate bank account in your name or in your attorney's trust account. You agree that you will serve as a trustee over those funds to the extent of the benefits the Plan has paid.

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

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

WORKERS COMPENSATION

The policy is not issued in lieu of nor does it affect any requirement for coverage by Workers' Compensation for a bodily injury or sickness arising from or sustained in the course of any occupation or employment for compensation, profit or gain, is not covered under this policy, except when such occupation or employment is as a domestic servant; employee of a farmer or other employer that is not required to have Worker's Compensation coverage; volunteer; or sole proprietor, partner in or sole proprietor or LLC member of a business on a substantially part-time basis. This exclusion applies whether or not you actually have Worker's Compensation coverage, or file a claim or receive benefits under any coverage you have. If the Plan paid for the treatment of any such bodily injury or sickness, the Plan has the right to recover such payments as described under the Right to Recovery provision of the Coordination of Benefits section of this certificate unless the bodily injury or sickness arose from or was sustained in the course of occupation or employment as a domestic servant; employee of a farmer or other employer that is not required to have Worker's Compensation coverage; volunteer; or sole

proprietor, partner in or sole proprietor of LLC member of a business on a substantially part-time basis.. You must

reimburse the Plan, and the Plan will exercise the right to recover against you.

The recovery rights will be applied even though:

1. Any Workers' Compensation benefits are in dispute or are made by means of settlement or compromise; or
2. No final determination is made that the bodily injury or sickness arose from or was sustained in the course of any occupation or for compensation, profit or gain; or
3. The amount of any Workers' Compensation due for medical or health care is not agreed upon or defined by you or Workers' Compensation carrier; or
4. The medical or health care benefits are specifically excluded from any Workers' Compensation settlement or compromise.

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

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

DEFINITIONS

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

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

Allowable expenses under any other plan include the benefits that would have been payable if (a) a claim had been duly made; or (b) the member had complied with all plan provisions, such as prior authorization 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 parents' plans and a court order awards custody of the child to one parent, benefits for the child are determined in this order:
   a) First, the Plan of the parent with custody of the child;
   b) Then, the Plan of the spouse of the parent who has custody of the child; and
   c) Finally, the Plan of the parent who does not have custody of the child.

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

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 Determination rules. The benefits of this Plan will be reduced when the sum of the following exceeds the allowable expenses in a claim determination period:

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

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

MERCYCARE'S RIGHTS UNDER THE COORDINATION OF BENEFITS PROVISION

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

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

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

COORDINATION OF BENEFITS WITH MEDICARE

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

1. The Plan will pay participating providers directly for covered services you receive, and you will not have to submit a claim. However, if you use a 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.
2. How you file a claim for benefits depends on the type of claim it is. You or your authorized representative may file a claim. There are several There are several categories of claims for benefits:

   Pre-service Claim – a claim for a benefit under the policy with respect to which the terms of the policy require approval of the benefit in advance of obtaining medical services

   Urgent Care Claim – any claim for medical care or treatment with respect to which, in the opinion of the treating physician, lack of immediate processing of the claim could seriously jeopardize the life or health of you or your insured dependent or subject you or your insured dependent to sever pain that cannot be adequately managed without the care or treatment that is the subject of the claim. This type of claim generally includes those situations commonly treated as emergencies.

   Concurrent Care Claim – a claim for an extension of the duration or number of treatments provided through a previously approved claim. Where possible, this type of claim should be filed at least 24 hours in before the expiration of any course of treatment for which an extension is being sought.

   Post-service Care Claim – a claim for payment ore reimbursement after services have been rendered

   Disability Claim – a claim reviewed under the policy's definition of total disability, e.g., extended benefits.

   Pre-service Care, Urgent Care and Concurrent Care Claims may also be described as requests for coverage or authorization of benefits. These terms may be used interchangeably in your member materials and in the administration of your coverage.

3. 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

   Written proof of your claim includes: (1) the completed claim forms if required by us; (2) the actual itemized bill for each service; and (3) all other information that we need to determine our liability to pay benefits under the policy, including, but not limited to, medical records and reports. 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.

