MercyCare Health Plans
2021 Individual HMO Member Policy

ENTIRE POLICY

This Policy document, issued by MercyCare HMO, Inc. (referred to in this Policy as "MercyCare") describes the terms, conditions and limitations of coverage for certain Hospital, medical and other services provided under this Policy. This Policy document, the Schedule of Benefits, Your Application, and any addendums or riders, make up Your Policy with MercyCare.

IMPORTANT NOTICE CONCERNING STATEMENTS IN THE APPLICATION FOR YOUR INSURANCE

Please read the copy of the Application accompanying this Policy. OMISSIONS OR MISSTATEMENTS IN THE APPLICATION COULD CAUSE AN OTHERWISE VALID CLAIM TO BE DENIED. Carefully check the Application and write to us within 10 days if any information shown on the form is not correct and complete. The Application is part of the insurance contract. The insurance coverage was issued on the basis that the answers to all questions and any other material information shown on the Application are correct and complete.

YOUR RIGHT TO RETURN THIS POLICY

Please read this Policy right away. If You are not satisfied with this Policy for any reason, You may return it to us within ten (10) days of receiving it. Upon return, the Policy becomes invalid. If You return the Policy within the ten days, We will refund all premium payments to the person who paid them.

GUARANTEED RENEWABILITY

The Policy is guaranteed renewable except as stated in the "Termination of Coverage/Disenrollment" provision of the "Coverage Information" section of this Policy.

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: (800) 895-2421, Your agent, or the *American Health Benefits Exchange,* also called the *Health Insurance Marketplace (Marketplace),* if You wish to purchase pediatric dental coverage or a stand-alone dental services product.

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580 N. Washington St.
P.O. Box 550
Janesville, Wisconsin 53547-0550

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mercycarehealthplans.com

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INTRODUCTION

UNDERSTANDING THIS POLICY

This Policy document, the Schedule of Benefits, Your Application, and any addendums or riders, make up Your Policy with MercyCare. These documents, combined, explain the terms and conditions of Your insurance coverage.

Once You are enrolled, this is Your Policy for as long as You remain eligible for coverage and make all required premium payments. This Policy replaces any previous policies that You may have been issued.

You should read this Policy document, the Schedule of Benefits, and any addendums or riders carefully. They contain a great deal of information about the services and supplies covered under this Policy. It is important that You understand all parts of this Policy in order to get the most out of Your coverage.

As a 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 Policy have specific meanings and are capitalized throughout the document. These terms and their meanings can be found in the "Glossary" section of this Policy.

INTERPRETING THIS POLICY

We (MercyCare) have the authority to interpret this Policy and all questions that arise under it.

In general, We only cover services if they are Medically Necessary. When required, We will review the provided factual information and determine whether a Member's requested service is Medically Necessary, consistent with the terms of this Policy.

QUESTIONS?

If, after You read this Policy, You have questions, please call Our Customer Service Department at (800) 895-2421. Any quotation of benefits given by MercyCare or its representative is not a guarantee of coverage. Coverage is determined based on the terms and conditions of Your Policy.

Benefits listed in this document are only available as long as the Policy and your coverage are in effect. You must read this document together with the Schedule of Benefits and other Policy documents to ensure accurate information regarding coverage, obligations and responsibilities under the Policy. Please refer to the Schedule of Benefits to find any applicable Copayment, Coinsurance and/or Deductible amounts and other types of limitations affecting coverage. Unless otherwise stated in this Policy, services and supplies will be Covered Expenses only if they are Medically Necessary and rendered by a Participating Provider. Certain services and supplies require Prior Authorization in order to be covered; a list describing what requires Prior Authorization can be found in the "Obtaining Services" section of this Policy document. Definitions of the capitalized terms within this Policy can be found in the Glossary.

OBTAINING SERVICES

PROVIDER DIRECTORY

Providers listed in Our provider directory are Participating Providers. Providers who are not listed in Our provider directory are Non-Participating Providers. You can access Our provider directory online on Our website at mercycarehealthplans.com, or You can request a paper copy by calling Customer Service at (800) 895-2421.

In order to provide You with the most up-to-date provider directory, We reserve the right to modify the list of Participating Providers at any time.

PRIMARY CARE PROVIDER SELECTION

At the time You enroll in this Policy, You are required to select a Primary Care Provider (PCP). Each family member may have a different PCP.

A Primary Care Provider:
- Provides entry into Our health care system.
- Evaluates a Member's total health care needs.
- Provides personal medical care in one or more medical fields.
- Is in charge of coordinating other health services and referring the Member to other Health Care Providers when appropriate.

For newborns, before You deliver You should choose a Primary Care Provider who is a Participating Provider so that the chosen provider can be notified upon delivery.

You must notify Us of Your PCP selection. You may have indicated Your selection on Your Application. If You did not, or You wish to change that selection, please call Customer Service at (800) 895-2421. You may change Your PCP at any time as long as You notify Customer Service.

NON-EMERGENCY CARE

Unless You need Emergency or Urgent Care, You must receive services described in this Policy directly from one of the following, to be covered:
- A Participating Provider; or
- A Non-Participating Provider for whom You have gotten an approved Referral from Us.

REFERRALS

You do not need a Referral from Your Primary Care Provider to receive Covered Services from any Participating Provider, including but not limited to obstetrical and gynecological (OB-GYN) care. Because you do not need a referral from a Primary Care Provider to access a Specialty Care Provider, you also do not need to obtain a standing referral.

If We do not have a Participating Provider in Our Provider Network who can provide the Medically Necessary care You need, We may reimburse Covered Expenses from a Non-Participating Provider as if You are seeing a Participating Provider. The following rules apply:

- You or Your Participating Provider must request and We must approve a Referral to a Non-Participating Provider before You receive care.
- A Participating Provider must complete a Referral form. A verbal request for Referral to a Non-Participating Provider is not acceptable.
- A Referral that is not submitted for Our review, or one which We do not approve, is not valid.

If We approve the Referral:
- We will reimburse Your Covered Expenses as if You saw a Participating Provider. We will base Our payment on the lesser of, the Non-Participating Provider's charges or the amount We negotiate with the Non-Participating Provider. You will be responsible for only the Deductible, Coinsurance and/or Copayment amounts that apply to a Participating Provider.
- We will determine with the referring Participating Provider, the duration of the Referral and/or the number of visits for which coverage is authorized based on Medical Necessity.

A Referral request to see a Non-Participating Provider is often only approved for an initial consultation or office visit. If the Non-Participating Provider determines that You need additional services, he or she must request Our Prior Authorization for the additional services. If We determine that these additional services are Medically Necessary but can be provided by a Participating Provider, We may deny the Prior Authorization request and refer You to a Participating Provider. If We do not approve the request, We will not cover these services if You choose to obtain them from a Non-Participating Provider.

The referring Participating Provider and Our 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.

It is Your responsibility to make sure Your Participating Provider gets an approved Referral before You receive services from a Non-Participating Provider. Failure to follow the above requirements may result in non-coverage of Claims associated with Non-Participating Provider Services, except for Emergency or Urgent Care. Please see the "Emergency and Urgent Care" section of this Policy for more information.

PRIOR AUTHORIZATION

Certain services and supplies require Prior Authorization in order to be covered, except in an Emergency. This is true whether they are provided by a Participating or a Non-Participating Provider. When required, Prior Authorization must be obtained before the service or supply is provided to or received by the Member.

If Your Health Care Provider fails to get Prior Authorization when it is required, We will deny coverage unless it is for a state-mandated benefit or an essential health benefit. We will review state mandated and essential health benefit services or supplies for Medical Necessity prior to processing the Claim. If We deny the Claim, You will be responsible for payment.

Categories of Covered Services requiring Prior Authorization are listed below. This is not a complete list. You should contact Our Customer Service department at (800) 895-2421 to verify whether a procedure or service needs Prior Authorization.

- Autism Spectrum Disorder treatment and therapy
- Behavioral health and substance use disorder services
    - Inpatient, partial hospitalization and care provided at a Residential Treatment Center
    - ECT therapy or other behavioral health procedures
- Biofeedback services
- Cardiac rehabilitation
- Congenital heart disease surgeries
- Cosmetic or reconstructive surgery

- Dental and oral surgery
- Durable Medical Equipment and supplies
- Genetic Testing
- Home health care
- Home infusions
- Hospice care
- Hospital services, inpatient and outpatient
- Insulin pumps
- Maternity services received outside the Service Area in the last 30 days of pregnancy
- Medical supplies
- Non-emergency ambulance transportation
- Non-Participating Provider (out-of-network) admissions, procedures, imaging, services and supplies
- Pharmaceuticals administered in the Health Care Provider's office
- Prosthesis
- Radiology services:
    - Non-emergency magnetic resonance imaging (MRI)
    - Positron emission tomography (PET) scan
- Reproductive services, inpatient
- Surgical services: inpatient, outpatient, and at a 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 described in the "Claims Provisions" section of this Policy.

For questions about the Prior Authorization process, please call Our Customer Service Department at (800) 895-2421.

CONCURRENT REVIEW

Concurrent review occurs at intervals during the course of the Member's inpatient or outpatient treatment. If We are advised that a Member needs treatment for longer than was initially Prior Authorized, We will ask the treating Physician to provide additional medical information to evaluate the Member's need for additional services.

If the Member continues the course of inpatient or outpatient treatment for longer than was originally Prior Authorized, and We do not authorize additional services through the concurrent review process, benefits may not be payable for the additional services.

CONTINUITY OF CARE

You must contact Us to arrange for continuity of care as stated in this section. If, at the time of Your enrollment or most recent renewal, Our materials indicated that Your Primary Care Provider was or would be a Participating Provider, We will continue to treat Your Primary Care Provider as a Participating Provider throughout Your entire Contract Period. This is true even if Your Primary Care Provider terminates as a Participating Provider during Your Contract Period.

If You are undergoing a course of treatment with a Health Care Provider who terminates as a Participating Provider, We will continue to cover treatment provided by this Health Care Provider as a Participating Provider for You as follows:

- If receiving services from a Primary Care Provider, until the end of Your Contract Period.
- If receiving services from a provider who is not a Primary Care Provider, until the earliest of:
    - The end of the course of treatment;

- 90 days from the provider's termination; or
- The end of Your Contract Period.

If You are in Your second or third trimester of pregnancy when Your Health Care Provider terminates as a Participating Provider, We will continue to cover services provided by this Health Care Provider as a Participating Provider until the end of Your post-partum care.

These continuity of care rules do not apply to a Health Care Provider who is no longer practicing in the Service Area or who was terminated from the Provider Network for professional misconduct.

DEDUCTIBLES, COPAYMENTS AND COINSURANCE

Except for listed preventive care services, You must pay a Deductible, Copayment or Coinsurance amount for most Covered Expenses. Definitions of these cost-sharing features are found in the Glossary. Your Schedule of Benefits shows the Deductible, Copayment and/or Coinsurance amounts that apply to Covered Expenses.

Deductibles
Most Covered Expenses are subject to a Deductible as specified in the Schedule of Benefits.

The single Deductible amount is the most that any Member must pay each Contract Period before We will pay for Covered Expenses. Once a Member has met the single Deductible amount, We will begin paying Claims for that Member as described in the Schedule of Benefits.

The family Deductible amount is the most that the Subscriber and his or her covered Dependents must pay in a Contract Period before We will pay for Covered Expenses. Once the family Deductible amount has been met, We will begin paying Claims for the entire family as described in the Schedule of Benefits.

You will not receive Deductible credit for any of the following:
- Any Copayments You pay.
- Any amounts You pay for Covered Expenses that are noted in the Schedule of Benefits as not subject to the Deductible.
- Any amounts You pay to Non-Participating Providers, except when You have an approved Referral from Us.
- Any amounts You pay for services or supplies that are not Covered Expenses.

Copayments and Coinsurance
For most Covered Expenses, You will be required to pay a portion of the total cost. The amount of Copayment or Coinsurance that applies to Covered Expenses depends on the Covered Service received.

You must pay any fixed dollar Copayments regardless of whether You have satisfied Your Deductible. Coinsurance payments begin once You meet the Deductible, if a Deductible applies.

OUT-OF-POCKET MAXIMUM

The Out-of-Pocket Maximum is the most You will pay in Deductible, Coinsurance, and Copayment amounts for Covered Expenses in a Contract Period. This includes both medical and pharmacy services. You can find the Out-of-Pocket Maximum amount in Your Schedule of Benefits.

The single Out-of-Pocket Maximum amount is the most that each Member will pay out-of-pocket each Contract Period. The family Out-of-Pocket Maximum amount is the most that the Subscriber and his or her covered Dependents, combined, will pay out-of-pocket each Contract Period.

The following **never** apply to the Out-of-Pocket Maximum amounts:

- Amounts You pay for services or supplies that are not Covered Services;
- Amounts You pay for services or supplies that are subject to coverage limitations, and You exceed those limitations;
- Amounts You pay for services or supplies that require Prior Authorization without first getting Prior Authorization from Us;
- Amounts You pay for services that require a Referral without getting an approved Referral from Us before receiving services, unless they are related to Emergency Care.

In these circumstances, You may be responsible for charges even if You have met Your Out-of-Pocket Maximum for the Contract Period.

FULL-TIME STUDENTS

Medical/Surgical Benefits

Full-Time Students are covered the same as other Members under this Policy.

All routine, preventive, and follow-up care must be provided by a Participating Provider or with a Referral authorized by Us. Urgent or Emergency care is covered as described in the "Emergency and Urgent Care" section of this Policy.

Behavioral Health and Substance Use Disorder Benefits

Full-Time Students attending school in Wisconsin but outside Our Service Area will have coverage for limited outpatient behavioral health and substance use disorder services received from Non-Participating Providers.

This coverage includes a clinical assessment by a Non-Participating Provider. If outpatient services are recommended, We will cover five (5) outpatient visits to a Non-Participating Provider. All such outpatient treatments should be provided in facilities or by Health Care Providers located within the State of Wisconsin and within reasonable proximity to the school in which the student is enrolled.

If We (or our designee) determine that treatment will prevent a Full-Time Student from attending school on a regular basis, or the Full-Time Student is no longer enrolled in school, We will not cover services provided by a Non-Participating Provider. After completing five (5) visits, We (or our designee) must approve continuing care provided by the Non-Participating Provider.

