Filing at a Glance

Company: Mercy Health Plans

Product Name: PHIARCOC_2009R
TOI: H16G Group Health - Major Medical
Sub-TOI: H16G.001A Any Size Group - PPO
Filing Type: Form

SERFF Tr Num: MHPL-125852164
SERFF Status: Closed
Co Tr Num:
Co Status:
Authors: Karen Hosack, Suzanne McGinnis
Date Submitted: 10/10/2008

State: ArkansasLH
State Tr Num: 40508
State Status: Approved-Closed
Reviewer(s): Rosalind Minor
Disposition Date: 10/16/2008
Disposition Status: Approved-Closed

Implementation Date Requested: 01/01/2009
Implementation Date:

State Filing Description:

General Information

Project Name:
Project Number:
Requested Filing Mode: Review & Approval
Explanation for Combination/Other:
Submission Type: New Submission
Overall Rate Impact:
Filing Status Changed: 10/16/2008
State Status Changed: 10/16/2008
Corresponding Filing Tracking Number:

Status of Filing in Domicile:
Date Approved in Domicile:
Domicile Status Comments:
Market Type: Group
Group Market Size: Small and Large
Group Market Type: Employer, Association

Deemer Date:

Filing Description:

Ms. Rosalind Minor

Senior Certified Rate and Form Analyst

Arkansas Insurance Department

Life and Health Division

1200 West Third Street

Little Rock, AR 72201-1904

RE: PHI AR 2009COC v. 2 (01/09), et al. NAIC: 11529

Dear Ms. Minor:

I have attached the above-referenced documents for your review and approval along with the required Policy Form Compliance Certification and a filing fee of $50. These documents are very similar to those recently filed and approved on 7/7/08.
See SERFF Tracking # MHPL- 125714909 and State Tracking # 39459.

The only difference between these documents and the previously filed version is the addition of variable language that would allow this product to be marketed in Arkansas as a traditional PPO plan or a High Deductible Health Plan (HDHP) with a Health Savings Account (HSA) or Health Reimbursement Arrangement (HRA) component. In addition, we made changes to the Outpatient Diagnostic benefit cost-sharing for 2009; specifically, certain imaging tests will incur the Outpatient Diagnostic cost-sharing regardless of the place of service.

Redlined copies of all documents are included for your convenience. The above-mentioned documents are intended to replace these previously filed versions listed in the table below:

Description	Form Number	Date Approved
PPO Group Certificate of Coverage	PHI AR COC (01/09)	7/7/08
PPO Group Schedule of Coverage & Benefits	PHI AR SCH (01/09)	7/7/08
PPO Group Master Application	PHI AR GMA (01/09)	7/7/08
PPO Group Prescription Drug Rider	PHI AR RX RIDER (01/09)	7/7/08
PPO Group Employee Assistance (EAP) Rider	PHI AR RDR/EAP (01/09)	7/7/08
PPO Group Prescription Eyewear Rider	PHI AR RDR/EW (01/09)	7/7/08
PPO Group Family Services Rider	PHI AR RDR/FAM (01/09)	7/7/08
PPO Group Hearing Aid Rider	PHI AR RDR/HA (01/09)	7/7/08
PPO Group TMJ Rider	PHI AR RDR/TMJ (01/09)	7/7/08
PPO Group Birth Control Services Rider	PHI AR RDR/BC (01/09)	7/7/08

In order to expedite this filing, here are some responses we had to recent objections on this similar filing:

Fraud Statement in compliance with ACA 23-66-503 and Bulletin 7-97 – This is in the Group Master Application, page 5 “Read this Important Information”, first paragraph.

Prescription Drug Rider – “Specialty Pharmaceuticals” referenced are to the actual drugs dispensed that are limited to a 30-day supply. The specialty pharmaceuticals (specialty drugs) can be purchased through either of these providers: The Retail or Specialty Pharmacy, a 90-Day Retail Pharmacy, or the Mail Service Pharmacy. We, therefore, believe that the policy is in compliance with ACA 23-79-149 since the limit on specialty drugs is consistent and applied uniformly to all pharmacy providers within our network. Regardless of where the specialty pharmaceuticals are purchased, they are limited to a 30-day supply.

Because these documents are very similar to those just recently approved, I look forward to your expeditious review and approval. Please contact me at (314) 214-2342 or by email at khosack@mhp.mercy.net if you have any questions.

Sincerely,
Karen Hosack, ACP
Compliance Analyst

Company and Contact

Filing Contact Information

Karen Hosack, Compliance Analyst	khosack@mhp.mercy.net
Mercy Health Plans	(314) 214-2342 [Phone]
Chesterfield, MO 63017	(314) 214-8103[FAX]

Filing Company Information

Mercy Health Plans	CoCode: 11529	State of Domicile: Missouri
14528 South Outer Forty Rd.	Group Code:	Company Type: LAH/PPO
Suite 300		
Chesterfield, MO 63017	Group Name:	State ID Number:
(314) 214-8100 ext. [Phone]	FEIN Number: 48-1262342	

Filing Fees

Fee Required?	No
Retaliatory?	No
Fee Explanation:	
Per Company:	No

CHECK NUMBER	CHECK AMOUNT	CHECK DATE
0000099888	$50.00	10/08/2008

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	10/16/2008	10/16/2008

Objection Letters and Response Letters

Objection Letters				Response Letters		
Status	**Created By**	**Created On**	**Date Submitted**	**Responded By**	**Created On**	**Date Submitted**
Pending Industry Response	Rosalind Minor	10/15/2008	10/15/2008	Karen Hosack	10/16/2008	10/16/2008

Disposition

Disposition Date: 10/16/2008

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*MHPL-125852164*	*State:*	*Arkansas*
Filing Company:	*Mercy Health Plans*	*State Tracking Number:*	*40508*
Company Tracking Number:			
TOI:	*H16G Group Health - Major Medical*	*Sub-TOI:*	*H16G.001A Any Size Group - PPO*
Product Name:	*PHIARCOC_2009R*		
Project Name/Number:	*/*		

Item Type	Item Name	Item Status	Public Access
Supporting Document	Certification/Notice	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Redlined Documents	Approved-Closed	Yes
Form *(revised)*	PPO Certificate of Coverage	Approved-Closed	Yes
Form	PPO Certificate of Coverage	Replaced	Yes
Form	PPO Schedule of Benefits	Approved-Closed	Yes
Form	PPO Group Master Application	Approved-Closed	Yes
Form	PPO Group Prescription Drug Rider	Approved-Closed	Yes
Form	PPO Group Employee Assistance Program Rider	Approved-Closed	Yes
Form	PPO Group Prescription Eyewear Rider	Approved-Closed	Yes
Form	PPO Group Family Services Rider	Approved-Closed	Yes
Form	PPO Group Hearing Aid Services Rider	Approved-Closed	Yes
Form	PPO Group TMJ Rider	Approved-Closed	Yes
Form	PPO Group Birth Control Services Rider	Approved-Closed	Yes

Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	10/15/2008
Submitted Date	10/15/2008
Respond By Date	

Dear Karen Hosack,

This will acknowledge receipt of the captioned filing.

Objection 1

- PPO Certificate of Coverage (Form)

Comment: Under the Conversion language it is stated that a converted policy need not be made available if termination occured for any of the following reasons: For any other reasons, and You have not been continuously covered under the Group Policy, and for similar Benefits under any group policy which it replaced, during the entire three-month period ending with such termination. The three month period does not comply with our conversion law as outlined under ACA 23-86-115.

Please feel free to contact me if you have questions.
Sincerely,
Rosalind Minor

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	10/16/2008
Submitted Date	10/16/2008

Dear Rosalind Minor,

Comments:

Response 1

Comments: This was an oversight. We have deleted the bullet referenced in your objection (page 31 of the COC) so that this section is now in compliance with ACA 23-86-115.

Related Objection 1

Applies To:

- PPO Certificate of Coverage (Form)

Comment:

Under the Conversion language it is stated that a converted policy need not be made available if termination occured for any of the following reasons: For any other reasons, and You have not been continuously covered under the Group Policy, and for similar Benefits under any group policy which it replaced, during the entire three-month period ending with such termination. The three month period does not comply with our conversion law as outlined under ACA 23-86-115.

Changed Items:

No Supporting Documents changed.

Form Schedule Item Changes

Form Name	Form Number	Edition Date	Form Type	Action	Action Specific Data	Readability Score	Attach Document
PPO Certificate of Coverage	PHI AR 2009COC v.2 (01/09)		Certificate	Initial			AR COC_2009R_10.15.08 .pdf
Previous Version							
PPO Certificate of Coverage	*PHI AR 2009COC v.2 (01/09)*		*Certificate*	*Initial*			AR COC_2009R_10.08.08 .pdf

No Rate/Rule Schedule items changed.

Sincerely,
Karen Hosack, Suzanne McGinnis

Form Schedule

Lead Form Number:

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed	PHI AR 2009COC v.2 (01/09)	Certificate	PPO Certificate of Coverage	Initial			AR COC_2009R_10.15.08 .pdf
Approved-Closed	PHI AR GRP SCHD v.2 (01/09)	Schedule Pages	PPO Schedule of Benefits	Initial			AR PPO_Sch of Benefits_2009R_10.08.08.pdf
Approved-Closed	PHI AR GMA v.2 (01/09)	Application/Enrollment Form	PPO Group Master Application	Initial			AR GMA_2009R_10.08.08.pdf
Approved-Closed	PHI AR Rx Rider v.2 (01/09)	Certificate Amendment, Insert Page, Endorsement or Rider	PPO Group Prescription Drug Rider	Initial			AR Group Drug Rider_2009R_10.08.08..pdf
Approved-Closed	PHI AR RDR/EAP v.2 (01/09)	Certificate Amendment, Insert Page, Endorsement or Rider	PPO Group Employee Assistance Program Rider	Initial			AR Group EAP Rider_2009R_10.08.08.pdf
Approved-Closed	PHI AR RDR/EW v.2 (01/09)	Certificate Amendment, Insert Page, Endorsement or Rider	PPO Group Prescription Eyewear Rider	Initial			AR Group Eyewear Rider_2009R_10.08.08.pdf
Approved-Closed	PHI AR RDR/FAM v.2 (01/09)	Certificate Amendment, Insert	PPO Group Family Services Rider	Initial			AR Group Family Services

		Page, Endorsement or Rider			Rider_2009R_10.08.08.pdf
Approved-Closed	PHI AR RDR/HA v.2 (01/09)	Certificate Amendment, Insert Page, Endorsement or Rider	PPO Group Hearing Aid Services Rider	Initial	AR Group Hearing Aid Rider_2009R_10.08.08.pdf
Approved-Closed	PHI AR RDR/TMJ v.2 (01/09)	Certificate Amendment, Insert Page, Endorsement or Rider	PPO Group TMJ Rider	Initial	AR Group TMJ Rider_2009R_10.08.08.pdf
Approved-Closed	PHI AR RDR/BC v.2 (01/09)	Certificate Amendment, Insert Page, Endorsement or Rider	PPO Group Birth Control Services Rider	Initial	AR Group Birth Control Rider_2009R_10.08.08.pdf

Mercy Health Plans

[YEAR]

Your Certificate of Coverage

[(A High Deductible Health Plan (HDHP) [with a Health Savings Account (HSA) or Health Reimbursement Arrangement (HRA)]]

Issued by: Mercy Health Plans

www.mercyhealthplans.com

This Health Plan is underwritten by Mercy Health Plans
The Benefits and main points of coverage under the Plan are set forth in this Certificate.
The Benefits are effective only while You are covered by the Group Insurance Policy.

Mercy Health Plans
First Security Center
521 President Clinton Avenue, Suite 700
Little Rock, Arkansas 72201
866-647-5568

Certificate of Coverage

This Certificate of Coverage is part of the Group Policy that is a legal document between Mercy Health Plans **("The Plan", "We", "Us", "Our")** and the Group Policyholder to provide Benefits to Covered Persons **("You", "Your")**, subject to the terms, conditions, exclusions and limitations of this Policy. We issue this Policy based on the Enrolling Group's application and payment of the required Policy Charges.

In addition to this Certificate, the Policy includes:

- The Enrolling Group's application
- Any Amendments and Riders
- Schedule of Coverage and Benefits and any Inserts to the Certificate of Coverage

You can review this Policy at the office of the Group Policyholder during regular business hours.

Changes to the Document

We may from time to time modify this Certificate by attaching legal documents called Riders and/or Amendments that may change certain provisions of the Certificate. When that happens We will send You a new Certificate, Rider or Amendment pages.

No one has authority to make any changes to this Policy unless those changes are in writing and signed by an officer of Mercy Health Plans. No change will be valid until approved and made part of this Policy. Only the Plan has the right to change, interpret, modify, withdraw or add Benefits, or to terminate this Policy, as permitted by law, without Your approval.

Information You Should Have

This Certificate describes Benefits in effect as of Effective Date of Certificate Issuance.

On its Effective Date, this Certificate replaces and overrules any certificate that We may have previously issued to You. This Certificate will in turn be overruled by any Certificate We issue to You in the future.

This Policy will take effect on the date specified in the Group Policy. Coverage under this Policy will begin at 12:01 a.m. on the Effective Date and end at 12:00 midnight on the Termination Date. This Policy will remain in effect as long as the Policy Premiums are paid when they are due, subject to termination of this Policy.

We are delivering this Policy in the State of Arkansas. Unless otherwise prohibited by law, the Group Policyholder intends this Policy to be an employee welfare benefit plan as defined by ERISA. To the extent that state law applies, the laws of the State of Arkansas are the laws that govern this Policy.

The validity of this Policy will not be contested after this Policy has been in force for three (3) years from the date of issue. No statement relating to insurability made by any person covered under this Policy will be used to contest the validity of this Policy after it has been in force for a period of three (3) years. In addition, the statement must be contained in a written instrument signed by the person making the statement. The assertion, at any time, of defenses based upon the person's ineligibility for coverage under this Policy or upon other provisions in this Policy will not be precluded.

Table of Contents

Certificate of Coverage i

Changes to the Document i
Information You Should Have i

Table of Contents ii

Introduction to Your Certificate 1

We encourage You to read Your Certificate and any attached Riders and/or Amendments carefully. 1
Information about Defined Terms 1
Your Contribution to the Required Premiums 1
Don't Hesitate to Contact Us 1

Section 1: Eligibility 2

How to Enroll 2
If You Are Hospitalized When Your Coverage Begins 2
If You Are Eligible for Medicare 2
Who is Eligible for Coverage? 2

Section 2: When Coverage Begins 4

Section 3: When Coverage Ends 6

Section 4: How You Get Care 8

Identification cards 8
Where You get covered care: 8
- Network Providers 8
- Network Benefits 9
- Designated Facilities and Other Providers 9
- Non-Network Benefits 9

What You must do to get covered care 9
Care Management 9
Emergency Health Services 9

Section 5: Your Cost for Covered Services 11

Copayments 11
Coinsurance 11
Deductible 11
Eligible Expenses 11
Out-of-Pocket Maximum 11
Maximum Policy Benefit 12
[Carryover] 12

Section 6: How to File a Claim 13

Section 7: Coordinating Benefits with Other Coverage 15

When You have coverage under more than one plan 15
When You have other health coverage 16
When other Government agencies are responsible for Your care 16
Order of Benefit Determination Rules 16
General 16
Rules: 16
Effect on the Benefits of this Plan 18
Coordinating Benefit Payments 19
Right to Receive and Release Needed Information 19
Reconciliation of Payments 19
Right of Recovery 19

Section 8: Complaints, Grievances & Appeals 21

Section 9: Utilization Review 24

Section 10: Continuation of Coverage 27

Section 11: General Provisions 32

- Your Relationship with Us 32
- Our Relationship with Enrolling Groups 32
- Your Relationship with Providers and Enrolling Groups 32
- Administrative Services 33
- Amendments to the Policy 33
- Case Management 33
- Clerical Error 33
- Commission or Omission 33
- Entire Policy/Changes 33
- Examination of Covered Persons 34
- Incentives to Providers 34
- Incentives to You 34
- Incorporation by Reference 34
- Information and Records 34
- Interpretation of Eligibility and Benefits 35
- Legal Actions 35
- Medicare Eligibility 35
- Notice 35
- Policies, Identification Cards and Applications 35
- Statements by Enrolling Group or Subscriber 35
- Statement of ERISA Rights 35
- Time Limit on Certain Defenses 36
- Workers' Compensation not Affected 36

Section 12: Covered Benefits 37

Section 13: Exclusions – Things We Don't Cover 52

Section 14: Definitions of Terms 60

- NOTICE OF PRIVACY PRACTICES 72
- NOTICE CONCERNING COVERAGE LIMITATIONS AND EXCLUSIONS UNDER THE ARKANSAS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT 74

[HEALTH SAVINGS ACCOUNT (HSA) AMENDMENT]

[HEALTH REIMBURSEMENT ACCOUNT (HRA) AMENDMENT]

[SCHEDULE OF COVERAGE AND BENEFITS]

Introduction to Your Certificate

We encourage You to read Your Certificate and any attached Riders and/or Amendments carefully.

[This Plan has a [Health Savings Account (HSA)] [Health Reimbursement Arrangement (HRA)] component. HSAs and HRAs are governed by the Internal Revenue Code (IRC). It is important that You understand and follow the IRC rules in order to protect the tax-free status of Your account. Please refer to the attached HSA/HRA Amendment for more information.]

Information about Defined Terms

Because this Certificate is part of a legal document, We want to give You information about the document that will help You understand it. Certain capitalized words have special meanings. We have defined these words in Section 14 (Definitions of Terms). You can refer to Section 14 as You read this document to have a clearer understanding of Your Certificate of Coverage.

When We use the words **"The Plan"**, **"We", "Us",** and **"Our"** in this document, We are referring to **Mercy Health Plans** When We use the words **"You"** and **"Your"** We are referring to people who are **Covered Persons** as the term is defined in (14: Definitions of Terms).

This Certificate and the other Policy documents describe Your Benefits as well as Your rights and responsibilities under this Policy.

We especially encourage You to review the Benefit limitations of this Certificate by reading Section 12 (Covered Benefits) and Section 13 (Exclusions.) You should also carefully read Section 11 (General Provisions) in order to understand how this Certificate and Your Benefits work. You should call Us if You have questions about the coverage available to You.

Many of the sections of the Certificate are related to other sections of the document. You may not have all of the information You need by reading just one section. We also encourage You to keep Your Certificate and any attachments in a safe place for Your future reference.

Please be aware that Your Physician does not have a copy of Your Certificate of Coverage, and is not responsible for knowing or communicating Your Benefits.

Your Contribution to the Required Premiums

This Policy may require the Subscriber to contribute to the required Premiums. You can contact Your Enrolling Group for information about any part of the Premium cost You are responsible for paying.

Don't Hesitate to Contact Us

Throughout the document, You will find statements that encourage You to contact Us for further information. Whenever You have a question or concern regarding Your Benefits, please call Us using the telephone number for Our Customer Contact Center listed on Your ID card.

Section 1: Eligibility

How to Enroll

To enroll, You must complete an enrollment form. The Enrolling Group will give You the necessary forms. The Enrolling Group will then submit the completed forms to Us, along with any required Premium. We will not provide Benefits for health services that You receive before Your Effective Date of coverage.

If You Are Hospitalized When Your Coverage Begins

If You are a patient in a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility on the Effective Date of this Policy, We will pay Benefits for Covered Health Services related to that Inpatient Stay as long as You receive Covered Health Services in accordance with the terms of this Policy.

You should notify Us within forty-eight (48) hours of the day Your coverage begins, or as soon as is reasonably possible. Network Benefits are available only if You receive Covered Health Services from Network Providers.

If You Are Eligible for Medicare

[Your Benefits under this Policy may be reduced if You are eligible for Medicare but do not enroll in and maintain coverage under both Medicare Part A and Part B.]
[If you are eligible for Medicare, You are not eligible to participate in an HSA plan. Refer to Your HSA Amendment, section entitled, "Eligibility Requirements" for more information.]

Who is Eligible for Coverage?

Subscriber
When You enroll in the Plan, We refer to You as a Subscriber. For a definition of Eligible Person and Subscriber, see Section 14 (Definitions of Terms).

To be eligible for this coverage, You must reside within the United States and meet all the applicable eligibility requirements agreed upon by the Group Policyholder and the Plan [and as described in Your HSA Amendment]. If the Group elects, the number of hours worked per week may be waived to include coverage for retired employees.

If coverage is contributory, Subscriber must agree to make the required contributions. Any such coverage must be arranged by the Subscriber and the Group.

If both Spouses are Eligible to enroll, each may enroll as a Subscriber, or one Spouse may enroll as a Dependent of the other, but not both.

Except as We have described in Section 2 (When Coverage Begins), You may not enroll without Our written permission.

Dependents

Dependent generally refers to the Subscriber's Spouse and children. When a Dependent actually enrolls, We refer to that person as an Enrolled Dependent. Dependents may include Full-Time Students as determined by the Enrolling Group. For a complete definition of Dependent and Enrolled Dependent, or Full-Time Student, see Section 14 (Definitions of Terms).

Dependents of an Eligible Person may not enroll unless the Eligible Person is also covered under this Policy. If both parents of a Dependent child are enrolled as a Subscriber, only one parent may enroll the child as a Dependent.

Note: If the Subscriber's unmarried Dependent's infant child is eligible for coverage, such coverage will be available as described in this section, provided that appropriate notices and Premiums have been timely delivered to the Plan.

Enrollment of a Dependent child will not be denied for any of the following reasons:

- The child was born out of wedlock.
- The child is not claimed as a Dependent on Your Federal income tax return.
- The child does not reside with You.

The Subscriber must reimburse Us for any Benefits that We pay for a child at a time when the child did not satisfy these conditions. Except as We have described in Section 2 (When Coverage Begins), Dependents may not enroll without Our written permission.

Who is not Eligible to Enroll?

Persons not eligible for coverage include -

a) Those whose coverage was previously terminated for the following causes:
   - Fraud or misrepresentation in the Application
   - Abuse of services or facilities
   - Improper use of ID Card
   - Misconduct detrimental to Plan operations and the delivery of services

Refer to Section 3 (When Coverage Ends) for a detailed description of these causes that lead to termination.

b) Those who fail to enroll during the prescribed enrollment periods described in Section 2 (When Coverage Begins).

[Note: You must meet the eligibility requirements for an HSA/HRA plan as described in the HSA/HRA Amendment to enroll in an HSA/HRA plan.]

Notification of Change in Eligibility

It is the responsibility of both the Subscriber and the Group Policyholder to notify the Plan within fifteen (15) days of the date the Subscriber or Dependent(s) become ineligible. Failure to notify the Plan will make the Subscriber and the Group Policyholder jointly and severally liable to the Plan for expenses incurred and/or payment of services rendered by the Plan.

Coverage for a Disabled Child

Coverage for an unmarried Enrolled Dependent child who is totally disabled because of a mental or a physical disability will not end just because the child has reached a certain age. We will extend the coverage for the disabled child beyond the limiting age if both of the following are true:

- The disabled child is not able to be self-supporting because of a mental or physical disability; **and**
- The disabled child depends primarily on the Subscriber for support and maintenance due to the mental or physical disability.

Coverage will continue as long as the Enrolled Dependent is disabled and continues to satisfy both of these qualifying conditions, unless coverage is otherwise terminated in accordance with the terms of this Policy.

We will ask You to furnish Us with proof of the disabled child's incapacity and dependency. Before We agree to this extension of coverage for the child, We may require that a Physician chosen by Us examine the child. We will pay for that examination.

We may continue to ask You for proof that the disabled child still meets these two conditions, but will not ask more than once per year. The proof We ask for might include medical examinations at Our expense.

Section 2: When Coverage Begins

Initial Enrollment Period

When Your Enrolling Group purchases coverage under this Policy from Us, the Initial Enrollment Period is the first period of time when You can enroll. You may enroll yourself and Your dependents. Coverage begins on the Effective Date identified in Your Policy, when We receive the completed enrollment form and any required Premium within thirty-one (31) days of the date You are eligible to enroll. For a definition of Enrolling Group, see Section 14 (Definitions of Terms).

Open Enrollment Period

The Open Enrollment Period is the date identified by the Enrolling Group, if We receive the completed enrollment form and any required Premium within thirty-one (31) days of the date You are eligible to enroll. You may enroll yourself and Your Dependents.

Special Enrollment Period

An Eligible Person and/ or Dependent may also be able to enroll during a Special Enrollment Period. A Special Enrollment Period is not available to an Eligible Person and his or her Dependents if coverage under the prior plan was terminated for cause, or because Premiums were not paid on a timely basis.

A Special Enrollment Period applies to an Eligible Person and/or Dependent who did not enroll during the Initial Enrollment Period or Open Enrollment Period if the following are true:

- The Eligible Person and/or Dependent had existing health coverage under another plan at the time they had an opportunity to enroll during the Initial Enrollment Period or Open Enrollment Period; and
- Coverage under the prior plan ended because of any of the following:
  - Loss of eligibility.
  - The employer stopped paying the contributions.
  - In the case of COBRA continuation coverage, the coverage ended.

Coverage begins on the day immediately following the day coverage under the prior plan ends, if We receive the completed enrollment form and any required Premium within thirty-one (31) days of the date coverage under the prior plan ended.

A Special Enrollment Period also applies to an Eligible Person and any Dependents when one of the following events described below occurs. Subscribers may enroll Dependents who join their family because of any of the following events:

- Birth
- Legal adoption
- Placement for adoption
- Marriage
- Legal permanent general guardianship
- Court or administrative order

Newborn children of the Subscriber and/or Subscriber's Spouse, who are Members, will be covered for the lesser of: (a) 5 days from birth, or (b) mother's discharge, if family/Dependent coverage is available through the Subscriber's group plan on the date of birth, and the Subscriber elects Dependent coverage (if not previously elected) within ninety (90) days after the date of birth. Coverage will include necessary care and treatment of medically diagnosed Congenital defects and birth abnormalities, including premature birth.