   In accordance with Wisconsin law, if circumstances beyond your control prevent you form submitting such proof to us within this time period, we will accept a proof of claim, if provided as soon as possible and within one year following the 90-day period. If we do not receive the written proof of claim required by us within that one-year and 90-day period, no benefits are payable for that service.

   An incomplete claim is a correctly filed claim that requires additional information, including but not limited to, medical information, coordination of benefits questionnaire, or a subrogation questionnaire. An incorrectly filed claim is one that lacks information which enables us to determine what, if nay, benefits are payable under the terms and conditions of the policy. Examples include, but are not limited to, claims filed that are missing procedure codes, diagnosis information or dates of service.

4. Procedures for Appointing an Authorized Representative. You or your dependent may have someone act on your behalf for purposes of filing claims, making inquiries and filing appeals. Please contact the Customer Service Department at 1-800-895-2421 for more information about appointing someone to represent you.

5. Timing of Claims Determinations

   Urgent Care Claims. If your claim involves urgent care, you or your authorized representative will be notified of MercyCare's initial decision on the claim as soon as feasible, but in no event more than 24 hours after receiving the claim. If the claim does not include sufficient information for us to make a decision, you or your representative will be notified within 24 hours after receipt of the claim of the need to provide additional information. You will have at least 48 hours to respond to this request; MercyCare

must then inform you of its decision within 48 hours of receiving the additional information.

Concurrent Care Claims. If your claim is one involving concurrent care, we will notify you of this decision within 24 hours after receiving the claim, if the claim was for urgent care and was received by MercyCare at least 24 hours before the expiration of the previously approved time period for treatment or number of treatments. You will be given time to provide any additional information required to reach a decision. If your concurrent care claim does not involve urgent care or is filed less than 24 hours before the expiration of the previously approved time period for treatment or number of treatments, we will respond according to the type of claim involved (i.e., urgent, pre-service or post-service.).

Pre-service Claims. A pre-service claim is any claim for a benefit under the policy, which requires prior approval or precertification before obtaining medical care. If your claim is for pre-service authorization, we sill notify you of our initial determination as soon as possible, but not more than 15 days from the date we receive the claim. This 15-day period may be extended by MercyCare for an additional 15 days if the extension is required due to matters beyond our control. You will have at least 45 days to provide any additional information requested of you by MercyCare.

If you fail to follow MercyCare's procedures for filing a pre-service claim, you or your authorized representative shall be notified orally or in writing not alter than 5 days (24 hours in the case of urgent care) following the failure. This notice, however, applies only when you submit a claim to the appropriate claims unite with the requested identifying claim information.

Post-service Claim. If your claim is for a post-service reimbursement or payment of benefits, we will notify you within 30 days of receipt of the claim if the claim has been denied or if further information is required. The 30 days can be extended to 45 if MercyCare notifies you within the initial 30 days of the circumstances beyond our control that require an extension of the time period, and the date by which we expect to render a decision.

If more information is necessary to decide a post-service claim, we will notify you of the specific information necessary to complete the claim. You will be given at least 45 days from the receipt of the notice to provide the necessary information.

Disability Claims. If your claim requires us to decide whether you have a disability as defined by MercyCare, you will be notified of our decision no later than 45 days after our receipt of the claim. If we determine that an extension of time is needed to process your claim due to matters beyond the control of MercyCare, you will be notified before the end of the 45-day period after filing of the claim. The extended period may not exceed 75 days after the filing of the claim. If another extension is required for reasons beyond the control of MercyCare, you will be notified before the end of the 75-day period after filing the claim. The second extended period may not exceed 75 days after the filing of the claim. Any notice of extension will explain the standard on which the entitlement to a disability benefit under the policy is based and the unresolved issues that prevent a decision in the claim as well as additional information needed to resolve the claim. You will have at least 45 days from the receipt of the notice to submit the requested information. We will make a decision after the requested information has been received within the required time period.

6. Notice of Claims Denial

   If, for any reason, your claim is denied, in whole or in part, we will send you a written notice containing the basis for the decision, including information you need to identify the claim such as the date of service, the health care provider, the claim amount, the diagnosis code and its meaning, and the treatment code and its meaning); the denial code and its meaning and a description of the standard that was used to deny the claim; a description of available internal appeals and external review processes, information on how to initiate an appeal; information you need to perfect the claim; and information about the appeal process and about filing an action in federal court under section 502 of ERISA, if you disagree with our decision on the claim.