If You have any questions about how we cover services for Full-Time Students, please contact the Customer Service Department at (800) 895-2421.

EMERGENCY AND URGENT CARE

EMERGENCY CARE

Emergency Care must be provided on an outpatient basis at a Hospital or Alternative Facility.

Emergencies Outside Our Service Area

If You need Emergency Care while You are outside the Service Area and cannot return without medical harm, You should go to the nearest medical facility for assistance. **If You receive Emergency Care and are admitted to a Non-Participating Provider Hospital, please contact our Customer Service Department at (800) 895-2421 within 48 hours after receiving services or when it is medically feasible for You to provide such notice, whichever is later.**

We may request that You be transferred to a Participating Provider facility after You are Stabilized. If You do not wish to be transferred to a Participating Provider facility, we may not continue to cover Your care. If You need any follow-up care or additional non-Emergency Care after You have been Stabilized, You must get it from a Participating Provider for the services to be covered under the Policy, unless You have received Our Prior Authorization to get it from a Non-Participating Provider.

Emergencies Within Our Service Area

If You need Emergency Care while You are inside the Service Area, please go to the nearest Participating Provider whenever possible. If You are unable to reach a Participating Provider, You should go to the nearest medical facility for help.

If You receive Emergency Care and are admitted to a Non-Participating Provider Hospital, please contact our Customer Service Department at (800) 895-2421 within 48 hours after receiving services or when it is medically feasible for You to provide such notice, whichever is later.

We may request that You be transferred to a Participating Provider facility after You are Stabilized. If You do not wish to be transferred to a Participating Provider facility, we may not continue to cover Your care.

If You need any follow-up care or additional non-Emergency Care after You have been Stabilized, You must get it from a Participating Provider for the services to be covered under the Policy, unless You have received Our Prior Authorization to get it from a Non-Participating Provider.

Examples of situations for which Emergency Care is appropriate include, but are not limited to:

- Heart attack;
- Stroke;
- Loss of consciousness;
- Significant blood loss or Acute hemorrhage;
- Suffocation;
- Attempted suicide;
- Convulsions;
- Epileptic seizures;
- Acute allergic reactions;
- Acute asthmatic attacks;
- Acute appendicitis;
- Coma;
- Drug overdose;

- Any condition for which You are admitted to the Hospital as an inpatient from the Emergency room.
- Other Acute conditions when these four elements exist:
    - Immediate medical care is required for Bodily Injury or Sickness;
    - Symptoms are unexpected and severe enough to cause a person to seek medical help right away;
    - Immediate care is secured; and
    - The diagnosis or the symptoms themselves show that immediate care was required.

Prior Authorization for Emergency Care is not required. Coverage for Emergency Care is the same whether a Participating or Non-Participating Provider provides it. We reimburse Covered Expenses for Emergency Care as if You saw a Participating Provider.

Coverage of Emergency Care includes the facility charge, supplies and all professional services required to treat Your Emergency Medical Condition. It also includes placement in an observation bed for the purpose of monitoring Your Emergency Medical Condition.

You are responsible for paying any applicable Deductible, Copayment or Coinsurance amount for Emergency Care as listed in the Schedule of Benefits. The ER Copayment is waived if the You are admitted as an inpatient directly from the emergency visit.

URGENT CARE

Urgent Care services must be provided at an Urgent Care center. Mercyhealth Urgent Care locations can be found at mercyhealthsystem.org. Other Urgent Care Participating Providers can be found at mercycarehealthplans.com.

Urgent Care Outside Our Service Area
If You need Urgent Care while You are outside the Service Area and cannot return without medical harm, You should go to the nearest medical facility for help. To be covered, any necessary follow-up care or additional non-Emergency Care must be provided by a Participating Provider.

Urgent Care Within Our Service Area
If You need Urgent Care while you are inside the Service Area, please go to the nearest Participating Provider whenever possible. If You are unable to reach a Participating Provider, You should go to the nearest medical facility for help. To be covered, any necessary follow-up care or additional non-Emergency Care must be provided by a Participating Provider.

Examples of situations for which Urgent Care is appropriate include, but are not limited to:
- Broken bones;
- Sprains;
- Non-severe bleeding;
- Minor cuts and burns; and
- Drug reactions.

MEDICAL BENEFIT PROVISIONS

Members are entitled to these benefit provisions subject to the terms, conditions and exclusions of the Policy. MercyCare's determinations in the administration of the Plan, includes determinations as to whether charges for services or supplies are Covered Services. Coverage is subject to any Copayment, Coinsurance, Deductible and/or other limits shown in the Schedule of Benefits.

AMBULANCE SERVICES

Covered Services:

- Professional ground or air ambulance transportation during an emergency situation when medical attention is required along the way.
- Non-emergency ground or air ambulance transportation (as We determine appropriate) between facilities in the following situations:
    - From a Non-Participating Provider to a Participating Provider
    - From a Hospital to the nearest Hospital equipped to provide treatment not available at the original facility.
    - To a more cost-effective acute care facility.
    - From an acute-care facility to a sub-acute setting.

Non-Covered Services:

- Non-emergency ground or air ambulance transportation, unless Prior Authorized by Us.

AUTISM TREATMENT

Covered Services:

- Diagnostic testing and evaluation by a Qualified Provider (as defined under state law) and approved by Us.
- Up to four (4) cumulative years of Intensive-Level Services:
    - Coverage requires Prior Authorization by Us.
    - The Member must have a verified diagnosis of Autism Spectrum Disorder.
        - The diagnosis must have been made by a diagnostician skilled in testing and in the use of empirically-validated tools specific for Autism Spectrum Disorders.
    - Intensive-Level Services must begin after the Member turns two years old, but before the Member turns nine years old.
    - Intensive-Level Services must:
        - Be provided at least 20 hours per week over a six-month period of time.
        - Be based on a treatment plan developed by an individual who at least meets the requirements of a Qualified Intensive-Level Provider or a Qualified Intensive-Level Professional.
        - Be provided by a Qualified Intensive-Level Provider or Qualified Intensive-Level Professional who directly observes the Member at least once every two months.
        - Be implemented by Qualified Providers, Qualified Professionals or Qualified Therapists, or Qualified Paraprofessionals.
        - Consist of intensive, Behavioral Evidence-Based Therapy, treatment and services with specific cognitive, social, communicative, self-care or behavioral goals that are clearly defined, directly observed and continually measured, and that address the characteristics of Autism Spectrum Disorders.
            - The treatment plan must require that the Member be present and engaged in the intervention.
        - Be provided in an environment most conducive to achieving the goals of the Member's treatment plan.
        - Be provided a majority of the time in the presence of an engaged parent or legal guardian.

        - Implement identified therapeutic goals developed by the team including training and consultation, participating in team meetings and active involvement of the Member's family.
    - The Member's progress must be assessed and documented throughout the course of treatment. We reserve the right to review the Member's treatment plan and a summary of progress on a periodic basis.
- Non-Intensive Level Services:
    - Coverage requires Prior Authorization by Us.
    - The Member must have a verified diagnosis of Autism Spectrum Disorder.
        - The diagnosis must have been made by a diagnostician skilled in testing and in the use of empirically-validated tools specific for Autism Spectrum Disorders.
    - Non-Intensive Level Services must:
        - Be provided in either of the following conditions:
            - After the completion of Intensive-Level Services and designed to sustain and maximize gains made during Intensive-Level Services treatment.
            - To a Member who has not and will not receive Intensive-Level Services but for whom Non-Intensive Level Services will improved the Member's condition.
        - Be based upon a treatment plan developed by an individual who minimally meets the requirements as a Qualified Provider, a Qualified Professional or a Qualified Therapist.
        - Be implemented by a person who is at least a Qualified Provider, Qualified Professional, Qualified Therapist, or a Qualified Paraprofessional.
        - Consist of specific Evidence-Based Therapy goals that are clearly defined, directly observed and continually measured and that address the characteristics of Autism Spectrum Disorders.
        - Be provided in an environment most conducive to achieving the goals of the Member's treatment plan.
        - Implement identified therapeutic goals developed by the team including training and consultation, participation in team meetings and active involvement of the Member's family.
        - May include direct or consultative services when provided by Qualified Providers, Qualified Supervising Providers, Qualified Professionals, Qualified Therapists, or Qualified Paraprofessionals.
    - The Member's progress must be assessed and documented throughout the course of treatment. We reserve the right to review the Member's treatment plan and a summary of progress on a periodic basis.

Non-Covered Services:

- Any services provided without Prior Authorization.
- Custodial or respite care.
- Travel time for Qualified Providers, Qualified Supervising Providers, Qualified Professionals, Qualified Therapists, or Qualified Paraprofessionals.
- Animal-based therapy, including hippotherapy.
- Auditory integration training.
- Chelation therapy.
- Child care fees.
- Cranial sacral therapy.
- Hyperbaric oxygen therapy.
- Special diets or supplements.
- Treatment provided by parents or legal guardians.
- Autism therapy, treatment or services provided to a Member who is residing in a Residential Treatment Center, inpatient treatment or day treatment facility.
- The cost for the facility or location when treatment, therapy or services are provided outside a Member's home.

BEHAVIORAL HEALTH AND SUBSTANCE USE DISORDER SERVICES

Covered Services:

- Outpatient Treatment
  - Treatment received while not Confined to a Hospital or Qualified Treatment Facility or participating in transitional treatment.
- Transitional Treatment
  - Treatment received in an outpatient setting that is more intensive than traditional outpatient care but less restrictive than traditional inpatient care.
  - 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 partial hospitalization/day treatment programs;
    - Services for Chronic mental Illness in community support programs;
    - Services for alcohol or drug dependent Members in certified Residential Treatment Centers;
    - Services for the treatment of psychological disorders in certified Residential Treatment Center; and
    - Programs to provide coordinated Emergency mental health services for Members who are experiencing a mental health crisis, or who are in a situation likely to turn into a mental health crisis if support is not provided for the period of time the Member is experiencing a mental health crisis, until the Member is Stabilized or referred to other Providers for stabilization. Programs providing coordinated Emergency mental health services for Members must provide timely notice to Us to facilitate coordination of such services.
- Inpatient Treatment
  - Treatment received while Confined as a registered bed patient in a Hospital or Qualified Treatment Facility.
- Prescription Drugs used for the treatment of behavioral health and substance use disorders.
- Court-ordered mental health services.
- Services provided pursuant to an emergency detention.
  - May be provided by any Health Care Provider;
  - We must be notified within 72-hours so that continuing care may be arranged;
  - Emergency detention services provided by a Non-Participating Provider are not covered after We have arranged for services by a Participating Provider in a more appropriate setting.
- Family therapy, if the Member seeking behavioral health or substance use disorder services is present at the family therapy session.

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, Qualified Supervising Providers, Qualified Professionals, Qualified Therapists or Qualified Paraprofessionals.
- Animal-based therapy, including hippotherapy.
- Auditory integration training.
- Chelation therapy.
- Child care fees.
- Cranial sacral therapy.

Benefits listed in this document are only available as long as the Policy and your coverage are in effect. You must read this document together with the Schedule of Benefits and other Policy documents to ensure accurate information regarding coverage, obligations and responsibilities under the Policy. Please refer to the Schedule of Benefits to find any applicable Copayment, Coinsurance and/or Deductible amounts and other types of limitations affecting coverage. Unless otherwise stated in this Policy, services and supplies will be Covered Expenses only if they are Medically Necessary and rendered by a Participating Provider. Certain services and supplies require Prior Authorization in order to be covered; a list describing what requires Prior Authorization can be found in the "Obtaining Services" section of this Policy document. Definitions of the capitalized terms within this Policy can be found in the Glossary.

- Hyperbaric oxygen therapy.
- Special diets or supplements.
- Treatment provided by parents or legal guardians.

BIOFEEDBACK

Biofeedback services are covered only when provided for the treatment of headaches, spastic torticollis, urinary incontinence, or post-traumatic stress disorder.

CARDIAC REHABILITATION

Covered Services:
- Phase I & II cardiac rehabilitation, as follows:
    - Member must have a recent history of:
        - a heart attack;
        - coronary bypass surgery;
        - onset of angina pectoris;
        - heart valve surgery;
        - onset of decubital angina;
        - percutaneous transitional angioplasty, or
        - cardiac transplant.
    - Services must be provided in an outpatient department of a Hospital, in a medical center, or in a clinic program.
    - Member must 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 CARE

Covered Services:
- Medically Necessary chiropractic services.

Non-Covered Services:
- Maintenance or Long Term Therapy, as determined by Us after review of the Member's case history or treatment plan submitted by the provider.

CONGENITAL HEART DISEASE SURGERIES

Covered Services:
- Congenital heart disease (CHD) surgeries to treat conditions including, but not limited to, coarctation of the aorta, aortic stenosis, tetralogy of fallot, transposition of the great vessels and hypoplastic left or right heart syndrome.
    - Coverage under this provision includes the facility charge and the charge for supplies and equipment.
    - Coverage for professional services is described in the "Physician Services" provision of this section.
    - Surgery may be performed as open or closed surgical procedures or may be performed through interventional cardiac catheterization.

COSMETIC AND RECONSTRUCTIVE SURGERY

Covered Services:

- Reconstructive surgery which is:
  - Performed due to Bodily Injury or Sickness; or
  - Incidental to or following surgery performed due to Bodily Injury or Sickness; or
  - For a Dependent child, performed due to a Congenital disease or abnormality that results in a functional defect.
- Reconstructive surgery following mastectomy, including:
  - All states of reconstruction of the breast on which a mastectomy was performed.
  - Surgery and reconstruction of the other breast to produce a symmetrical appearance.
  - Prostheses; and
  - Physical complications of all stages of mastectomy, including lymphedemas.

Non-Covered Services:

- Plastic or Cosmetic Surgery which is not Medically Necessary for the correction of a functional defect caused by a Bodily Injury or Sickness. Psychological reasons do not represent a medical/surgical necessity.