Newly Acquired Eligible Dependent, other than a newborn child, who has an enrollment application submitted on his/her behalf within thirty-one (31) days of the events listed above, will be covered as of the date of the event. This includes a new Spouse, stepchild, or child placed by an authorized Federal or state governmental agent in the Subscriber's physical custody. Upon receiving notification of a new Dependent, We will provide You with an enrollment application and instructions necessary to enroll the new Dependent.

A newly adopted child, including a newborn, will be covered under the Plan effective from the date of birth, if We receive an application submitted on his/her behalf within sixty (60) days of the date You filed a petition for adoption of the child for which You have physical custody and who is under Your charge, care and control. Coverage will begin on the date of the filing of the petition for adoption, or from the moment of birth, if the petition is filed for adoption of a newborn within sixty (60) days after the birth of the child. Coverage will continue unless the placement is disrupted prior to legal adoption and the child is removed from placement. 'Placement' means in the physical custody of the adoptive parent. For coverage, You must notify the Plan, submit an application for Your new Dependent, and pay the required Premium.

Newly Eligible Dependents, including newborn children, not added to coverage within the Special Enrollment Period described above may not be added until the next Group Open Enrollment Period.

[HSA Plan]

[Eligible employees and their qualified family Dependent may enroll in an HSA plan anytime during the plan year if they are enrolled in a Mercy Health Plans High Deductible Health Plan. Please refer to Your HSA Amendment, or contact Your Benefits Administrator for more information about Your HSA Plan.]

Section 3: When Coverage Ends

General Information about When Coverage Ends:

- This Certificate of Coverage will continue in effect for the term agreed upon between the Group Policyholder and the Plan. The Certificate will automatically renew for one-year or other time periods, as determined by the Enrolling Group, unless it is terminated as described below. While coverage is renewable, Premium rates may change. The Plan may not terminate this Policy prior to the first Anniversary Date except for nonpayment of the required Premium or failure to meet continued underwriting standards.
- We may discontinue this Benefit plan and/or all similar benefit plans at any time for the reasons explained in this Policy, as permitted by law.
- Your entitlement to Benefits automatically ends on the date that coverage ends, unless You are hospitalized on that date, in which case Your coverage ends on the date of your inpatient confinement to the hospital.
- When Your coverage ends, We will still pay claims for Covered Health Services that You received before Your coverage ended. However, once Your coverage ends, We do not provide Benefits for health services that You receive for medical conditions that occurred after Your coverage ended.
- An Enrolled Dependent's coverage ends on the date the Subscriber's coverage ends.

Events Ending Your Coverage

Your coverage ends on the earliest of the dates specified in the following outline:

Event	Description
The Entire Group Policy Ends	Your coverage ends on the date the Group Policy ends. The Group may terminate this Policy on any Anniversary Date by providing written notice to the Plan at least sixty (60) days before such Anniversary Date. The Enrolling Group is responsible for notifying You that Your coverage has ended, except as follows: • If We terminate this Policy because We will no longer issue this particular type of group health benefit plan within the applicable market, We will provide at least ninety (90) days prior written notice to the Enrolling Group and all Covered Persons. • If We terminate this Policy because We will no longer issue any employer health benefit plan within the applicable market, We will provide at least one-hundred-eighty (180) days prior written notice to the applicable state authority, the Enrolling Group and all Covered Persons. The entire Group Policy ends when the Group fails to comply with the employer's contribution or Group participation rules, or if the Group membership in an association ceases and coverage terminates uniformly to all covered individuals.
You Lose Eligibility for Coverage	Your coverage ends on the date You are no longer eligible to be a Subscriber or Enrolled Dependent. Please refer to Section 1 (Eligibility) and Section 14 (Definition of Terms) for more information.
We Receive Notice to End Coverage	Your coverage ends on the date requested in a written notice. The Enrolling Group is responsible for providing written notice to Us to end Your coverage.

Event	Description
Subscriber Retires or Is Pensioned	Your coverage ends on the date the Subscriber is retired or pensioned under the Enrolling Group's plan. The Enrolling Group is responsible for providing written notice to Us to end Your coverage. This provision applies unless a specific coverage classification is designated for retired or pensioned persons in the Enrolling Group's application, and only if the Subscriber continues to meet any applicable eligibility requirements. The Enrolling Group can provide You with specific information about what coverage is available for retirees.
Fraud, Misrepresentation or False Information	When Your coverage is terminated because of fraud or misrepresentation, We will provide written notice to the Subscriber that coverage has ended on the date We identify in the notice. During the first two years this Policy is in effect, if You provided Us with false information or misrepresentation of material facts regarding Your application or coverage, We have the right to demand that You pay back all Benefits We paid to You, or paid in Your name, during the time You were incorrectly covered under this Policy. After the first two years, We can only demand that You pay back these Benefits if the written application contained a fraudulent misstatement. Fraud on the part of the Group: In the event of fraud concerning claims, employee verification, or other material misrepresentation on the part of the Group, all coverage may be canceled upon thirty-one (31) days written notice from the Plan to the Group. The Group will also be required to reimburse the Plan for all expenses incurred as a consequence of the fraud.
Abuse of Services or Facilities	In the event of abuse by a Covered Person in the use of services or facilities, that person's coverage may be restricted or canceled by the Plan upon at least thirty-one (31) days prior written notice to the Group and the Member.
Improper Use of ID Card	You permitted an unauthorized person to use Your ID card, or You used another person's card. When Your coverage is terminated because of improper use of Your ID card, We will provide written notice to the Subscriber that coverage has ended on the date We identify in the notice.
Misconduct	In the event Your misconduct is detrimental to the safe Plan operations and the delivery of services, Your coverage may be canceled immediately.
Death of Subscriber	Coverage ends for the Subscriber and his/her Dependents as of the date of the Subscriber's death. See Section 10 (Continuation of Coverage) for other options.
Default in Payment of Premiums	If any required Premium is not timely paid by You or on Your behalf, Your coverage may be canceled after not less than thirty-one (31) days written notice. The Plan will give notice to the Group at least ten (10) days prior to the date of termination of Benefits. The Group shall remain liable for all Premiums (and any interest accrued thereon) not paid prior to termination.

Notification of Members' Ineligibility

The Group and/or Subscriber must notify the Plan within fifteen (15) days after a Member ceases to be eligible for Benefits under this Policy. Failure to do so will make the Group and/or Subscriber jointly and severally liable for any expenses for Benefits or services incurred by the Plan, whether or not paid, due to the failure to notify the Plan pursuant to this provision. The Plan reserves the right to recover payments for Covered Health Services made on behalf of the Member after his/her Termination Date.

Section 4: How You Get Care

Identification cards

We will send You an identification (ID) card when You enroll. You should carry Your ID card with You at all times. You must show it whenever You receive services from a Network Provider, or fill a prescription at a Network pharmacy. If You do not show Your ID card, Network Providers have no way of knowing that You are enrolled under Our PPO Policy. As a result, they may bill You for the entire cost of the services You receive.

If You do not receive Your ID card within thirty (30) days after the Effective Date of Your enrollment, or if You need replacement cards, call Us at 866-647-5568. You may also request replacement cards through Our Web site: *www.mercyhealthplans.com.* You must show Your (ID) card every time You request Health Care Services from a Network Provider.

Where You get covered care:

You can choose to receive either Network Benefits or Non-Network Benefits. To obtain Network Benefits You must see a Network Physician or other Network Provider.

Benefits are available only if all of the following are true:

- Covered Health Services are received while the Group Policy is in effect;
- Covered Health Services are received prior to the date that any of the individual termination conditions listed in Section 3 (When Coverage Ends) occurs;
- The person who received Covered Health Services is a Covered Person and meets all eligibility requirements specified in this Policy.

You will only pay Copayments, Deductibles, and/or Coinsurances when receiving care from a Network Provider for a Covered Health Service. If You use Non-Network Providers, it will cost You more.

• Network Providers

Network Providers are physicians and other health care professionals that We contract with to provide Covered Services to Our Members. Network Providers are independent practitioners. They are not Our employees. It is Your responsibility to select Your provider. We credential Network Providers according to national standards. Our credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided.

You will be given a directory of Network Providers at no charge. However, before obtaining services You should always verify the Network status of a provider. A provider's status may change. You can verify the provider's status by calling Customer Contact Center.

We list Network Providers in the *Provider Directory*, which We update periodically. The list is also on Our Web site at www.mercyhealthplans.com.

It is possible that You might not be able to obtain services from a particular Network Provider. The network of providers is subject to change. You might find that a particular Network Provider may not be accepting new patients. If a provider leaves the Network or is otherwise not available to You, You must choose another Network Provider to get Network Benefits.

Do not assume that a Network Provider's agreement includes all Covered Health Services. Some Network Providers contract with Us to provide only certain Covered Health Services, but not all Covered Health Services. Some Network Providers choose to be a Network Provider for only some of Our products. Refer to Your provider directory or contact Us for assistance.

Extended Provider Network

Mercy Health Plans has an extended provider network **outside** of Our contracted Network called Private Healthcare Systems Preferred Provider Organization (PHCS PPO). This extended Provider Network is available to You as Network Benefits only when you are **outside** of Our contracted Network. To find a PHCS PPO provider, call Our Customer Contact Center or visit www.phcs.com and select the PPO Network.

PHCS PPO Network is not available when you receive services **within** Mercy Health Plans' contracted Network.

- **Network Benefits**

Network Benefits are generally paid at a higher level than Non-Network Benefits. Network Benefits are payable for Covered Health Services that are described as Network Benefits in Section 12 (Covered Benefits) and are any of the following:

- Provided by a Network Physician or other Network Provider
- Emergency Room Services

Please note that Mental Health/Substance Abuse Services must be authorized by the Mental Health/Substance Abuse Designee. Please see Section 12 (Covered Benefits) under the headings for Mental Health and Substance Abuse Services.

- **Designated Facilities and Other Providers**

If You have a medical condition that We believe needs special services, We may direct You to a Network Designated Facility or other Network provider chosen by Us. Network Benefits will only be paid if Your Covered Health Services for that condition are provided by, or arranged by the Network Designated Facility, or other Network provider chosen by Us. Non-Network Benefits will apply to any Non-Network facility or provider.

- **Non-Network Benefits**

Non-Network Benefits are generally paid at a lower level than Network Benefits. Non-Network Benefits are payable for Covered Health Services that are provided by Non-Network Physicians or Non-Network Providers.

What You must do to get covered care

You or Your Physician must notify Us and obtain **Prior Authorization** before getting certain Covered Health Services from either Network or Non-Network Providers. However, **You are responsible for ensuring that Your provider obtains any required Prior Authorization <u>before</u> You receive Covered Health Services.** A current list of those services and supplies requiring Prior Authorization is available by calling Our Customer Contact Center at the number listed on Your ID Card, or by visiting www.mercyhealthplans.com. Verify with your Physician, or Our Contact Center, the authorized date range, and the number and type of services.

We urge You to confirm with Us that the services You plan to receive are Covered Health Services. Prior Authorization does not mean Benefits are payable in all cases. That is because in some instances, certain procedures may not meet the definition of a Covered Health Service and, therefore, are excluded. In other instances, the same procedure may meet the definition of Covered Health Services. By calling *before* You receive treatment, You can check to see if the service is subject to limitations or exclusions including, but not limited to:

- The Cosmetic Procedures exclusion. Examples of procedures that may or may not be considered cosmetic include: breast reconstruction; vein stripping, ligation and sclerotherapy, and upper lid blepharoplasty.
- The Experimental, Investigational or Unproven Services exclusion.
- Any other contract limitation or exclusion.

Note: Mental Health and Substance Abuse services must be Prior Authorized by the Mental Health/Substance Abuse Designee. Please see Section 12 (Covered Benefits) under the headings for Mental Health and Substance Abuse services.

FAILURE TO PREAUTHORIZE CERTAIN BENEFITS MAY RESULT IN A REDUCTION OF ELIGIBLE EXPENSES.

Care Management

When You notify Us as described above, We will work together to implement the care management process and to provide You with information about additional services that are available to You, such as disease management programs, health education, pre-admission counseling and patient advocacy.

Emergency Room Services

We provide Benefits for Emergency Room Services when required for stabilization and initiation of treatment as provided by or under the direction of a Physician.

Network Benefits are paid for Emergency Room Services, even if a Non-Network Provider

provides the services. Emergency Services and any follow-up care rendered by a Non-Network Provider must be:

1) Of such immediate nature that Your health would be jeopardized if taken to a Network Hospital where the services of a Participating Physician would be available, or
2) Provided under circumstances under which You are unable, due to Your condition, to request treatment at a location where the services of a Participating Physician would be available.

- If You are admitted as an inpatient to a **Network** or **Non-Network Hospital** after You receive Emergency Room Services, We must be notified within two (2) business days or on the same day of admission, or as soon as reasonably possible, to receive authorization for continued services. Continuation of care as for any Inpatient Stay requires Prior Authorization and approval by the Plan.
- If You are admitted as an inpatient to a **Non-Network Hospital** after You receive Emergency Room Services, We may elect to transfer You to a Network Hospital as soon as it is medically appropriate to do so. If You choose to stay in the Non-Network Hospital after the date We decide a transfer is medically appropriate, Non-Network Benefits may be available if the continued stay is determined to be a Covered Health Service.
- If You are admitted as an inpatient to a **Network** or **Non-Network Hospital** within twenty-four (24) hours of receiving treatment for the same condition as an Emergency Health Service, You will not have to pay the Copayment/Coinsurance for Emergency Room Services. The Copayment/Coinsurance for an Inpatient Stay in a Network Hospital will apply instead.

Urgent Care Services

Covered Health Services that are required to prevent serious deterioration of Your health within twenty-four (24) hours of the onset of an unforeseen Sickness, Injury, or the onset of acute or severe symptoms. Urgent care is not the same as Emergency Care.

Special Note Regarding Medicare

If You are enrolled for Medicare on a primary basis (Medicare pays before We pay Benefits under this Policy), the notification requirements described in this Certificate of Coverage do not apply to You. Since Medicare is the primary payer, We will pay as secondary payer as described in (Section 7: Coordinating Benefits with Other Coverage). You are not required to notify Us before receiving Covered Health Services; however, You are required to follow any Provider participation guidelines and Prior Authorization requirements of Your primary Medicare carrier in order for Us to pay Benefits.

Section 5: Your Cost for Covered Services

This is what You will pay for covered care:

Copayments

A Copayment is a fixed amount of money You pay to the provider, facility, pharmacy, etc., when You receive *certain* services. **Copayments do not count towards Your Out-of-Pocket Maximum or Your Deductible.** Copayment amounts are listed on the Schedule of Coverage and Benefits next to the description for each Covered Health Service.

Coinsurance

Coinsurance is the percentage of Our Eligible Expenses that You must pay for Your care. Coinsurance does not begin until after You meet Your Deductible. **[Only] [Coinsurances count toward Your Out-of-Pocket Maximum[, including Coinsurances under any Rider(s), if applicable].].**

Deductible

A Deductible is a fixed expense You must incur within a [Calendar Year] [Plan Year] for certain Covered Services and supplies before We start paying Benefits for them. For a complete definition of [Annual] [Plan Year] Deductible, see Section14 (Definitions of Terms).

[NOTE: The Network Deductible applies to the Non-Network Deductible; however, the Non-Network Deductible does NOT apply to the Network Deductible.]

[NOTE: Charges that apply to one Deductible (e.g., Network Deductible) also apply to the other (e.g., Non-Network Deductible) and vice versa.]

[NOTE: Charges that apply to one Deductible (e.g., Network Deductible) do not apply to the other (e.g., Non-Network Deductible).]

[Deductibles do not apply to Your Out-of-Pocket Maximum.] [All Deductibles for Covered Health Services will count towards Your Out-of-Pocket Maximum.]

[You must meet Your Annual Deductible before [medical and pharmacy] Benefits are payable, except for preventive health/wellness services, [and] routine immunizations [and prescription drugs on the Preventive Drug list]. [Pharmacy Benefits are payable only under a Prescription Drug Rider and are not covered under Your medical Benefit.] Coinsurances are not included in Your Deductible**.]**

For Your [Annual][Plan Year] Deductible see Your Schedule of Coverage and Benefits.

Eligible Expenses

Eligible Expenses are the amount We determine that We will pay for Benefits minus any Copayment, Coinsurance or Deductible. We will pay a contracted rate for Network Providers. For Non-Network Providers, however, We will pay the Usual and Customary Rate (UCR) as determined by Us. For a complete definition of Eligible Expenses and UCR that describes how We determine payment, see Section 14 (Definitions of Terms).

Charges in Excess of UCR

Charges by a provider in excess of UCR will not be covered under this Policy and will not be counted toward Your Out-Of-Pocket Maximum limit or Deductible.

For Network Benefits, You are not responsible for any difference between the Eligible Expenses and the amount the provider bills, but You are responsible for all Copayments, Coinsurances or Deductibles.

For Non-Network Benefits, You are responsible to pay directly to the Non-Network Provider any difference between the amount the provider bills You and the UCR amount We will pay for Eligible Expenses. Please see Section 13 (Exclusions).

Out-of-Pocket Maximum

The maximum You pay out of Your pocket in a [Calendar] [Plan] Year for [Deductibles and] Coinsurances [for medical [and pharmacy] expenses]. [Pharmacy Benefits are payable only under a Prescription Drug Rider and are not covered under Your medical Benefit For a complete definition of Out-of-Pocket Maximum, see Section 14 (Definitions of Terms).

The Out-of-Pocket Maximum does **not** include any of the following:

- Any charges for non-Covered Health Services;
- [Copayments][and][Coinsurances] for Covered Health Services available by an optional Rider;
- The amount of any reduced Benefits if You do not obtain Prior Authorization as described in Section 12 (Covered Benefits) ;
- Charges that exceed Eligible Expenses;
- Any Copayments for Covered Health Services in Section 12 (Covered Benefits);
- [The Annual Deductible.]

For Your [Annual] [Plan Year] Out-of-Pocket Maximum see Your Schedule of Coverage and Benefits.

Maximum Policy Benefit

The maximum amount that We will pay for Benefits during the entire period of time You are enrolled under this Policy. For a complete definition of Maximum Policy Benefit, see Section 14 (Definitions of Terms).

For Your Maximum Policy Benefit see Your Schedule of Coverage and Benefits.

[Carryover]

[The fourth-quarter Deductible expenses incurred in a Calendar Year that is applied (or "carries over") to the next Calendar Year.]

Section 6: How to File a Claim

- **Network Provider** — We pay Network Providers directly for Your Covered Health Services. If a Network Provider bills You for any Covered Health Service, contact Us. However, You will be responsible for paying any Copayments or Coinsurance at the time of service.

- **Non-Network Provider** — When You receive Covered Health Services from a Non-Network Provider, You may be responsible for paying for all expenses up front and then requesting reimbursement from Us.

How to File a Claim

While You do not need to fill out a specific claim form, You must file the claim in a format that contains all of the information We require, as described below.

If a Subscriber provides written authorization to a Non-Network Provider for payment of medical Benefits for any Eligible Expenses, reimbursement may be paid directly to that Provider. If the subscriber did not sign authorization for payment of medical Benefits, the subscriber may be responsible for paying for all expenses up front and then requesting reimbursement from Us. We will not reimburse third parties who have purchased or been assigned Benefits by Physicians and other providers.

Required Information for Claims

When You request payment of Benefits from Us, You must provide Us with all of the following information:

1. The Subscriber's name and address;
2. The patient's name and age;
3. The number stated on Your ID card;
4. The name, address, phone number and Tax ID of the provider of the service(s);
5. A diagnosis from the Physician;
6. An itemized bill from the provider of service includes the Current Procedural Terminology (CPT) codes or a description of each charge;
7. The date the Injury or Sickness began;
8. A statement indicating whether You are, or You are not, enrolled for coverage under any other health insurance plan or program. If You are enrolled for other coverage You must include the name of the other carrier(s), the name and date of birth of the subscriber for that coverage, and the Effective Date of the coverage.

Proof of Loss

Written proof of loss and notice of claim must be provided to Us within ninety (90) days after the date of such loss. Failure to furnish such proof within such time will neither invalidate nor reduce any claim if it was not reasonably possible to furnish such proof within such time. In no event, except in the absence of legal capacity of the claimant, will a claim be valid later than one (1) year from the time proof is otherwise required. All Benefits payable under this Policy will be payable not more than thirty (30) days after receipt of proof. Written proofs of claim must be furnished to the Plan at P. O. Box 4568, Springfield, MO 65808.

Time of Payment of Claims

Eligible reimbursements payable under this Policy will be paid upon receipt of due written proof of such claim. All eligible reimbursement will be payable to Providers. We will send You an Explanation of Benefits form or letter. This will show You what services were paid, how much was paid, who was paid, when payment was made, or why payment for some services was not made or was made in part. There may be some circumstances for which We must seek additional information from You to process the claim. If this occurs, We will send You written notice within thirty (30) days after receipt of the claim. The notice will contain an explanation of the additional information that is required. We will suspend (pend) the claim until We receive the requested information from You. If You present the information after the thirty (30) days allocated, the claim will be reprocessed in accordance to the terms and Benefits of Your coverage. If We deny all or any part of Your claim, We will send You an Explanation of Benefits form or a letter telling You why it was denied. The form or letter may also tell You what other information, if any, We would need to

reconsider Our decision. If You do not agree with Our decision, You have the right to appeal Your claim. See Section 8 (Complaints, Grievances and Appeals). You may also call or write Us, or You may contact the Arkansas Insurance Department.

Action on Claims

If a claim is denied, We will send You a written notice that contains the reason for the denial and information on Your right to appeal. If You believe there is a discrepancy between the Benefits, the Certificate of Coverage, and the processing of such claim, or if You have a Grievance, You must notify the Plan no later than one-hundred and eighty (180) days from the date that written notice was sent from the Plan informing You of the event that gave rise to a Grievance. If a claim is denied, You may obtain a review of the denial through the Complaint and Grievance Procedure. See Section 8 (Complaints, Grievances and Appeals).

Release of Records

During the processing of Your claim, We might need to review Your health records. As a Covered Person, You hereby authorize the release to Us of all health records related to Your claim. This release constitutes authorization of any provision of law forbidding such disclosure. Your records will be maintained with strict confidentiality under the terms of applicable privacy laws. This authorization also applies to any Covered Dependent under this Policy.

Direct Payment to Public Hospitals

Benefits for Covered Health Services will be paid, with or without an assignment from You, to public hospitals or clinics for services and supplies provided to You if proper claim is submitted by the public hospital or clinic. No Benefits will be paid under this section to the public hospital or clinic, if such Benefits have been paid to You prior to Us receiving Your claim. Payment to the public hospital or clinic will discharge Us from all liability to You to the extent of the Benefits so paid.

Section 7: Coordinating Benefits with Other Coverage

When You have coverage under more than one plan

When You have coverage under more than one plan, Section 7 pertains to you. Please read this section carefully. This section describes how Benefits under this Policy will be coordinated with those of any other plan that provides Benefits to You.

The order of Benefit determination rules below determine which plan will pay as the Primary Plan. The Primary Plan is the plan that pays first without regard to the possibility that another Plan may cover some expenses. A Secondary Plan pays after the Primary Plan and may reduce the Benefits it pays, so that payment from all group plans do not exceed 100% of the Plan's Allowable Expenses.

Definitions

For purposes of this section, terms are defined as follows:

Other (Another) Plan

A Plan, or "other plan" is any of those which provides benefits or services for, or because of, medical or dental care or treatment:

(1) Group insurance or group-type coverage, whether insured or uninsured. This includes prepayment, group practice or individual practice coverage. It also includes coverage other than school accident-type coverage.

(2) Coverage under a governmental plan, or coverage required or provided by law. This does not include a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act). Each contract or other arrangement for coverage under (1) or (2) is a separate plan. In addition, if an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate plan.

This Plan

This Group contract that provides Benefits for health care expenses under Mercy Health Plans.

Primary Plan/Secondary Plan

The order of benefit determination rules state whether this plan is a Primary Plan or Secondary Plan. When this plan is a Primary Plan, its Benefits are determined *before* those of the other plan, and without considering the other plan's benefits. When this plan is a Secondary Plan, its Benefits are determined *after* those of the other plan, and may be reduced because of the other plan's benefits.

Allowable Expense

A necessary, customary and reasonable health care service or expense, including Copayments or Coinsurance that is covered, at least in part, by any of the Plans that provide benefits to You. The difference between the cost of a private hospital room and the cost of a Semi-Private Room is not considered an Allowable Expense under this definition, unless the patient's stay in a private hospital room is medically necessary, either in terms of generally accepted medical practice or as specifically defined in the plan.

When a plan provides benefit in the form of services, the reasonable cash value of each service rendered will be considered both an Allowable Expense and a benefit paid. When benefits are reduced under a Primary Plan because You do not comply with the plan provisions, the amount of that reduction will not be considered an Allowable Expense. Examples of these provisions are those related to second surgical opinions, precertification of admissions or services, and preferred provider arrangements.

Claim determination period

This period refers to a Calendar Year. However, it does not include any part of a year during which You have no coverage under this plan, or any part of a year before the date this COB provision or similar provision takes effect.

General Information:

When You have other health coverage

You must tell Us if You or a covered family member have coverage under any other health plan. This is called "double coverage."

When You have double coverage, one plan normally pays its benefits in full as the Primary payer and the other Plan pays a reduced benefit as the Secondary payer. We, like other insurers, determine which coverage is primary according to the National Association of Insurance Commissioners' guidelines.

When We are the Primary payer, We will pay the Benefits described in this Policy.

When We are the Secondary payer, We will determine Our allowance. After the primary plan pays, We will pay what is left of Our allowance, up to Our regular benefit. We will not pay more than Our allowance.

When other Government agencies are responsible for Your care

We do not cover services and supplies when a local, State, or Federal government agency directly or indirectly pays for them.

Order of Benefit Determination Rules

When coordination of benefits (COB) applies, the Order of Benefit Determination Rules should be looked at first. These rules determine whether the Benefits of this Plan are determined before or after those of another Plan. The Benefits of this Plan:

- Will not be reduced when, under the order of benefit determination rules, this Plan is the Primary payer; but
- May be reduced when, under the order of benefit determination rules, this Plan is the Secondary payer. This reduction is described later in this section.