7. 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.

8. 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.

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

CONSENT AND AUTHORIZATION

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

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

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

PHYSICIAN and HOSPITAL REPORTS

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

RIGHT TO COLLECT NEEDED INFORMATION

You must cooperate with the Plan and when asked will assist the Plan by:

1. Authorizing the release of medical information including the names of all providers from whom you received medical attention; and
2. Providing information regarding the circumstances of your bodily injury or sickness; and
3. Providing information about other health care and insurance coverage and benefits.

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

VERBAL COMPLAINT

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

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

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

GRIEVANCE

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

1. General Grievance Process.

To file a formal grievance, you or anyone else on your behalf should write down your concerns and mail or deliver your written grievance (in any form) along with copies of any supporting documents to us.

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

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

At your grievance hearing, you and/or a representative you have chosen to act on your behalf have the right to be present and/or a representative you have chosen to act on your behalf may present information relevant to the grievance. If you choose not to be present, you may also participate in the hearing through a conference call. The Grievance Committee will then make a decision on the resolution of the grievance.

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

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

An expedited review may be obtained if a delay of service could seriously jeopardize your life or health or your ability to regain maximum function, or if a reviewing physician advises us that you would 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.

2. Process relating to an adverse benefits determination.

When your grievance relates to any adverse benefit determination, then the following procedures apply in addition to the general grievance process.

An appeal of an adverse benefit determination must be in writing (unless the adverse benefits determination involves urgent care, in which case the appeal may be made orally). Your request for review must contain your name and address; your reasons for making the appeal; and the facts supporting your appeal.

In connection with your right to appeal the adverse benefits determination, you may review pertinent documents and submit issues and comments in writing; will be given the opportunity to submit written comments, documents, records, or any other matter relevant to your claim; will, at your request and free of charge, be given reasonable access to, and copies of, all documents, records and other information relevant to the claim for benefits; and be given a review that takes into account all comments, documents, records and other information

submitted or considered in the initial benefits determination.

The claim will be reviewed by an appropriate named fiduciary, who is neither the individual who made the initial denial nor a subordinate of that individual. The fiduciary will be impartial, and the fiduciary's hiring, compensation, termination, promotion and other matters will not be based on the likelihood that the fiduciary will support the denial of benefits. The review will be conducted without giving deference to the initial adverse benefits determination. If the initial adverse benefits determination was based in whole or in part on a medical judgment, the reviewer will consult with a health care professional who has the appropriate training and experience in the filed of medicine involved in the medical judgment. The health care professional shall not be an individual who was consulted on the initial adverse benefits determination, nor the subordinate of such an individual. Upon request, we will identify by name any medical or vocational experts consulted in the review process. The review will consider all information submitted, regardless of whether it was considered during the initial adverse benefits determination.

3. Timetable for Deciding Appeals

We will issue a decision on your appeal according to the following timetable:

Urgent Care Claims – not later than 72 hours after receiving your request for a review

Pre-service Claims – not later than 30 days after receiving your request for a review.

Post-service Claims – not later than 30 days after receiving your request for a review.

Disability Claims – not later than 30 days after receiving your request for a review. If we determine that an extension of time is required, you will be notified before the end of the 30-day period after filing your appeal. The extend period may not exceed 60 days after the date of receiving your request for review.

Decisions will be issued on concurrent claim appeals within the timeframe appropriate for the type of concurrent care claim (i.e., urgent, pre-service or post-service.)

4. Notice of Decision on Appeal.

If your appeal is denied, in whole or in part, we will send you a written notice that states the basis for the decision, including information you need to identify the claim or issue involved such as the date of service, the health care provider, the claim amount, the diagnosis code and its meaning, and the treatment code and its meaning); the denial code and its meaning, a description of the standard that was used to deny the claim; a description of available external review processes; any information you need to perfect the claim or issue; a statement that you may request reasonable access to and copies of all documents, records and other information relevant to your appeal, which we will provide free of charge; and information about the appeal process and about filing an action in federal court under section 502 of ERISA, if you disagree with our decision on the appeal.