DENTAL/ORAL SURGERY

Covered Services:

Treatment with Prior Authorization from Us including:

- Bodily Injury to permanent, Sound and Natural Teeth and bone, but only if:
  - The Bodily Injury occurs while You are a Member covered by the Plan; and
  - The Bodily Injury is not caused by chewing or biting; and
  - The treatment begins within 90 days of the Bodily Injury with a maximum of 180 days from the date of Bodily
  - Injury to complete treatment.
- Consultation by an oral surgeon or appropriate Specialist. Included with this would be the cost of X-rays or other diagnostic tests performed in conjunction with given evaluation.
- Covered procedures include:
  - Surgical removal of completely-bony-impacted teeth.
  - Excision of tumors or cysts from the jaws, cheeks, lips, tongue, roof or floor of the mouth.
  - Excision of exostoses of the jaws and hard palate (provided that this procedure is not done in preparation for dentures or other prostheses).
  - Treatment of fractures of the facial bones.
  - External incision and drainage of abscesses or cellulitis.
  - Incision or excision of accessory sinuses, salivary glands or ducts.
  - Surgical procedures to address Congenital deformities and conditions resulting from medical disease or previous medical therapeutic processes affecting the jaws, cheeks, lips, tongue, roof or floor of the mouth.
  - Surgical procedures to correct accidental injuries of the jaws, cheeks, lips, tongue, roof or floor of the mouth.
  - Surgical treatment of accidental injuries to any teeth which had an intact root or were part of a permanent bridge, prior to the injury. This particular benefit covers complete restoration of the injured teeth.
  - Implants to support a dental prosthesis when an integral part of treatment for medical conditions as described above.
    - Any abutment or dental prosthesis resting on these implants is not covered, except to replace a tooth that had originally been injured, as described above.
- Durable Medical Equipment or prosthetic appliances such as obturators or surgical splints are covered, when an integral part of treatment for conditions described above.
- Charges incurred for Hospital care and anesthesia that is provided in conjunction with dental care provided in a Hospital, ambulatory surgical treatment center, or by a certified anesthesiologist, if the Member:
  - 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
    - Has a medical condition that requires Hospital Confinement or general anesthesia for dental care.

Non-Covered Services:
- Oral surgery performed solely for the fitting of dentures or the restoration or correction of teeth.
- All services performed by a dentist or orthodontist, except those specifically listed in this Policy. These exclusions include, but are not limited to:
    - Dental implants.
    - Services (regardless of cause or complexity) provided for the care, treatment, removal, or replacement of teeth or structures directly supporting teeth (e.g., preparation of the mouth for dentures, removal of diseased teeth in an infected jaw.) Structures directly supporting the teeth mean the periodontium, which includes the gingivae, periodontal membrane, cementum of the teeth, and the alveolar bone (i.e. alveolar process and tooth sockets).
    - Shortening of the mandible or maxilla.
    - Correction of malocclusion.
    - Treatment for any jaw joint problems, other than temporomandibular disorders, including cranio-maxillary, craniomandibular disorder, or other conditions of the joint linking the jaw bone and skull.
    - Hospital costs for any of these services except as specifically described in the Policy.
    - Oral surgery except as specifically described in this Policy.
    - All periodontal procedures.
    - Any treatment for bruxism - including splint devices.
    - Braces or oral fixation devices.

DIABETES SERVICES AND SUPPLIES

Covered Services:
- Outpatient self-management education programs for the treatment of diabetes, and 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 and supplies.
- Insulin pumps. We will cover the purchase of no more than one insulin infusion pump during a Contract Period.
- Insulin.

DURABLE MEDICAL EQUIPMENT AND MEDICAL SUPPLIES

Covered Services:
- Medical supplies and Durable Medical Equipment (DME)
    - *Coverage conditions:*
        - Must be ordered or prescribed by a Participating Provider or by a Non-Participating Provider with an active, authorized Referral from Us.
        - We will decide if the equipment should be purchased or rented.
        - DME items cannot be generally available over the counter (OTC).
        - Must be purchased or rented from a Participating DME provider or a provider Prior Authorized by Us.
        - If more than one item can meet Your functional needs, We will only cover the item that meets the minimum specifications for Your needs.
            - If You rent or purchase an item that exceeds the minimum specifications, You must pay the cost difference between the item You rent or purchase and the item We have determined is the most cost-effective.
    - Examples of covered 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, as follows:
    - Braces that stabilize an injured body part.
    - Braces to treat curvature of the spine.
    - Braces that straighten or change the shape of a body (Orthotic braces).
    - Necessary adjustments to shoes to accommodate braces
- 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.
- Burn garments.
- Insulin pumps and all related necessary supplies as described under "Diabetes Services and Supplies" provision in this section.
- External cochlear devices and systems.
    - Benefits for cochlear implantation are provided under the applicable medical/surgical Benefit categories in this Policy.
- Ostomy supplies, as follows:
    - Pouches, face plates and belts.
    - Irrigation sleeves, bags and ostomy irrigation catheters.
    - Skin barriers.
- Speech aid devices and tracheo-esophageal voice devices required for treatment of severe speech impediment or lack of speech that is directly attributed to a Sickness or Bodily Injury.
    - Must complete a required three-month rental period.
- Breast pump and breastfeeding supplies
    - Provided for the duration of breastfeeding.
    - Provided in conjunction with each birth.

Non-Covered Services:

- Repair or replacement of an item due to misuse, malicious damage or gross neglect.
- Replacement for damaged, lost or stolen items.
- DME required for athletic performance and/or participation.
- Garments and/or other equipment and supplies not Medically Necessary to treat a covered Bodily Injury or Sickness.
- 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: treadmill, exercise bike, bicycle, 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 a motorized wheelchair when Medically Necessary.
- 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:
    - Disposable supplies necessary for the effective use of covered DME, including but not limited to diabetic or ostomy-related supplies.
- Tubing and masks, except when used with DME as described under this section.
- Any device, appliance, pump (excluding an insulin pump), machine, stimulator, or monitor that is surgically implanted into the body.
- Deodorants, filters, lubricants, tape, appliance cleansers, adhesive remover or other ostomy-related supplies not described as covered under this Policy.
- Dental braces.

DME for comfort, personal hygiene or convenience, including but not limited to:

A – D	F – O	P – Z

A – D	F – O	P – Z
• Air conditioners • Air cleaners • Air purifiers • Air humidifiers • Air dehumidifiers • Alcohol wipes • Alternative communication devices (except as otherwise described as covered in this Policy) • Automobile modifications or lifts • Band-Aids • Baskets (for wheelchairs or walkers) • Bath benches • Bath chairs • Car seats • Cervical pillows • Dressing sticks or aids • Diapers • Disposable gloves • Disposable undergarments • Eating utensils • Egg crate mattress pads • Electric patient lifts • Ergonomic chairs	• Feeding aids • Grab bars • Grooming aids • Heating pads • Home bathtub spas • Home massage equipment • Home remodeling or modifications • Lamb's wool sheepskin padding • Lap trays not used for trunk support • Lumbar rolls or cushions • Massagers or Thera Cane • Non-medical self-help devices • Occipital release boards • Orthotic socks • Oral hygiene products • Oral nutritional supplements or infant formula available OTC • OTC antibiotic ointments • OTC dressing supplies (e.g. 4X4 gauze, tape, betadine, etc.) • glasses)	• Pillows • Portable care or travel nebulizers • Raised toilet seats • Reaching aid • Safety equipment (e.g. gait belts, knee and elbow pads or safety glasses) • Shower chairs • Strollers • Stroller or wheelchair canopies • Toileting systems or lifts • Tongue depressors • Vaporizers • Vehicle transfer or safety tie down restraints • Wheelchair attendant controls • Wheelchair backpacks or clips • Wheelchair swingaway, retractable or removable hardware when not needed for slide transfer • Wheelchair work or cut-out trays • Wigs

EMERGENCY CARE

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

GENETIC TESTING AND COUNSELING

Covered Services:

- Genetic Testing, when:
  - The test is not considered Experimental or Investigational;
  - The test is Medically Necessary; and
  - The results will affect the course of Medically Necessary treatment.
- Genetic Counseling, 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, as follows:
  - One new hearing aid per ear is covered every 36 months.
  - The reconditioning and repair of existing aids is covered when considered Medically Necessary.
- Cochlear implants, as follows:
  - Covered for children under the age of 19.
  - May be covered for individuals over age 19 if there is evidence-based justification that a cochlear implant is Medically Necessary and effective for the Member.
- Post-cochlear implant aural therapy.
- Implantable bone conduction hearing aid (bone-anchored hearing aid or Baha®), as follows:
  - Covered for Members with conductive hearing losses (unilateral or bilateral), or mixed hearing losses, if:
    - the Member 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:
      - Congenital or surgically induced malformations of the external ear canal and/or middle ear (example: atresia);
      - Tumors of the external ear canal and/or tympanic cavity;
      - Severe Chronic external otitis or otitis media;
      - Otosclerosis in those who are not suitable candidates for stapedectomy;
      - Dermatitis of the external ear canal, including reactions from ear molds used for typical air conduction hearing aids; or
      - Other conditions in which an air conduction hearing aid is contraindicated (example: relapsing polychondritis).
  - Covered for the treatment of unilateral sensorineural hearing loss (single-sided deafness) when there is normal hearing in the opposite ear (defined as a 10 dBHL air conduction pure tone average).
  - The procedure and related services to implant a bone conduction hearing aid are covered under the applicable medical or surgical provisions of this section. The bone-anchored hearing aid device is covered under the hearing aid benefit of this section. See Your Schedule of Benefits for any applicable coverage limitations.

Non-Covered Services:

- More than one hearing aid per ear in any 36-month period.
- Cochlear implants for Members age 19 and older, except as described above.

HOME HEALTH CARE

Covered Services:

- Home health care services, as follows:
  - *Description of home health care services:*
    - The evaluation of the need for home care when approved or requested by the attending Physician;
    - Occasional or part-time home nursing care that is provided or supervised by a registered nurse.
    - Physical, respiratory, occupational and speech therapy.
    - Medical supplies, drugs and medicines prescribed by a Physician.
    - Lab services by or from a Hospital.
      - Covered as if You are Confined to a Hospital.
    - Nutritional counseling under the supervision of a registered or certified dietitian if considered Medically Necessary as part of the home care plan.
  - *Home health care visit definition:*

        - 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 four consecutive hours in a 24-hour period of home health services are considered one home care visit.
            - The maximum weekly cost for such coverage may not exceed the weekly cost for care in a Skilled Nursing Facility.
    - *Coverage conditions:*
        - The attending Physician must certify that:
            - Confinement in a Hospital or Skilled Nursing Facility would be necessary if home care were not provided.
            - The Member's immediate family, or others living with the Member, cannot provide the necessary care without undue hardship.
            - The home health care services are provided and coordinated by a state-licensed or Medicare-certified home health agency or certified Rehabilitation agency.
        - The attending Physician must establish a home health care plan, approve it in writing and review this plan at least every 2 months, unless the attending Physician determines that less frequent reviews are sufficient.
        - 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.

Non-Covered Services:
- Custodial Care.

HOSPICE CARE

Covered Services:
- Hospice care services when a Member is terminally ill, as follows:
    - *Description of Hospice care services:*
        - Care designed to ease pain and make the Member as comfortable as possible.
        - Available on an intermittent basis, with on-call services available 24 hours per day.
    - *Coverage conditions:*
        - Must be provided through a licensed hospice care provider approved by Us.

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

HOSPITAL SERVICES

Covered Services:
- Inpatient Hospital services, as follows:
    - *Description of inpatient Hospital services:*
        - 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 Us to be Medically Necessary.
        - Medically Necessary Hospital services and supplies utilized during Your Confinement, including drugs administered to You as an inpatient.
    - *Coverage conditions:*
        - Services must be provided in a Hospital.
        - Care must be directed by a Health Care Provider and Prior Authorized by Us.
- Outpatient Hospital services, as follows:
    - *Description of outpatient Hospital services*
        - Services and supplies, including drugs, when incurred for the following:

- Emergency room treatment provided in accordance with the "Emergency or Urgent Care" section of this Policy.
- Surgical day care.
- Regularly scheduled treatment such as chemotherapy, inhalation therapy, and radiation therapy.
- Diagnostic testing, including laboratory, x-ray and other diagnostic testing.

- *Coverage conditions:*
  - Services must be provided in a Hospital or Free-Standing Surgical Facility.

Non-Covered Services:

- Inpatient Hospital services for days that are NOT certified by Us 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. Please see the "Durable Medical Equipment" provision of this section of the Policy.

KIDNEY DISEASE TREATMENT

Covered Services:

- Inpatient and outpatient services directly related to the treatment of kidney disease, including but not limited to:
  - Dialysis;
  - Transplantation, including donor-related services; and
  - Physician charges.

NEWBORN CARE

Covered Services:

- Newborn care, including the following services:
  - Nursery room, board, and care.
  - Routine or Preventive exam and other routine or Preventive professional services when received by the newborn child before release from the Hospital.
  - Circumcisions when rendered prior to discharge from the Hospital.
  - Plastic surgery, in order to reconstruct or restore function to a body part with a functional defect present at birth.
  - Well child care provided after release from the Hospital.
  - Preventive care and screening as described under the "Preventive Care Services" provision in this section of the Policy.

PHYSICAL, SPEECH, OCCUPATIONAL AND PULMONARY THERAPY

Covered Services:

- Habilitative and rehabilitative outpatient physical therapy, speech therapy, occupational therapy and pulmonary therapy, as follows:
  - Rehabilitative 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.
  - Habilitative Services must be Medically Necessary to help a Member keep, learn or improve skills and functioning for daily living.
  - The therapy must be needed for a medical condition and not be primarily educational in nature.

- The therapy provider must be a registered physical, occupational pulmonary 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" provision within this section of the Policy.

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 provided 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, except as otherwise described in this Policy.

PHYSICIAN SERVICES

Covered Services:
- In office services, unless otherwise excluded by this Policy.
- Routine or Preventive physicals.
- Inpatient, outpatient and home visits.
- Surgical services.

Non-Covered Services:
- Any services and/or supplies given primarily at the request of, for the protection of, or to meet the requirements of, someone other than the Member, when such services and/or supplies are not otherwise Medically Necessary or appropriate. This exclusion does not apply if the services and/or supplies are state-mandated.
  - This exclusion includes, but is not limited to, 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:
- Medically Necessary examinations.
- Routine Foot Care (including callous removal and nail care) for Members who are diabetic or have documented diagnosis of peripheral vascular disease.