General

When two or more Plans pay benefits, the rules for determining the order of payment are as follows:

This Plan is a Secondary Plan, which has its benefits determined after those of the other Plan, unless:

1. The other Plan has rules coordinating its benefits with those of this Plan; and
2. Both those rules and this Plan's rules require that this Plan's benefits be determined before those of the other Plan.

Rules:

This plan determines its order of benefits using the first of the following rules which applies:

1. Nondependent / Dependent

The Plan that covers You as a Subscriber (other than as a Dependent, for example, as an employee or Member) is the Primary Plan.

The benefits of the Primary Plan are determined *before* those of the Plan which covers You as a Dependent; **except**, if You are also a Medicare beneficiary and as a result of the rule established by Title XVII of the Social Security Act and implementing regulations, Medicare is:

a) Secondary to the Plan covering You as a Dependent; and
b) Primary to the Plan covering You as other than a Dependent (for example, a retired employee). The benefits of the Plan covering You as a Dependent are determined before those of the Plan covering You as other than a Dependent.

2. Dependent child whose parents are not separated or divorced

When this Plan and another Plan cover the same child as a Dependent, the order of benefits is the **"Birthday Rule"** described below:

a) The Primary Plan is the Plan of the parent whose birthday falls earlier in a year;
b) If both parents have the same birthday, the Plan that covered either of the parents longer is Primary. However, if the other Plan does not have this rule (#2) and if, as a result, the Plans do not agree on the order of benefits, the rule in the other Plan will

determine the order of benefits.

Note: The word, "birthday", refers only to the month and day in a Calendar Year, not the year in which the person was born.

3. Dependent child of unmarried (whether or not they ever have been married), separated, or divorced parents

When this Plan and another Plan cover the same child as a Dependent of divorced or separated parents, benefits for the child are determined in this order:

a) First, the Plan of the parent with custody of the child *(custodial parent)*; then
b) The Plan of the Spouse of the parent with custody of the child *(Spouse of the custodial parent)*; then
c) The plan of the parent not having custody of the child *(Non-custodial parent)*.
d) However, if the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses or health care coverage, and the Plan of that parent has actual knowledge of those terms, that Plan is Primary. The Plan of the other parent will be the Secondary Plan. This rule applies to claim determination periods or plan years beginning after the Plan is given notice of the court decree.

4. Joint Custody

If the specific terms of the court decree state that the parents will 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 will follow the "Birthday Rule" described above.

5. Active or inactive employee

The Plan that covers You as an employee is Primary, if You are neither laid off nor retired. The same would hold true if You are a Dependent of a person covered as a retiree and an employee. 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 (#5) is ignored.

6. Continuation coverage

If Your coverage is provided under a right of continuation provided by Federal or state law, and You are also covered under another Plan, the benefits of the Plan that covers You as an employee, retiree, Member or Subscriber (or as that person's Dependent) is Primary; and the continuation coverage is Secondary.

If the other Plan does not have the rule described here and if, as a result, the Plans do not agree on the order of the benefits, this rule (#6) is ignored.

7. Longer/Shorter length of coverage

If none of the previous rules determine the order of benefits, the benefits of the Plan that covered an employee, Member, Subscriber or retiree longer is Primary.

a) To determine length of time a person has been covered under a Plan, two Plans will be treated as one, if the Member was eligible under the second within twenty-four (24) hours after the first ended.
b) The start of a new Plan does not include
   i. A change in the amount or scope of a Plan's benefits;
   ii. A change in the entry which pays, provides or administers the Plan's benefits; or
   iii. A change from one type of plan to another (such as, from a single employer plan to that of a multiple employer plan).
c) The length of time You are covered under a Plan is measured from Your first date of coverage under that Plan. If that date is not readily available, the date You first became a Member of the Group will be used as the date from which to determine the length of time Your coverage under the present Plan has been in force.

8. Special Rules for Medicare Members

A. When You or Your covered Spouse are age 65 or over, have Medicare and…

1) You have coverage on Your own as an active employee, or

2) Through Your Spouse who is an active employee

This Plan is Primary for the individual with Medicare. This rule may vary Dependent upon the size of Group and status of Your employment. Please see Figure 1 below in this section.

B. When You or a covered family Member…

1) Have Medicare solely based on end stage renal disease (ESRD) and

- It is *within the first thirty (30) months* of eligibility for or entitlement to Medicare due

to ESRD (30-month coordination period) – This Plan is Primary;

- It is *beyond the thirty (30) month* coordination period and You or a family Member are still entitled to Medicare due to ESRD – Medicare is Primary;

2) Become eligible for Medicare due to ESRD while already a Medicare beneficiary and

- This Plan was the Primary payer before eligibility due to ESRD – This Plan is Primary (for the 30-month coordination period beginning on the date of Your first renal dialysis);
- Medicare was the Primary payer before eligibility due to ESRD – Medicare is Primary;

C. When either You or a covered family Member are eligible for Medicare solely due to disability and You…

- Have this Plan's coverage on Your own as an active employee, or through a family Member who is an active employee, Medicare or this Plan may be Primary depending upon the size of Group and status of Your employment. Please see Figure 1 below in this section.

When You are enrolled in Part A and Part B of Medicare, and Medicare is the Primary insurer, the Plan will pay all Medicare Deductible and Copayments/Coinsurances for services on Your behalf (as well as for Covered Services that are not covered by Medicare that meet the requirements set forth in this Policy), up to the total Allowable Expenses. You will still be responsible for Copayments/Coinsurances required under this Plan.

If You are eligible for Medicare and receive benefits from the Plan that would otherwise have been paid or reimbursed by Medicare, but You failed to enroll in Medicare's coverage, then the Plan will only pay for Benefits to the extent it would have paid had You enrolled under Medicare's coverage.

Medicare always makes the final determination as to whether they are the Primary payer. The following chart illustrates whether Medicare or this Plan should be the Primary payer for You according to Your employment status and other factors determined by Medicare. It is critical that You tell Us if You or a covered family Member has Medicare coverage so We can administer these requirements correctly.

GROUP SIZE	Medicare eligibility AGE 65	Medicare due to DISABILITY	Medicare due to ESRD ONLY
1 – 19	Medicare Primary	Medicare Primary	This Plan Primary (First 30 months)
20 – 99	This Plan Primary	Medicare Primary	This Plan Primary (First 30 months)
100 and over	This Plan Primary	This Plan Primary	This Plan Primary (First 30 months)

Figure 1. Coordination of Benefits with Medicare

Effect on the Benefits of this Plan When Plan is Secondary

When this Plan is Secondary, We may reduce Your Benefits so that the total Benefits paid or provided by all Plans during a claim determination period are no more that 100% of total Allowable Expenses.

a. **Reduction in this Plan's Benefits.** The Benefits of this Plan will be reduced when the sum of:

i. The Benefits that would be payable for the Allowable Expense under this Plan in the absence of this COB provision; and
ii. 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 COB provision (whether or not claim is made) exceeds those Allowable Expenses in a claim determination period. In that case, 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. When the Benefits of this plan are reduced as described previously, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of this Plan.

b. **When You become eligible for Medicare**, all Benefits for Covered Health Services otherwise payable will be reduced by any Benefits that We determine have been paid, or would be payable by Medicare. You will be deemed to have full Medicare coverage whether or not You are enrolled. Benefits under this Certificate will be reduced by any Benefits that would be payable, or the value of any services provided under Medicare for the same condition.

Coordinating Benefit Payments

The Plan will make every effort to expedite the exchange of COB information required to process Your claim (s) under these COB provisions. Eligible reimbursements payable under this Policy will be paid upon receipt of due written proof of such claim and any additional information requested including COB information. Payment will be made within 30 days after receipt of a completed claim form. See "Time Payment of Claims" in Section 6 for more information.

Right to Receive and Release Needed Information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine Benefits payable under this Plan. We may get the facts We need from, or give them to, other organizations or persons for the purpose of applying these rules and determining Benefits payable under this Plan.

By accepting Coverage under this Policy, You agree to:

1. Provide this Plan with information about other coverage and promptly notify Us of any coverage changes;
2. Give Us the right to obtain information as needed from others to coordinate Benefits;
3. Return any excess amounts paid to You if the Plan or Your provider gives You a credit or payment and later finds that the other Plan's coverage should have been primary.

We need not tell, or get the consent of, any person to do this. Each person claiming Benefits under this Plan must give Us any facts We need to apply these rules and determine Benefits payable. If You do not provide Us the information We need to apply these rules and determine the Benefits payable, Your claim for Benefits will be denied.

Reconciliation of Payments

A Primary payment made under another Plan may include an amount that should have been paid as Primary under this Plan. If this occurs, We may pay that amount to the organization that incorrectly made the payment. That amount will then be treated as though it were a benefit paid under this Plan. We will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

Right of Recovery

If the amount of the payments We made is more than We should have paid under this COB provision, We may recover the excess from one or more of:

1. The person We have paid or for whom We have paid;
2. Insurance companies; or
3. Other organizations.

The "amount of the payments made" includes the reasonable cash value of any Benefits provided in the form of services.

Right of Reimbursement

In consideration of the coverage provided by this Certificate of Coverage, We have the right to be reimbursed by You for the reasonable value of any services and benefits We provide to You, from any or all of the following listed below:

- Third parties, including any person alleged to have caused You to suffer injuries or damages;
- Your employer;
- Any person or entity who is or may be obligated to provide benefits or payments to You, including benefits or payments for underinsured or uninsured motorist protection, no-fault traditional auto insurance, medical payment coverage (auto, homeowners or otherwise), Workers' Compensation coverage, other insurance carriers or third party administrators;
- Any person or entity who is liable for payment to You on any equitable or legal liability theory.

These third parties and persons or entities are collectively referred to as "Third Parties". You agree as follows:

- That You will cooperate with Us in protecting Our legal and equitable rights to subrogation and reimbursement, including, but not limited to:
  - Providing any relevant information requested by Us,
  - Signing and/or delivering such documents as We or Our agents reasonably request to secure the subrogation and reimbursement claim,
  - Responding to requests for information about any accident or injuries,
  - Making court appearances, and
  - Obtaining Our consent or Our agents' consent before releasing any party from liability or payment of medical expenses.
- That We have the sole authority and discretion to resolve all disputes regarding the interpretation of the language stated herein;
- That regardless of whether You have been fully compensated or made whole, We may collect from You the proceeds of any full or partial recovery that You or Your legal representative obtain, whether in the form of a settlement (either before of after any determination of liability) or an non-economic damage settlement or judgment;
- That benefits paid by Us may also be considered to be benefits advanced;
- That You will not accept any settlement that does not fully compensate or reimburse Us without Our written approval, nor will You do anything to prejudice Our rights under this provision;
- That, upon Our request, You will assign to Us all rights of recovery against Third Parties, to the extent of the tortfeasors for whom You are seeking recovery, to be paid before any other of Your claims are paid;
- That We may, at Our option, take necessary and appropriate action to preserve Our right under these subrogation provisions, including filing suit in Your name, which does not obligate Us in any way to pay Your part of any recovery We might obtain;
- That We shall not be obligated in any way to pursue this right independently or on Your behalf.

Section 8: Complaints, Grievances & Appeals

These procedures address all Complaints, Grievances, and appeals from Members concerning operation of the Plan, **except** any Complaints that allege or indicate possible professional liability. These procedures are designed to provide timely, thorough and fair review of determinations in utilization management and claims payment.

A Member, a Member's authorized representative, or a provider can make a Complaint or Grievance at any time. Complaints can be about anything, including: the Plan's service, Utilization Review, or a provider's service. A Complaint or Grievance can always be directed to the Arkansas Insurance Department at the following address and telephone number:

Arkansas Insurance Department
Consumer Services Division
1200 West Third Street
Little Rock, AR 72201
(501) 371-2640, (800) 852-5494
Fax: (501) 371-2749
Email: insurance.consumers@arkansas.gov
www.insurance.arkansas.gov

Step	Description
1	**What to do first. Contact Our Customer Contact Center. The telephone number is shown on Your ID card.** Customer Contact Center Representatives are available to take Your call during regular business hours, 8:00 a.m. – 5:00 p.m., Monday through Friday. At other times, You may leave a message on voicemail. A Customer Contact Center Representative will return Your call. If You would rather send Your Complaint to Us in writing at this point, You may write to Us at the address listed below. The Plan agrees to investigate and endeavor to resolve any and all Complaints received from Members with regard to the nature of professional services rendered or Benefits provided under this Policy. Oral Complaints or inquiries can be made to the Plan by telephone or an arranged appointment with the Customer Contact Center Representative at: Mercy Health Plans ATTN: Customer Contact Center 14528 S. Outer 40, Suite 300 Chesterfield, Missouri 63017-5743 (866)647-5568 The Customer Contact Center Representative will make every effort to resolve the concern to Your satisfaction during the initial telephone call or interview with the Plan. Resolution of Complaints through this process will not preclude Your rightful access to review through the formal Grievance Process.
2	**Ask Us in writing to reconsider Our initial decision.** ***Minimum Time to File a Grievance:*** You must file a Grievance no later than one hundred and eighty (180) days from the date that written notice was sent from the Plan informing You of the event that gave rise to the Grievance. ***Grievance Procedure:*** Ask Us in writing to reconsider Our initial decision. You, Your authorized representative, or Your Provider can submit a Grievance described below. a) Write to Us no later than one hundred and eighty (180) days from the date that written notice was sent from the Plan to You, informing You of the event that gave rise to the Grievance; and b) Send Your request to: Mercy Health Plans, Attn: Corporate Appeals, 14528 S. Outer 40, Suite 300, Chesterfield, Missouri 63017-5743. c) Include a statement about why You believe Our initial decision was wrong, based on specific benefit provisions in this brochure; and d) Include copies of documents that support Your claim, such as physician letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms.

The Plan will acknowledge receipt of Your Grievance in writing. A complete investigation of the Grievance will follow. Someone who is neither the individual who made the initial determination nor the subordinate of such individual will conduct the review. In the case of a Grievance involving a medical judgment, the Plan will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, and who is neither the individual who was consulted on the initial claim determination, nor the subordinate of such individual.

We will notify You of Our determination in writing as follows:

- Within thirty (30) calendar days for a service You have not yet received (pre-service); or
- Within sixty (60) calendar days for a service You have already received (post-service).

This written determination will include information about Your right to file request an External Independent Review (if We maintain Our denial of an Adverse Determination), and Your right to other voluntary alternative dispute resolution options including any rights You may have under ERISA.

3 ***Expedited Grievance Procedure***: When the standard time frames of the Grievance procedure would seriously jeopardize Your life or health, or would jeopardize Your ability to regain maximum function, a request for an expedited review can be submitted. An expedited review request may be made verbally or in writing. A decision will be made within seventy-two (72) hours after receiving a request for an expedited review. This will be followed by written notification of that decision.

4 ***Ask Us for an External Independent Review, only if Your appeal was related to an Adverse Determination.***

Within sixty (60) days of the date You or Your authorized representative receive written notice of an Adverse Determination, You or Your authorized representative may initiate an External Review. A request for a standard External Review must be made in writing or via electronic media, and should include any information or documentation to support Your request for the covered service. **Note: Only appeals that are related to an Adverse Determination and that involve treatment, services, equipment, supplies, or drugs that would require the health benefit plan to expend five hundred dollars ($500) or more of expenditures are afforded an external independent review.**

"Adverse Determination" means a determination by the Plan that an admission, availability of care, continued stay or other health care service has been reviewed and, based upon the information provided, the requested payment for the service is denied, reduced or terminated, because:

(a) The requested health care service does not meet the health benefit plan's requirements for medical necessity, or
(b) The requested health care service has been found to be "experimental/investigational."

The Plan will select an independent review organization from a list of independent review organizations approved by the Arkansas Insurance Department. The Plan shall be solely responsible for paying the fees of the external independent review organization selected to perform the review. For the purposes of this Section, an external Independent Reviewer shall: (a) be a clinical peer; (b) have no direct financial interest in connection with the case; and (c) have not been informed of the specific identity of the Member.

The independent review organization will complete its review within forty-five (45) calendar days after the receipt of the request for an External Review and will provide a written notice of its decision to You, or Your authorized representative and the Plan.

An expedited external independent review may be requested for a situation when a delay would significantly increase the risk to Your health or when extended health care services for a course of treatment that You are undergoing is at issue. Upon submission of a request for expedited external independent review, the Plan will immediately assign an independent review organization approved by the Arkansas Insurance Department. The independent review organization shall make a determination and verbally notify You, Your authorized representative, and the Plan of its decision within seventy-two (72) hours after receipt of all necessary information. The decision by the Independent Reviewer is final. Within two (2) calendar days, the independent review organization will follow up with a written notice of the determination via mail.

Nothing in this Section shall be construed to require the Plan to pay for a health care service not covered under this Policy.

5 At any time, You have the right to contact the Arkansas Insurance Department's consumer complaint hotline at: **1-800-852-5494** regarding Your Grievance, or write to the Arkansas Insurance Department at the following address: **Arkansas Insurance Department, Consumer Services Division, 1200 West Third Street, Little Rock, AR 72201**.

Grievance and Appeal Decisions

You will receive a decision from the Plan within the timeframes set forth above for the Grievance process. The decision will be provided in writing. However, in the case of an Expedited Grievance, the decision will be provided verbally and in writing. Any denial of Your Grievance will contain the following information:

a) The specific reason or reasons for the denial;
b) Reference to the specific Plan provisions on which the denial is based;
c) A statement that You are entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to Your claim for Benefits;
d) A statement of Your right to bring a civil action under ERISA;
e) Any specific guideline that was relied upon in issuing the denial, or a statement that such guideline will be provided to You free of charge upon request;
f) If the denial is based on medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to Your medical circumstances, or a statement that such explanation will be provided free of charge upon request; and
g) The following statement: "You and Your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact Your local U.S. Department of Labor Office and Your State insurance regulatory agency."

Section 9: Utilization Review

The following is information pertaining to utilization review decisions and procedures. Please note that in addition to utilization reviews, Mercy Health Plans practices care management and therefore may provide You with information about additional services that are available to You, such as disease management programs, health education, pre-admission counseling and patient advocacy.

Initial Determinations

For initial determinations, the Plan will make the determination within two (2) working days of obtaining all necessary information regarding a proposed admission, procedure or service requiring a review determination. For purposes of this section, "necessary information" includes the results of any face-to-face clinical evaluation or second opinion that may be required.

In the case of a determination to certify an admission, procedure or service, the Plan will notify the provider rendering the service by telephone within twenty-four (24) hours of making the initial certification.

In the case of an Adverse Determination, the Plan will notify the provider rendering the service by telephone within twenty-four (24) hours of making the Adverse Determination; and will provide written or electronic confirmation of the telephone notification to You and Your provider within one (1)working day of making the Adverse Determination.

Concurrent Review Determinations

For concurrent review determinations, the Plan will make the determination within one (1) working day of obtaining all necessary information.

In the case of a determination to certify an extended stay or additional services, the Plan will notify by telephone the provider rendering the service within one (1) working day of making the certification.

In the case of an Adverse Determination, the Plan will notify by telephone the provider rendering the services within twenty-four (24) hours of making the Adverse Determination, and provide written or electronic notification to You and Your provider within one (1) working day of the telephone notification. The services will be continued without liability to You until You have been notified of the determination.

Retrospective Review Determinations

For retrospective review determinations, the Plan will make the determination within thirty (30) working days of receiving all necessary information. The Plan will provide notice in writing of Our determination to You within ten (10) working days of making the determination.

Adverse Determination

A written notification of an Adverse Determination will include the principal reason or reasons for the determination, the instructions for initiating an appeal or reconsideration of the determination, and the instructions for requesting a written statement of the clinical rationale, including the clinical review criteria used to make the determination. The Plan will provide the clinical rationale in writing for an Adverse Determination, including the clinical review criteria used to make that determination, to any party who received notice of the Adverse Determination and who requests such information.

Reconsideration of an Adverse Determination

In a case involving an initial determination or a concurrent review determination, the Plan will give the provider rendering the service an opportunity to request on Your behalf a reconsideration of an Adverse Determination by the reviewer making the Adverse Determination.

The reconsideration will occur within one (1) working day of the receipt of the request and will be conducted between the provider rendering the service and the reviewer who made the Adverse Determination, or a clinical peer designated by the reviewer who made the Adverse Determination (if the reviewer who made the Adverse Determination is not available within one (1) working day).

If the reconsideration process does not resolve the difference of opinion, You or Your provider may appeal the Adverse Determination. Reconsideration is not a prerequisite to a standard appeal or an expedited appeal of an Adverse Determination.

Lack of Information

The Plan will have written procedures to address failure or inability of a provider or an enrollee to provide all necessary Information for review. In cases where the provider or an enrollee will not release necessary information, the Plan may deny certification of an admission, procedure or service.

Benefit Determinations and Appeal Procedures

Per the requirements of the Department of Labor Regulation Section 2560.503-1, the Plan establishes and maintains the following procedures to govern benefit determinations, Your claim for Benefits and the filing of appeals under the Plan. You are entitled to a full and fair review of Your benefit determination and the denial, which means:

(a) You may submit written comments, documents, records, and other information relating to the claim for Benefits;
(b) You may obtain upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to Your claim for Benefits;
(c) The review will take into account all comments, documents, records, and other information You submit, without regard to whether such information was submitted or considered with respect to the initial determination;
(d) Someone who is neither the individual who made the initial determination, nor the subordinate of such individual will conduct the review;
(f) Any medical or vocational experts whose advice was obtained in connection with the initial determination will be identified, regardless of whether the advice was relied upon in the initial determination; and
(g) In the case of an urgent care determination, the appeal may be submitted orally or in writing and all necessary information, including the decision on the appeal, will be transmitted between You and Mercy Health Plans by telephone, facsimile, or other available similarly expeditious method.

The timeframes within which You must submit appeals to Mercy Health Plans, and within which Mercy Health Plans must respond to such appeals, vary depending on whether Your claim for Benefits is an urgent care request, a pre-service request, a post-service request or a concurrent care request. If requested, the Plan will arrange for a referral to a Physician with the necessary expertise to provide a second opinion or consultation when You choose to seek a second medical opinion. You may select a physician in the same or a similar specialty for a second opinion, however You will be responsible for all Copayments, Coinsurances and/or Deductibles.

NOTE: SHOULD ANY CONFLICT ARISE BETWEEN ARKANSAS LAW AND THE DEPARTMENT OF LABOR REGULATIONS, THE RULE THAT PROVIDES YOU WITH THE BEST BENEFIT WILL PREVAIL.

The following is a description of each of these four types of benefit determinations:

1. Urgent Care Request

A request for medical care or treatment, which if a determination is not made expeditiously: (a) could seriously jeopardize Your life or health or Your ability to regain maximum function; or (b) in the opinion of a physician with the knowledge of Your medical condition, would subject You to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim for Benefits.

(a) **Initial Determination** – We will make an initial decision as soon as possible, taking into account the medical exigencies, but no later than seventy-two (72) hours after receipt of the requested service.
(b) **Insufficient Information to Process Request** – We will notify Your provider of insufficiency as soon as possible, but not later than twenty-four (24) hours. Your provider then has forty-eight (48) hours to provide the specified information.
(c) **Determination After Notice of Insufficiency** – As soon as possible, but no later than forty-eight (48) hours after the earlier of: (1) Our receipt of specified information; or (2) the end of the forty-eight (48) hour period afforded Your provider to submit additional information.
(d) **Time Within Which to Appeal Denial** – You or Your provider must appeal no later than one hundred and eighty (180) days after receipt of denial.
(e) **Appeal Determination** – We will make a determination on the appeal within seventy-two (72) hours after receipt of You or Your provider's request for review.

2. Pre-Service Request

A request for a benefit *in advance* of obtaining medical care.

(a) **Initial Determination** – We will make an initial decision within a reasonable period of time appropriate to the medical circumstances, but no later than fifteen (15) days after receipt of the requested service.

(b) **Extension of Time for Processing Request** – One additional period of fifteen (15) days from the end of the initial period, if the extension is necessary for reasons beyond the control of the Plan. If the reason for the extension is You or Your provider's failure to submit necessary information, the determination period is tolled from the date notice of insufficiency is given, until You or Your provider respond to the notice. You or Your provider have forty-five (45) days to respond to the notice.

(c) **Time Within Which to Appeal Denial** – You or Your provider must appeal no later than one hundred and eighty (180) days after receipt of denial.

(d) **Appeal Determination** – We will make a determination on the appeal within a reasonable time appropriate to the medical circumstances, but no later than thirty (30) days after request for review.

3. Post-Service Claim

A request for a benefit You have *already received*.

(a) **Initial Determination** – We will make an initial decision within a reasonable period of time appropriate to the medical circumstances, but no later than thirty (30) days after receipt of the claim.

(b) **Extension of Time for Processing Claim** – One additional period of fifteen (15) days from the end of the initial period, if the extension is necessary for reasons beyond the control of the Plan. If the reason for the extension is claimant's failure to provide necessary information, the determination period is tolled from the date notice of insufficiency is given, until You or Your provider respond to the notice. You or Your provider have forty-five (45) days to respond to the notice.

(c) **Time Within Which to Appeal Denial** – You or Your provider must appeal no later than one hundred and eighty (180) days after receipt of denial.

(d) **Appeal Determination** – We will make a determination on the appeal within a reasonable time appropriate to the medical circumstances, but no later than sixty (60) days after request for review.

4. Concurrent Care Review

If the Plan has approved an ongoing course of treatment to be provided over a period of time or number of treatments, any reduction or termination of the course of treatment will be treated as a benefit denial. We must notify You of the denial sufficiently in advance of the reduction or termination to allow You or Your provider to appeal and obtain a determination on review before the benefit is reduced or terminated. Any request by You or Your provider to extend the course of treatment beyond the period of time or number of treatments authorized must be decided as soon as possible, taking into account the medical exigencies, but no later than twenty-four (24) hours after receipt of the request, provided the request is made within twenty-four (24) hours prior to the expiration of the prescribed period or number of treatments.