You may not begin any legal action, including proceedings before government agencies, until you have followed the appeal procedures in this section. However, if we fail to strictly adhere to all the procedures in this section, then you will be deemed to have followed these procedures. You may, at your own expense, have legal representation at any stage of these appeal procedures. These appeal procedures shall be the only means though which an adverse benefit determination may be appealed.

EXTERNAL REVIEW

1. Definitions.

"Adverse benefit determination." A decision by MercyCare:

- To deny or terminate a benefit or fail to make a payment (in whole or in part) for any benefit on the basis that you are not eligible to participate in a plan, due to a utilization review, or on the basis that the item or service requested is experimental, investigational or not medically necessary or appropriate;
- To rescind your coverage, whether or not there is an adverse effect on a particular benefit at the time of the rescission.

"Final internal adverse benefit determination." An adverse benefit determination that has been upheld by MercyCare after you exhaust the internal appeals process described in the *Grievance* section of this certificate. The term also includes any adverse benefit determination that is deemed to have exhausted the internal appeals process because MercyCare has not strictly complied with that process.

"Independent review organization" or "IRO." A neutral organization engaged by MercyCare to independently review adverse benefit determinations. Independent review organizations

must be accredited by URAC or by a similar nationally-recognized accrediting organization.

"Preliminary review." The initial review of your request for external appeal conducted by MercyCare to determine if your request is complete and eligible for external review.

2. Request an External Review.

   You have the right to request and obtain an independent external review of any final internal adverse benefit determination. To request an external review, you must submit a request with MercyCare within four months after the date you receive a notice of a final internal adverse benefit determination. If there is no corresponding date four months after the date you receive a notice, then the request must be filed by the first day of the fifth month following the receipt of the notice. For example, if the date you receive the notice is October 30, because there is no February 30, the request must be filed by March 1.

   The request for external review must be made in writing and sent to MercyCare, Customer Service Department, External Review, at P.O. Box 550, Janesville, Wisconsin 53547-0550. The request should contain the following:

   - Your name, address, and phone number.
   - The reason you disagree with MercyCare's decision, including any documents that support your position.
   - A statement authorizing your representative to pursue external review on your behalf if you choose to use one.

3. Preliminary Review.

   Within five business days after you file a request for an external review, MercyCare will complete a preliminary review to determine whether your request is complete and eligible for external review. MercyCare will notify you of the results of its preliminary review within one business day after completing the review. If your request is not complete, you will have the opportunity to provide the information or materials needed to make the request complete within the four-month filing period or within the 48 hour period following your receipt of the results of our preliminary review, whichever is later.

4. Referral to an Independent Review Organization.

   If your request is complete and is eligible for external review, MercyCare will randomly assign an IRO from among the IROs it has engaged to conduct external reviews. MercyCare will forward your request to the assigned IRO within five business days after the assignment. Upon receipt of your request, the assigned IRO will notify you in writing of your request's eligibility and acceptance for external review.

5. Review by Independent Review Organization.

   The assigned IRO will review all the information and documents it timely receives. It will review MercyCare's decision independent of any decision or conclusions reached by MercyCare as part of its internal appeals process.

   You may submit additional information in writing to the assigned IRO. The IRO is required to consider any information or materials provided within 10 business days after you receive the initial notice from the IRO that your request for external review has been accepted. The IRO may, but is not required to, accept and consider additional information submitted after 10 business days. The IRO will forward any additional information you submit to MercyCare.

   If, on the basis of any additional information you submit, MercyCare reconsiders your case and decides that the treatment should be covered, the external review is terminated. An external review does not include appearances by you or your authorized representative, any person representing MercyCare, or any witness on behalf of either you or MercyCare.

   The assigned IRO will provide written notice of its final decision to you and to MercyCare within 45 days after the IRO receives the request for external review. The written decision will include a general description of the reason for the request including information necessary to identify the claim, the date the IRO received the assignment to conduct the external review and the date of the IRO's decision, references to the evidence or documents the IRO considered in reaching its decision, and a discussion of the principal reason for its decision.