Non-Covered Services:
- The following services are not covered except when prescribed by a Participating Provider who is treating a Member for diabetes or peripheral vascular disease:
  - 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.
  - Services related to the cutting, trimming or other non-operative partial removal of toenails.
  - Treatment of flexible flat feet.

PREGNANCY CARE

Covered Services:
- Pregnancy Care for the Subscriber, the Subscriber's covered Dependent spouse, or the Subscriber's covered Dependent child, as follows:
  - Pre-natal and post-natal care.

- Inpatient Hospital care, including:
  - A minimum of 48 hours of inpatient care following a vaginal delivery for the mother and the newborn;
  - A minimum of 96 hours of inpatient care following delivery by caesarean section for the mother and newborn.

Non-Covered Services:

- Elective abortions.
- Treatment, services or supplies required as the result of a written or unwritten agreement for the benefit an individual other than the Member, or as a volunteer for that individual.
- Maternity services received out of the Service Area in the last 30 days of pregnancy without Prior Authorization from Us, except in an emergency. Prior Authorization is based on Medical Necessity.
- Amniocentesis or chorionic villi sampling (CVS) solely for sex determination.

PREVENTIVE CARE SERVICES

In addition to the benefits otherwise provided in this Policy (and notwithstanding anything in your Policy to the contrary), the following preventive care services will be considered Covered Services to the extent required by law, and will not be subject to any Deductible, Coinsurance, Copayment, or benefit dollar maximum:

- Evidence-based items or services that have in effect a rating of 'A' or 'B' in the current recommendations of the United States Preventive Services Task Force (USPSTF).
- Immunizations that are recommended by the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC) with respect to the individual involved.
- For infants, children and adolescents, evidence-informed preventive care and screenings recommended in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA).
- For women, additional preventive care and screenings recommended in comprehensive guidelines supported by the HRSA. This includes, but is not limited to:
  - Well-woman visits.
  - Screening and counseling for gestational diabetes, HIV and sexually transmitted infections.
  - Testing for human papillomavirus.
  - Contraceptive methods and counseling.
  - Breastfeeding support, supplies and counseling, including breast pumps.
  - Screening and counseling for interpersonal and domestic violence.
- Dependents under age 7 and Dependents who did not receive the age-appropriate immunizations while under age seven, the following immunizations:
  - Diphtheria;
  - Measles;
  - Hepatitis B;
  - Polio;
  - Pertussis;
  - Mumps;
  - Varicella;
  - Tetanus;
  - Rubella; and
  - Haemophilus Influenza B.

The preventive care services described above may change as USPSTF, CDC and HRSA guidelines are modified.

More information about the preventive services coverage required under the Affordable Care Act can be found at https://www.healthcare.gov/coverage/preventive-care-benefits/.

If a recommendation or guideline for a particular preventive service does not specify the frequency, method, treatment or setting in which it must be provided, We may use reasonable medical management techniques to determine coverage.

If a covered preventive care service is provided during an office visit and is billed separately from the office visit, You may be responsible for cost-sharing for the office visit only. If an office visit and the preventive care service are billed together and the primary purpose of the visit was not the preventive care service, You may be responsible for cost-sharing for the office visit including the preventive care service.

Some laboratory or diagnostic studies may be subject to a Deductible and/or Coinsurance if We determine they are not part of a routine preventive or screening examination. When a Member has symptoms or a history of a Sickness or Bodily Injury, laboratory or diagnostic studies relating to that Sickness or Bodily injury are no longer considered part of a Preventive visit.

PROSTHETIC DEVICES

Covered Services:

- Prosthetic devices, as follows:
    - Replacement of natural or artificial limbs and eyes no longer functional due to physiological change or malfunction beyond repair.
    - Breast prosthesis as required by the Women's Health and Cancer Rights Act of 1998, including mastectomy bras and lymphedema stockings for the arm.

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 Us.

REPRODUCTIVE SERVICES

Covered Services:

- Services to treat or correct underlying causes of Infertility.
- Contraceptive methods, as follows:
    - All contraceptive methods currently identified by the federal Food and Drug Administration (FDA), including but not limited to the following:
        - Tubal ligation;
        - Vasectomy;
        - Diaphragms;
        - Intrauterine devices (IUD);
        - Depo Provera shots; and
        - Implantable birth control devices.
    - Contraceptive methods available through the pharmacy are covered under the Prescription Drug benefit. See the “Prescription Drug Benefit Provisions” section for more information.
- Consultation for contraceptive methods.

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 (i.e. services needed to achieve pregnancy) which are not for the treatment of Sickness or Bodily Injury. The diagnosis of Infertility alone does not constitute a Sickness.
- Reversal of previous voluntary sterilization procedures.
- Donor sperm.
- Storage and collection fees for sperm and ovum.
- Charges for donor, laboratory or biological fees directly related to an artificial insemination procedure.
- Revision of scarring caused by implantable birth control devices.
- Elective abortions.

- Treatment, services or supplies required as the result of a written or unwritten agreement for the benefit of an individual other than the Member, or as a volunteer for that individual.

SCOPIC PROCEDURES – OUTPATIENT DIAGNOSTIC AND THERAPEUTIC

Covered Services:

- Outpatient diagnostic and therapeutic scopic procedures used for visualization, biopsy and polyp removal purposes.
    - Examples include:
        - Colonoscopy
        - Sigmoidoscopy
        - Endoscopy
    - When performed for Preventive screening purposes, these scopic procedures and related services are covered under the "Preventive Care Services" provision within this section of the Policy.
- The facility charge and the charge for supplies and equipment, including anesthesia.
- Physician services for anesthesiologists, pathologists and radiologists.

SKILLED NURSING FACILITY / HABILITATIVE AND REHABILITATIVE SERVICES

Covered Services:

- Skilled Nursing Facility and Habilitative and Rehabilitative Services, as follows:
    - *Description of covered Skilled Nursing Facility and Habilitative and Rehabilitative Services:*
        - Charges for daily room and board and general nursing services.
        - Physical, occupational, and speech therapy;
        - Durable Medical Equipment.
    - *Coverage conditions*
        - The Member must enter the facility within 24 hours after discharged 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.
        - Your PCP 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.

Non-Covered Services:

- Custodial care.
- Skilled Nursing Facility days (measured per Confinement) in excess of the number specified in the Schedule of Benefits.

TEMPOROMANDIBULAR DISORDERS

Covered Services:

- Diagnostic procedures and Medically Necessary surgical and non-surgical treatment for the correction of temporomandibular disorders (TMJ), including a prescribed intraoral splint therapy device, as follows:
    - The condition must have been caused by a Congenital, developmental or acquired deformity, Sickness or Bodily Injury.
    - The procedure or device must be reasonable and appropriate for the diagnosis or treatment of the condition, under the accepted standards of the profession of the Health Care Provider providing the service.
    - The purpose of the procedure or device must be to control or eliminate pain, infection, disease or dysfunction.

Non-Covered Services:

- Cosmetic or elective orthodontic care, periodontal care or general dental care except as described in this Policy.

- Any treatment or supplies for bruxism.

TOBACCO CESSATION

We provide free of charge, online and telephone tobacco cessation services. Please visit our website at mercycarehealthplans.com or call us at (800) 895-2421 for more information about how to obtain these services. We also cover with no Copayment or other cost-sharing, Prescription Drugs approved by the FDA for tobacco cessation.

TRANSPLANTS

Covered Services:

- Organ and tissue transplant surgery, when ordered by a Health Care Provider and determined Medically Necessary by Us.
    - *Coverage conditions:*
        - "Organ" includes bone marrow and stem cells.
        - Coverage is limited to those procedures that are considered by Us to be Medically Necessary, non-Experimental and effective.
        - You must obtain Prior Authorization for all transplant-related services.
        - You must obtain Prior Authorization for the facility where the transplant and related services will be performed.
        - For kidney transplants, see the "Kidney Disease Treatment" provision within this section of the Policy.
- Services related to the procurement of transplant organs, including surgical removal procedures, storage and transportation of the organ obtained for transplant.

Non-Covered Services:

- Procedures involving non-human and/or artificial organs.
- Lodging expenses.
- Transportation expenses other than Medically Necessary ambulance services.
- Transplant services from Health Care Providers and/or facilities not approved by Us.
- Transplants and all related expenses that have not been Prior Authorized by Us.
- Organ transplant expenses of a donor if the recipient is not an eligible 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 Policy.

VIRTUAL VISITS

Your Plan provides benefits for Covered Services obtained through a Virtual Visit. A Virtual Visit is a real-time audio or visual interaction via the use of technology, between patients and Health Care Providers at different locations for assessment, diagnosis, consultation, treatment, education, care management, and self-management. Services covered under this benefit include Virtual Visits for rendering mental health or substance use disorders services.

Not all conditions can be addressed via a Virtual Visit. If the Virtual Visit provider cannot provide the care that You need, he or she may refer You to a more appropriate setting for diagnosis or treatment. Cost-sharing will apply to the Virtual Visit, even if the Virtual Visit Provider refers You to another care setting.

VISION CARE

Covered Services:

- Medical eye examinations provided as part of the treatment for pathological conditions when performed by or at the direction of a Participating Provider.
- 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:
    - Routine or preventive eye exams when performed by an ophthalmologist or optometrist who is a Participating Provider.
    - Prescription glasses (including lenses and frames) or contact lenses, limited to one pair per Contract Period

Non-Covered Services:

- Eyeglass frames, lenses, or contact lenses, except those otherwise described as covered under this Policy.
- 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.
- CT scans, PET scans, MRI, MRA, nuclear medicine, and major diagnostic services.
- Mammograms
    - Covered according to the recommendations described in the "Preventive Care Services" provision within this section of the Policy and Wisconsin state law.
- Blood lead tests for Members conducted according to the rules established by the Wisconsin Department of Health 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 would otherwise be a Covered Expense.
- Routine Patient Care provided to You in connection with a Qualified Clinical Trial if such services are also Covered Services under this Policy.
- Registered dietitian services at a Hospital or Participating Provider's office.
- Allergy testing when performed in conjunction with a diagnosis of asthma.
- Allergy injections and disease immunizations.
- Infusion therapy.
- A second opinion from a Participating Provider regarding Covered Services.

PRESCRIPTION DRUG BENEFIT PROVIONS

BENEFIT LEVELS AND FORMULARY

Benefit Levels
This Policy covers Prescription Drugs through a Prescription Drug plan that incorporates six levels of benefits. The Formulary specifies the tier in which each drug is placed.

- Tier 1 is for Preferred Generic drugs, and some (but not all) Preferred brand name drugs.
- Tier 2 covers Preferred brand name drugs and Select Generic drugs.
- Tier 3 represents all Non-Preferred drugs, and clinically-appropriate non-Formulary drugs by that have been Prior Authorized by Us.
- Tier 4 covers only Select Generic drugs, Select brand name drugs, specialty drugs, and clinically-appropriate non-Formulary specialty drugs with Prior Authorization from Us.
- Tier $0 is for Affordable Care Act-compliant drugs that are listed on the U.S. Preventive Services Task Force (USPSTF) list of recommended Preventive services. Category A or B, are covered with no Copayment or other cost-sharing amount.
- Tier M is for drugs that are not covered under this "Prescription Drug Benefit Provisions" section. They are instead covered under the "Medical Benefit Provisions" section of this Policy.

Formulary
This Prescription Drug plan has a closed Formulary, which means that only those drugs listed on the Formulary are covered. See the "Non-Covered Drugs" provision below for more information.

We determine the placement of drugs within each tier of this Formulary. We may make changes to this Formulary; changes are published on the Formulary on a monthly basis.

The MercyCare Drug Formulary is available to all Members on the MercyCare website at mercycarehealthplans.com. You may obtain a copy of the Formulary by calling the Customer Service Department at (800) 895-2421.

COVERED PRESCRIPTION DRUGS

- Any Prescription Drug or insulin listed on the Formulary that has been prescribed by your Health Care Provider.
- Insulin syringes.
- Any medication compounded by the Participating Pharmacy that contains a covered Prescription Drug.
- Over-the-counter (OTC) contraceptive methods, such as spermicides and sponges, if the method is approved by the FDA and prescribed for a woman by her Health Care Provider.

Please also review "Special Information for Certain Prescription Drug Types" provision below for more specific guidelines regarding coverage of certain types of Prescription Drugs and related expenses.

GENERAL COVERAGE REQUIREMENTS AND GUIDELINES

Coverage Requirements
- The covered drug or expense must have been prescribed by:
  - A Participating Provider;
  - A Non-Participating Provider for treatment of an Emergency Medical Condition; or
  - A Non-Participating Provider that a Member has been Prior Authorized by Us to see.

- The covered drug or expense must be:
    - Medically Necessary for Your medical condition and appropriate given Your medical history;
    - Prescribed in a manner consistent with its FDA approval and manufacturer recommendations;
    - Prescribed in its most cost-effective dosing regimen; and
    - Used in a manner consistent with any and all guidelines and criteria developed, adopted, or researched by Us.

- Medical Necessity: In general, We only cover Prescription Drugs if they are Medically Necessary. When dictated by the Policy, We will review the provided factual information and determine whether a Member's requested Prescription Drug is Medically Necessary.

Appeals
- You have the right to appeal a denial or other Adverse Determination for a Formulary or non-Formulary drug.
- Please refer to the "Complaint Procedures" section to find out how to file an appeal.

Coverage Guidelines
- Tell Your Health Care Provider about your Prescription Drug coverage. Doing so can help him or her to make decisions about which prescriptions to prescribe and how they should be filled.
- Use the same pharmacy for all Your prescriptions as much as possible. This allows Your pharmacist an opportunity to know and learn about Your medical conditions, allergies, and Prescription Drug coverage.
- Ask Your pharmacist to talk with Your doctor to help make sure You receive the most appropriate Prescription Drugs for Your medical condition.

COVERAGE RESTRICTIONS

Drug Quantity Limits
The maximum amount of a Prescription Drug you may obtain in a single prescription is a 30-day supply.