Complaint and Grievance Procedures

These procedures address all Complaints, Grievances, and appeals concerning operation of Mercy Health Plans <u>except</u> any Complaints that allege or indicate possible professional liability. These procedures are designed to provide timely, thorough and fair review of determinations in utilization management and claims payment. The Grievance procedure is more fully described in Section 8 (Complaints, Grievances and Appeals).

Section 10: Continuation of Coverage

General Information about Continuation of Coverage:

- If Your coverage ends under this Policy, You may be entitled to elect continuation coverage (coverage that continues on in some form) in accordance with Federal or state law.
- Continuation coverage under COBRA (the Federal Consolidated Omnibus Budget Reconciliation Act) is available only to Enrolling Groups that are subject to the terms of COBRA. You can contact Your plan administrator to determine if Your Enrolling Group is subject to the provisions of COBRA.
- If You selected continuation coverage under a prior plan which was then replaced by coverage under this Policy, continuation coverage will end as scheduled under the prior plan or in accordance with the terminating events listed below, whichever is earlier.
- We are not the Enrolling Group's designated "plan administrator" as that term is used in Federal law, and We do not assume any responsibilities of a "plan administrator" according to Federal law.
- We are not obligated to provide continuation coverage to You if the Enrolling Group or its plan administrator fails to perform its responsibilities under Federal law. Examples of the responsibilities of the Enrolling Group or its plan administrator are:
  - Notifying You in a timely manner of the right to elect continuation coverage.
  - Notifying Us in a timely manner of Your election of continuation coverage.

Continuation Coverage under Federal Law (COBRA)

Much of the language in this section comes from the Federal law that governs continuation coverage. You should call Your Enrolling Group's plan administrator if You have questions about Your right to continue coverage.

In order to be eligible for continuation coverage under Federal law, You must meet the definition of a "Qualified Beneficiary". A Qualified Beneficiary is any of the following persons who was covered under this Policy on the day before a qualifying event:

- A Subscriber.
- A Subscriber's Enrolled Dependent, including with respect to the Subscriber's children, a child born to or placed for adoption with the Subscriber during a period of continuation coverage under Federal law.
- A Subscriber's Spouse.

Qualifying Events for Continuation Coverage under Federal Law (COBRA)

If the coverage of a Qualified Beneficiary would ordinarily terminate due to one of the following qualifying events, then the Qualified Beneficiary is entitled to continue coverage. The Qualified Beneficiary is entitled to elect the same coverage that she or he had on the day before the qualifying event (QE).

QE-1. Termination of the Subscriber from employment with the Enrolling Group, for any reason other than gross misconduct, or reduction of hours; or
QE-2. Death of the Subscriber; or
QE-3. Divorce or legal separation of the Subscriber; or
QE-4. Loss of eligibility by an Enrolled Dependent who is a child; or
QE-5. Entitlement of the Subscriber to Medicare benefits; or
QE-6. The Enrolling Group filing for bankruptcy, under Title XI, United States Code, on or after July 1, 1986, but only for a retired Subscriber and his or her Enrolled Dependents. This is also a qualifying event for any retired Subscriber and his or her Enrolled Dependents if there is a substantial elimination of coverage within one (1) year before or after the date the bankruptcy was filed.

Notification Requirements and Election Period for Continuation Coverage under Federal Law (COBRA)

The Subscriber or other Qualified Beneficiary must notify the Enrolling Group's designated plan administrator within sixty (60) days of the Subscriber's divorce, legal separation or an Enrolled Dependent's loss of eligibility as an Enrolled Dependent. If the Subscriber or other Qualified Beneficiary fails to notify the designated plan administrator of these events within the sixty (60) day period, the

Enrolling Group and its plan administrator are not obligated to provide continued coverage to the affected Qualified Beneficiary. If a Subscriber is continuing coverage under Federal Law, the Subscriber must notify the Enrolling Group's designated plan administrator within sixty (60) days of the birth or adoption of a child.

Continuation must be elected by the later of: (i) sixty (60) days after the qualifying event occurs, or (ii) sixty (60) days after the Qualified Beneficiary receives notice of the continuation right from the Enrolling Group's designated plan administrator.

In no event will an application for continuation coverage be accepted if filed more than sixty (60) days following the later of the date of the qualifying event or the date of the first notice of COBRA entitlement in connection with that qualifying event.

If the Qualified Beneficiary's coverage was terminated due to a qualifying event, then the initial Premium due to the Enrolling Group's designated plan administrator must be paid on or before the 45th day after electing continuation.

Terminating Events for Continuation Coverage under Federal Law (COBRA)

Continuation under this Policy will end on the earliest of the following dates:

A. Eighteen (18) months from the date of the qualifying event, if the Qualified Beneficiary's coverage would have ended because the Subscriber's employment was terminated or hours were reduced (QE-1). Refer to the Qualifying Events (QE) listed above.

   If a Qualified Beneficiary is determined to have been disabled by the Social Security Administration at anytime within the first sixty (60) days of continuation coverage under QE-1, then the Qualified Beneficiary may elect an additional eleven (11) months of continuation coverage (for a total of twenty-nine (29) months of continued coverage) subject to the following conditions: (i) notice of such disability must be provided within sixty (60) days after the date of determination of the disability, and in no event later than the end of the first eighteen (18) months; (ii) the Qualified Beneficiary must agree to pay any increase in the required Premium for the additional eleven (11) months; and (iii) if the Qualified Beneficiary entitled to the eleven (11) months of coverage has non-disabled family Members who are also Qualified Beneficiaries, then those non-disabled Qualified Beneficiaries are also entitled to the additional eleven (11) months of continuation coverage. Notice of any final determination that the Qualified Beneficiary is no longer disabled must be provided within thirty (30) days of such determination. Continuation coverage that was extended due to the disability may be terminated on the first day of the month that begins more than thirty (30) days after the date of that determination.

B. Thirty-six (36) months from the date of the qualifying event for an Enrolled Dependent whose coverage ended because of the death of the Subscriber, divorce or legal separation of the Subscriber, or loss of eligibility by an Enrolled Dependent who is a child (QE-2, QE-3, or QE-4).

C. For the Enrolled Dependents of a Subscriber who was entitled to Medicare (QE-5) prior to a qualifying event that was due to either the termination of employment or work hours being reduced, eighteen (18) months from the date of the qualifying event, or, if later, thirty-six (36) months from the date of the Subscriber's Medicare entitlement.

D. The date coverage terminates under this Policy for failure to make timely payment of the Premium.

E. The date, after electing continuation coverage, that coverage is first obtained under any other Group health plan. If such coverage contains a limitation or exclusion with respect to any pre-existing condition, continuation shall end on the date such limitation or exclusion ends. The other Group health coverage shall be primary for all health services except those health services that are subject to the pre-existing condition limitation or exclusion.

F. The date, after electing continuation coverage, that the Qualified Beneficiary first becomes entitled to Medicare, except that this shall not apply in the event that coverage was terminated because the Enrolling Group filed for bankruptcy, (i.e. QE-6).

G. The date the entire Policy ends.

H. The date coverage would otherwise terminate under this Policy as described in Section 3 under the heading, *Events Ending Your Coverage.*

If a Qualified Beneficiary is entitled to eighteen (18) months of continuation and a second qualifying event occurs during that time, the Qualified Beneficiary's coverage may be extended up to a maximum of thirty-six (36) months from the date coverage ended because employment was terminated or hours were reduced. If the Qualified Beneficiary was entitled to continuation because the Enrolling Group filed for bankruptcy, (i.e. QE-6.) and the retired Subscriber dies during the continuation period, then the other Qualified Beneficiaries shall be entitled to continue coverage for thirty-six (36) months from the date of the Subscriber's death. Terminating events B through G described in this section will apply during the extended continuation period.

Continuation coverage for Qualified Beneficiaries whose continuation coverage terminates because the Subscriber becomes entitled to Medicare may be extended for an additional period of time. Such Qualified Beneficiaries should contact the Enrolling Group's designated plan administrator for information regarding the continuation period.

Qualifying Event for Continuation Coverage Under Arkansas State Law

Covered Person whose coverage under the Group Policy are entitled to continue their Hospital, surgical or major medical coverage, including coverage for their eligible dependents, if such coverage would otherwise terminate because employment or membership ends. Such continuation is subject to the following terms and conditions:

- Continuation shall only be available to a Subscriber who has been continuously insured under the Group Policy, and for similar Benefits under any Group Policy which is replaced, during the entire three-month period ending with such termination. If employment is reinstated during the continuation period, then coverage under the Group Policy will be reinstated for the Subscriber and any Dependents who were covered under continuation.
- Continuation is not available for either of the following:
  - Any person covered under this Policy who is or could be covered by Medicare.
  - Any person who is or could be covered by any other insured or uninsured arrangement which provides Hospital, surgical or major medical coverage for individuals in a Group and under which the person was not covered immediately prior to such termination.
- Continuation need not include dental, vision care or prescription drug benefits or any other Benefits provided under this Policy in addition to its Hospital, surgical or major medical Benefits, but continuation must include maternity Benefits if those Benefits are provided under the Group Policy.

Notification Requirements and Election Period for Continuation Coverage Under Arkansas State Law

The Covered Person must do both of the following within ten (10) days of the date coverage would otherwise terminate:

- Request such continuation in writing.
- Pay the Enrolling Group, on a monthly basis, the amount of contribution required to continue coverage. Such Premium contribution shall not be more than the group rate of the insurance being continued on the due date of each payment; but, if any Benefits are omitted (such as dental, vision care, and prescription drug), such Premium contribution shall be reduced accordingly.

The Enrolling Group must notify Covered Persons, in writing, of its duties under this subdivision not later than the date on which coverage would otherwise terminate.

Terminating Events for Continuation Coverage Under Arkansas State Law

Continuation coverage under this Policy will end on the earliest of the following dates:

A. The date four (4) months after the date the Covered Person's Coverage under this Policy would have terminated because of termination of employment;

B. If the Covered Person fails to make timely payment of a required Premium contribution, the end of the period for which contributions were made;

C. The date this Policy is terminated or, in the case of a Subscriber, the date the Enrolling Group terminates participation under a Group Policy. However, if the Coverage ceasing by reason of termination is replaced by similar coverage under another Group Policy, then:

   1. The Covered Person shall have the right to become covered under that other policy for the balance of the period that the Covered Person would have remained covered under the prior policy in accordance with the conditions of this section;

   2. The minimum level of Benefits to be provided by the other policy shall be the applicable level of Benefits of the prior policy reduced by any Benefits payable under that prior policy; and

   3. The prior Group Policy shall continue to provide Benefits to the extent of its accrued liabilities and extensions of Benefits as if the replacement had not occurred.

Continuation of Coverage During a Military Leave

The Uniformed Service Employment and Reemployment Rights Act (USERRA) requires that an employer continue to provide coverage during this Plan during a military leave that is covered by the Act for You or Your dependents. The coverage provided must be identical to the coverage provided under the employer's plan to similarly situated, active employees and dependents. This means that if the coverage for similarly situated, active employees and dependents is modified, coverage for the individual on military leave will be modified. The cost of such coverage will be:

1. For military leaves of thirty (30) days or less, the same as the employee contribution required for active employees.

2. For military leaves of thirty-one (31) days or more, up to 102% of the full cost of the coverage, e.g., the employee and employer share.

Continuation coverage rights apply to medical, dental, prescription drugs and other health coverage. Short and long term disability and life Benefits are not subject to continuation rights.

Continued coverage provided under USERRA will reduce any continuation provided under COBRA.

Maximum Period of Coverage During Military Leave

Continued coverage under this provision will terminate on the earlier of the following events:

1. The date You fail to return to Employment with the Company following completion of Your military leave. Employees must return to employment within:
   - The first full business day after completing military service, for leaves of thirty (30) days or less. A reasonable amount of travel time will be allowed for returning from such military service.
   - Fourteen (14) days after completing military service for leaves of thirty-one (31) to one hundred and eighty (180) days.
   - Ninety (90) days after completing military service, for leave of more than one hundred and eighty (180) days; or
2. Eighteen (18) months from the date Your leave began.

Reinstatement of Coverage Following Military Leave

The law also requires, regardless of whether continuation coverage as stated above was elected, that Your coverage and Your Dependent coverage be reinstated immediately upon Your honorable discharge from military service and return to employment, if You return within:

1. The first full business day after completing military service, for leaves of thirty (30) days or less. A reasonable amount of travel time will be allowed for returning from such military service;
2. Fourteen (14) days after completing military service for leaves of thirty-one (31) to one hundred and eighty (180) days;
3. Ninety (90) days after completing military service, for leave of more than one hundred and eighty (180) days; or

If due to sickness or Injury caused or aggravated by Your military service, You cannot return to work within the times stated above, You may take up to a period of two (2) years, or as soon as reasonably possible if for reasons beyond Your control You cannot return within two (2) years, to recover from such sickness or Injury and return to employment within the times stated above.

If Your coverage under the Plan is reinstated, all provisions and limitations of the Plan will apply to the extent that they would have applied if You had not taken military leave and Your coverage had been continual under the Plan. The eligibility period will be waived and the Pre-Existing Condition Limitation will be credited as if You had been continually covered under the Plan from Your original Effective Date.

This waiver of limitations does not provide coverage for any sickness or Injury caused or aggravated by Your military services, as determined by the Secretary of Veterans Affairs.

Conversion Coverage

If Your coverage terminates for one of the reasons described below, You may apply for conversion coverage without furnishing evidence of insurability.

Reasons for termination:

- The Subscriber is retired or pensioned;
- You cease to be eligible as a Subscriber or Enrolled Dependent;
- Continuation coverage ends;
- The entire Policy ends and is not replaced.

A converted Policy need not be made available if termination occurred for any of the following reasons:

- You failed to make timely payment of any required contribution, or were terminated for any reason (s) listed in Section 3 (When Coverage Ends);
- The Group Policy terminated or a Group's participation terminated, and the insurance is replaced by similar coverage under another Group Policy within thirty-one (31) days of the date of termination.

Application and payment of the initial Premium must be made within thirty (30) days after coverage ends under this Policy. Conversion coverage will be issued in accordance with the terms and conditions in effect at the time of application. Conversion coverage may be substantially different from coverage provided under this Policy.

The converted Policy shall cover the employee or Member and his/her dependents who were covered by the Group Policy on the date of termination of insurance. At the option of the insurer, a separate converted Policy may be issued to cover any Dependent.

We are not required to issue a converted Policy covering any person if such person is or could be covered by Medicare. Furthermore, We shall not be required to issue a converted Policy covering any person if:

- Such person is or could be covered for similar Benefits by another individual Policy; such person is or could be covered for similar Benefits under any arrangement of coverage for individuals in a Group, whether insured or uninsured; or similar Benefits are provided for or available to such person, by reasons of state or Federal law; and
- The Benefits under sources of the kind referred to above for such person, or Benefits provided or available under sources of the kind referred to above for such person, together with the converted Policy's Benefits would result in over-insurance according to the insurer's standards for over-insurance.

Section 11: General Provisions

Your Relationship with Us

In order to make choices about Your health care coverage and treatment, We believe that it is important for You to understand how We interact with Your Enrolling Group's benefit plan and how it may affect You. We help finance or administer the Enrolling Group's benefit plan in which You are enrolled. We do not provide medical services or make treatment decisions. This means:

- We communicate to You decisions about whether the Enrolling Group's benefit plan will cover or pay for the health care that You may receive. The plan pays for certain medical costs, which are more fully described in this Certificate. The plan may not pay for all treatments You or Your Physician may believe are necessary. If the plan does not pay, You will be responsible for the cost.
- We do not decide what care You need or will receive. You and Your Physician make those decisions.

We may use individually identifiable information about You to identify for You (and You alone) procedures, products or services that You may find valuable. We will use individually identifiable information about You as permitted or required by law, in Our operations and in Our research. We will use de-identified data for commercial purposes including research.

Our Relationship with Enrolling Groups

The relationship between Enrolling Groups and Us is solely a contractual relationship between independent contractors. Enrolling Groups are not Our agents or employees. Neither We, nor any of Our employees, are agents or employees of the Enrolling Groups.

We do not provide Health Care Services or supplies, nor do We practice medicine. We are **not** liable for any act or omission of any provider.

We are not considered to be an employer for any purpose with respect to the administration or provision of Benefits under the Enrolling Group's benefit plan. We are not responsible for fulfilling any duties or obligations of an employer with respect to the Enrolling Group's benefit plan.

The Enrolling Group is solely responsible for all of the following:

- Enrollment and classification changes (including classification changes resulting in Your enrollment or the termination of Your coverage).
- The timely payment of the Policy Charge to Us.
- Notifying You of the termination of this Policy.

When the Enrolling Group purchases a Policy to provide coverage under a benefit plan governed by the Employee Retirement Income Security Act ("ERISA"), 29 U.S.C. §1001 et seq., We are not the plan administrator or named fiduciary of the benefit plan, as those terms are used in ERISA. If You have questions about Your welfare benefit plan, You should contact the Enrolling Group. If You have any questions about this statement or about Your rights under ERISA, contact the nearest area office of the Pension and Welfare Benefits Administration, U. S. Department of Labor.

Your Relationship with Providers and Enrolling Groups

The relationship between You and any provider is that of provider and patient.

- You are responsible for choosing Your own provider.
- You must decide if any provider treating You is right for You.

This includes providers You choose and providers to whom You have been referred.

- You must decide with Your provider what care You should receive.
- Your provider is solely responsible for the quality of the services provided to You.

The relationship between You and the Enrolling Group is that of employer and employee, Dependent or other classification as deemed in this Policy.

Administrative Services

We may, in Our sole discretion, arrange for various persons or entities to provide administrative services in regard to this Policy, such as claims processing. The identity of the service providers and the nature of the services they provide may be changed from time to time in Our sole discretion. We are not required to give You prior notice of any such change, nor are We required to obtain Your approval. You must cooperate with those persons or entities in the performance of their responsibilities.

Amendments to this Policy

To the extent permitted by law, We reserve the right, in Our sole discretion and without Your approval, to change, interpret, modify, withdraw or add Benefits or terminate this Policy.

Any provision of this Policy that on its Effective Date is in conflict with the requirements of state or Federal statutes or regulations (of the jurisdiction in which this Policy is delivered) is hereby amended to conform to the minimum requirements of such statutes and regulations.

No other change may be made to this Policy unless it is made by an Amendment or Rider that has been signed by one of Our officers. All of the following conditions apply:

- Amendments to this Policy are effective thirty-one (31) days after We send a written notice to the Enrolling Group.
- Riders are effective on the date We specify.
- No agent has the authority to change this Policy or to waive any of its provisions.
- No one has authority to make any oral changes or amendments to this Policy.

Case Management

Case Management is a service that assists individuals with treatment needs that extend beyond the acute care setting. The goal of Case Management is to ensure that patients receive appropriate care in the most effective setting possible, whether at home, as an outpatient, or an inpatient in a hospital or specialized facility. Should the need for Case Management arise, a Case Management professional will work closely with the patient, his or her family and the attending physician to determine appropriate treatment options that will best meet the patient's needs and keep costs manageable. The case manager will help coordinate the treatment program and arrange for necessary resources. Case managers are also available to answer questions and provide ongoing support for the family in times of medical crisis.

Case managers are Registered Nurses (RNs) and other credentialed health care professionals, each trained in a clinical specialty area such as trauma, high risk Pregnancy and neonates, oncology, mental health, rehabilitation or general medicine and surgery. A case manager trained in the appropriate clinical specialty area will be assigned to You or Your dependent. In addition, case managers are supported by a panel of physician advisors, who offer guidance on up-to-date treatment programs and medical technology. While the case manager recommends alternate treatment programs and helps coordinate needed resources, the patient's attending physician remains responsible for the actual medical care.

Clerical Error

If a clerical error or other mistake occurs, that error will not deprive You of Benefits under this Policy, nor will it create a right to Benefits. If the Enrolling Group makes a clerical error (including, but not limited to, sending Us inaccurate information regarding Your enrollment for coverage or the termination of Your coverage under this Policy) We will not make retroactive adjustments beyond a sixty (60) day time period.

Commission or Omission

No Hospital, Physician or other Provider of service will be liable for any act of commission or omission by Us. We will not be liable for any act of commission or omission by (1) any Hospital or Hospital's agent or employee; (2) any Physician or Physician's agent or employee; (3) any other Providers or services or their agent or employee; or (4) You.

Entire Policy/Changes

This Policy issued to the Enrolling Group, including this Certificate of Coverage, the Enrolling Group's application, Amendments and Riders, constitutes the entire Policy. No change in this Policy will be valid until approved by one of Our executive officers and unless

such approval be endorsed hereon or attached hereto. No agent has authority to change this Policy or waive any of its provisions.

Examination of Covered Persons

In the event of a question or dispute regarding Your right to Benefits, We may require that a Network Physician of Our choice examine You at Our expense.

Incentives to Providers

We pay certain providers through various types of contractual arrangements, some of which may include financial incentives to promote the delivery of health care in a cost efficient and effective manner. These financial incentives are not intended to affect Your access to health care.

Examples of financial incentives for providers are bonuses for performance based on factors that may include quality, Member satisfaction, and/or cost effectiveness.

We use various payment methods to pay specific providers. From time to time, the payment method may change. If You have questions about whether Your provider has a contract with Us and if that contract includes any financial incentives, We encourage You to discuss those questions with Your provider.

Incentives to You

Sometimes We may offer coupons or other incentives to encourage You to participate in various wellness programs or certain disease management programs. The decision about whether or not to participate is yours alone, but We recommend that You discuss participating in such programs with Your Physician. These incentives are not Benefits and do not alter or affect Your Benefits. Contact Us if You have any questions.

Incorporation by Reference

Unless otherwise stated therein, the Schedule of Coverage and Benefits, the schedule of rates and Premiums, any riders, the application, the member handbook, and any amendments to any of the foregoing, form a part of this Policy as if fully incorporated herein.

Information and Records

At times, We may need additional information from You. You agree to furnish Us with all information and proofs that We may reasonably require regarding any matters pertaining to this Policy. If You do not provide this information when requested, We may delay or deny payment of Your Benefits.

By accepting Benefits under this Policy, You authorize and direct any person or institution that has provided services to You to furnish Us with all information or copies of records relating to the services provided to You. We have the right to request this information at any reasonable time. This applies to all Covered Persons, including Enrolled Dependents, whether or not they have signed the Subscriber's enrollment form. We agree that such information and records will be considered confidential.

We have the right to release any and all records concerning Health Care Services that are necessary to implement and administer the terms of this Policy for appropriate medical review, quality assessment, or as We are required to do by law or regulation. During and after the term of this Policy, We and Our related entities may use and transfer the information gathered under this Policy in a de-identified format for commercial purposes, including research and analytic purposes.

For complete listings of Your medical records or billing statements We recommend that You contact Your health care provider. Providers may charge You reasonable fees to cover their costs for providing records or completing requested forms.

If You request medical forms or records from Us, We also may charge You reasonable fees to cover costs for completing the forms or providing the records.

In some cases, We will designate other persons or entities to request records or information from or related to You, and to release those records as necessary. Our designees have the same rights to this information as We have.

Interpretation of Eligibility and Benefits

Mercy Health Plans (MHP) has sole discretion to determine eligibility or interpret Plan Benefits. This function is the responsibility of MHP. We may delegate this authority to other persons or entities that provide services in regards to the administration of this Policy. Note: You have the right to appeal the decision, file a Grievance, seek relief through the Department of Insurance, or seek legal action to enforce the contract.

In certain circumstances, for purposes of overall cost savings or efficiency, We may, in Our sole discretion, offer Benefits for services that would otherwise not be Covered Health Services. The fact that We do so in any particular case will not in any way be deemed to require Us to do so in other similar cases.

Legal Actions

You may not bring any action of law or in equity concerning a claims payment until sixty (60) days after written proof of claim for Benefit payment has been furnished in accordance with the requirement of this Policy. Any such action must begin within three (3) years of the date a claim is required to be sent to Us.

Medicare Eligibility

Benefits under this Policy are not intended to supplement any coverage provided by Medicare. In some circumstances, Covered Persons who are eligible for or enrolled in Medicare may also be enrolled under this Policy.

If You are eligible for or enrolled in Medicare, please read the following information carefully.

If You are eligible for Medicare, and Medicare would be Your Primary payer (Medicare pays before Benefits under this Policy), You **should** enroll in and maintain coverage under both Medicare Part A and Part B. If You don't enroll and maintain that coverage, and if We are the Secondary payer as described in Section 7 (Coordinating Benefits with Other Coverage), We will pay Benefits under this Policy as if You were covered under both Medicare Part A **and** Part B. As a result, You will be responsible for the costs that Medicare would have paid and You will incur a larger out-of-pocket cost.

Notice

When We provide written notice regarding administration of this Policy to an authorized representative of the Enrolling Group, that notice is deemed notice to all affected Subscribers and their Enrolled Dependents. The Enrolling Group is responsible for giving notice to You.

Policies, Identification Cards and Applications

We will furnish You with identification cards, copies of this Policy, and applications.

Statements by Enrolling Group or Subscriber

Except for fraudulent statements, all statements made by the Enrolling Group or by a Subscriber will be deemed representations and not warranties and that no statement made for the purpose of effecting insurance shall void the insurance or reduce benefits, unless contained in a written instrument signed by the policyholder of the insured person, a copy of which has been furnished to the policyholder or to the person or his or her beneficiary.

Statement of ERISA Rights

As a participant in the Plan, You are entitled to certain rights and protection under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Members shall be entitled to:

Receive Information About Your Plan and Benefits

– Examine, without charge, at the Plan Administrator's office and at other locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U. S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.

- Obtain, upon written request to the Plan Administrator, copies of documents governing the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated *Summary Plan Description*. The Plan Administrator may make a reasonable charge for the copies.

- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of the summary annual report.