   If the assigned IRO provides written notice to MercyCare that it is reversing the final internal adverse benefit determination, MercyCare will immediately provide coverage or payment for the requested item or service.

6. Expedited Review.

An adverse benefit determination is eligible for an expedited external review if it involves a medical condition for which the timeframe for completion of an expedited internal appeal under the interim final regulations would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function and if you have filed a request for an expedited internal appeal.

A final adverse benefit determination is eligible for an expedited external review if it involves a medical condition for which the timeframe for completion of a standard external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, or if the final internal adverse benefit determination concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, but you have not been discharged from a facility.

If MercyCare receives a request for an expedited external review, it will immediately conduct the preliminary review described above. If the request is not complete or is not eligible, MercyCare will immediately notify you of the results of its preliminary review. If the request is both eligible and complete, MercyCare will assign the IRO and transmit all necessary documents and information to the assigned IRO.

The IRO will provide notice of its final decision as quickly as your medical condition or circumstance requires, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the notice is not in writing, within 48 hours after the date it provided the notice, the assigned IRO will provide written confirmation of that decision to you and to MercyCare.

OFFICE OF THE COMMISSIONER OF INSURANCE

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

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

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

ACTIVE STATUS
Active status means performing your job on a regular, full-time basis as defined in the group application. 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, or (b) due to a health factor.

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

ADVERSE BENEFIT DETERMINATION
An adverse benefit determination includes any of the following:
(i) denial, reduction or termination of, or failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a your eligibility to participate in a plan, including resulting from the application of any utilization review,
(ii) the failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate,
(iii) any rescission, including any cancellation or discontinuance of coverage that has a retroactive effect, or
(iv) any decision to deny coverage in an initial eligibility determination.

ALTERNATIVE FACILITY
Alternative Facility means a health care facility that is not a Hospital and that provides one or more of the following services on an outpatient basis, as permitted by law:

- Surgical services
- Emergency Health Services
- Rehabilitative, laboratory, diagnostic or therapeutic Services.

An Alternate Facility may also provide mental health services or substance use disorder services on an outpatient or inpatient basis.

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

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

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

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

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

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

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

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

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

CONTRACT YEAR (Policy Year)
Contract year, or policy year, means the 12-month period beginning on the effective date of the Group's policy.

CO-PAYMENT
Co-payment means the member's portion, expressed as a fixed dollar amount, that you are required to pay for certain covered services provided under this policy.

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

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

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

DEPENDENT
Dependent means the following:

1. a covered employee's lawful spouse; or

2. a covered employee's natural blood-related child, adopted child, child placed for adoption with the covered employee, stepchild or legal ward who is under the age of 26; or

3. a dependent child (as described in paragraph 2 of this definition, regardless of age) who is a full-time student as defined in this Certificate, if the child was called to federal active duty in the National Guard or in a reserve component of the U.S. armed forces while the child was under 27 years of age when attending, on a full-time basis, an institution of higher learning; to qualify under this paragraph, the child must apply to an institution of higher education as a full-time student within 12 months from the date the child fulfilled his or her active duty obligation and, when a child is called to active duty more than once within a 4-year period of time, we will use the adult child's age when first called to active duty for determining eligibility under this paragraph; or

4. an unmarried, natural child of a dependent child (as described above) until the dependent child is 18 years of age.

In the case of a child placed for adoption with the covered employee, "placed for adoption" is defined in section 632.896, Wisconsin Statutes.

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 Services or the equivalent agency if the birth was outside of the state of Wisconsin. Upon qualification, coverage for the child will be effective according to the Eligibility and Effective Date of Coverage section.

A spouse and stepchild cease to be a dependent on the date in which a divorce decree is granted, and may be terminated subject to Continuation and Conversion privileges.