Prior Authorization
- Prior Authorization Overview
    - We require that You obtain Prior Authorization for certain Prescription Drugs before We will cover them. This ensures that these Prescription Drugs are used in a manner consistent with the coverage requirements discussed above.
    - The Formulary indicates which Formulary Prescription Drugs require Prior Authorization.
    - Depending on how urgently you need access to the Prescription Drug, you may submit either a Standard or Expedited Prior Authorization Request. If We deny Your request, You may also request an Independent External Review of Our decision. See below for more specific information regarding the Prior Authorization request process.
- Prior Authorization Standard Request
    - To submit a standard Prior Authorization request, Your Health Care Provider must send the appropriate Prior Authorization form and all necessary documentation to Us for review.
    - We will notify You (and Your designee or prescriber) of Our decision no later than 72 hours after We receive Your Prior Authorization request.
    - If We approve Your request, We will cover the Prescription Drug for the length of the prescription, including refills. In addition, coverage of the approved drug will be treated as an essential health benefit.
- Prior Authorization Expedited Request
    - If, due to urgent circumstances, You need a fast response to a Prior Authorization request, You (or Your designee or prescriber) may request an expedited review. Urgent circumstances exist if:
        - You are suffering from a health condition that may seriously jeopardize Your life, health or ability to gain maximum function; or
        - You are undergoing a course of treatment using a non-Formulary Prescription Drug.
    - To submit an expedited Prior Authorization request, Your Physician must send the appropriate Prior Authorization form and all necessary documentation to Us for review.

- We will notify You (and Your designee or prescriber) of Our decision no later than 24 hours after We receive Your Prior Authorization request.
- If We approve Your request, We will cover the Prescription Drug for the length of the prescription, including refills. In addition, coverage of the approved drug will be treated as an essential health benefit.

Exception Requests
You may request a coverage exception for a prescription drug that is not included on the Formulary, and thus is not covered. The processes for requesting standard and expedited coverage exceptions are the same as the Prior Authorization processes described above.

Independent External Review of Prior Authorization and Exception Requests
If We deny Your request for Prior Authorization, of a clinically appropriate Formulary or non-Formulary drug, You may request an Independent External Review (IER) of Our decision. If Your IER request is approved, We will cover the Prescription Drug for the length of the prescription, including refills. In addition, coverage of the approved drug will be treated as an essential health benefit.

Please refer to the "Complaint Procedures" section of this Policy to find more information related to requesting an independent external review.

GETTING YOUR PRESCRIPTION DRUGS

Filling a Prescription
To fill a prescription, Your pharmacist will need:
- Your prescription; and
- Your Member Identification Card.

Once the information from Your Member Identification Card is entered into the pharmacist's computer, the pharmacist will be able to:
- Verify that You are eligible to receive drugs under this Prescription Drug plan.
- Check to see if the Prescription Drug You have requested is covered.
- See the listing price of the prescription and the amount You will be expected to pay.

Paying for a Prescription
See the Schedule of Benefits to determine how much, if any, you will have to pay out of pocket for your Prescription Drug. This is usually a Copayment, Deductible and/or Coinsurance amount. If the price of Your Prescription Drug is less than the Copayment stated in the Schedule of Benefits, You will only be required to pay the amount of the Prescription Drug.

SPECIAL INFORMATION FOR CERTAIN PRESCRIPTION DRUG TYPES

Pain Management and Narcotics
If You are prescribed narcotics for Chronic pain, You are at risk of becoming addicted. One of the important ways We can help You avoid addiction is to encourage You to get Your prescriptions for narcotics only from the Health Care Provider who is managing Your pain.

For Chronic pain, We will only cover prescriptions for long-acting narcotics or for large quantities of short-acting narcotics if the prescriptions are written by Participating Providers who are pain Specialists or Prior Authorized Non-Participating Providers who are pain Specialists.

If We become aware of a Member who has Chronic pain and is on narcotics, We have the right to limit the Member's coverage of prescription narcotics to the one Health Care Provider who has the primary responsibility for managing the Member's condition**.**

Specialty Drugs
For many health conditions, treatment involves Prescription Drugs that require special delivery and instructions. These Prescription Drugs are called specialty drugs.

- The Formulary indicates which drugs are specialty drugs.
- If Prior Authorization is required, coverage will be limited to the quantity approved in the Prior Authorization, usually measured by how many days the supply will last.
- Specialty drugs are only covered when you get them from a designated specialty pharmacy. You can find a list of designated specialty pharmacies on mercycarehealthplans.com.

Oral Chemotherapy
Oral chemotherapy is covered, when medically necessary, as described in the Schedule of Benefits.

Prescription Eye Drops
You may request covered prescription eye drop refills when 75 percent or more of the days have elapsed from the later of, the original date the prescription was distributed, or the date on which the most recent refill was distributed, as long as the refill does not exceed the number of refills allowed by the prescription.

NON-COVERED DRUGS AND EXPENSES

- A Prescription Drug prescribed by a Non-Participating Provider when:
  - The Member was seeking care from this Non-Participating Provider for reasons other than treatment of an Emergency Medical Condition; or
  - The Member did not receive Prior Authorization to see this Non-Participating Provider.
- Prescription Drugs not listed on the Formulary, unless we approve an exception request.
- Prescription Drugs newly approved by the FDA that We have not yet evaluated.
- Fertility drugs.
- Replacement of any lost, stolen, or destroyed Prescription Drugs.
- Therapeutic devices or appliances, including hypodermic needles or syringes (except for diabetic supplies listed on the Formulary)
- Any Prescription Drug or medicine that is administered or delivered to You by the Health Care Provider.
- A brand name Prescription Drug when a Generic is available, unless indicated as covered on the Formulary.
- A Generic or brand name Prescription Drug that:
  - Is available over-the-counter; AND
  - The over-the-counter version is listed as covered on the Formulary.
- A non-Formulary prescription drug that is available over-the-counter, even if You have a prescription.
- A specialty Prescription Drug that is not obtained from the designated specialty pharmacy.
- Any drug or medicine which is taken by or administered to You while You are a patient in a licensed Hospital, rest home or sanitarium, extended care facility, convalescent Hospital, Skilled Nursing Facility or similar institution.
- Any drug labeled “Caution: limited by Federal Law to Investigational use” or other wording with similar intent; Experimental drugs; or FDA-approved drugs used for non-FDA approved uses, or FDA-approved drugs used in non-FDA approved regimens, even if You are charged. This exclusion does not include any Prescription Drug which meets the following criteria:
  - The drug is prescribed for the treatment of HIV infection or an Illness or medical condition arising from or related to HIV infection; AND
  - The drug Is FDA-approved, including phase-3 Investigational drugs; AND
  - If the drug is an Investigational new drug, it is prescribed and administered in accordance with the treatment protocol approved by the FDA for Investigational new drugs.
- Anabolic steroids.
- Growth hormones.
- Brand name anti-obesity and anorexients (weight loss drugs), unless listed as covered on the Formulary.
- Any Prescription Drug which is not Medically Necessary.

- Any Prescription Drug for a non-covered procedure or service, or the treatment of a complication from a non-covered procedure or service.
- Any Prescription Drug for a Sickness or Bodily Injury not covered by the Plan.
- Medication, other than Prescription Drugs or preferred OTC drugs, for which a Member does not have a prescription.
- Prescription Drugs which a Member is entitled to get without charge under any Worker's Compensation laws or any municipal state or federal program.
- Nutritional supplements.
- Any Prescription Drugs dispensed to a Member prior to the Member's Effective Date of coverage under this Policy, or after the Member's Policy termination date.
- Any drug when used for cosmetic treatment.
- Any drug when used for treatment of hair loss or hair growth.
- Unless listed as covered on the Formulary, any medication used to obtain, treat, or enhance sexual performance and/or function, even if the problem is caused by organic diseases or a mental health condition.
- Any Prescription Drugs administered by injection, except for insulin injections and injections approved for coverage by Our Pharmacy and Therapeutics Committee.
- Homeopathic Medications.
- Special formulations of covered drugs, such as sustained release, which are intended primarily for Member convenience.
- Special packaging of covered drugs intended primarily for Member convenience. This includes drugs that are not prescribed in their most cost-effective dosing regimen.
- Any drug used to treat hyperhidrosis.

GENERAL EXCLUSIONS AND LIMITATIONS

- Services or supplies related to treatment of a Bodily Injury or Sickness which arose from or was sustained in the course of any occupation or employment (for compensation, profit or gain).
    - This exclusion applies whether You have Worker's Compensative coverage, or file a claim or receive benefits under any coverage You have.
    - This exclusion does not apply if:
        - You are employed as a domestic servant;
        - You are an employee of a farmer or other employer that is not required to have Worker's Compensation coverage;
        - You are a partner in or sole proprietor or LLC member of a business on a substantially part-time basis; or
        - You were working as a volunteer.
- Treatment, services or supplies for any Bodily Injury or Sickness caused by war (declared or undeclared) or 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 We determine are, Experimental or Investigative,
    - This includes services or supplies:
        - That are not recognized as conforming to commonly accepted medical practice within the Service Area; or
        - For which the required approval of a government agency has not been granted at the time the services and supplies are provided,
    - This exclusion does not apply to any covered drug which meets the following criteria:
        - It is prescribed for the treatment of HIV infection or an Illness or medical condition arising from or related to HIV infections; and
        - It is approved by the FDA, including phase-3 Investigational drugs; and
        - If the drug is an Investigational new drug, it is prescribed and administered in accordance with the treatment protocol approved by the FDA for the Investigational new drug.
- Unless otherwise described as covered under this Policy, services or supplies that You received:
    - Prior to the date Your coverage under this Policy;
    - After the date Your coverage under this Policy terminates; or
    - After the date You are disenrolled from this Policy.
- Medical expenses resulting from Your commission or attempted commission of a civil or criminal battery or felony.
- Charges for any treatment related to a non-Covered Expense, unless We are required by law to cover it.
    - This exclusion does not include Routine Patient Care that is administered to a Member in a Qualified Clinical Trial that would be covered under this Policy if the Member were not enrolled in a Qualified Clinical Trial.
- Any treatment or services rendered by or at the direction of:
    - A person residing in Your household; or
    - 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/or treatment of a covered Bodily Injury or Sickness.
- Services and supplies for which You are not charged, or for which You would not have to pay without this coverage.
- Any Copayment, Coinsurance, and/or Deductible amounts that You must pay, as described in the Schedule of Benefits and/or in any rider attached to this Policy.
- All services not specifically covered in the "Medical Benefit Provisions" or "Prescription Drug Benefit Provisions" sections of this Policy or by any rider attached to the Policy.
- Any service not provided or received in accordance with the terms and conditions of this Policy.
- Ancillary medical services (including Hospital facility charges, anesthesia charges, and lab and x-ray charges) provided during the course of a non-covered Bodily Injury or Sickness.

Benefits listed in this document are only available as long as the Policy and your coverage are in effect. You must read this document together with the Schedule of Benefits and other Policy documents to ensure accurate information regarding coverage, obligations and responsibilities under the Policy. Please refer to the Schedule of Benefits to find any applicable Copayment, Coinsurance and/or Deductible amounts and other types of limitations affecting coverage. Unless otherwise stated in this Policy, services and supplies will be Covered Expenses only if they are Medically Necessary and rendered by a Participating Provider. Certain services and supplies require Prior Authorization in order to be covered; a list describing what requires Prior Authorization can be found in the "Obtaining Services" section of this Policy document. Definitions of the capitalized terms within this Policy can be found in the Glossary.

    - This exclusion does not apply to benefits for dental surgery as described in the “Medical Benefit Provisions” section.
- Expenses for medical reports, including preparation and presentation.
- If a Member is eligible for Medicare, services, supplies or treatments which are covered by Medicare.
    - This exclusion applies even if the Medicare-eligible Member has not enrolled in Medicare coverage.
    - This exclusion does not apply if this Policy is considered the primary payer under applicable federal law.
- Treatment, services, and supplies furnished by the U.S. Veterans Administration, except when this Policy is the primary payer 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 the Member is 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 bariatric surgery, ileal bypass, gastric bypass, or stapling.
- Skin tag removal.
- Services of a blood donor.
- Allergy testing, except when performed in conjunction with a diagnosis of asthma.
- Sublingual (under the tongue) allergy treatment.
- Work or education related preventive treatment.
- Sexual counseling services that are commonly used by providers for conditions producing significant physical and mental symptoms.
- Any treatment, services or devices used to obtain, treat, or enhance sexual performance and/or function. This includes dysfunction caused by organic diseases.
- Genetic Counseling, except Genetic Counseling specifically described as covered under this Policy.
- Acupuncture.
- 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 someone other than a Member, when such services and/or supplies are not otherwise Medically Necessary or appropriate.
    - Excluded services and supplies include, but are not limited to:
        - Physical exams;
        - Disease immunizations;
        - Services and supplies needed for employment (including travel for employment); licensing; marriage; adoption; insurance; camp; school; sports; or travel.
    - This exclusion does not apply if the services and/or supplies are mandated by law
- Weight loss programs, including dietary and nutritional treatment for obesity.
- Private duty nursing.
    - Private duty nursing is defined as providing individual and continuous care (in contrast to part-time or intermittent care) of four or more hours according to an individual plan of care, including shift care by a registered or licensed practical nurse or a certified nursing assistant.

COVERAGE INFORMATION

ELIGIBILITY FOR COVERAGE

Eligibility Overview
Generally, to qualify for enrollment, an individual must:

- Be a citizen of the United States or a resident legal alien; and
- Reside within Our Service Area. Except for Dependent children, We consider a Member's residence to be the location in which he or she spends at least nine months out of a 12-month Contract Period.

To be enrolled as a Member and be eligible for benefits, an individual must also qualify as either a Subscriber or Dependent as described below.

No one can be denied coverage because of a pre-existing medical condition.

Subscriber
A Subscriber is the individual who carries the Policy. That typically is a parent or the oldest enrolled Member in a family.

Dependent
Dependent means all of the following:

- An eligible individual's lawful spouse;
  - A spouse ceases to be a Dependent on the date in which a divorce decree is granted.
- An eligible individual's natural blood-related child; adopted child; child placed for adoption with the eligible individual; stepchild(ren); or child(ren) under the age of 26 for whom the eligible individual acts as legal guardian.
  - "Placed for adoption" is defined in Wis. Stat. § 632.896.
  - If the eligible individual 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 "Coverage Information" section.
  - A stepchild ceases to be a Dependent on the date in which a divorce decree is granted.
  - A child who is considered a Dependent ceases to be a Dependent on the date the child becomes insured as an eligible individual.
- An unmarried, natural child of a Dependent child (as described above) (e.g. grandchild(ren)) until the Dependent child is 18 years of age.