Continue Group Health Plan Coverage

- Continue health care coverage for yourself, Spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or Your dependents may have to pay for such coverage. Review this *Summary Plan Description* and the document governing the Plan on the rule governing Your COBRA continuation coverage rights.
- Reduction or elimination of exclusionary periods of coverage for preexisting conditions under Your Group health plan, if You have Continuous Creditable Coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from Your Group health plan or health insurance issuer when You lose coverage under the Plan, when You become entitled to elect COBRA continuation coverage, when Your COBRA continuation coverage ceases, if You request it before losing coverage, or if You request it up to twenty-four (24) months after losing coverage. Without evidence of Continuous Creditable Coverage, You may be subject to preexisting condition exclusion for twelve (12) months after Your enrollment date in Your coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit Plan. The people who operate the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of You and other Plan participants and beneficiaries. No one, including Your employer, Your union, or any other person may fire You or otherwise discriminate against You in any way to prevent You from obtaining a welfare benefit or exercising Your rights under ERISA.

Enforce Your Rights

If a claim for a welfare benefit is denied or ignored, in whole or in part, You have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any steps You can take to enforce the above rights. For instance, if You request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, You may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay You up to $110 a day until You receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If You have a claim for Benefits which is denied or ignored, in whole or in part, You may file suit in a state or Federal court. If it should happen that Plan fiduciaries misuse the Plan's money or if You are discriminated against for asserting Your rights, You may seek assistance from the U. S. Department of Labor, or You may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If You are successful, the court may order the person You have sued to pay these costs and fees. If You lose, the court may order You to pay these costs and fees, for example, if it finds Your claim is frivolous.

Assistance With Your Questions

If You have any questions about Your Plan, You should contact the Plan administrator. If You have any questions about this statement or about Your rights under ERISA, or if You need assistance in obtaining document from the Plan Administrator, You should contact the nearest office of the Pension and Welfare Benefits Administration, United States Department of Labor listed in Your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. You may also obtain certain publications about Your rights and responsibilities under ERISA by calling the publication hotline of the Pension and Welfare Benefits Administration.

Time Limit on Certain Defenses

1. After three (3) years from the date of issue of this Policy, no misstatements, except fraudulent misstatements, made by the applicant in the application for such Policy shall be used to void this Policy or to deny a claim for charges incurred after the expiration of such three (3) year period.
2. The time limits of this Policy for charges incurred due to a Preexisting Condition, if applicable, are set forth in Section 13 (M).

Workers' Compensation not Affected

Benefits provided under this Policy do not substitute for and do not affect any requirements for coverage by Workers' Compensation insurance.

Section 12: Covered Benefits

Benefit	Description **See Schedule of Coverage and Benefits for Your cost-sharing Amount** [Note: Copayments [and Deductibles] do not count towards Your Out-of-Pocket (OOP) Maximum; only Coinsurances [and Deductibles] apply to Your OOP Maximum.]
1. Allergy Services	• Office visits • Injections and serum, treatment, or testing (when no charge is made for physician services)
2. Ambulance Services-Emergency Only	Medically Necessary ambulance service (either by a licensed ambulance service - ground or air ambulance) to the most appropriate Hospital where Emergency Care can be provided in the case of a Medical Emergency Condition; however, use of air ambulance must be approved in advance or as soon as reasonable possible by the Plan. Ambulance services do not include safety evacuation or medical transportation from foreign countries, even in Emergency situations. See Section 13, R., for related exclusions.
3. Dental -Anesthesia and Facility Charges	Administration of general anesthesia and Hospital charges for dental care if: • The Covered Person is a child under the age of seven (7) who is determined by two (2) licensed dentists to require, without delay, necessary dental treatment in a hospital or ambulatory surgical center for a significantly complex dental condition; or • The Covered Person is diagnosed with a serious mental or physical condition; or • The Covered Person has a significant behavioral problem as determined by the Covered Person's Physician. Limitations and Exclusions are described in Section 13, C. **Prior Authorization Required** Unless We pre-approve these services, Network and Non-Network Benefits for dental anesthesia and related facility charges will be reduced by 50% of Eligible Expenses.
4. Dental Services - Accident only	Dental services when all of the following are true: • Treatment is necessary because of accidental damage • Dental services are received from a Doctor of Dental Surgery, "D.D.S." or Doctor of Medical Dentistry, "D.M.D." • The dental damage is severe enough that initial contact with a Physician or dentist occurred within seventy-two (72) hours of the accident Benefits are available only for treatment of a sound, natural tooth. Sound, natural teeth means teeth and tissue that are viable, functional, and free of disease. The Physician or dentist must certify that the injured tooth was: • A virgin or unrestored tooth • A tooth that has no decay, no filling on more than two surfaces, no gum disease associated with bone loss, no root canal therapy, is not a dental implant and functions normally in chewing and speech. Dental services for final treatment to repair the damage must be completed within the timeframe described in Your Schedule of Coverage and Benefits. Dental x-rays and narrative report for independent dental consultant review may be required. Coverage does not include Benefits for the repair or replacement of dental prosthetics, including but not limited to bridges, dentures, crowns, implants, braces, and retainers. Please note that dental damage that occurs as a result of normal activities of daily living or extraordinary use of the teeth other than for normal biting or chewing is not considered an "accident". Benefits are not available for repairs to teeth that are injured as a result of such activities, or specifically excluded in Section 13, C.

Benefit	Description **See Schedule of Coverage and Benefits for Your cost-sharing Amount** [Note: Copayments [and Deductibles] do not count towards Your Out-of-Pocket (OOP) Maximum; only Coinsurances [and Deductibles] apply to Your OOP Maximum.]
	Prior Authorization Required You do not have to notify Us before the initial Emergency treatment. However, You must obtain Prior Authorization as soon as possible and before follow-up (post-Emergency treatment) begins. Unless We pre-approve post-emergency treatment, coverage for accidental dental services will be reduced by 50% of Eligible Expenses.
5. Diabetes Services	Medically appropriate and necessary equipment, supplies and self-management training for the management and treatment of diabetes. Services are provided for persons with gestational, type I or type II diabetes. Coverage is provided for insulin infusion devices, insulin pumps, and associated supplies. Services for **diabetes self-management training**: Covered Health Services are limited to a program that complies with the National Standards for Diabetes Self-Management Education Program as developed by the American Diabetes Association. Diabetes self-management training shall be provided only upon prescription by a licensed physician and a licensed health care professional must certify that the Covered Person successfully completed the training program. Coverage is limited to one (1) program during the entire time a Covered Person is Covered under this Certificate. However, a Physician may prescribe additional training, due to a significant change in the Covered Person's symptoms or condition. A provider licensed, registered, and/or certified in the state to provide appropriate Health Care Services must provide diabetes self-management training program. Training is to be provided upon the initial diagnosis of diabetes, where there is a significant change in the Member's symptoms and when the Food and Drug Administration for the treatment of diabetes approve new techniques and treatments. **Prior Authorization Required** You must obtain Prior Authorization before receiving services for insulin pumps. Diabetes services are not subject to any durable medical equipment (DME) limits. Unless We pre-approve these services, Network and Non-Network Benefits will be reduced by 50% of Eligible Expenses
6. Dialysis	Medically Necessary dialysis is a covered Benefit.
7. DME, Orthotics and Prosthetics	***Durable Medical Equipment (DME)*** and its associated supplies that meet each of the following criteria: • Ordered or provided by a Physician for outpatient use; • Standard Basic Hospital-type Equipment that meets the medical need; • It can withstand repeated use; • Used for medical purposes; • Not consumable or disposable; • Not of use to a person in the absence of a disease or disability; • It is not primarily a device for enhancing the environmental setting in which the patient is placed or altering air quality or temperature; • It is not used for exercising or training; and • It is not used for monitoring health conditions. If more than one piece of Standard Basic Hospital-type Equipment can meet Your functional needs, Benefits are available only for the most cost effective piece of equipment. Examples of DME include: • Equipment to assist mobility, such as a standard wheelchair. • A standard Hospital-type bed. • Oxygen and the rental of equipment to administer oxygen (including tubing, connectors and masks.)

Benefit	Description **See Schedule of Coverage and Benefits for Your cost-sharing Amount** [Note: Copayments [and Deductibles] do not count towards Your Out-of-Pocket (OOP) Maximum; only Coinsurances [and Deductibles] apply to Your OOP Maximum.]
	We will decide if the equipment should be purchased or rented. If more than one piece of Standard Basic Hospital-type Equipment can meet Your functional needs, Benefits are available only for the most cost effective piece of equipment. DME is not modified, repaired, or replaced unless necessitated by the Member's medical condition. The Plan may replace an item because of severe damage or loss through no intentional act of the Member; however, an item is generally not replaced more than once per [Calendar][Plan] Year. Please note that any DME limitation is not applicable to any equipment, supplies or self-management training for the treatment of diabetes. In no event shall orthodontic braces, humidifiers, air conditioners, dehumidifiers or similar personal comfort items be treated as DME for purposes of this Plan. See Section 13, B. and G., for information on medical supplies and equipment that We do not cover. ***Orthotics*** Covered orthotic device/equipment is the Standard Basic Equipment necessary to continue average daily activities. The Plan may replace an item because of severe damage or loss through no intentional act of the Member; however, an item is generally not replaced more than once per [Calendar][Plan] Year. The following items are covered when ordered and provided by a Physician and obtained from an orthotic provider: • Braces/support including necessary adjustments to shoes to accommodate braces. Braces that stabilize an Injured body part are considered Durable Medical Equipment and are a Covered Health Service. • Trusses • Splints • Collars • Foot orthotics are a covered treatment for neuropathy or severe vascular insufficiency due to diabetes, or vascular disease. Braces that straighten or change the shape of a body part are orthotic devices, and are covered only for Instrumental Activities of Daily Living. Orthotics for sports-related activities are not covered. Dental braces are also excluded from coverage. See Section 13, C., F. and G. for mechanical equipment, medical supplies and other related services that are not covered. ***Prosthetics*** The purchase, fitting, necessary adjustment of prosthetic devices which replace or repair all or part of a limb including tissue, or replace all or part of the function of a permanently inoperative or malfunctioning body organ is a covered benefit. Supplies, adjustments, and repair or replacement of these devices, necessary to maintain their effective use, is provided when needed due to irreparable damage, normal wear or a change in the patient's condition, and deemed necessary by the Plan. As long as the device remains Medically Necessary, it will be covered even if the device has been in use prior to the user's enrollment; however an item is generally not replaced more than once per [Calendar] [Plan] Year. Covered prosthetic equipment is the Standard Basic Equipment necessary to continue average daily activities. If more than one prosthetic device can meet Your functional needs, Benefits are available only for the most cost-effective prosthetic device. The following devices and related services are not covered as prosthetic equipment: a. All mechanical organs b. Computer assisted devices c. Dental and TMJ appliances d. Devices employing robotics e. Electrical continence aids, anal or urethral f. Investigational or obsolete devices and supplies g. Remote control devices See Section 13, K., Q., B and C., for more details on related exclusions. Breast prosthesis as required by the Women's Health and Cancer Rights Act of 1998 is also

Benefit	Description **See Schedule of Coverage and Benefits for Your cost-sharing Amount** [Note: Copayments [and Deductibles] do not count towards Your Out-of-Pocket (OOP) Maximum; only Coinsurances [and Deductibles] apply to Your OOP Maximum.]
	covered. Breast prosthesis may follow a mastectomy at any time. Coverage includes a post-mastectomy brassiere. Please note that any limitation for prosthetics does not apply to breast prostheses. **Note:** The Plan is not responsible for any DME/Orthotics/Prosthetics loss or damage that is that is the result of action of a third party (i.e., loss of luggage containing DME equipment or orthotic/prosthetic devices by an airliner). [Any combination of Network and Non-Network Benefits for DME, Orthotics and Prosthetics [(combined Benefit)] is limited according to Your Schedule of Coverage and Benefits.] **Prior Authorization Required** We must pre-approve any single item of DME, orthotics or prosthetics that costs more than $1,000 (either purchase price or cumulative rental of a single item). Unless We pre-approve services over $1,000, You will be responsible for paying 100% of the charges and no Benefits will be paid.
8. Emergency Room Services	Emergency Services that are required to stabilize or initiate treatment in an Emergency. Emergency Room Services must be received on an outpatient basis at a Hospital or Alternate Facility. You will find more information about Benefits for Emergency Health Services in Section 4 (How You Get Care). Please remember that if You are admitted to a Hospital as a result of an Emergency, You must notify Us within two (2) business days or the same day of admission, or as soon as reasonably possible to receive authorization for continued services related to post-stabilization as needed. If You don't notify Us, Benefits for the Hospital Inpatient Stay will be reduced by 50% of Eligible Expenses. Benefits will not be reduced for the outpatient Emergency Room Services. Please refer to *Inpatient Hospital Services* below. If an Emergency Room admission results in a conversion to an Inpatient Stay or Observation Care for the same condition within 24 hours, the Emergency Room Copayment/Coinsurance will be waived. The alternate higher level Copayment/Coinsurance will apply.
9. Eye Examinations	Expenses for one (1) routine eye examinations per [Calendar] [Plan] Year by an Ophthalmologist or Optometrist at the frequency listed in Your Schedule of Coverage and Benefits. Please note that Benefits are not available for charges connected to the purchase or fitting of eyeglasses or contact lenses. See Section 13, S., for more information on limitations and exclusions related to vision care.
10. Hearing Screenings for Newborns	Newborn hearing screenings, necessary rescreening, audiological assessment and follow-up, and initial amplification.
11. Home Health Care	Services received from a Home Health Agency that are: • Ordered by a physician; • Provided by or supervised by a registered nurse in Your home; and • You are Homebound or Your physical or mental condition pose a serious and significant impediment to receiving medically necessary services outside the home. Benefits are available only when the Home Health Agency services are provided on a part-time, intermittent schedule and when skilled care is required. Skilled care is skilled nursing, skilled teaching and skilled rehabilitation services when all of the following are true: • It must be delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome, and provide for the safety of the patient. • It is ordered by a Physician.

Benefit	Description **See Schedule of Coverage and Benefits for Your cost-sharing Amount** [Note: Copayments [and Deductibles] do not count towards Your Out-of-Pocket (OOP) Maximum; only Coinsurances [and Deductibles] apply to Your OOP Maximum.]
	• It is not delivered for the purpose of assisting with activities of daily living, including but not limited to dressing, feeding, bathing, or transferring from a bed to a chair. • It requires clinical training in order to be delivered safely and effectively. • It is not Custodial Care. We will decide if skilled care is required by reviewing both the skilled nature of the service and the need for Physician-directed Medical management. A service will not be determined to be "skilled" simply because there is not an available caregiver. Certain extended home infusion services may be more appropriately performed in the home even if You are not Homebound. Any combination of Network and Non-Network Benefits is limited according to Your Schedule of Coverage and Benefits. Services primarily for hygiene, feeding, exercising, moving the patient, homemaking, companionship or giving oral medication are excluded. See Section 13,.J. for related exclusions. **Prior Authorization Required** Unless We pre-approve home health services, Network and Non-Network Benefits will be reduced by 50% of Eligible Expenses.
12. Hospice/Palliative Care	Hospice/Palliative care that is recommended by a Physician. Hospice/Palliative care is an integrated program that provides comfort and support services for the terminally ill. An individual is considered to be terminally ill if the medical prognosis for the life expectancy of that individual is six (6) months or less. A written or oral certification of the terminal illness must be provided to the hospice agency no later than two (2) calendar days after hospice care is initiated. Hospice care includes physical, psychological, social and spiritual care for the terminally ill person, and short-term grief counseling for immediate family members. Services can be provided either on an inpatient or on an outpatient basis. Benefits are available when hospice care is received from a licensed hospice agency. Discharge from a hospice may occur because You: • Revoke the hospice benefit; • Move away from the geographic area serviced by the hospice agency; • Transfer to another hospice; • Your condition improves and You are no longer considered terminally ill; or • You are deceased. Please contact Us for more information regarding Our guidelines for hospice care. You can contact Us at the telephone number on Your ID card. Any combination of Network and Non-Network Benefits is limited to one hundred and eighty (180) days during the entire period of time You are covered under this Policy. **Prior Authorization Required** Unless We pre-approve hospice/palliative care services, Network and Non-Network Benefits will be reduced by 50% of Eligible Expenses.
13. Immunizations (Routine Only)	Routine immunizations as defined by the Plan. Coverage limitations may apply but only for adults over eighteen (18) years of age. Immunizations required for international travel are excluded. A list of routine immunizations can be obtained at www.mercyhealthplans.com or by calling Our Customer Contact Center at the number listed on Your ID card.Applicable [Copayment] [Deductible] [and] [Coinsurance] for office visit(s) will apply.
14. Injectables/Infusions	Benefits are available for injections/infusions received in a Physician's office, infusion center or through home health, when no other health service is received. Some injectables and infusions received in the locations listed above may incur a [Copayment] [or] [Deductible and][Coinsurance] for the injectable/infusion, in addition to any cost-sharing for the Physician's

Benefit	Description **See Schedule of Coverage and Benefits for Your cost-sharing Amount** [Note: Copayments [and Deductibles] do not count towards Your Out-of-Pocket (OOP) Maximum; only Coinsurances [and Deductibles] apply to Your OOP Maximum.]
	office visit, infusion center or home health service, regardless of whether other health services are received. [Regardless of the place where these services are performed, the cost-sharing for injectables/infusions will apply.] **Prior Authorization Required** Some injectables/infusions require Prior Authorization. A list of injectables/infusions requiring Prior Authorization can be obtained at www.mercyhealthplans.com or by calling Our Customer Contact Center at the number listed on Your ID card. Unless We pre-approve injectable/infusions that require Prior Authorization, Network and Non-Network Benefits will be reduced by 100% of Eligible Expenses.
15. Inpatient Hospital Services	Inpatient Stay in a Hospital. Benefits are available for: • Services and supplies received during the Inpatient Stay. • Room and board in a Semi-Private Room (a room with two or more beds), or • A private room only when medically necessary and approved in advance by the Plan. **Prior Authorization Required** Please remember that You must notify Us as follows: • For elective admissions; and • For Emergency admissions: within two (2) business days or the same day of admission, or as soon as is reasonably possible. Unless We pre-approve inpatient Hospital services, Network and Non-Network Benefits will be reduced by 50% of Eligible Expenses.

16. In-Vitro Fertilization	Covered Health Services for In-Vitro Fertilization (IVF) include the following charges:
	
	• IVF associated lab;
	• Medication (covered under the pharmacy benefit);
	• Imaging and procedures including female and male pre-testing;
	• The IVF process, and;
	• Cryopreservation.
	
	Benefits are provided for in-vitro fertilization if the following conditions are met:
	• The patient's oocytes are fertilized with the sperm of the patient's Spouse, and
	• The patient and the patient's Spouse have a history of unexplained infertility of at least two (2) years' duration; or
	• The infertility is associated with one or more of the following medical conditions:
	  • Endometriosis;
	  • Exposure in utero to Diethylstilbestrol, commonly known as DES;
	  • Blockage of or removal of one or both fallopian tubes (lateral or bilateral salpingectomy) not a result of voluntary sterilization; or
	  • Abnormal male factors contributing to the infertility, and
	• The in-vitro fertilization procedures are performed at a medical facility, licensed or certified by the Arkansas Department of Health, those performed at a facility certified by the Arkansas Department of Health which conform to the American College of Obstetricians and Gynecologists' guidelines for in vitro fertilization clinics, or those performed at a facility certified by the Arkansas Department of Health which meet the American Fertility Society's minimal standards for programs of in vitro fertilization.
	
	Any combination of Network and Non-Network Benefits is limited to a lifetime maximum benefit of $15,000 during the entire period of time You are covered under this Policy. See Section 13, N. for related exclusions.
	
	Prior Authorization Required

Benefit	Description **See Schedule of Coverage and Benefits for Your cost-sharing Amount** [Note: Copayments [and Deductibles] do not count towards Your Out-of-Pocket (OOP) Maximum; only Coinsurances [and Deductibles] apply to Your OOP Maximum.]
	Unless We pre-approve these services, Network and Non-Network Benefits will be reduced by 50% of Eligible Expenses.
17. Maternity Services	Benefits for Pregnancy will be paid at the same level as Benefits for any other condition, Sickness or Injury. This includes all maternity related medical services for prenatal care, postnatal care, delivery, and any Complications of Pregnancy. Laboratory, x-ray and other diagnostic testing services such as ultrasounds related to a Pregnancy are also covered. Ultrasounds in uncomplicated Pregnancies are limited to two (2) per Pregnancy. We will pay Benefits for an Inpatient Stay of: • Forty-eight (48) hours for the mother and newborn child following a normal vaginal delivery. • Ninety-six (96) hours for the mother and newborn child following a cesarean section delivery. • Five (5) full days in a hospital nursery or until the mother is discharged from the hospital following the birth of the child, whichever is the lesser period of time. If the mother agrees, the attending provider may discharge the mother and/or the newborn child earlier than these minimum time frames. Early discharge requires that both of the following requirements are met: • The discharge complies with the guidelines of the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists. • The mother and child are provided post-discharge care as determined by the attending physician. Post-discharge care shall consist of a minimum of two (2) visits, at least one (1) of which shall be in the home, in accordance with accepted maternal and neonatal physical assessments, by a registered professional nurse with experience in maternal and child health nursing or a physician; and includes parent education, training in breast or bottle-feeding, and appropriate testing of the mother and child. Copayments/Coinsurances and Deductible requirements apply to normal newborn admissions and both the mother and newborn will incur separate inpatient Copayments/Deductible as follows: • If the mother and newborn are discharged from the same hospital on the same day, applicable Copayments/Coinsurances and Deductible will apply separately for the mother and the newborn; however, the Deductible will be waived for the newborn; • If the mother and newborn are *not* discharged from the same hospital on the same day, both the mother and newborn will each incur applicable Copayments/Coinsurances and Deductibles for their inpatient hospital stay. The newborn's inpatient hospital Copayment/Coinsurance and Deductible will cover the dates of service *after* the mother's discharge, or dates of service at a different hospital. • If the newborn remains hospitalized after the mother's discharge date, an inpatient authorization is required for the dates of service after the mother's discharge date, and vice versa. See "Prior Authorization Required" below. **Note:** The number of prenatal visits or change in Physicians may affect your Copayment or Coinsurance. Maternity care Benefits will be extended to a Subscriber's unmarried Dependent child. The Subscriber provides no Benefits for the infant child of the Subscriber's unmarried Dependent child, unless the infant child of the unmarried Dependent is otherwise eligible for coverage. **Prior Authorization Required** Please remember that You must notify Us as soon as reasonably possible if the Inpatient Stay for the mother and/or the newborn will be more than the time frames described above. Unless We pre-approve any extended inpatient Hospital services beyond labor and delivery for either You or Your newborn, Your Network and Non-Network Benefits for the extended stay will be reduced

Benefit	Description **See Schedule of Coverage and Benefits for Your cost-sharing Amount** [Note: Copayments [and Deductibles] do not count towards Your Out-of-Pocket (OOP) Maximum; only Coinsurances [and Deductibles] apply to Your OOP Maximum.]
	by 50% of Eligible Benefits.
18. Mental Health and Substance Abuse Services - Outpatient	Mental Health, Substance Abuse and a Chemical Dependency evaluations and assessment prescribed by a licensed professional. • Diagnosis • Treatment planning • Referral services • Medication management • Short-term individual, family and group therapeutic services (including Intensive Outpatient Program) • Crisis intervention For Network Benefits, referrals to a mental health/substance abuse provider are at the sole discretion of the Mental Health/Substance Abuse Designee, who is responsible for coordinating all of Your care. Contact the Mental Health/Substance Abuse Designee regarding Network Benefits for outpatient Mental Health and Substance Abuse Services. Any combination of Network and Non-Network Benefits for these outpatient Mental Health Services and/or Substance Abuse Services is limited according to Your Schedule of Coverage and Benefits. See Section 13, J., P. for exclusions related to this Benefit. **Prior Authorization Required** Please remember that You must call and get authorization to receive these Benefits in advance of any treatment through the Mental Health/Substance Abuse Designee. The Mental Health / Substance Abuse Designee phone number appears on Your ID card. Unless We pre-approve these services, Network and Non-Network Benefits will be reduced by 100% of Eligible Expenses.
19. Mental Health and Substance Abuse Services – Inpatient and Intermediate	Mental Health and Substance Abuse Services received on an inpatient or intermediate care basis in a Hospital or an Alternate Facility. Benefits include detoxification from abusive chemical or substances that is limited to physical detoxification when necessary to protect Your physical health and well-being. The Mental Health/Substance Abuse Designee, who will arrange for the service, will determine the appropriate setting for the treatment. If an Inpatient Stay is required, it is covered on a Semi-Private Room basis. At the discretion of the Mental Health/Substance Abuse Designee, two (2) sessions of intermediate care (such as Partial Hospital Treatment Program) may be substituted for one (1) inpatient day. Network Benefits for Mental Health Services and Substance Abuse Services must be provided by or under the direction of the Mental Health/Substance Abuse Designee. For Network Benefits, referrals to a mental health/substance abuse provider are at the sole discretion of the Mental Health/Substance Abuse Designee, who is responsible for coordination all of Your care. Contact the Mental Health/Substance Abuse Designee regarding Benefits for inpatient/intermediate Mental Health Services and Substance Abuse Services. Any combination of Network and Non-Network Benefits for these inpatient and intermediate Mental Health Services and Substance Abuse is limited according to Your Schedule of Coverage and Benefits. Residential treatment services are not covered. See Section 13, J., P. for exclusions related to this Benefit. **Prior Authorization Required** Please remember that You must call and get authorization to receive these Benefits in advance of any treatment through the Mental Health/Substance Abuse Designee. The Mental Health / Substance Abuse Designee phone number appears on Your ID card. Unless We pre-approve these

Benefit	Description **See Schedule of Coverage and Benefits for Your cost-sharing Amount** [Note: Copayments [and Deductibles] do not count towards Your Out-of-Pocket (OOP) Maximum; only Coinsurances [and Deductibles] apply to Your OOP Maximum.]
	services, Network and Non-Network Benefits will be reduced by 100% of Eligible Expenses.
20. Neuropsychological Testing	Neuropsychological Testing is a covered benefit for an individual who has suffered a brain injury, dementia (including cognitive degeneration as seen in individuals with Alzheimer's), cerebrovascular disease, and is covered when: ▪ Results of the assessment will significantly alter the treatment plan; and ▪ This type of assessment is the least intrusive, as well as most time and resource efficient method of meeting treatment goals for; and ▪ The testing is not used to confirm previous testing/diagnostic results; ▪ There are only mild or questionable deficits on standard mental status testing, and more precise evaluation is needed to establish the presence of abnormalities or distinguish them from changes that may occur with normal aging or the expected progression of other disease processes; or ▪ There is a need to quantify the patient's deficits, particularly when the information will be useful in determining a prognosis; or ▪ There is a need to characterize the strengths and weaknesses of a patient, as a guide to treatment or rehabilitation planning; or ▪ Neuropsychological data can provide a more comprehensive profile of function that, when combined with clinical, laboratory, and imaging data, may assist in determining a diagnosis; or ▪ The patient is being considered for epilepsy surgery; and ▪ Will affect medical treatment choices. **Note:** Neuropsychological Testing to assist in planning educational and vocational programs, for the purpose of disability determinations, and/or for forensic determinations is not a covered benefit. See Section 13, P. for exclusions related to this Benefit. **Prior Authorization Required** Unless We pre-approve these services, Network and Non-Network Benefits will be reduced by 50% of Eligible Expenses.
21. Newborn Child Coverage	Coverage for newborn children begins from the moment of birth. Benefits include coverage for illness, injury, congenital defects, premature birth, tests for hypothyroidism, phenylketonuria, galactosemia, sickle-cell anemia, all other disorders of metabolism, and routine nursery care and pediatric charges for a well newborn child for up to five (5) full days in a hospital nursery or until the mother is discharged from the hospital following the birth of the child, whichever is the lesser period. **Prior Authorization Required** We must be notified within ninety (90) days of birth, or Your next Premium due date, whichever is greater. If You don't notify Us, You will be responsible for paying 100% of the charges incurred after the lesser of five (5) days, or the mother's discharge date.
22. Nutritional Counseling	Nutritional counseling that is appropriately included as part of the course of treatment based on the efficacy of the diet and lifestyle and treatment of the disease states, in accordance with Plan policies and procedures, which are subject to change. Expenses for nutritional counseling for up to three (3) visits in a [Calendar] [Plan] Year are covered. Coverage is provided for only certain conditions such as diabetic education, congestive heart failure, malnutrition and nutritional deficiencies. See Section 13, I. and K., for related limitations or exclusions to this benefit.