If a child is described in item 3 above, such child, who is a full-time student, if otherwise eligible, ceases to be a dependent when the child ceases to be full-time student. Full-time student means the child is in regular full-time attendance at an accredited secondary school; accredited vocational, technical or adult education school, or an accredited college or university which provides a schedule of courses or classes and whose principal activity is the provision of an education. Proof of attendance is required upon request from MercyCare. Full-time student status is to be defined by the institution in which the student is enrolled. Full-time student status includes any intervening vacation period if the child continues to be a full-time student. Full-time student status also includes a medically necessary leave of absence during which the child ceases to be a full-time student. MercyCare may require the child to submit documentation and certification of the medical necessity of the leave of absence from the child's attending physician. Full-time student status due to a medically necessary leave of absence ends when any of the following occurs:

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

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 may require the dependent to be examined from time to time by a participating provider for the purpose of determining the existence of the incapacity prior to granting continued coverage. Such examinations may occur at reasonable intervals during the first two years after continuation under this section is granted and annually thereafter. The employee must notify MercyCare immediately of a cessation of incapacity or dependency.

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

DEVELOPMENTAL DISABILITY

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

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

DUAL CHOICE ENROLLMENT PERIOD

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

EFFICACIOUS TREATMENT OR STRATEGY

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

ELECTIVE HOSPITAL ADMISSION

An admission to a hospital for a treatment or surgical procedure not requiring immediate attention and therefore planned for the patient's convenience.

EMERGENCY

Emergency means a medical condition that manifests itself by acute symptoms of sufficient severity, including severe pain, to lead a prudent layperson with an average knowledge of health and medicine reasonably to conclude that a lack of immediate medical attention will likely result in any of the following:

- Serious jeopardy to the person's health or, with respect to a pregnant woman, serious jeopardy to the health of the woman or her unborn child;
- Serious impairment to the person's bodily functions
- Serious dysfunction of one or more of the person's body organs or parts.

EMPLOYEE

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

ENROLLMENT FORM

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

EVIDENCE-BASED THERAPY

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

EXPERIMENTAL/INVESTIGATIVE

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

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 a member's bodily injury or sickness.

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

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. The member has 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.

FREE-STANDING SURGICAL FACILITY

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

GENETIC COUNSELING

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

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

GENETIC TESTING

A genetic test is a test using deoxyribonucleic acid (DNA) extracted from an individual's cells in order to determine the presence of a genetic disease or disorder or the individual's predisposition for a particular genetic disease or disorder.

GRIEVANCE

Grievance means any dissatisfaction that you have with MercyCare or with a participating or non-participating provider that has been expressed in writing by you or on your behalf. See the Complaint, 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.

HABILITATIVE SERVICES

Habilitative services means health care services that help a person keep, learn, or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

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;
   a) Provides such care on an inpatient basis; and
   b) 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.

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.

INFERTILITY

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

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

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

LEVEL 1 PROVIDER
A provider color-coded red in our most recently published provider directory.

LEVEL 2 PROVIDER
A provider in our most recently published provider directory that is not color-coded in red.

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

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

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

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

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

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

MERCYCARE
MercyCare means MercyCare HMO, Inc. for benefits received from a participating provider, and benefits received from a non-participating provider with a referral, and it means MercyCare Insurance Company for benefits that are received from a non-participating provider without a referral

NON-CONTRACTED PROVIDER
A Level 2 provider who has not signed a contract with the Plan to provide services at a discounted fee for service.

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 not listed in the most current provider directory.

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

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

PARTICIPATING PROVIDER
Participating provider means a provider of health care under contract with MeryCare to provide health care services, items or supplies to members. Participating

providers are listed in the most current provider directory.

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

PLAN
Plan means the group health plan offered by MercyCare Insurance Company and MercyCare HMO, Inc. as described in this certificate.

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

POLICYHOLDER
Policyholder means the Group.

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

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

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

Each family member may have a different primary care physician. A member's primary care physician:
1. Provides entry into MercyCare's health care system.
2. Evaluates a member's total health care needs.
3. Provides personal medical care in one or more medical fields.
4. Is in charge of coordinating other health services and referring the member to other providers of health care when appropriate.

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

PROVIDER NETWORK
A provider network is a group of providers contracted with the Plan to provide services for members within a specific geographic location. The primary care physician you select directly determines the provider network with which you will be associated.

PROVIDERS OF HEALTH CARE
Providers of health care include:
a) Medical or osteopathic physicians, hospitals, and clinics.
b) Podiatrists, physical therapists, physician's assistants, psychologists, chiropractors, nurse practitioners, and dentists licensed by the State of Wisconsin, or other applicable jurisdiction to provide covered services.
c) Nurses licensed by the State of Wisconsin and certified as a nurse anesthetist to provide covered services.
d) Nurse midwives licensed by the State in which they practice to provide covered services.