Coverage for Full-Time Students on Medical Leave following Active Duty Service
Coverage is also provided for a Dependent child (as described above, regardless of age) who is a Full-Time Student as defined in this Policy, 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 item, the child must apply to an institution of higher education as a Full-Time Student within 12 months of the date the child fulfilled his or her active duty obligation.
- If the 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.
- The child eligible, ceases to be a Dependent when the child ceases to be Full-Time Student.
  - Proof of attendance is required upon request from Us.
  - 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. We 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:

- The child advises Us that he or she does not intend to return to school full time.
- The child becomes employed full time.
- The child obtains other health care coverage.
- The child marries and is eligible for coverage under his or her spouse's health care coverage.
- Coverage of the eligible individual is discontinued or not renewed.
- 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.

Continued Coverage for Disabled Dependent

A covered Dependent child who attains the limiting age while insured under the Policy shall remain covered if and as long as he or she is:

- Incapable of self-sustaining employment because of intellectual or physical disability which existed before the Dependent attained the limiting age; and
- Is chiefly dependent on the eligible individual for support and maintenance.

Written proof of incapacity and dependency must be provided to Us in a form satisfactory to Us within 31 days after the Dependent's attainment of the limiting age.

We 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.

You must notify Us immediately of a cessation of incapacity or dependency.

Eligibility Questions

If You enrolled directly through MercyCare and have further questions about Your eligibility, please call the Customer Service Department at (800) 895-2421.

If You enrolled through the Marketplace, please contact the Marketplace at www.healthcare.gov.

ENROLLMENT PERIODS AND EFFECTIVE DATES

You may apply for enrollment in the Plan by submitting a completed Application. MercyCare will notify You of the Effective Date of Your coverage. If You complete an Application for coverage through the Marketplace, the Marketplace will determine Your Effective Date.

Enrollment Periods

Eligible individuals and their Dependents can either enroll in coverage:

- During the annual open enrollment period; or
- During a special enrollment period if they experience a qualifying event.
    - Examples of qualifying events include:
        - The eligible individual or his or her Dependents lose coverage (except when the loss of coverage is due to a failure to pay premiums or due to any situations that would give MercyCare the right to rescind or cancel coverage).
        - The eligible individual gains a Dependent or becomes a Dependent through marriage, birth, adoption or placement for adoption, or legal guardianship.
        - The eligible individual gains access to new qualified health plans as a result of a permanent move.
        - The Marketplace determines that the eligible individual (or his or her Dependent) is eligible to enroll or change health plans.

- The eligible individual has 60 days from the date of the qualifying event to enroll.
  - If the eligible individual knows that he or she will be losing coverage under another health plan in advance, he or she can notify Us up to 60 days prior to the date he or she loses coverage.
- Members who purchased coverage through the Marketplace must notify the Marketplace of any changes within 60 days before or after the qualifying event.

If You wish to add or delete Dependents or change the information contained in Your Application, You must complete a Change of Status Form. If You applied for coverage through the Marketplace, You may complete the form through the Marketplace. If You applied for coverage directly from MercyCare, You may obtain a Change of Status Form from MercyCare.

Effective Dates

- If you enroll during the annual open enrollment period, your coverage effective date will be January 1.
- If you enroll during a special enrollment period, your coverage effective date will be as follows:
  - In the following circumstances, coverage is effective on the first day of the month after the individual notifies Us or the Marketplace that the qualifying event has occurred (where applicable):
    - Marriage; or
    - The eligible individual or his or her Dependent loses coverage under another health plan.
      - However, if the eligible individual or his or her Dependent notifies Us in advance that he or she will lose coverage under another health plan, then his or her coverage will be effective on the first day of the month following the date he or she loses coverage
  - In the following circumstances, coverage is effective on the date of the qualifying event, unless the eligible individual elects a coverage effective date of the first day of the month following the qualifying event.
    - Birth;
    - Adoption;
    - Placement for adoption; or
    - Placement in legal guardianship.
- A newborn child is covered from the moment of birth and for the next 60 days.
  - In order to continue coverage beyond 60 days:
    - If you enrolled directly through MercyCare, you must notify Us of the child's birth and pay the required premium.
      - You must do this before the end of the first 60 days of coverage.
    - If you enrolled through the Marketplace, you must notify the Marketplace of the child's birth and pay the required premium.
      - You must do this before end of the first 60 days of coverage.
  - If you fail to notify MercyCare or the Marketplace (where applicable), then the newborn's coverage will terminate at the end of the 60-day period, unless, within one year of the child's birth, You pay all past due premiums plus interest on those premiums at the rate of 5.5% per year.
- You must pay all required premium amounts for Your coverage to become effective.

BENEFIT CHANGES

MercyCare will notify You of any benefit changes, in writing, at least 60 calendar days before the Policy renews. Benefit changes become effective when the Policy renews.

GRACE PERIOD

Non-APTC Grace Period
If You do not receive an Advanced Premium Tax Credit (APTC), You have a 10-day grace period to make a premium payment. If You do not make a premium payment by the end of the grace period, Your coverage under this Policy will terminate as of the last day of the month Your premium was paid in full.

APTC Grace Period
If You receive an APTC, You have a 90-day grace period to make a premium payment. If You do not make a premium payment by the end of the grace period, Your coverage under this Policy will terminate as of the last day of the first month of your grace period. If Your coverage is terminated, You are responsible for any Claims costs we incur on Your behalf after Your coverage ends.

TERMINATION OF COVERAGE / DISENROLLMENT

You must promptly provide notification of any event triggering termination. Either MercyCare or the Marketplace may terminate benefits or cancel the Policy. Generally, if You obtained coverage through the Marketplace, Your coverage will end on the date determined by the Marketplace. If MercyCare terminates Your coverage, We will send the termination effective date to the Marketplace with the reason for termination.

Disenrollment
We may disenroll You as follows when any of the following occur:

- If You fail to pay the required premiums by the end of Your grace period, Your coverage will end as described under the "Grace Period" provision, above
- If You have performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact in connection with Your coverage, Your coverage will end on the earliest date permitted by state law.
    - Examples of fraud or misrepresentation of material fact include providing false information to obtain coverage or allowing someone else to use Your ID card to make a Claim.
    - If You use fraud or a misrepresentation of material fact to obtain coverage and/or make a claim, We can require You to pay back the amount that We have paid on Your behalf.
- If You have moved Outside the Service Area, Your coverage will end on the last day of the month following the date You establish residence outside the Service Area.

Dependent Loss of Eligibility
Coverage that terminates due to a Dependent Child reaching the limiting age of 26 will terminate at the end of the month in which the Dependent Child reaches the limiting age.

Coverage for a Dependent who loses eligibility for any other reason will generally terminate on the date of the event, but no later than the last day of the month following the date of the event.

Voluntary Disenrollment
If You enrolled directly through Us, Your coverage will end either on the last day of the month We received Your notice to end coverage, or the date You requested in the notice.

If You enrolled through the Marketplace, Your coverage will end on the date determined by the Marketplace.

EXTENSION OF BENEFITS

Termination of Policy

If You are covered under this Policy and are Totally Disabled as a result of a covered Bodily Injury or Sickness existing on the date the Policy terminates, We will continue to provide coverage until the earliest of the following:

- The date Your Primary Care Provider certifies that You are no longer Totally Disabled; or
- The end of 12 consecutive months immediately following the date of termination of coverage; or
- The date You obtain similar coverage under another policy, other than temporary coverage, for the condition or conditions causing the Total Disability.

Termination of Member's Coverage

If You are Confined in the Hospital on the date Your coverage terminates under this Policy, We will continue cover the inpatient Hospital services You receive 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; 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 Expenses relating to the condition(s) which existed on the date Your coverage terminated.

GENERAL PROVISIONS

ADVANCE DIRECTIVES

If You are over the age of 18 and of sound mind, You may execute a living will or durable power of attorney for health care. The documents tell others what Your wishes are if You are physically 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 Provider. 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 Us.

CASE MANAGEMENT / ALTERNATIVE TREATMENT

Case management is a program We offer to Members. We employ a professional staff to provide case management services. As part of this case management, We reserve the right to direct treatment to the most effective option available.

CLERICAL ERRORS

No clerical errors made by Us 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

We are 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 We may use and disclose this information and how You can access this information. The Notice is available at mercycarehealthplans.com.

CONFORMITY WITH STATE STATUTES

Any provision of this Policy which, on the Policy effective date, conflicts 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 two years, We cannot contest the validity of coverage on the basis of any statement that You made regarding Your insurability, except for fraudulent misrepresentation of material fact. No statement You make can be contested unless it is in written form and signed by You. A copy of the form must then be given to You and becomes a part of this Policy.

LIMITATIONS ON SUITS

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

PHYSICAL EXAMINATION

We have the right to request a Member to receive a physical examination to determine eligibility for claimed services or benefits. We 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 ASSURANCE

Our Medical Management Program is designed to ensure that quality medical care is accessible and appropriate to Your needs, and to identify problems with care and correct those problems.

There are many elements to this Program, including a process for choosing and deciding whether to retain participating Providers; guidelines and education for Providers regarding medical management and quality of care; review of medical data to monitor provision of care and treatment results; and consideration of Member complaints and Grievances to detect problems in provision of care.

If You have any questions about this Program, please contact Our Customer Service Department.

REINSTATEMENT

In the event the premium is not paid within the time granted, including any grace period, and coverage is terminated, reinstatement of coverage under this Policy is subject to the approval from the Health Insurance Marketplace and is subject to the Enrollment Periods described in this Policy. MercyCare requires all past due premium amounts to be paid in full prior to reinstatement of coverage.

MEMBER RIGHTS AND RESPONSIBILITIES

We offer members a three-way partnership between You, Your doctors and Your health plan. Our goal is to assure You receive appropriate, quality health care and develop a relationship with a Primary Care Provider who coordinates and manages Your medical care. As a health plan Member and a patient, You have rights and responsibilities as part of the MercyCare partnership. Please visit Our website at www.mercycarehealthplans.com or call Us at (800) 895-2421 for more information about Your Member rights and responsibilities.

RIGHTS OF RECOVERY

SUBROGATION AND REIMBURSEMENT

Except as otherwise provided in the "Coordination of Benefits" section of this Policy, in the event We make payment on Your behalf for Covered Expenses, We shall be subrogated to all of Your rights of recovery against any person or organization for such payments. Our 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.

When You receive benefits under this Policy, We are subrogated to Your right to recover for Bodily Injury or Sickness allegedly caused by or for which another party may be liable, to the extent of the reasonable value of the benefits provided to You. In providing benefits to You, We may compensate providers on a capitated basis. Regardless of any such capitation arrangement, when You receive a benefit under this Policy for a Sickness or Bodily Injury, We are subrogated to Your right to recover the reasonable value of the benefit provided on account of such Bodily Injury or Sickness, which reasonable value shall be deemed to be the amount that We would have paid the provider on a fee for service basis.

Our 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 Expenses, We are granted a lien on the proceeds of any settlement, judgment, or other payment, which You receive, and You consent to said lien. We are 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 Our 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 Us secure said lien and to execute and deliver all instruments and papers and do whatever else is necessary to secure the Our rights of subrogation and reimbursement. You agree to cooperate with Our representatives in completing such forms and in giving such information surrounding any Sickness or Bodily Injury as Our representatives deem necessary.

You agree to do nothing to prejudice Our rights under this provision. You agree not to make any settlement that specifically excludes or attempts to exclude the benefits paid by Us. You may not accept any settlement that does not fully reimburse Us without Our written approval. You agree to notify Us 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 Us 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 We have paid.

Under applicable state law, We may have no right to recover from You if You have not been made whole. However, if you have been made whole, We have a first priority right to recover up to 100% of the benefits paid by Us out of the proceeds of any settlement, judgment, or other payment before You receive any proceeds. 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, We 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 Us 100% of Our interest without written consent from Us or Our representative.

WORKERS COMPENSATION

The Policy is not issued in lieu of nor does it affect any requirement for coverage by Workers' Compensation. If You are eligible for Worker's Compensation coverage for a Bodily Injury or Sickness arising from or sustained in the course of any occupation or employment for compensation, profit or gain that Bodily Injury or Sickness is not covered under this Policy, 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, or LLC Member of a business on a substantially full-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 We paid for the treatment of any such Bodily Injury or Sickness, We have the right to recover such payments as described under the "Right to Recovery" provision of the "Coordination of Benefits" section of this Policy, unless the Bodily Injury or Sickness arose from or was sustained in the course of one of the exceptions described in the above paragraph. You must reimburse Us, and We will exercise the right to recover against You.

The recovery rights will be applied even if:

- Any Workers' Compensation benefits are in dispute or are made by means of settlement or compromise; or
- 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
- 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
- The medical or health care benefits are specifically excluded from any Workers' Compensation settlement or compromise.

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

COORDINATION OF BENEFITS

DEFINITIONS

The following definitions apply to this section.

Allowable Expense
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. We 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
A Contract Period. 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:

- Individual or 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.
- 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.

Each contract or other arrangement for coverage under those listed above is a separate Plan. If an arrangement has two parts and coordination of benefits rules apply only to one of the two, each of the parts is a separate Plan.

Primary Plan/Secondary Plan
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 Expenses 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
The health plan offered by MercyCare and described in this Policy.

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.
    - Exception to the Birthday Rule: 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:

    - First, the plan of the parent with custody of the child;
    - Then, the plan of the spouse of the parent who has custody of the child; and
    - 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.

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

5. ***Dependent Child if Parents Share Joint Custody:*** If the specific terms of a court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules outlined in #4 above.

6. ***Young Adults as a Dependent:*** For a Dependent child who has coverage under either or both parents' plans and also has his or her own coverage as a Dependent under a spouse's plan, rule 9, "Longer/Shorter Length of Coverage" applies. In the event the Dependent child's coverage under the spouse's plan began on the same date as the Dependent child's coverage under either or both parents' plans, the order of benefits shall be determined by applying the birthday rule of rule #4 to the Dependent child's parent or parents and the Dependent's spouse.