Benefit	Description **See Schedule of Coverage and Benefits for Your cost-sharing Amount** [Note: Copayments [and Deductibles] do not count towards Your Out-of-Pocket (OOP) Maximum; only Coinsurances [and Deductibles] apply to Your OOP Maximum.]
23. Nutritional Supplements	Nutritional supplements are covered Benefits only when tube feeding (enteral administration) using nutritional supplements is the sole source of a member's nutrition for a permanent condition, or when parenteral (intravenous administration) nutritional requirements exists (i.e., hyperemesis of pregnancy). Coverage is only provided when the following conditions exist: (a) A permanent non-function or disease of the structures that normally permit food to reach the small bowel; or (b) Disease of the small bowel which impairs digestion and absorption of an oral diet, leading to insufficient nutrition to maintain weight and strength commensurate with the member's overall health status; or (c) Because the member is taking medication or undergoing treatment that is depleting the body's normal supply of nutrients. Oral nutrition (including Medical Foods) is not considered a covered benefit, except for PKU formula, or low protein modified food products described below. See Section 13, I for limitations and exclusions related to this benefit. **Prior Authorization Required** Unless We pre-approve these services, Network and Non-Network Benefits will be reduced by 50% of Eligible Expenses.
24. Observation Care	Observation Care are those services furnished by a hospital on the hospital's premises, including use of a bed and periodic monitoring by a hospital's nursing or other staff, that are reasonable and necessary to evaluate an outpatient's condition or determine the need for a possible admission to the Hospital as an inpatient. Most Observation services do not exceed one (1) day. Some patients, however, may require a second day of outpatient Observation services. Members may be admitted as Observation status to beds in the Emergency room, an Observation unit, the intensive care unit, or a regular floor. If an Observation admission results in a conversion to an Inpatient Admission for the same condition within 24 hours, the Observation Copayment/Coinsurance will be waived. The alternate Copayment/Coinsurance will apply. **Prior Authorization Required** Unless We pre-approve services that exceeds one (1) day, Network and Non-Network Benefits will be reduced by 50% of Eligible Expenses.
25. Osteoporosis Services/Bone Mineral Density (BMD) Testing	Diagnosis, treatment, and appropriate management of osteoporosis for Covered Persons with a condition or medical history for which bone mass measurement is medically indicated. **Prior Authorization Required** Coverage limitations may apply. Some services require Prior Authorization. A list of services requiring Prior Authorization can be obtained at www.mercyhealthplans.com or by calling Our Customer Contact Center at the number listed on Your ID card. Unless We pre-approve BMD testing that requires Prior Authorization, Network and Non-Network Benefits will be reduced by 50% of Eligible Expenses.
26. Outpatient Diagnostic Services	Covered Health Services received on an outpatient basis at a Hospital or Alternate Facility for laboratory and medical diagnostic services. • Laboratory services • X-ray/Imaging services • Other diagnostic tests and therapeutic treatments (including cancer Chemotherapy or intravenous infusion therapy) The following services are subject to the outpatient diagnostic cost-sharing, regardless of the

Benefit	Description **See Schedule of Coverage and Benefits for Your cost-sharing Amount** [Note: Copayments [and Deductibles] do not count towards Your Out-of-Pocket (OOP) Maximum; only Coinsurances [and Deductibles] apply to Your OOP Maximum.]
	place of service: • MRA • MRI • CT Scan • PET Scan • Nuclear Cardiology Imaging studies [Benefits under this section include only the facility charge and the charge for required services, supplies and equipment. When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services* below.] [Regardless of the place where these services are performed the applicable cost-sharing will apply.] **Prior Authorization Required** Some services require Prior Authorization. A list of services requiring Prior Authorization can be obtained at www.mercyhealthplans.com or by calling Our Customer Contact Center at the number listed on Your ID card. Unless We pre-approve these services, Network and Non-Network Benefits will be reduced by 50% of Eligible Expenses.
27. Outpatient Surgery/Hospital Procedures	Covered surgical services and other medical care received on an outpatient basis at a Hospital or Alternate Facility. Benefits under this section include only the facility charge and the charge for required services, supplies and equipment. Benefits for related professional fees are described under *Professional Fees for Surgical and Medical Services* below and may incur separate Copayment/Coinsurance in addition to the outpatient facility Copayment/Coinsurance. [Regardless of the place where these services are performed, the applicable cost-sharing will apply.] **Surgical Implants**, whether inserted in the inpatient, outpatient, or office setting, including pacemakers, stents, and other implantable devices or treatments. Copayment/Coinsurance is consistent with type of service required. Implants for cosmetic or psychological reasons are excluded, see Section 13, K. **Prior Authorization Required** Some services require Prior Authorization. A list of services requiring Prior Authorization can be obtained at www.mercyhealthplans.com or by calling Our Customer Contact Center at the number listed on Your ID card. Unless We pre-approve these services, Network and Non-Network Benefits will be reduced by 50% of Eligible Expenses.
28. Physician's Office Services	Covered Health Services received in a Physician's office including: • Treatment of a Sickness or Injury; • Preventive medical care; • Well-baby and well-child care including children's preventive health care services for children from birth through 18 years of age; • Routine physical examinations; • Vision and hearing screenings. (Vision screenings do not include refractive examinations to detect vision impairment. See *Eye Examination* earlier in this Section.) • Testing for lead poisoning; • Second opinion rendered by a specialist in that specific diagnosis area, including but not limited to when a patient with a newly diagnosed cancer is referred to such specialist by his or her attending physician. Coverage for this second opinion is subject to the same conditions as any other benefit when the specialist is not a Network Physician. [For Preventive Health/Wellness care in a Physician's office, see *Preventive Health/Wellness Services* below.]

Benefit	Description **See Schedule of Coverage and Benefits for Your cost-sharing Amount** [Note: Copayments [and Deductibles] do not count towards Your Out-of-Pocket (OOP) Maximum; only Coinsurances [and Deductibles] apply to Your OOP Maximum.]
29. PKU Formula and Medical Foods for Metabolic Disorders	Benefits are provided for PKU formula Medical Foods and Low Protein Modified Food Products if the following are met: • The Medical Food or Low Protein Modified Food Products are prescribed as medically necessary for the therapeutic treatment of phenylketonuria, galactosemia, organic acidemias, and disorders of amino acid metabolism; • The products are administered under the direction of a physician licensed; and • The cost of the Medical Food or Low Protein Modified Food Products for an individual or a family with a Dependent person or persons exceeds $2,400 per year per person. See Section 13, I. for limitations and exclusions related to this Benefit.
30. Preventive Health & Wellness Care	Preventive Health Screenings in accordance with the American Cancer Society guidelines and additional preventive Benefits provided by Mercy Health Plans. [Preventive Health Screenings listed in this section below are not subject to the Deductible. The Plan pays 100% for the Preventive Health Screenings only when you use Network providers.] Preventive Health Screenings include one (1) routine test of each of the following every [Calendar] [Plan] Year, unless otherwise indicated: • Cholesterol Tests • Colon Screening: – Fecal Occult Blood Test – Colonoscopy – one (1) routine screening every ten (10) years starting at age 50 – Double-contrast Barium Enema one (1) routine screening every five (5) years starting at age 50 – Flexible Sigmoidoscopy one (1) routine screening every five (5) years starting at age 50 • Mammography starting at age 35 and older • Pap Test • Pelvic Exam • Prostate Exam • PSA test starting at age 40 • [Preventive care in a Physician's office including: One (1) annual physical exam per [Calendar] [Plan] Year, periodic visits for well-baby and well-child care, hearing and vision screenings.] [Preventive Health Screenings are covered in-Network with no Deductible. Deductible and Coinsurances will apply to services received from a Non-Network Provider.] [Regardless of the place where these services are performed the applicable cost-sharing will apply.]
31. Professional Fees for Surgical and Medical Services	Professional fees for surgical procedures and other medical care provided in an outpatient facility. You may incur a separate Copayment/Coinsurance in addition to the outpatient facility charge. When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services* above.
32. Reconstructive Procedures	Services for reconstructive procedures, when a physical impairment exists and the primary purpose of the procedure is to improve or restore physiologic function. Reconstructive procedures include surgery or other procedures which are associated with an Injury, Sickness or Congenital Anomaly. The fact that physical appearance may change or improve as a result of a reconstructive procedure does not classify such surgery as a Cosmetic Procedure when a physical impairment exists, and the surgery restores or improves function. Cosmetic Procedures are excluded from coverage. Procedures that correct an anatomical Congenital Anomaly without improving or restoring physiologic function are considered

Benefit	Description **See Schedule of Coverage and Benefits for Your cost-sharing Amount** [Note: Copayments [and Deductibles] do not count towards Your Out-of-Pocket (OOP) Maximum; only Coinsurances [and Deductibles] apply to Your OOP Maximum.]
	Cosmetic Procedures. The fact that a Covered Person may suffer psychological consequences or socially avoidant behavior as a result of an Injury, Sickness or Congenital Anomaly does not classify surgery or other procedures done to relieve such consequences or behavior as a reconstructive procedure. See Section 13, K. for related limitations and exclusions. Please note that Benefits for reconstructive procedures include breast reconstruction following a mastectomy related to breast disease, and reconstruction of the non-affected breast to achieve symmetry. Reconstructive surgery for breast reconstruction and the receipt of related prosthetic devices may follow a mastectomy at any time. Other services required by the Women's Health and Cancer Rights Act of 1998, including breast prostheses and treatment of complications, are provided in the same manner and at the same level as those for any other Covered Health Service. You can contact Us at the telephone number on Your ID card for more information about Benefits for mastectomy-related services. **Prior Authorization Required** You must notify Us before receiving services. When You notify Us, We can verify that the service is a reconstructive procedure rather than a Cosmetic Procedure. Cosmetic Procedures are always excluded from coverage. Unless We pre-approve a Covered reconstructive Service, Network and Non-Network Benefits for reconstructive procedures will be reduced by 100% of Eligible Expenses.
33. Rehabilitation Services	***Outpatient Rehabilitation Therapy*** Short-term outpatient rehabilitation services for: • Physical Therapy • Occupational Therapy • Speech Therapy • Pulmonary Rehabilitation therapy • Cardiac Rehabilitation therapy Also includes covered Health Services received on an outpatient basis at a Hospital or Alternate Facility for treatment for loss or impairment of speech or hearing. "Short-term" means rehabilitation services that are expected to result in significant physical improvement in Your condition within two (2) months of the start of treatment. Rehabilitation services must be performed by a licensed therapy provider, under the direction of a Physician. Home rehabilitation services are limited to the Homebound patient and considered separately under the home health Benefit. Please note that We will pay Benefits for speech therapy only when the speech impediment or speech dysfunction results from Injury, stroke or a Congenital Anomaly. Exclusions are described in Section 13, P. Any combination of Network and Non-Network Benefits is limited according to Your Schedule of Coverage and Benefits. ***Inpatient Rehabilitation Services*** Medically Necessary services for an Inpatient Stay in an Inpatient Rehabilitation Facility. Benefits are available for: • Services and supplies received during the Inpatient Stay • Room and board in a Semi-Private Room Any combination of Network and Non-Network Benefits is limited according to Your Schedule of Coverage and Benefits. Please note that Benefits are available only for the care and treatment of an Injury or Sickness that would have otherwise required an Inpatient Stay in a Hospital.

Benefit	Description **See Schedule of Coverage and Benefits for Your cost-sharing Amount** [Note: Copayments [and Deductibles] do not count towards Your Out-of-Pocket (OOP) Maximum; only Coinsurances [and Deductibles] apply to Your OOP Maximum.]
	Prior Authorization Required We must pre-approve services for an elective or non-elective inpatient rehabilitation admission. Unless We pre-approve inpatient rehabilitation services, Network and Non-Network Benefits will be reduced by 50% of Eligible Expenses. For Emergency Admission, You must notify Us within two (2) business days or as soon as reasonably possible.
34. Skilled Nursing Facility(SNF)	Medically Necessary services for an Inpatient Stay in a Skilled Nursing Facility. Benefits are available for: • Services and supplies received during the Inpatient Stay • Room and board in a Semi-Private Room (a room with two or more beds) Any combination of Network and Non-Network Benefits is limited according to Your Schedule of Coverage and Benefits. Please note that Benefits are available only for the care and treatment of an Injury or Sickness that would have otherwise required an Inpatient Stay in a Hospital. **Prior Authorization Required** We must pre-approve services for an elective or non-elective SNF admission. Unless We pre-approve these services, Network and Non-Network Benefits will be reduced by 50% of Eligible Expenses. For emergency admission, You must notify Us within two (2) business days or as soon as reasonably possible.
35. Spinal Treatment	Benefits for Spinal Treatment when provided by a licensed Spinal Treatment provider in the provider's office. Benefits for Spinal Treatment are limited to one (1) visit and treatment per day. Any combination of Network and Non-Network Benefits for Spinal Treatment is limited according to Your Schedule of Coverage and Benefits.
36. Tobacco Cessation Education Program	Education Benefits are available for up to one (1) tobacco cessation group support program per year. Providers generally offer up to five (5) American Lung Association certified sessions per program. One Copayment/Coinsurance applies to each program. Tobacco cessation products are available only through a prescription drug Rider.
37. Transplant Services	Covered Health Services for the following organ and tissue transplants when ordered by a Physician. For Network Benefits, transplant services must be received at an approved facility in the designated transplant Network. Benefits are available for the transplants listed below when the transplant is Medically Necessary and is not an Experimental, Investigational or Unproven Service: • Bone marrow transplants (either from You or from a compatible donor) and peripheral stem cell transplants, with or without high dose Chemotherapy. Not all bone marrow transplants meet the definition of a Covered Health Service. Benefits include the treatment of breast cancer by dose-intensive Chemotherapy bone marrow transplants or stem cell transplants, when performed pursuant to nationally accepted peer review protocols. • Heart transplants • Heart/lung transplants • Lung transplants • Kidney transplants • Kidney/Pancreas transplants • Kidney/Liver • Liver transplants • Liver/small bowel transplants • Pancreas transplants • Small bowel transplants

Benefit	Description **See Schedule of Coverage and Benefits for Your cost-sharing Amount** [Note: Copayments [and Deductibles] do not count towards Your Out-of-Pocket (OOP) Maximum; only Coinsurances [and Deductibles] apply to Your OOP Maximum.]
	Benefits are also available for cornea transplants that are provided by a Physician at a Hospital. We do not require that cornea transplants be performed at a Designated Facility in order for You to receive Network or Non-Network Benefits. Corneal transplant does not require Prior Authorization. We have specific guidelines regarding Benefits for transplant services and there are related limitations in Section 13, Q. Contact Us at the telephone number on Your ID card for information about these guidelines. Note: You always have the option to receive Non-Network care; however, Non-Network transplant Benefits will be paid at the Usual and Customary global fee, which could result in much greater out-of-pocket costs. **Prior Authorization Required** You must notify Us as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). Unless We pre-approve these services (and before a pre-transplantation evaluation is performed at a transplant center), Network and Non-Network Benefits for transplant will be reduced by 100% of Eligible Expenses.
38. Urgent Care Center Services	Covered Health Services received at an Urgent Care Center. If radiology and other diagnostics services are provided and billed separately from the Urgent Care Center, additional Copayments/Coinsurances may apply. [When services to treat urgent health care needs are provided in a Physician's office, Benefits are available as described under *Physician's Office Services*above.] [When Urgent Care services are provided in a Physician's office, applicable Copayment/Coinsurance will be charged, regardless of the place where these services are performed.]
39. [Acupuncture Services]	[Acupuncture services for pain therapy when both of the following are true: • Another method of pain management has failed. • The service is performed by a provider in the provider's office. • Prior Authorization is required. Any combination of Network and Non-Network Benefits is limited to according to Your Schedule of Coverage and Benefits.]

Section 13: Exclusions – Things We Don't Cover

This section contains information about Medical services that are not covered. We call these Exclusions. It is important for You to know what services and supplies are not covered under this Policy.

We do not pay Benefits for exclusions or any related complications.

We will not pay Benefits for any of the services, treatments, items or supplies described in this section, even if any of the following is true:

- It is recommended or prescribed by a Physician.
- It is the only available treatment for Your condition.

The services, treatments, items or supplies listed in this section are not Covered Health Services, except as may be specifically provided for in Section 12 (Covered Benefits) or through a Rider to this Policy.

Category	Description
A. Alternative Treatments	We do not cover alternative treatments, including but not limited to: 1. Acupressure **[**and Acupuncture.**]** 2. Aromatherapy. 3. Hypnotism. 4. Massage Therapy. 5. Rolfing. 6. Herbal remedies. 7. Ayurvedic therapies. 8. Reflexology. 9. Biofeedback and neurofeedback therapy. 10. Other forms of alternative treatment as defined by the Office of Alternative Medicine of the National Institutes of Health.
B. Comfort or Convenience	1. Television. 2. Telephone. 3. Beauty/Barber service. 4. Guest service. 5. Automated travel devices (motor scooters). 6. Supplies, equipment and similar incidental services and supplies for personal comfort or convenience. Examples include: - Air conditioners - Batteries and battery chargers - Electrostatic machines - Portable room heaters, grab bars, etc. - Tanning booths, - Breast pumps unless newborn is in NICU - Raised or regular toilet seats - Air purifiers and filters - Dehumidifiers and Humidifiers - Lights/lighting - Vaporizers - Bath chairs - Exercise equipment - Whirlpools, saunas, and hot tubs 7. Devices and computers to assist in communication and speech. Augmentative communication devices, including but not limited to computer assisted speech devices, speech teaching machines, telephones, TDD equipment, Braille teaching texts, computers, and telephone alert systems. Exceptions include basic, Non-digital voice systems, such as the Electro-Larynx, after post-radical neck or other invasive surgery that interferes with laryngeal function. 8. Personal hygiene items and hygienic items, including but not limited to shower chairs, commodes (unless the individual is confined to room or bed), incontinence pads, bed baths, etc.

Category	Description
	9. Devices that are primarily non-medical in nature or used primarily for comfort, including but not limited to: - Bed boards - Elevators - Foam pads - Heating pads - Beds other than standard single hospital beds - Carafes - Emesis basins - Maternity belts - Bathtub seats - Standing tables - Overbed tables 10. Chair lifts, bathtub lifts, bed lifter, and other similar devices. 11. Exercise equipment including but not limited to parallel bars, weights, bicycles, rowing machines, and treadmills.
C. Dental	1. Dental care except as described in Section 12 (Covered Benefits) under the heading, "Dental Services Accident Only" and "Dental – Anesthesia and Facility Charges". 2. Preventive care, diagnosis, treatment of or related to the teeth, jawbones or gums, whether the services are considered to be medical or dental in nature. Examples include all of the following: – Extraction, restoration and replacement of teeth; – Medical or surgical treatments of dental conditions; – Services to improve dental clinical outcomes; – Services for overbite or underbite; – Services related to surgery for cutting through the lower or upper jaw bone; – Maxillary and mandibulary osteotomies 3. Dental implants and associated oral surgery and supplies, even if associated with Accidental Dental Services. This includes but is not limited to any enabling procedures for implants, as well as placement, maintenance, restoration, and removal of dental implants. Any prosthetic superstructure fabricated upon a dental implant is also excluded. 4. Dental braces and occlusal splints, even if associated with Accidental Dental Services. 5. Dental X-rays, supplies and appliances and all associated expenses, including hospitalizations and anesthesia. The only exceptions to this are for any of the following: – Transplant preparation; – Initiation of immunosuppressives; – The direct treatment of acute traumatic Injury; – The direct treatment of cancer (i.e., injury to teeth as a direct effect of cancer treatment); – Cleft palate; – Covered Persons with conditions outlined in Section 12(Covered Benefits) under Dental – Anesthesia and Facility Charges; 6. Treatment of congenitally missing, malpositioned, or super numerary teeth, even if part of a Congenital Anomaly. 7. Orthodontic services. 8. Services for the evaluation and treatment of temporomandibular joint syndrome (TMJ), whether the services are considered to be medical or dental in nature. 9. Upper and lower jawbone surgery except as required for direct treatment of acute traumatic injury or cancer. 10. Orthognathic surgery, jaw alignment and treatment for the temporomandibular joint syndrome, except as a treatment of obstructive sleep apnea.
D. Drugs	1. Prescription drug products for outpatient use (including self-injectables) that are filled by a prescription order or refill. 2. Non-injectable medications given in a Physician's office except as required in an Emergency. 3. Over the counter drugs and treatments.

Category	Description
	4. Charges for supplies for use beyond the first twenty-four (24) hours following discharge from the Hospital as an Inpatient or following the provision of Emergency Care, including any prescription drugs intended primarily for home use.
E. Experimental, Investigational or Unproven Services	1. Experimental, Investigational or Unproven Services are excluded. The fact that an Experimental, Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Benefits if the procedure is considered to be Experimental, Investigational or Unproven in the treatment of that particular condition.
F. Foot Care	1. Routine foot care (including the cutting or removal of corns and calluses). 2. Nail trimming, cutting, or debriding, unless the charges are for the removal of a nail or root in connection with the treatment of a metabolic or peripheral-vascular disease or infection. 3. Hygienic and preventive maintenance foot care. Examples include the following: – Cleaning and soaking the feet; – Applying skin creams in order to maintain skin tone; – Other services that are performed when there is not a localized illness, Injury or symptom involving the foot. 4. Treatment of flat feet, painful feet, fallen arches, metatarsalgia, plantar fasciitis, neuromas, tendonitis, bursitis, varus or valgus deformities, and other conditions of the feet unless otherwise noted in this document. 5. Treatment of subluxation of the foot. 6. Shoe orthotics, orthopedic shoes and other supportive appliances for feet, except as otherwise noted in this document.
G. Medical Supplies and Appliances	1. Devices used specifically as safety items or to affect performance in sports-related activities. 2. Prescribed or Non-prescribed medical supplies and disposable supplies. Examples include: – Elastic stockings – Ace bandages – Gauze and dressings – Disposable sheets and bags – Fabric supports – Surgical face masks – Incontinent pads, including diapers – Irrigating kits – Pressure leotards – Surgical leggings and support hose Exceptions include diabetic supplies covered under the medical benefit and ostomy supplies and supplies associated with equipment and home care services that have been provided in accordance with Plan policies and procedures. 3. Orthotic and prosthetic appliances for sports-related activities. 4. Tubings and masks are not covered except when used with Durable Medical Equipment as described in Section 12 (Covered Benefits). 5. Devices and equipment that are not normally appropriate outside of a hospital (or other provider) setting, including but not limited to: – Home monitoring devices and supplies, except Medically Necessary cardiac monitoring devices (such as holter monitors and event recorders) – Home prenatal monitoring and associated nursing support 6. The following are not covered under the medical benefit: – Insulin syringes with needles – Lancets and lancet devices – Glucometers, test strips and related supplies. 7. Lift Seats.