QUALIFIED CLINICAL TRIAL
Qualified clinical trial means a clinical trial that meets all of the following criteria:
1. Is sponsored and provided by a cancer center that has been designated by the National Cancer Institute (NCI) as a Clinical Cancer Center or Comprehensive Cancer Center or be sponsored by any of the following:
   a) National Institutes of Health (NIH). (Includes National Cancer Institute (NCI).)
   b) Centers for Disease Control and Prevention (CDC)
   c) Agency for Healthcare Research and Quality (AHRQ)
   d) Centers for Medicare and Medicaid Services (CMS).
   e) Department of Defense (DOD).
   f) Veterans Administration (VA).
2. The clinical trial must have a written protocol that describes a scientifically sound study and have been approved by all relevant institutional review boards (IRBs) before participants are enrolled in the trial.

   We may, at any time, request documentation about the trial to confirm that the clinical trial meets current standards for scientific merit and has the relevant IRB approvals.
3. The subject or purpose of the trial must be the evaluation of an item or service that meets the definition of covered services under this plan and is not otherwise excluded under the Certificate.

QUALIFIED PARAPROFESSIONAL

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

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

QUALIFIED PROFESSIONAL

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

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

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

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

QUALIFIED PROVIDER

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

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

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

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

QUALIFIED SUPERVISING PROVIDER

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

QUALIFIED THERAPIST

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

1. Seven hundred fifty (750) hours supervised training involving direct 1:1 work with individuals, including pediatric individuals, with autism spectrum disorders using evidence-based, efficacious therapy models.
2. Supervised experience with all of the following:

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

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

REFERRAL AND STANDING REFERRAL
A referral is the process by which any service that requires prior authorization will be reviewed by MercyCare's Quality Health Management Department. Your doctor will complete a referral form, which will function as a request for authorization for any services that require prior authorization , or a standing referral to any one or more providers. This form is submitted to MercyCare, where the Quality Health Management Department will determine whether or not the requested services will be approved. See page 2 for referral process requirements.

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

ROUTINE PATIENT CARE
Routine patient care includes items, services, and drugs provided to you in connection with a qualified clinical trial that would be covered under this Plan if you were not enrolled in such qualified clinical trial, provided that you were eligible to participate in the qualified clinical trial according to the trial protocol with respect to treatment of cancer or other life-threatening disease or condition and either (a) the referring participating provider has concluded that your participation in the qualified clinical trial is appropriate according to the trial protocol or (b) you provide medical and scientific information establishing that your participation in the qualified clinical trial is appropriate according to the trial protocol. Routine patient care does not include the investigational item, devise, or service, itself; items and services provided solely to satisfy data collection and analysis needs and that are not used in your direct clinical management; and a service that is clearly inconsistent with widely accepted and established standards of care for your diagnosis.

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

SERVICE AREA
Service area means the geographical area in which MercyCare is authorized to offer a health Plan.

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

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

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

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

TOTAL DISABILITY OR TOTALLY DISABLED
Total disability or totally disabled means, for an employee or his or her employed covered spouse, that the person is at all times prevented from engaging in any job or occupation for wage or profit for which he or she is reasonably qualified by education, training, or experience.

For a covered spouse who is not employed and a covered dependent child, total disability means a disability preventing the person from engaging in

substantially all of the usual and customary activities of a person in good health and of the same age and sex.

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

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

USUAL AND CUSTOMARY (U&C)
Usual and customary charge is the greater of: (1) the dollar amount for a treatment, service, or supply provided by a health care provider that is reasonable, as determined by the Plan, when taking into consideration among other factors, determined by MercyCare, amounts charged by health care providers for similar treatment, services, and supplies when provided in the same geographic area under similar or comparable circumstances; (2) the participating provider reimbursement amount as defined by applicable law, or (3) the Medicare reimbursement amount as defined by applicable law.

WE
We means MercyCare Health Plans.

YOU/YOUR
You/your means any member enrolled in the Plan

INDEX

R

S

T

U

V

W

X