7. ***Active/Inactive Employee:*** The benefits of either a plan that covers a person as an Employee who is neither laid off nor retired (or as that Employee's Dependent) are determined before those of a plan that covers that person as a laid-off or retired Employee (or as that Employee's Dependent). If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule shall not apply.

8. ***Continuation of Coverage:*** If a person whose coverage is provided under a right of continuation pursuant to federal or state law also is covered under another plan, the following shall be the order of benefit determination:
    - First, the benefits of a plan covering the person as an Employee, Member or subscriber (or as that person's Dependent);
    - Second, the benefits under the continuation coverage. If the other plan does not contain the order of benefits determination described within this section, and if, as a result, the programs do not agree on the order of benefits, this requirement shall be ignored.

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

EFFECT ON BENEFITS WHEN THIS PLAN IS SECONDARY

We 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:

- The benefits that would be payable for the allowable expenses under this Plan in the absence of this Coordination of Benefits provision; and
- 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, We may require certain information. We have the right to decide what information We need in order to determine Our payment, and to obtain that information from any organization or person. We 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
We will adjust payments made under any other plan that should have been made by Us. 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 Us that exceed the amount that We should have paid may be recovered by Us. We 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.

CLAIMS PROVISIONS

CLAIMS PROVISIONS

We Will Pay Claims Directly
We will pay participating Providers directly for Covered Expenses You receive, and You will not have to submit a Claim. However, if You use a Non-Participating Provider or receive a bill for some other reason, a Claim must be submitted within 60 days after the services are received, or as soon as possible. If We do not receive the Claim as soon as reasonably possible and within 12 months after the date it was otherwise required, We may deny coverage of the Claim.

In accordance with Wisconsin law, if circumstances beyond Your control prevent You from 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 60-day period. If We do not receive the written proof of Claim required by Us within that one-year and 60-day period, no benefits are payable for that service.

Types of Claims
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 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 covered Dependent or subject You or Your covered Dependent to severe 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 or reimbursement after services have been provided.
- **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.

How to Submit a Claim
To submit a Claim, send an itemized bill from the Physician, Hospital, or other provider to the following address:

MercyCare HMO, Inc.
Claims Department
P.O. Box 550
Janesville, WI 53547-0550

Written proof of Your Claim includes:

- The completed Claim forms if required by us;
- The actual itemized bill for each service; and
- 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 with Your Claim. Also, 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.

Incomplete and Incorrectly Filed Claims

- 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 any, 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.

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 (800) 895-2421 for more information about appointing someone to represent You.

Timing of Claims Determinations

- Urgent Care Claims
    - If Your Claim involves Urgent Care, We will notify You or Your authorized representative of Our initial decision on the Claim as soon as feasible, but in no event more than 72 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 We receive the Claim of the need to provide additional information.
    - If You do not respond within 48 hours to Our request, Your Claim may be denied.
- Concurrent Care Claims
    - If Your Claim involves concurrent care, We will notify You of this decision within 72 hours after receiving the Claim, if the Claim was for Urgent Care and was received by Us at least 24 hours before the expiration of the previously approved time period for treatment or number of treatments. We will give You 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 will 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 Us 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 We request from You.
    - If You fail to follow Our procedures for filing a pre-service Claim, You or Your authorized representative shall be notified orally or in writing not more 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 unit 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 receiving Your Claim if the Claim has been denied or if further information is required. The 30 days can be extended to 45 days if We notify 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 make a decision.
    - If We need more information to decide a post-service Claim, We will notify You of the specific information We need 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 Us, We will notify You of our decision no later than 45 days after We receive the Claim.

- If We determine that an extension of time is needed to process Your Claim due to matters beyond Our control, We will notify You 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 Our control, 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, the unresolved issues that prevent a decision in the Claim, and any 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.

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.

Claims Payment

We may pay all or a portion of any benefits provided for health care services to the provider or to the eligible individual, if so directed in writing at the time the Claim is filed.

Benefit Payment Upon Death

Benefits accrued on Your behalf upon death shall be paid, at Our option, to any one of more of the following:

- Your spouse; or
- Your Dependent children, including legally adopted children; or
- Your parents; or
- Your brothers and sisters; or
- Your estate.

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

Question or Dispute About Services or Payment

In the event of a question or dispute concerning the provision of health care services or payment for such services under the Policy, We may require that You be examined, at the expense of Us, by a Participating Provider designated by Us.

If You have any questions about a Claim, please contact Customer Service at (800) 895-2421.

CONSENT TO RELEASE INFORMATION

CONSENT AND AUTHORIZATION

A Member consents to the release of medical and/or legal information to Us for himself or herself and for his/her covered Dependents when he/she signs the Application and when his/her Identification Card is used to receive health care services. We have the right to deny coverage for the health services of any Member who will not consent to release information to Us.

Each Member authorizes and directs any person or institution that has examined or treated the Member to furnish to Us 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. We agree that such information and records will be considered confidential to the extent required by law. We 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 Us will be the responsibility of the Member.

PHYSICIAN AND HOSPITAL REPORTS

Physicians and Hospitals must give Us reports to help Us determine contract benefits due to You. You agree to cooperate with Us to execute releases that authorize physicians, Hospitals, and other Health Care Providers to release all records to Us regarding services You receive. It is also a condition of the Plan to pay benefits. All information must be furnished to the extent We deem it necessary in a particular situation and as allowed by pertinent statutes.

RIGHT TO COLLECT NEEDED INFORMATION

You must cooperate with Us and when asked will assist Us by:

- Authorizing the release of medical information including the names of all Providers from whom You received medical attention;
- Providing information regarding the circumstances of Your Bodily Injury or Sickness; and
- Providing information to Us about other health care and insurance coverage and benefits.

COMPLAINT PROCEDURES

COMMITMENT

We are 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 Us 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 Us, or with any other aspect of the Plan.

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 30 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. We will resolve the case within thirty calendar days after giving this notice.

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

Adverse Benefit 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 Benefit 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 Benefit 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 Benefit Determination. If the initial Adverse Benefit 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 field of medicine involved in the medical judgment. The health care professional shall not be an individual who was consulted on the initial Adverse Benefit 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 Benefit Determination.

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.)

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

Definitions

- **Adverse Benefit Determination:** A decision by Us:
  - 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 Us after You exhaust the internal appeals process described in the "Grievance" provision within the "Complaint Procedures" section of this Policy. The term also includes any Adverse Benefit Determination that is deemed to have exhausted the internal appeals process because We have not strictly complied with that process.
- **Independent review organization or IRO:** A neutral organization engaged by Us 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 Us to determine if Your request is complete and eligible for external review.

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 to Us 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 Our 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.

Preliminary Review

Within five business days after You file a request for an external review, We will complete a preliminary review to determine whether Your request is complete and eligible for external review. We will notify You of the results of Our 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.

Referral to an Independent Review Organization

If Your request is complete and is eligible for external review, We will randomly assign an IRO from among the IROs We have engaged to conduct external reviews. We 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.

Review by Independent Review Organization
The assigned IRO will review all the information and documents it timely receives. It will review Our decision independent of any decision or conclusions reached by Us 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 Us.

If, on the basis of any additional information You submit, We reconsider Your case and decide 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 Us, or any witness on behalf of either You or Us.

The assigned IRO will provide written notice of its final decision to You and to Us 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 Us that it is reversing the final internal Adverse Benefit Determination, We will immediately provide coverage or payment for the requested item or service.

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 Care, but You have not been discharged from a facility.

If We receive a request for an expedited external review, We will immediately conduct the preliminary review described above. If the request is not complete or is not eligible, We will immediately notify You of the results of Our preliminary review. If the request is both eligible and complete, We 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 Us.

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 (OCI) to file a complaint. The Office of the Commissioner of Insurance is a state agency that enforces Wisconsin's insurance laws. To file a complaint online or to print a complaint form, visit OCI's website at www.oci.wi.gov, or contact OCI at:

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

Benefits listed in this document are only available as long as the Policy and your coverage are in effect. You must read this document together with the Schedule of Benefits and other Policy documents to ensure accurate information regarding coverage, obligations and responsibilities under the Policy. Please refer to the Schedule of Benefits to find any applicable Copayment, Coinsurance and/or Deductible amounts and other types of limitations affecting coverage. Unless otherwise stated in this Policy, services and supplies will be Covered Expenses only if they are Medically Necessary and rendered by a Participating Provider. Certain services and supplies require Prior Authorization in order to be covered; a list describing what requires Prior Authorization can be found in the "Obtaining Services" section of this Policy document. Definitions of the capitalized terms within this Policy can be found in the Glossary.

GLOSSARY

The terms defined below appear throughout this Certificate. When these terms are capitalized, they have the meaning that is defined below.

ACUTE (ILLNESS/INJURY)
An Illness or Injury with a rapid onset and an expected short-term duration.

ADVERSE BENEFIT DETERMINATION
Includes any of the following:

- 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,
- 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,
- Any rescission, including any cancellation or discontinuance of coverage that has a retroactive effect, or
- Any decision to deny coverage in an initial eligibility determination.

ALTERNATIVE FACILITY
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.

APPLICATION
The form completed by a potential Member requesting coverage from MercyCare and listing all Dependents to be covered on the effective date of coverage. Applications may be submitted either to the Marketplace or to MercyCare.

AUTISM SPECTRUM DISORDER
Pervasive developmental disorders as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, including autism disorder, Asperger's Disorder and pervasive developmental disorder not otherwise specified.

BEHAVIOR ANALYST
A person certified by the Behavior Analyst Certification Board, Inc., or successor organization as a board-certified behavior analyst and has been granted a license to engage in the practice of behavior analysis.

BEHAVIORAL (THERAPY)
Interactive therapies that target observable behaviors to build needed skills and to reduce problem behaviors using well-established principles of learning utilized to change socially important behaviors with the goal of building a range of communication, social and learning skills, as well as reducing challenging behaviors. **NOTE: Only applies in the context of Autism Spectrum Disorder coverage/treatment**

BODILY INJURY (or INJURY)
An injury resulting from an accident, independent of all other causes.

CHANGE OF STATUS FORM
The form You must complete if You wish to add or delete Dependents or change the information contained on Your Application.

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

CLAIM
A demand for payment due in exchange for health care services rendered.

COINSURANCE
The Member's portion, expressed as a percentage of the fee for Covered Expenses that You are required to pay for certain Covered Services provided under the Policy.

CONFINEMENT/CONFINED
- The period of time between admission as an inpatient or outpatient to a Hospital, alcohol and other drug abuse (AODA) Residential Treatment Center, Qualified Treatment Facility, Skilled Nursing Facility or licensed ambulatory surgical center, and discharge therefrom; or
- 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
A condition that exists at birth but is not hereditary.

CONTRACT PERIOD
The period beginning with the Effective Date or the Renewal Date of the Policy and ending on December 31 of the year in which this Policy became effective. All eligible expenses and all payment amounts listed in this Policy are per Contract Period, unless otherwise stated in the specific benefit provision within this Policy.

COINSURANCE
The Member's portion, expressed as a percentage of the fee for Covered Expenses that You are required to pay for certain Covered Services under the Policy.

COPAYMENT
A fixed dollar amount that You are required to pay for certain Covered Services, usually when you receive the service. You are responsible for paying the Copayment directly to the provider.

COVERED SERVICE
A Medically Necessary treatment, service or supply that is eligible for payment under this Policy.

COVERED EXPENSE
A charge for a Covered Service.

CUSTODIAL CARE
The 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
The pre-determined amount that You must pay each Contract Period before We start to pay for Covered Expenses. For more specific information about Your Deductible, including the difference between the single and family Deductible amounts, please see the "Obtaining Services" section of this Policy.

DEPENDENT
See the "Eligibility for Coverage" provision in the "Coverage Information" section of this Certificate.

DURABLE MEDICAL EQUIPMENT
Medical equipment that is:
- Able to withstand repeated use;
- Is not disposable;
- Primarily and customarily used to serve a medical purpose;
- Not generally useful except for the treatment of a Bodily Injury or Sickness,
- Is appropriate for use in the home;
- Is not implantable in the body; and
- 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.

EFFECTIVE DATE
The date that a Member becomes enrolled and entitled to the benefits specified in this Policy.

EFFICACIOUS TREATMENT OR STRATEGY
Treatment or strategies designed to address cognitive, social or behavioral conditions associated with Autism Spectrum Disorders; to sustain and maximize gains made during Intensive-Level Services; or to improve the condition of an individual with Autism Spectrum Disorder.

EMERGENCY CARE
- A medical screening examination that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department, to evaluate such Emergency Medical Condition; and
- Such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities at the hospital, as are required to Stabilize the patient.

EMERGENCY MEDICAL CONDITION
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:
- Placing the health of the individual or, with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy.
- Serious impairment to the person's bodily functions.
- Serious dysfunction of one or more of the person's body organs or parts.

EVIDENCE-BASED THERAPY
Therapy, service and treatment that is:
- Based upon medical and scientific evidence;
- Determined to be an Efficacious Treatment or Strategy;
- Has been approved by the FDA, if the treatment is subject to the approval of the FDA;
- Medically and scientifically accepted evidence clearly demonstrates that the treatment is safe; and
- Prescribed to improve the individual's condition or to achieve social, cognitive, communication, self-care or behavioral goals that are clearly defined within the Member's treatment plan.

EXPERIMENTAL / INVESTIGATIVE
The use of any service, treatment, procedure, facility, equipment, drug, devices or supply for a Member's Bodily Injury or Sickness that:

- Requires the approval by the appropriate federal or other governmental agency that has not been granted at the time it is used; or
- Is not yet recognized as acceptable medical practice to treat that Bodily Injury or Sickness, as determined by Us for a Member's Bodily Injury or Sickness.

The criteria that Our 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:

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

FORMULARY
The comprehensive listing of Prescription Drugs available to You as a Member.

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

FULL-TIME STUDENT
A covered Dependent who is enrolled in an accredited post-high school academic, professional or trade school that provides a schedule of courses or classes and whose principal activity is the procurement of an education.

The school in which the student is enrolled defines full-time status. A Full-Time Student is considered enrolled on the date that person is recognized as a Full-Time Student by the school, which is typically the first day of classes. Student status includes any intervening vacation period if the Dependent continues to be a Full-Time Student immediately following such vacation period.