Category	Description
H. Mental Health/Substance Abuse	1. Services performed in connection with conditions not classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. 2. Services utilizing methadone treatment as maintenance, L.A.A.M (1-Alpha-Acetyl-Methadol), Cyclazocine, or their equivalents. 3. Psychosurgery. 4. Vagus nerve stimulation (VNS) for depression. 5. Treatment provided in connection with or to comply with involuntary commitments, police detentions and other similar arrangements unless medically necessary and authorized by the Mental Health/Substance Abuse Designee. Medically Necessary care may include any of the following: a. Not consistent with prevailing national standards of clinical practice for the treatment of such conditions including but not limited to Mental Health Services and Substance Abuse Services that extend beyond the period necessary for short term evaluation, diagnosis, treatment or crisis intervention. b. Not consistent with prevailing professional research demonstrating that the services or supplies will have a measurable and beneficial health outcome. c. Typically do not result in outcomes demonstrably better than other available treatment alternatives that are less intensive or more cost effective. d. Not consistent with the Mental Health/Substance Abuse Designee's level of care guidelines or best practices as modified from time to time. 6. Services or supplies for the diagnosis or treatment of Mental Illness, alcoholism or substance abuse disorders that, in the reasonable judgment of the Mental Health/Substance Abuse Designee, are any of the following: a. Not consistent with prevailing national standards of clinical practice for the treatment of such conditions including but not limited to Mental Health Services and Substance Abuse Services that extend beyond the period necessary for short term evaluation, diagnosis, treatment or crisis intervention. b. Not consistent with prevailing professional research demonstrating that the services or supplies will have a measurable and beneficial health outcome. c. Typically do not result in outcomes demonstrably better than other available treatment alternatives that are less intensive or more cost effective. d. Not consistent with the Mental Health/Substance Abuse Designee's level of care guidelines or best practices as modified from time to time. 7. Mental Health Services and Substance Abuse Services that extend beyond the period necessary for short-term evaluation, diagnosis, treatment or crisis. Intervention. 8. Mental Health Services as treatment for insomnia and other sleep disorders, neurological disorders and other disorders with a known physical basis. 9. Treatment or services, except for the initial diagnosis, for a primary diagnosis of Mental Retardation, Learning, Motor Skills, and Communication Disorders, Pervasive Developmental Disorder, Conduct Disorder, Dementia, Sexual, Paraphilia, and Gender Identity Disorders, and Personality Disorders, as well as other Mental Illnesses that will not substantially improve beyond the current level of functioning, or that are not subject to modification or management according to prevailing national standards of clinical practice, as reasonably determined by the Mental Health/Substance Abuse Designee. 10. Residential treatment services. The Mental Health/Substance Abuse Designee may consult with professional clinical consultants, peer review committees or other appropriate sources for recommendations and information regarding whether a service or supply meets any of these criteria.
I. Nutrition	1. Megavitamin and nutrition based therapy (for any purpose). 2. Vitamins (other than those prenatal vitamins prescribed for a Member who is then pregnant). 3. Nutritional counseling and other hospital-based educational programs for either individuals or groups, except for treatment of Diabetes or certain illnesses or

Category	Description
	conditions. 4. Medical foods and other nutritional and electrolyte supplements taken orallyor enterally regardless of the disease state, including infant formula and donor breast milk. This exclusion does not apply to the treatment of Phenylketonuria or any inherited disease of amino or organic acids, or nutritional supplements ordered by a Physician in connection with home care, which requires the Member to have a feeding tube as a sole source of nutrition.
J. Personal	1. Physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments that are otherwise covered under this Policy when: a. Required solely for purposes of career, education, sports or camp, travel, recreation, employment, insurance, marriage or adoption. b. Related to judicial or administrative proceedings or orders. c. Conducted for purposes of medical research. d. Required to obtain or maintain a license of any type. 2. Custodial Care. See Section 14 (Definitions of Terms). 3. Domiciliary care or any nursing care on full-time basis in Your home. 4. Private Duty Nursing. See Section 14 (Definitions of Terms). 5. Respite care. 6. Rest cures. 7. Medical and surgical treatment of excessive sweating (hyperhidrosis). 8. Medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea. 9. Oral appliances for snoring. 10. Care for an Injury or Illness resulting from participation in, or in consequence of having participated in an illegal occupation or the commission of an assault or felony. 11. Work place evaluations and work hardening treatment.
K. Physical Appearance	1. Cosmetic Procedures. See the definition in Section 14 (Definitions of Terms). Examples include: – Pharmacological regimens, nutritional procedures or treatments; – Scar, keloid or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures); – Skin abrasion procedures performed as a treatment for acne; – Liposuction; – Hair transplant for baldness; – Correction of asymmetric breasts or abnormal nipple-areolar complexes and protruding ears; – All other cosmetic services **except** if medically necessary to: i. Repair a functional disorder caused by a disease or an accidental injury suffered while insured by the Plan; ii. Restore or improve function for a structurally abnormal Congenital or developmental defect or anomaly in a Member under age nineteen (19). Anomaly is defined as a marked deviation beyond the range of normal human variation; or iii. Reconstructive breast surgery performed post-mastectomy; 2. Replacement of an existing breast implant if the earlier breast implant was performed as a Cosmetic Procedure. 3. Physical conditioning programs such as athletic training, bodybuilding, exercise, fitness, flexibility, and diversion or general motivation. 4. Weight loss programs whether or not they are under medical supervision. Weight loss programs for medical reasons are also excluded. 5. Wigs, regardless of the reason for the hair loss, except as otherwise provided by law. 6. Treatment of benign gynecomastia (abnormal breast enlargement in males). 7. Surgical and Non-surgical treatment of obesity, including morbid obesity. Treatment includes but is not limited to, stomach stapling, jaw wiring, gastric banding, gastric balloon or bypass surgery, dietary/nutritional supplements, behavioral/community support programs, exercise programs, and medical testing, medications, and office

Category	Description
	visits associated with any weight loss program. 8. Growth hormone except as determined medically necessary by the Plan to treat diagnostically proven growth hormone deficiency. Growth hormone(s) to treat idiopathic short stature (ISS) is expressly excluded. 9. Sex transformation operations. 10. Breast Reduction Surgery (Reduction Mammoplasty).
L. Preexisting Conditions	Benefits for the treatment of a Preexisting Condition are excluded until the date You have had Continuous Creditable Coverage for twelve (12) months except this waiting period will not apply to: a) A child who is placed in a Member's physical custody for purposes of adoption if the petition for adoption is filed within sixty (60) days of placement of such child; or b) A newborn if an application for coverage is filed within ninety (90) days of the birth of the child. c) A person who has had creditable coverage for eighteen (18) months without a break of sixty-three (63) days or more.
M. Providers	1. Services performed by a provider who is a family member by birth or marriage, including Spouse, brother, sister, parent or child. This includes any service the provider may perform on himself or herself. 2. Services performed by a provider with Your same legal residence. 3. Services provided at a freestanding or Hospital-based diagnostic facility without an order written by a Physician or other provider. Services that are self-directed to a free-standing or Hospital based diagnostic facility. Services ordered by a Physician or other provider who *is* an employee or representative of a free-standing or Hospital-based diagnostic facility, when that Physician or other provider: a. Has not been actively involved in Your medical care prior to ordering the service, or b. Is not actively involved in Your medical care after the service is received. This exclusion does not apply to mammography testing. 4. Charges Incurred for broken appointments with a Participating Physician.
N. Reproduction	1. Health services and associated expenses for Infertility treatments including, but not limited to, medical care or prescription drugs used to stimulate ovulation, or assisted reproductive technology (ART). ART includes any combination of chemical and/or mechanical means of obtaining a mature male or female reproductive cell and placing it into a medium (whether internal or external to the human body) to enhance the chance reproduction will occur. Examples of ART include, but are not limited to, artificial insemination, gametic intra fallopian transfer, zygote intra fallopian transfer, pronuclear state tubal transfer and surrogate Pregnancy. **ART does not include in-vitro fertilization.** 2. Surrogate parenting. 3. Voluntary sterilization or the reversal of voluntary sterilization. 4. Health services and associated expenses for elective abortion. Elective abortion means an abortion for any reason other than a spontaneous abortion or loss of the fetus as a result of the only treatment available to save the life of the mother. 5. Contraceptive supplies and services. 6. Fetal reduction surgery. 7. Health services associated with the use of non-surgical or drug induced Pregnancy termination. 8. Services (including pharmaceuticals) provided in connection with treatment or surgery to change gender or restore sexual function, unless otherwise covered in this Policy.
O. Services Provided under Another Plan	1. Health service for which other coverage is required by Federal, state or local law to be purchased or provided through other arrangements. 2. Health services for treatment of Injury, Sickness or Mental Illness arising out of or in the course of, any employment, whether or not covered by Workers' Compensation or

Category	Description
	similar law. If coverage under Workers' Compensation or similar legislation is optional for You because You could elect it, or could have it elected for You, Benefits will not be paid for any Injury, Sickness or Mental Illness that would have been covered under Workers' Compensation or similar legislation if that coverage had been elected. 3. Health services for treatment of military service-related disabilities, when You are legally entitled to other coverage and facilities are reasonably available to You. 4. Health services while on active military duty. 5. Injury or Illness incurred while incarcerated in any local, municipal, state or Federal facility.
P. Therapies/Psychological Testing	1. Speech, physical, occupational, and other rehabilitative services solely for speech/language delay or articulation disorders or other developmental delay, regardless of origin (unless otherwise covered under this policy, or by law). Speech therapy for central processing disorders, dyslexia, attention deficit disorder or other learning disabilities, stammering, stuttering, conceptual handicap, psychosocial speech delay, and voice therapy for vocational or avocational singers, and procedures that may be carried out effectively by the patient, family, or caregivers are not covered Benefits. Speech, physical, occupational, and other rehabilitative services are not covered except as required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke, or a Congenital Anomaly. 2. Cognitive therapy as a medical treatment (Non-mental health) unless provided for acute brain injury. 3. Psychological testing for services that are considered primarily educational or training in nature or related to improving academic or work performance, except when authorized in advance by the Mental Health/Substance Abuse designee. 4. Neuropsychological Testing to assist in planning educational, training, and vocational programs, for the purpose of disability determinations, and/or for forensic determinations including Neuropsychological Testing for any of the following diagnosis, except as otherwise provided by law: ▪ Attention-deficit/hyperactivity disorder (ADHD) ▪ Developmental disability, developmental delay ▪ Learning disability ▪ Mental retardation ▪ Tourette's syndrome ▪ Autism Spectrum Disorder 5. All Educational Services, including treatment of learning disorders and acquired cognitive deficits. 6. Water exercise and other exercises not under the supervision of a physical therapist. 7. Services or supplies that cannot reasonably be expected to lessen a Member's disability, and enable him/her to live outside an institution. 8. Therapy for conditions such as developmental delay, ADHD, and autism.
Q. Transplants	1. Health services for organ and tissue transplants, except those described in Section 12 (Covered Benefits). 2. Health services connected with the removal of an organ or tissue from You for purposes of a transplant to another person. (Donor costs for removal are payable for a transplant through the organ recipient's Benefits under this Policy). 3. Health services for transplants involving mechanical or animal organs. 4. Any multiple organ transplant not listed as a Covered Health Service under the heading *Transplantation Health Services* in Section 12 (Covered Benefits).
R. Travel	1. Health services provided in a foreign country, unless required as Emergency Services. 2. Travel or transportation expenses, even though prescribed by a Physician, except for medically necessary ambulance services. Some travel expenses related to covered transplantation services may be reimbursed at Our direction. 3. Air Ambulance Services outside the continental United States for any reason.

Category	Description
S. Vision and Hearing	1. Purchase cost of eye glasses, contact lenses (except for eyeglasses or contact lenses prescribed following cataract surgery, up to a maximum of a $300.00 dollar benefit per lifetime), or hearing aids. 2. Fitting charge for hearing aids, eye glasses or contact lenses. 3. Eye exercise therapy (orthoptics or pleoptic training). 4. Surgery that is intended to allow You to see better without glasses or other vision correction including radial keratotomy, laser, and other refractive eye surgery.
T. General/ Administrative	1. Health services and supplies that are not included in Section 12 (Covered Benefits), or that do not meet the definition of a Covered Health Service - see the definition in Section 14 (Definitions of Terms). 2. Health services received as a result of any catastrophic act or incident of war, whether declared or undeclared or caused during service in the armed forces of any country. 3. Health services received after the date Your coverage under this Policy ends, including health services for medical conditions arising before the date Your coverage under this Policy ends. This exclusion does not apply if You are eligible for and choose continuation coverage. For more information, see Section 10 (Continuation of Coverage) under Qualifying Events for Continuation Coverage under State Law. 4. Health services for which You have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under this Policy. 5. Charges in excess of the Usual and Customary Rate or in excess of any specified limitation. 6. Complications of Health Care Services that are not Covered Health Services. 7. Charges made for completion of forms and/or filing of claims in connection with the Benefits provided under this Plan. 8. Autopsies (post-mortem exams)

Section 14: Definitions of Terms

[Plan Year]

[Means the period of twelve (12) months commencing on the Effective Date of this Policy and each twelve (12) month period thereafter (or other periods as indicated in the Group Enrollment Policy), unless otherwise terminated as provided herein.]

Adverse Determination

A decision by Mercy Health Plans that an admission, availability of care or continued stay has been reviewed and, based upon the information provided, does not meet the Plan's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness (or is considered experimental or investigational) leading to a decision that coverage for the requested service is denied, reduced or terminated.

Allowable Expense

The necessary, reasonable and customary item of expense for health care when the item is covered at least in part under any of the plans involved in coordination of Benefits.

Alternate Facility

A health care facility that is not a Hospital or a facility that is attached to a Hospital and that is designated by the Hospital as an Alternate Facility. This facility provides one or more of the following services on an outpatient basis, as permitted by law:

- Pre-scheduled surgical services
- Emergency Room Services
- Pre-scheduled rehabilitative, laboratory or diagnostic services

Amendment

Any attached written description of additional or alternative provisions to this Policy. Amendments are effective only when signed by Us. Amendments are subject to all conditions, limitations and exclusions of this Policy, except for those that are specifically amended.

Anniversary Date

The annual anniversary of the Effective Date of this Policy.

Annual Deductible/Deductible

[If applicable, the amount You must pay for Covered Health Services in a [Calendar] [Plan] Year before We will begin paying for Benefits in that [Calendar] [Plan] Year.] [Deductible amounts are separate from and not reduced by Copayments. Deductible and Copayments are in addition to any Coinsurance You pay.] The Annual Deductible is included with any Coinsurance You pay to calculate Your total Out-of-Pocket Maximum.]

Benefits

Your right to payment for Covered Health Services that are available under this Policy. Your right to Benefits is subject to the terms, conditions, limitations and exclusions of this Policy, including this Certificate of Coverage and any attached Riders and Amendments.

Calendar Year

January 1 through December 31 of the same year.

Cardiac Rehabilitation

A comprehensive program to rehabilitate the heart.

Case Management

A coordinated set of activities conducted for individual patient management of serious, complicated, protracted or other health Conditions. Case Management may include:

1. Assessment of the Your individual benefit needs;
2. Formulation and modification of a comprehensive benefit plan of action;
3. Coordination of Benefits;
4. Evaluation of the effectiveness of the plan of action; and
5. Negotiation of extra-contractual services, if necessary.

Certificate of Coverage

This document including all riders, Amendments and Schedule of Coverage.

Chemical Dependency

The psychological or physiological dependence upon and abuse of drugs, including alcohol, characterized by drug tolerance or withdrawal and impairment of social or occupational role functioning or both.

Chemotherapy Treatment of disease by FDA-approved anti-neoplastic agents.

Chief Medical Officer(CMO) or Designee A licensed Physician under the employment of the Plan and/or such other licensed Physician or Health Professional as the Chief Medical Officer may designate, who shall be responsible for monitoring the quality of medical care rendered to Members.

Coinsurance Coinsurance is the percentage of Our allowance that You must pay for Your care. You may also be responsible for other costs for Your care such as a Deductible. See Section 5 (Your Cost for Covered Services).

Complaint Any communication primarily expressing a Grievance to the Plan by, or on behalf of the Member, or by the health care Provider. For purposes of this definition, communication is a written notice relating to the Plan's determinations, procedures, and administration and written or oral notice filed under the expedited Health Care Services appeal process or under the Utilization Review process.

Complications of Pregnancy Any complications associated with Pregnancy, i.e., conditions requiring hospital confinement (when pregnancy is not terminated), whose diagnoses are distinct from pregnancy but are affected by pregnancy, including but not limited to acute nephritis, nephrosis, cardiac decompensation, missed abortion, and similar medical and surgical conditions of comparable severity, but shall not included false labor, occasional spotting, physician prescribed rest period during the period of pregnancy, morning sickness, hyperemesis gravidarum, pre-eclampsia and similar conditions associated with the management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy; and non-elective cesarean section, termination of ectopic pregnancy, and spontaneous termination of pregnancy occurring during a period of gestation in which a viable birth is not possible.

Congenital Existing or dating from birth; acquired through development while in the uterus.

Congenital Anomaly A physical developmental defect that is present at birth, and is identified within the first twelve months of birth.

Continuous Creditable Coverage Health care coverage under any of the types of plans listed below, during which there was a break in coverage of no more than sixty-three (63) consecutive days, and provided there were eighteen (18) continuous months of eligible coverage:

- A Group health plan;
- Health insurance coverage;
- Medicare;
- Medicaid;
- Medical and dental care for Members and certain former Members of the uniformed services, and for their dependents;
- A medical care program of the Indian Health Services Program or a tribal organization;
- A state health benefit's risk pool;
- The Federal Employees Health Benefits Program;
- Any public health benefit program provided by a state, county, or other public subdivision of a state;
- A health benefit plan under the Peace Corps Act.

A waiting period for health care coverage will be included in the period of time counted as Continuous Creditable Coverage.

Copayment A Copayment is a fixed amount of money You pay when You receive Covered Services. See Section 5 (Your Cost for Covered Services).

Cosmetic Procedures Procedures or services that change or improve appearance without significantly improving physiological function, as determined by Us.

Covered Health Service(s)/Covered Service

A Covered Health Service is a Health Care Service or supply described in Section 12 (Covered Benefits) as a Covered Health Service. A Covered Health Service is a Health Care Service or supply which is not excluded under Section 13 (Exclusions) and meets the following conditions:

1) Prescribed by a Physician for the therapeutic treatment of Injury, Illness or Pregnancy;
2) Deemed Medically Necessary and appropriate in type, level, setting, and length of service; and if required by the Plan, is authorized on a prospective and timely basis by the Plan.
3) Rendered in accordance with generally accepted medical practice and professionally recognized standards;
4) Provided on or after the Effective Date and before Your coverage terminates in accordance with Section 3 (When Coverage Ends) and at a time when You met all applicable requirements for eligibility set forth in Section 2 (When Coverage Begins).
5) Not considered to be Experimental, Investigational, or which are performed for research purposes;
6) Services that are specifically included and not excluded or limited, or not specifically excluded by the Plan.

Covered Person

Either the Subscriber or an Enrolled Dependent, but this term applies only while the person is enrolled under this Policy. References to "You" and "Your" throughout this Certificate are references to a Covered Person.

Custodial Care

Services that:

- Are Non-health related services, such as assistance in activities *of* daily living (including but not limited to feeding, dressing, bathing, transferring and ambulating); *or*
- Are health-related services which do not seek to cure, or which are provided during periods when the medical condition of the patient who requires the service is not changing; or
- Do not require continued administration by trained medical personnel in order to be delivered safely and effectively.

Dependent

The Subscriber's legal Spouse or an unmarried Dependent child of the Subscriber. The term child includes any of the following:

- A natural child.
- A stepchild.
- A legally adopted child.
- A child placed for adoption.
- A child for whom permanent legal guardianship has been awarded to the Subscriber or the Subscriber's Spouse.

To be eligible for coverage under this Policy, a Dependent must reside within the United States. The definition of Dependent is subject to the conditions and limitations as set forth in the Schedule of Coverage and Benefits.

A Dependent also includes a child for whom health care coverage is required through a 'Qualified Medical Child Support Order' or other court or administrative order. The Enrolling Group is responsible for determining if an order meets the criteria of a Qualified Medical Child Support Order.

A Dependent does not include anyone who is enrolled as a Subscriber. No one can be a Dependent of more than one Subscriber.

Designated Facility

A Hospital that We name as a Designated Facility. A Designated Facility has entered into an agreement with Us, or with an organization contracting on Our behalf, to render Covered Health Services for the treatment of specified diseases or conditions. A Designated Facility may or may not be located within Our geographic area.

Durable Medical Equipment

Medical equipment that is all of the following:

- Can withstand repeated use;
- Is not disposable;
- Is used to serve a medical purpose with respect to treatment of a Sickness, Injury or their symptoms;
- Is generally not useful to a person in the absence of a Sickness, Injury or their symptoms;
- Is appropriate for use in the home.

Educational Service

A service provided as a means of training Members through formal instruction and supervised practice. Educational Services include those services designed to assist Members who do not currently meet maturation expectations in making progress towards those goals.

Effective Date

The Effective Date of coverage for the Group as specified in the Group Insurance Policy, or the separate Effective Date specified under any Rider, or for any particular individual as determined in accordance with Section 2 of this Policy.

Eligible Expenses

The amount We will pay for Covered Health Services, incurred while this Policy is in effect, are determined as stated below:

Eligible Expenses are determined solely in accordance with Our reimbursement policy guidelines. We develop Our reimbursement policy guidelines, in Our discretion, following evaluation and validation of all provider billings in accordance with one or more of the following methodologies:

- As indicated in the most recent edition of the Current Procedural Terminology (CPT), a publication of the American Medical Association;
- As reported by generally recognized professionals or publications;
- As used for Medicare;
- As determined by medical staff and outside medical consultants pursuant to other appropriate source or determination that We accept.

Eligible Person

An employee of the Enrolling Group or other person whose connection with the Enrolling Group meets the eligibility requirements specified in both the application and this Certificate of Coverage. An Eligible Person must reside within the United States.

Emergency

The sudden and, at the time, unexpected onset of a health condition that manifests itself by symptoms of sufficient severity that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that immediate medical care is required, which may include, but will not be limited to any of the following:

- Placing the person's health in significant jeopardy;
- Serious impairment to a bodily function;
- Serious dysfunction of any bodily organ or part;
- Inadequately controlled pain;
- With respect to a pregnant woman who is having contractions, either of the following:
  - Inadequate time to affect a safe transfer of a pregnant woman to another hospital before delivery;
  - The transfer to another hospital may pose a threat to the health or safety of the woman or unborn child.

Emergency Care/Emergency Room Services

Health Care Services and supplies necessary for the treatment of an Emergency.

Enrolled Dependent

A Dependent who is properly enrolled under this Policy.

Enrolling Group

The employer, or other defined or otherwise legally established Group, to whom this Policy is issued.

Experimental or Investigational Services

Medical, surgical, diagnostic, psychiatric, substance abuse or other Health Care Services, technologies, supplies, treatments, procedures, drug therapies or devices that, at the time We make a determination regarding coverage in a particular case, are determined to be any of the following:

- Not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service or the United States Pharmacopoeia Dispensing Information as appropriate for the proposed use.
- Subject to review and approval by any institutional review board for the proposed use.
- The subject of an ongoing clinical trial that meets the definition of a Phase 1 clinical trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight.

External Independent Reviewer

A clinical peer with no direct financial interest in connection with the Grievance/appeal in question and who has not been informed of the specific identity of the Enrollee.

External Review

A process, independent of all affected parties, to determine if a health care service is medically necessary or experimental/investigational.

Full-Time Student

An unmarried Dependent child who meets all the following conditions:

- The child must not be regularly employed on a full-time basis.
- The child must be primarily dependent upon the Subscriber for support and maintenance.
- The child must be attending, fulltime, a recognized course of study or training at one of the following:
  - An accredited high school;
  - An accredited college or university;
  - A licensed vocational school, technical school, beautician school, automotive school or similar training school.

Full-time Student status is determined in accordance with the standards set forth by the educational institution. You are no longer a Full-time Student on the date You graduate or otherwise cease to be enrolled and in attendance at the institution on a full-time basis.

You continue to be a Full-time Student during periods of regular vacation established by the institution. If You do not continue as a Full-time Student immediately following the period of vacation, the Full-time Student designation will end as described above.

Grievance

A written Complaint submitted by or on behalf of a Member regarding the a) availability, delivery or quality of Health Care Services, including a Complaint regarding an Adverse Determination made pursuant to Utilization Review; b) claims payment, handling or reimbursement for Health Care Services; or c) matters pertaining to the contractual relationship between a Member and the Company.

Group Policyholder/Group

The employer, labor union, trust, association, partnership, government agency, or other organization to which this Policy is issued and through which as agent for Subscriber only, and not for the Plan, a Subscriber and his/her Dependents become entitled to the coverage described in this Policy.

Health Care Service(s)

Those health services provided for cosmetic or other Non-medical purposes, or for the purpose of preventing, diagnosing or treating a Sickness, Injury, Mental Illness, substance abuse, or their symptoms, but do not include prescription drug benefits.

[Health Reimbursement Arrangement (HRA)]

[Tax-free health plan deposits provided by Your employer that allows You to accumulate savings for tax-free withdrawals for Qualified Medical Expenses. HRA reimbursements for medical expenses are not included in Your income. Unused funds are owned by Your

employer and are not portable when You terminate Your employment.]

[Health Savings Account (HSA)] [An HSA is a special, tax-advantaged account where money goes in tax-free, earns interest tax-free and is not taxed when it is withdrawn to pay for Qualified Medical Expenses under a High Deductible Health Plan. Either the employee or the employer can make contributions to the HSA. Unused funds are owned by the employee, can be rolled over annually, and are portable when You terminate Your employment, change health plan options, or change health plan carriers.]

[High Deductible Health Plan (HDHP)] [An HDHP is a plan with a Deductibles that meet the requirements established by the Internal Revenue Code making this plan eligible to coordinate with either an HSA or an HRA.]

Homebound Homebound means an individual who is confined to the home as a result of their physical or mental condition and that leaving home is a major effort and normally requires assistance. Leaving home is done to receive medical care or for short, infrequent non-medical reasons such as a trip to the grocery store, beauty parlor or barbershop, or to attend religious services.

Home Health Agency A program or organization authorized by law to provide Health Care Services in the home.

Hospital A legally constituted institution, having organized facilities for the care and treatment of sick and injured persons on a resident or inpatient basis, including facilities for diagnosis and surgery under supervision of a staff of one or more licensed physicians and which provides 24-hour nursing services by registered nurses on duty or call. It does not mean convalescent, nursing, rest or extended care facilities or facilities operated exclusively for treatment of the aged, drug addict or alcoholic, even though such facilities are operated as a separate institution by a hospital.

Implant(s) That which is implanted such as a piece of tissue, a pellet of medicine, or a tube or needle containing radioactive substance, a graft or an insert. Also included are liquid and solid materials used to augment tissues or to fill in areas traumatically or surgically removed. An object or material partially or totally inserted or grafted in to the body for prosthetic, therapeutic, or diagnostic purpose. Examples of surgical implants include stents, artificial joints, shunts, grafts, pins, plates, screws, anchors and radioactive seeds.