GENERIC
A Prescription Drug available from more than one drug manufacturer that has the same active therapeutic ingredient as the brand or trade name Prescription Drug prescribed to You.

GENETIC COUNSELING
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 TEST
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
Any dissatisfaction that You have with Us or with a provider of service that has been expressed in writing by You or on Your behalf. See the "Complaint Procedures" section in this Policy for more information.

HABILITATIVE SERVICES
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.

HEALTH CARE PROVIDER(S)
- Medical or osteopathic Physicians, Hospitals, and clinics.
- 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.
- Nurses licensed by the State of Wisconsin and certified as a nurse anesthetist to provide Covered Services
- Nurse midwives licensed by the State in which they practice to provide Covered Services.
- Licensed clinical psychologist, licensed clinical social worker, or licensed clinical professional counselor if the condition or disorder is covered by the Policy, and the Providers are authorized to provide said services under the statutes of Wisconsin and in accordance with accepted principles of their professions.

HOSPICE
A centrally administered program designed to provide for the physical, psychological and spiritual care for dying persons and their families. The goal of Hospice care is to allow the dying process to proceed with a minimum of patient discomfort while maintaining dignity and a quality of life. Hospice care program service is available in the home, Skilled Nursing Facility or special Hospice care unit.

HOSPITAL
- An institution that:
  - Is licensed and run according to Wisconsin laws, or other applicable jurisdictions, that apply to Hospitals;
  - Maintains at its location all the facilities needed to provide diagnosis of, and medical and surgical care for, Bodily Injury or Sickness; and
  - Provides this care for fees; provides such care on an inpatient basis; and provides continuous 24-hour nursing services by registered graduate nurses; OR
- An institution that:
  - Qualifies as a psychiatric or tuberculosis Hospital;
  - Is a Medicare provider; and
  - Is accredited as a Hospital by the Joint Commission on Accreditation of Healthcare Organizations.
- It does not mean an institution that is chiefly:
  - A place for treatment of chemical dependency;
  - A nursing home; or
  - A federal Hospital.

IDENTIFICATION CARD
The card We issue to You that indicates Your eligibility for coverage under this Policy.

INFERTILITY
The inability 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 a Sickness.

INTENSIVE-LEVEL SERVICES
- 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

- Evidence-Based behavioral 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.
- May include Evidence-Based speech therapy and occupational therapy provided by a Qualified Therapist when such therapy is based on, or related to, an individual's therapeutic goals and skills, and is concomitant with Evidence-Based behavioral therapy.

LEARNING DISABILITY
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.

LIFE-THREATENING DISEASE OR CONDITION
Any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

MAINTENANCE OR LONG TERM THERAPY
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 Us after reviewing an individual's case history or treatment plan submitted by a provider.

MEDICALLY NECESSARY or MEDICAL NECESSITY
Health care services or supplies needed to prevent, diagnose or treat an Sickness, Bodily Injury, condition, disease or its symptoms and that meet accepted standards of medicine.

MEDICAID
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.

MEDICAL SUPPLY
A disposable, consumable, Medically Necessary item which usually has a one time or limited time use and is then discarded.

MEDICARE
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
The eligible individual and his/her Dependents who have been enrolled and are entitled to benefits under the Policy.

MERCYCARE
MercyCare HMO, Inc.

NON-INTENSIVE LEVEL SERVICES
- Evidence-Based Therapy that occurs after the completion of treatment with intensive level services and that is designed to sustain and maximize gains made during treatment with intensive-level services; or
- For an individual who has not and will not receive intensive-level services, Evidence-Based Therapy that will improve the individual's condition.

NON-PARTICIPATING PHARMACY
Any pharmacy that does not have a contractual relationship with Us for the provision of pharmacy services or supplies to Members.

NON-PARTICIPATING PROVIDER
A provider not listed in the most current provider directory.

NON-PREFERRED DRUG
All drugs not on Our Preferred Drug list.

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

OUT-OF-POCKET MAXIMUM
The most You will pay in Deductible, Coinsurance, and Copayments for Your Covered Expenses in a Contract Period. Your Schedule of Benefits shows the Out-of-Pocket Maximum amounts.

PARTICIPATING PHARMACY
Any pharmacy that has contracted with Us to provide pharmacy services or supplies to Members.

PARTICIPATING PROVIDER
A Health Care Provider under contract with Us to provide health care services, items or supplies to Members. Participating Providers are listed in the most current provider directory.

PEDIATRIC AGE
Certain benefits are covered for those Members up to age 19. When a benefit has a Pediatric Age limit, the service is covered until the end of the month in which the enrollee turns age 19.

PHYSICIAN
A physician duly licensed to practice medicine in all of its branches.

PLAN
The health insurance coverage offered by MercyCare HMO, Inc. as described in the Policy.

POLICY
This document, a Member's Schedule of Benefits, the Application which You completed, and any addendums or riders included in Your Member materials which has been issued to You and which summarizes the terms, conditions, and limitations of Your health care coverage.

PREFERRED DRUG (PREFERRED)
Name brand, Generic or OTC drugs in our Preferred Drug list, as determined by Us.

PRESCRIPTION DRUG
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 PROVIDER
A Physician or nurse practitioner who practices family medicine, internal medicine, geriatric medicine or pediatrics that has accepted primary responsibility for a Member's health care.

You must name Your Primary Care Provider on Your Application or on a later Change of Status Form. Each family Member may have a different Primary Care Provider.

PRIOR AUTHORIZATION
A decision made by Us that a health care service, treatment plan, prescription drug or Durable Medical Equipment is Medically Necessary. This Policy outlines the types of Covered Services which require Prior Authorization.

To obtain Prior Authorization, contact Us at the address on the first page of this Policy document or at the telephone number printed on Your Identification Card.

Benefits listed in this document are only available as long as the Policy and your coverage are in effect. You must read this document together with the Schedule of Benefits and other Policy documents to ensure accurate information regarding coverage, obligations and responsibilities under the Policy. Please refer to the Schedule of Benefits to find any applicable Copayment, Coinsurance and/or Deductible amounts and other types of limitations affecting coverage. Unless otherwise stated in this Policy, services and supplies will be Covered Expenses only if they are Medically Necessary and rendered by a Participating Provider. Certain services and supplies require Prior Authorization in order to be covered; a list describing what requires Prior Authorization can be found in the “Obtaining Services” section of this Policy document. Definitions of the capitalized terms within this Policy can be found in the Glossary.

PROVIDER NETWORK
A group of Health Care Providers contracted with Us to provide services for Members within a specific geographic location. The Primary Care Provider You select directly determines the Provider Network with which You will be associated.

QUALIFIED CLINICAL TRIAL
- A Phase I, Phase II, Phase II, or Phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other Life-Threatening Disease or Condition, and is a type of trial that meets all of the following criteria:
    - 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:
        - National Institutes of Health (NIH). (Includes National Cancer Institute (NCI).)
        - Centers for Disease Control and Prevention (CDC)
        - Agency for Healthcare Research and Quality (AHRQ)
        - Centers for Medicare and Medicaid Services (CMS).
        - Department of Defense (DOD).
        - Veterans Administration (VA).
    - 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.
    - 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 Policy.

QUALIFIED INTENSIVE-LEVEL PROFESSIONAL
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 of training, education and experience, including all of the following:
- 1500 hours supervised training involving direct one-on-one work with individuals with Autism Spectrum Disorders using Evidence-Based, Efficacious therapy models.
- Supervised experience with all of the following:
    - Working with families as part of a treatment team and ensuring treatment compliance.
    - Treating individuals with Autism Spectrum Disorders who function at a variety of cognitive levels and exhibit a variety of skill deficits and strengths.
    - Treating individuals with Autism Spectrum Disorders with a variety of behavioral challenges.
    - Treating individuals with Autism Spectrum Disorders who have shown improvement to the average range in cognitive functioning, language ability, adaptive and social interaction skills.
    - 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 INTENSIVE-LEVEL PROVIDER
- Any of the following providers who provide Evidence-Based behavioral therapy which qualifies as Intensive-Level Services and has completed at least 2080 hours of training, education and experience as described below, or a Qualified Paraprofessional working under the supervision of one of these providers:
    - A psychiatrist acting within the scope of a currently valid, state-issued license for psychiatry.
    - A person who practices psychology that is acting within the scope of a currently valid, state-issued license for psychology.
    - A social worker acting within the scope of a currently valid, state-issued certificate or license to practice psychotherapy.
    - A Behavior Analyst who is acting with the scope of a currently valid, stated-issued license for behavior analysis.

- Required training, education and experience:
    - Fifteen hundred hours supervised training involving direct one-on-one work with individuals with Autism Spectrum Disorders using Evidence-Based, Efficacious therapy models.
    - Supervised experience with all of the following:
        - Working with families as the primary provider and ensuring treatment compliance.
        - Treating individuals with Autism Spectrum Disorders who function at a variety of cognitive levels and exhibit a variety of skill deficits and strengths.
        - Treating individuals with Autism Spectrum Disorders with a variety of behavioral challenges.
        - Treating individuals with Autism Spectrum Disorders who have shown improvement to the average range in cognitive functioning, language ability, adaptive and social interaction skills.
        - 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 PARAPROFESSIONAL

An individual working under the active supervision of a Qualified Supervising Provider, Qualified Intensive-Level Provider, or Qualified Provider and who complies with all of the following:

- Attains at least 18 years of age.
- Obtains a high school diploma.
- Completes a criminal background check.
- 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.
- Obtains at least ten 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.
- Receives regular, scheduled oversight by a Qualified Supervising Provider in implementing the treatment plan for the individual.

QUALIFIED PROFESSIONAL

A professional, acting within the scope of a currently valid state-issued license, who:

- Provides Evidence-Based Therapy; and
- Works under a Qualified Supervising Provider who periodically reviews all treatment plans developed by Qualified Professionals for individuals with Autism Spectrum Disorders.

QUALIFIED PROVIDER

One of the following types of providers who provide Evidence-Based Therapy:

- A psychiatrist, as defined in § 146.34(1)(h), who is acting within the scope of a currently valid, state-issued license for psychiatry.
- A person who practices psychology, as described in § 455.01(5), who is acting within the scope of a currently valid, state-issued license for psychology.
- A social worker, as defined in § 252.15(1), who is acting within the scope of a currently valid, state-issued certificate or license to practice psychotherapy, as defined in § 457.01(8m).
- A behavior analyst who is licensed under § 440.312 who is acting within the scope of a currently valid, state-issued license for behavior analysis.
- A paraprofessional working under the supervision of a provider listed above in numbers 1-4.

QUALIFIED SUPERVISING PROVIDER

A Qualified Intensive-Level Provider who has completed at least 4160 hours of experience as a supervisor of less experienced providers, professionals and paraprofessionals.

QUALIFIED THERAPIST
A speech-language pathologist or occupational therapist who is acting within the scope of a currently valid, state-issued license and who provides services concomitant with intensive-level, Evidence-Based behavioral therapy and all of the following:

- The Qualified Therapist provides Evidence-Based Therapy to an individual who has a primary diagnosis of an Autism Spectrum Disorder.
- The individual is actively receiving behavioral services from a Qualified Intensive-Level Provider or a Qualified Intensive-Level Professional.
- The Qualified Therapist develops and implements a treatment plan consistent with their license and the laws and regulations governing coverage of Autism Spectrum Disorder services.

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

REFERRAL
A written request submitted to Us by a Participating Provider, for You to obtain a service or treatment from another provider.

REHABILITATION/REHABILITATIVE SERVICES
Health care services that help a person keep, get back or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt or disabled. These services may include physical and occupational therapy, speech-language pathology and psychiatric Rehabilitation Services in a variety of inpatient and/or outpatient settings.

RENEWAL DATE
The date on which this Policy renews coverage.

RESIDENTIAL TREATMENT CENTER
A facility setting offering a defined course of therapeutic intervention and special programming in a controlled environment, which also offers a degree of security, supervision, structure and is licensed by the appropriate state and local authority to provide such service.

It does not include half-way houses, supervised living, group homes, boarding houses or other facilities that provide primarily a supportive environment and address long-term social needs, even if counseling is provided in such facilities.

Patients are medically monitored with 24-hour medical availability and 24-hour onsite nursing service for patients with mental illness and/or substance use disorders. The Plan requires that any mental health and/or substance use disorder Residential Treatment Center must be licensed in the state where it is located, or accredited by a national organization that is recognized by Us as set forth in Our current credentialing policy, and otherwise meets all other credentialing requirements set forth in such policy.

ROUTINE FOOT CARE

- 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;
- Services related to the cutting, trimming, or other non-operative partial removal of toenails; and
- Treatment of flexible flat feet.

ROUTINE OR PREVENTIVE
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
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
A summary of coverage and limitations provided under the Policy.

SELECT DRUG
Brand, Generic, or OTC drugs on Our Select Drug list, as determined by Us. They are chosen based on the efficacy, safety and cost of the drug.

SERVICE AREA
The geographical area in which We are authorized to offer a health Plan.

SICKNESS (or ILLNESS)
Any condition or disease that affects or causes loss of normal body function, other than those resulting from Bodily Injury.

SKILLED CARE
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
An institution, which is licensed by the State of Wisconsin, or other applicable jurisdiction.

SOUND AND NATURAL TEETH
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.

SPECIALIST (or SPECIALTY CARE PROVIDER)
Any Participating Provider who we do not consider a Primary Care Provider, who generally devotes attention to a particular branch of medicine.

STABILIZE
To provide such medical treatment of an Emergency Medical Condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility, or transfer of the individual between floors or departments in a single facility. For a pregnant woman having contractions, it means to deliver (including the placenta).

SUBSCRIBER
An eligible individual whose completed Application and premium have been accepted by Us.

TOTAL DISABILITY OR TOTALLY DISABLED

- For an employed eligible individual 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 Our Medical Director and other appropriate sources.

URGENT CARE

Care for an accident or Illness that You need sooner than a Routine doctor's visit. Examples include, but are not limited to, broken bones, sprains, non-severe bleeding, minor cuts and burns, and drug reactions.

WE/US/OUR

MercyCare HMO, Inc. (MercyCare)

YOU/YOUR

Any Member enrolled in the Plan.