Infertility The inability to conceive after one year of unprotected sexual intercourse or the inability to sustain a successful Pregnancy. (Sexual intercourse means the sexual union between a male and female). Infertility does not include individuals unable to conceive post-sterilization.

Initial Enrollment Period The initial period of time, as We agree with the Enrolling Group, during which Eligible Persons may enroll themselves and their Dependents under this Policy.

Injury Bodily damage other than Sickness, including all related conditions and recurrent symptoms.

Inpatient Rehabilitation Facility A Hospital (or a special unit of a Hospital that is designated as an Inpatient Rehabilitation Facility) that provides rehabilitation health services (physical therapy, occupational therapy and/or speech therapy) on an inpatient basis, as authorized by law.

Inpatient Mental Health An acute care facility for psychiatric treatment where a psychiatric physician supervises care. The patient receives care twenty-four (24) hour per day and may be on a locked unit and/or on psychiatric precautions (e.g., suicide, homicide, close observation precautions).

Inpatient Stay An uninterrupted confinement, following formal admission to a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility.

Intensive Outpatient Program Active therapeutic programming 3 ½ hours or less per session. Therapy sessions are usually two to three times per week and are a combination of individual and group work.

Instrumental Activities of Daily Living (IADL)

Activities related to independent living including preparing meals, managing money, shopping for groceries or personal items, performing light or heavy housework, and using the telephone.

Low Protein Modified Food Products

Food products specifically formulated to have less than one gram of protein per serving and intended for the dietary treatment of an inherited metabolic disease under the direction of a Physician.

Maximum Policy Benefit

The maximum amount that We will pay for Benefits during the entire period of time that You are enrolled under this Policy issued to the Enrolling Group. The Maximum Policy Benefit includes any amount that We have paid for Benefits under a former policy issued to the Enrolling Group that is replaced by the current Policy, as well as any amount that We may pay under a later Policy that replaces the Enrolling Group's current Policy. When the Maximum Policy Benefit applies, it is described in Section 5 (Your Cost for Covered Services).

Medical Emergency/Medical Emergency Condition

The sudden and, at the time, unexpected, onset of a health condition that manifests itself by symptoms of sufficient severity that would lead a prudent layperson, possessing an average knowledge of health and medicine, to believe that immediate medical care is required, which may include, but is not limited to:

a. Placing the Member's health in significant jeopardy;
b. Serious impairment to a bodily function;
c. Serious dysfunction of any bodily organ or part;
d. Inadequately controlled pain; or
e. With respect to a pregnant woman who is having contractions, when
    i. There is inadequate time to effect a safe transfer to another Hospital before delivery; or
    ii. Transfer to another Hospital may pose a threat to the health or safety of the woman or unborn child.

Medical Foods

Products that are intended to meet the distinctive nutritional requirements of a person with a particular disease or condition for which nutritional requirements are established by recognized scientific principles and formulated to be consumed or administered enterally under the direction of a physician.

Medically Necessary

Health Care Services that are ordered by a health provider, without which there would be significant risk of a serious deterioration and/or a significant impairment that, if not treated, could seriously affect one's ability to function within his or her normal environment. Although some Health Care Services are medically acceptable, they may not be medically necessary. Health Care Services need to be (1) medically appropriate and necessary to meet the basic health needs of the Member; (2) rendered in the most cost-efficient manner and type of setting appropriate for the delivery of the Covered Service; (3) consistent in type, frequency and duration of treatment with scientifically-based guidelines of national medical, research, or health care coverage organizations or governmental agencies that are accepted by the Plan; (4) consistent with the diagnosis of the conditions; and (5) of demonstrated medical value. Medically Necessary does not include care that is provided primarily for the convenience of the Member or a health provider, or care that is rendered more frequently than that accepted as medically appropriate by the medical profession.

Medicare

Parts A, B, C and D of the insurance program established by Title XVIII, United States Social Security Act, as amended by 42 U.S.C. Sections 1394, et seq. and as later amended.

Member

A Member means any Subscriber or Dependent.

Mental Health Services

Covered Health Services for the diagnosis and treatment of Mental Illnesses. The fact that a condition is listed in the current Diagnostic and Statistical Manual of the American Psychiatric Association does not mean that treatment for the condition is a Covered Health Service.

Mental Health/Substance Abuse Designee Refers to St. John's Mercy Managed Behavioral Health or other applicable designated agent that provides and manages Mental Health Services for the Plan.

Mental Illness Those Conditions classified as mental disorders in the American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders, except mental retardation.

Network Benefits Benefits for Covered Health Services that are provided by (or directed by) a Network Physician or other Network Provider in the provider's office or at a Network or Non-Network facility.

Network/Network Provider When used to describe a provider of Health Care Services, this means a provider that has a participation agreement in effect with Us or with Our affiliate (directly or through one or more other organizations) to provide Covered Health Services to Covered Persons.

A provider may enter into an agreement to provide only certain Covered Health Services, but not all Covered Health Services, or to be a Network Provider for only some of Our products. In this case, the provider will be a Network Provider for the Health Services and products included in the participation agreement, and a Non-Network Provider for other Health Services and products. The participation status of providers will change from time to time.

Neuropsychological Testing Neuropsychological testing is a quantitative, comprehensive evaluation of cognitive, motor and behavioral functional abilities related to developmental, degenerative and acquired brain disorders

Non-Network Benefits Benefits for Covered Health Services that are provided by a Non-Network Physician or other Non-Network Provider.

Non-Network Provider A Provider who is not contracted with Mercy Health Plans.

Observation Care Care in the Hospital to monitor evaluate or stabilize a patient in order to determine the need for further treatment or an inpatient admission. Such Care is not considered Inpatient Care, even though the patient may be confined to a Hospital bed.

Occupational Therapy Treatment of a physically or mentally disabled person through constructive activities designed to restore the ability to accomplish satisfactorily the ordinary activities of daily living. Activities of daily living include feeding, dressing, bathing and other types of self-care.

Open Enrollment Period A period of time that follows the Initial Enrollment Period during which Eligible Persons may enroll themselves and Dependents under this Policy. The Enrolling Group and Us will agree upon the period of time that is the Open Enrollment Period.

Out-of-Pocket Maximum If applicable, the maximum amount of [Deductible and] Coinsurance You pay every [Calendar] [Plan] Year [for Eligible Expenses]. If You use both Network Benefits and Non-Network Benefits, two separate Out-of-Pocket Maximums apply. Once You reach the Out-of-Pocket Maximum for Network Benefits, those Benefits are payable at 100% of Eligible Expenses during the rest of that [Calendar] [Plan] Year. Once You reach the Out-of-Pocket Maximum for Non-Network Benefits, those Benefits are payable at 100% of Eligible Expenses during the rest of that [Calendar] [Plan] Year. See Section 5 (You Cost for Covered Services).

Outpatient Mental Health Visits Psychotherapy and other mental health services provided in an individual practitioner office. Psychotherapy may be provided by a medical doctor (MD), clinical psychologist (Ph.D.), or Master's level licensed therapist.

Palliative Care Care provided to patients with progressive and advanced disease with little or no prospect of cure. A comprehensive approach to treating life-threatening illness that focuses on the physical, psychological, spiritual and existential needs of the patient. It is applicable early in the course of illness, in conjunction with other therapies that are intended to prolong life, such as Chemotherapy or radiation therapy, and includes investigations needed to evaluate

and treat clinical complications. Palliative care is meant to maintain the quality of life of patients and their families coping with the problems associated with life-threatening illness.

Partial Hospital Treatment Program Active therapeutic mental health programming and care given to a patient for 3 ½ hours or more per day in a facility setting. Mental health professionals have assessed that the patient can maintain safety outside of the hospital environment during Non-program hours. During this program, the patient may or may not see psychiatrist daily depending on condition.

Physical Therapy Treatment by physical means including hydrotherapy, heat, physical agents, and biomechanical and neurophysiological principles and devices that relieve pain or restore maximum bodily function. Physical Therapy does not include Cardiac Rehabilitation, Pulmonary Rehabilitation or Manipulation/Adjustment.

Physician Any Doctor of Medicine, "M.D.", or Doctor of Osteopathy, "D.O.", who is properly licensed and qualified by law.

Please Note: Any podiatrist, dentist, psychologist, chiropractor, optometrist, or other provider who acts within the scope of his or her license will be considered on the same basis as a Physician. The fact that We describe a provider as a Physician does not mean that Benefits for services from that provider are available to You under this Policy.

Plan (the Plan) The Plan refers to Mercy Health Plans.

Policy The entire agreement issued to the Enrolling Group, that includes all of the following:

- The Group Policy;
- This Certificate of Coverage;
- The Enrolling Group's application;
- Amendments;
- Riders.

These documents make up the entire agreement that is issued to the Enrolling Group.

Policy Charge The sum of the Premiums for all Subscribers and Enrolled Dependents enrolled under this Policy.

Preexisting Condition An Injury or Sickness that was diagnosed or treated, or for which prescription medications or drugs were prescribed or taken within the six (6) month period ending on the person's enrollment date. (The enrollment date is the date the person became covered under this Policy or, if earlier, the first day of any waiting period under this Policy.) A Preexisting Condition does not include Pregnancy. Genetic information is not an indicator of a Preexisting Condition, if there is not a diagnosis of a condition related to the genetic information. Preexisting Conditions do not apply for Covered Persons with Continuous Creditable Coverage.

Pregnancy Includes all of the following:

- Prenatal care
- Postnatal care
- Childbirth
-

Premium The periodic fee required for each Subscriber and each Enrolled Dependent, in accordance with the terms of this Policy.

Preventive Health Screening(s) Routine tests performed on a healthy individual who has no signs or symptoms of disease, or history of the disease being screened. Preventive Health Screenings are for the purpose of detecting abnormalities or malfunctions of bodily systems and parts according to accepted medical practice. Tests performed on a symptomatic patient or a patient previously diagnosed with the disease being screened are classified as diagnostic tests.

[Preventive Drug List] [A list of drugs or medications that are considered preventive care because they are used solely by a person who has developed risk factors for a disease that has not yet manifested itself or not yet become clinically apparent (i.e., asymptomatic), or used solely to prevent the reoccurrence of a disease from which a person has recovered.]

Prior Authorization Precertification review by the Plan, before services and treatment are rendered, to determine if the service meets the criteria as a Covered Health Service.

Private Duty Nursing Private Duty Nursing is defined as one-on-one care provided on an individual basis either in an institution or in a patient's home. Private duty skilled nursing care can be considered custodial after Non-professional personnel repetitively performs the care, making continuous attention by a health professional no longer necessary, and is therefore not a covered benefit.

Pulmonary Rehabilitation A comprehensive program to manage patients with substantial chronic lung disease. Includes diagnostic testing, monitored dynamic exercise and education under the direct supervision of a qualified Physician.

[Qualified Medical Expenses] [Those eligible expenses paid for care that qualifies for a tax-free withdrawal from your HSA as described in Section 213 and 223 of the Internal Revenue Code. For guidelines on Qualified Medical Expenses under Internal Revenue Code (IRC) Section 213, see IRS Publication 502. However, some items listed in this publication are not reimbursable under the HSA (e.g. premiums, except for certain premiums at age 65 or older). For HSA specific requirements under IRC Section 223, see IRS Publication 969.

As an HSA owner, You are responsible to keep records (for example, receipts) so that You can prove to the IRS that the withdrawals are for Qualified Medical Expenses that were not otherwise reimbursed.]

Rider Any attached written description of additional Covered Health Services not described in this Certificate. Covered Health Services provided by a Rider may be subject to payment of additional Premiums. Riders are effective only when signed by Us and are subject to all conditions, limitations and exclusions of this Policy except for those that are specifically amended in the Rider.

Semi-Private Room A room with two or more beds. When an Inpatient Stay in a Semi-Private Room is a Covered Health Service, the difference in cost between a Semi-Private Room and a private room is a Benefit only when a private room is necessary in terms of generally accepted medical practice, or when a Semi-Private Room is not available.

Sickness Physical illness, disease or Pregnancy. The term Sickness as used in this Certificate does not include Mental Illness or substance abuse, regardless of the cause or origin of the Mental Illness or substance abuse.

Skilled Nursing Facility A Hospital or nursing facility that is licensed and operated as required by law. A Skilled Nursing Facility is not, other than incidentally, a place that provides minimal Care, Custodial Care, ambulatory Care, part-time Care, or Care for Mental Illness and Substance Abuse, pulmonary tuberculosis or venereal disease.

Special Enrollment Period Any additional period of enrollment required by state and Federal law, in addition to the Open Enrollment Period.

Speech Therapy Treatment for loss or impairment of speech or hearing, including communicative disorders resulting from genetic defects, birth defects, injury, illness, disease, developmental disabilities or delays or other causes, whether of organic or non-organic etiology and whether or not the person suffering from that loss or impairment had the capacity for speech, language or hearing before the loss or impairment occurred.

Spinal Treatment — The detection or correction by manual or mechanical means of subluxation(s) in the body to remove nerve interference or its effects. The interference must be the result of, or related to, distortion, misalignment or subluxation of, or in, the vertebral column.

Spouse — One who is legally married to an Eligible Employee in a ceremony legally solemnized by a third party duly authorized by law to perform marriages.

Standard Basic Equipment — Equipment that is the usual or most common and simplest form that possesses the most fundamental level of function required to meet the needs of the member in performing Instrumental Activities of Daily Living.

Subscriber — An Eligible Person who is properly enrolled under this Policy. The Subscriber is the person (who is not a Dependent) on whose behalf this Policy is issued to the Enrolling Group.

Substance Abuse Services — Covered Health Services for the diagnosis and treatment of alcoholism and substance abuse disorders that are listed in the current Diagnostic and Statistical Manual of the America Psychiatric Association, unless those services are specifically excluded. The fact that a disorder in listed in the Diagnostic and Statistic Manual of the American Psychiatric Association does not mean that treatment of the disorder is a Covered Health Service.

Termination Date — Means:

a. For the Member, the last date on which the Member is eligible for coverage; or

b. For the Group, the last date on which this Policy is in force.

Unemancipated — A Dependent that is unmarried, relies on the Member for his/her major support, and is not eligible for Group health Benefits on his/her behalf. Dependent children must live with a parent, adult family Member, or someone appointed by an agency with legal jurisdiction, unless the Dependent is a student in an accredited school or institution of higher learning.

Unproven Services — Services that are not consistent with conclusions of prevailing medical research which demonstrate that the health service has a beneficial effect on health outcomes and that are not based on trials that meet either of the following designs:

- Well-conducted randomized controlled trials. (Two or more treatments are compared to each other, and the patient is not allowed to choose which treatment is received).
- Well-conducted cohort studies. (Patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group).

Decisions about whether to cover new technologies, procedures and treatments will be consistent with conclusions of prevailing medical research, based on well-conducted randomized trials or cohort studies, as described.

Urgent Care Center — A facility, other than a Hospital, that provides Covered Health Services that are required to prevent serious deterioration of Your health, within twenty-four (24) hours of the onset of an unforeseen Sickness, Injury, or the onset of acute or severe symptoms

Us/We/Our — Us/We/Our refers to Mercy Health Plans.

Usual and Customary Rate — Charges for Covered Services that do not exceed the fees and prices generally approved for cases of comparable nature and severity at the time and place when such Covered Services are rendered or received. In determining the Usual and Customary Rate (UCR), one or more of the following guidelines shall be taken into consideration:

a) The rate allowed by Medicare for the particular service or supply;
b) The prevailing rate of fees charged for identical or similar services in the same geographical area by health professionals of similar training and experience;
c) Unusual circumstances or complications that require additional time, skill and

experience in connection with the provided service or supply;

d) The actual charge by the provider (if less than Our UCR charge);
e) The frequency of the determination of the usual and customary fee;
f) A general description of the methodology used to determine usual and customary fees;
g) The percentile that determines the maximum benefit the Plan will pay for any Accidental Injury dental procedure, if the usual and customary fee is determined by taking a sample of fees submitted on actual claims from licensed dentists and then making the benefit by selecting a percentile of those fees.

Utilization Review

A set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency, of Health Care Services, procedures or settings. Utilization Review may include Ambulatory Review, Prospective Review, second opinion, Certification, Concurrent Review, Case Management, discharge planning or Retrospective Review, but will not include elective requests for clarification of Coverage.

You/Your

You/Your refers to the Subscriber and each Enrolled Dependent.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Mercy Health Plans by and on behalf of its wholly-owned subsidiaries, including Mercy Health Plans of Missouri, Inc., Mercy Health Plans, and Premier Benefits, Inc. (Collectively referred to as "the Plan"), respects the privacy of its Members and former Members and protects the security and confidentiality of their nonpublic personal information. We have instituted internal policies to: insure the security and confidentiality of Your personal and financial healthcare information; protect against any anticipated threats or hazards to the security or integrity of such records; and protect against unauthorized access to or use of information which could result in substantial harm or inconvenience to You. We are required by law to provide You with this Notice of Our legal duties and privacy practices. This Notice explains Your rights, Our legal duties, and Our privacy practices. To fulfill Our responsibilities to You, the Plan may use and disclose Your protected health information for treatment, payment, and healthcare operations, or when We are otherwise required or permitted to do so by law. Below is further detail explaining these situations.

Treatment. We may use and disclose protected health information with Your healthcare providers (physicians, pharmacies, hospitals and others) to assist in the diagnosis and treatment of Your injury or illness. For example, We may disclose Your protected health information to suggest treatment alternatives.

Payment. We may use and disclose protected health information to pay for Your covered health expenses. For example, We may use protected health information to process claims. We may also ask a healthcare provider for details about Your treatment so that We may pay the claim for Your care.

Healthcare Operations. We may use and disclose protected health information for Our healthcare operations. For example, We may use or disclose protected health information to perform quality assessment activities or provide You with Case Management services.

Business Associates. We may at times need to use the services of other companies in lieu of Our own staff, such as outsourcing data entry services, or, as part of Our routine business, We may require that outside entities, such as auditors perform operations that require access to Our healthcare information. In order for Us to share confidential information with these organizations, We must enter into agreements that require them to comply with the privacy regulations of the Plan.

Plan Sponsor. If You participate in a self-funded group health plan through Your employer (plan sponsor), We may share limited health information with Your employer as necessary to perform administrative functions. Plan sponsors that receive this information are required by law to have safeguards in place to protect against inappropriate use or disclosure of Your information.

You or Your Personal Representative. We must disclose Your health information to You as described in the Patient Rights section below. If You have a legally assigned personal representative or are an Unemancipated minor, We will release the information to Your personal representative or parent(s) as required by law.

Family/Friends. We may disclose Your health information to a family member or friend to the extent necessary to help with Your healthcare or with payment for Your healthcare if You agree that We may do so. If You wish to designate a person(s) to whom We may discuss Your healthcare, You may submit a request to the address listed below. If You are physically or mentally unable to participate in decisions regarding Your healthcare, We may need to communicate with a family member; however, only to the extent necessary to insure that You receive appropriate healthcare treatment.

Permitted or Required by Law. We must disclose protected health information about You when required to do so by law. Information about You may be used or disclosed to regulatory agencies, such as Medicare and Medicaid; for administrative or judicial hearings; public health authorities; or law enforcement officials, such as to comply with a court order or subpoena.

Member Authorization

Other uses or disclosures of Your protected health information will be made only with Your written authorization, unless otherwise permitted or required by law. You may revoke an authorization at any time in writing, except to the extent that We have already taken action on the information disclosed or if We are permitted by law to use the information to contest a claim or coverage under the Plan.

RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION

You have the following rights regarding protected health information that the Plan maintains about You. If You wish to exercise any of these rights, You may submit Your request in writing.

Right to Access Your Protected Health Information. You have the right to inspect and/or obtain a copy of individual protected health information that We maintain about You. We may charge a fee for the costs of producing, copying and mailing Your requested information, but We will tell You the cost in advance.

Right to Amend Your Protected Health Information. You have the right to request an amendment of individual protected health information that We maintain about You. All requests must be in writing and must include the reason for the change.

Right to an Accounting of Disclosures by the Plan. You have the right to request an accounting of disclosures of individual protected health information made by the Plan on or after the compliance date of April 14, 2003. All requests must be in writing and must state the period of time for which You want the accounting. We may charge for providing the accounting, but We will tell You the cost in advance.

Right to Request Restrictions on the Use and Disclosure of Your Protected Health Information. You have the right to request that the Plan restrict the use and disclosure of Your protected health information for treatment, payment, or healthcare operations. The Plan is not required to agree to the requested restriction; however, if the Plan does agree to the restriction, it must comply with Your request unless the information is needed for an emergency.

Right to Receive Confidential Communications. You have the right to request to receive communication of protected health information from the Plan through an alternative procedure (other than the standard means of communicating protected health information). All requests must be in writing and are subject to technical reasonability for the Plan.

Right to a Paper Copy of This Notice. You have the right at any time to receive a paper copy of this Notice, even if You had previously agreed to receive an electronic copy.

Changes

The Plan reserves the right to change the terms of this Notice at any time, effective for protected health information that We already have about You as well as any information that We receive in the future. We are required by law to comply with whatever Notice is currently in effect. We will communicate changes to Our Notice through subscriber newsletters, direct mail and/or Our Internet website (www.mercyhealthplans.com).

Complaints

If You believe Your privacy rights have been violated, You have the right to file a Complaint with the Plan and/or with the Federal Government. Complaints to the Plan may be directed to the appropriate Customer Contact Center listed at the end of this Notice or by calling the Customer Contact Center number listed on the back of Your ID card. You may also file a Complaint anonymously by calling the Plan's Fraud and Abuse Hotline at 1-877-349-5997. Complaints to the government may be sent to: Secretary of the Department of Health and Human Services, 200 Independence Avenue, S.W., Washington, D.C. 20201. You will not be penalized for filing a Complaint.

Contact The Plan

If You want more information about this Notice, how to exercise Your rights, or how to file a Complaint, please direct Your correspondence to the appropriate Customer Contact Center listed at the end of this Notice or call the Customer Contact Center phone number listed on the back of Your ID card. You can also contact Us through Our Internet website: www.mercyhealthplans.com

Mercy Health Plans
ATTN: Customer Contact Center
14528 S Outer 40, Suite 300,
Chesterfield, MO 63017-5743
(866) 647-5568

NOTICE CONCERNING COVERAGE LIMITATIONS AND EXCLUSIONS UNDER THE ARKANSAS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT

Residents of this state who purchase life insurance, annuities or health and accident insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the Arkansas Life and Health Insurance Guaranty Association ("Guaranty Association"). The purpose of the Guaranty Association is to assure that policy and contract owners will be protected, within certain limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the claims of policy owners who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by the member insurers through the Guaranty Association is not unlimited, however. And, as noted in the box below, this protection is not a substitute for consumers' care in selecting insurance companies that are well managed and financially stable.

DISCLAIMER

The Arkansas Life and Health Insurance Guaranty Association ("Guaranty Association") may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions and require continued residency in this state. You should not rely on coverage by the Guaranty Association in purchasing an insurance policy or contract.

Coverage is NOT provided for Your policy or contract or any portion of it that is not guaranteed by the insurer or for which You have assumed the risk, such as non-guaranteed amounts held in a separate account under a variable life or variable annuity contract.

Insurance companies or their agents are required by law to provide You with this notice. However, insurance companies and their agents are prohibited by law from using the existence of the Guaranty Association to induce You to purchase any kind of insurance policy.

The Arkansas Life and Health Insurance Guaranty Association
c/o The Liquidation Division
1023 West Capitol
Little Rock, Arkansas 72201

Arkansas Insurance Department
1200 West Third Street
Little Rock, Arkansas 72201-1904

The state law that provides for this safety-net is called the Arkansas Life and Health Insurance Guaranty Association Act ("Act"). Below is a brief summary of the Act's coverages, exclusions and limits. This summary does not cover all provisions of the Act; nor does it in any way change anyone's rights or obligations under the Act or the rights or obligations of the Guaranty Association.

COVERAGE

Generally, individuals will be protected by the Guaranty Association if they live in this state and hold a life, annuity or health insurance contract or policy, or if they are insured under a group insurance contract issued by a member insurer. The beneficiaries, payees or assignees of policy or contract owners are protected as well, even if they live in another state.

EXCLUSIONS FROM COVERAGE

However, persons owning such policies are NOT protected by the Guaranty Association if:

- They are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);
- The insurer was not authorized to do business in this state;
- Their policy or contract was issued by a nonprofit hospital or medical service organization, an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policy or contract owner is subject to future assessments, or by an insurance exchange.

The Guaranty Association also does NOT provide coverage for:

- Any policy or contract or portion thereof which is not guaranteed by the insurer or for which the owner has assumed the risk, such as non-guaranteed amounts held in a separate account under a variable life or variable annuity contract;
- Any policy of reinsurance (unless an assumption certificate was issued);
- Interest rate yields that exceed an average rate;
- Dividends and voting rights and experience rating credits;
- Credits given in connection with the administration of a policy by a group contract holder;
- Employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);
- Unallocated annuity contracts (which give rights to group contract holders, not individuals);

- Unallocated annuity contracts issued to/in connection with benefit plans protected under Federal Pension Benefit Corporation ("FPBC")(whether the FPBC is yet liable or not);
- Portions of an unallocated annuity contract not owned by a benefit plan or a government lottery (unless the owner is a resident) or issued to a collective investment trust or similar pooled fund offered by a bank or other financial institution);
- Portions of a policy or contract to the extent assessments required by law for the Guaranty Association are preempted by State or Federal law;
- Obligations that do not arise under the policy or contract, including claims based on marketing materials or side letters, riders, or other documents which do not meet filing requirements, or claims for policy misrepresentations, or extra-contractual or penalty claims;
- Contractual agreements establishing the member insurer's obligations to provide book value accounting guarantees for defined contribution benefit plan participants (by reference to a portfolio of assets owned by a nonaffiliate benefit plan or its trustees).

LIMITS ON AMOUNT OF COVERAGE

The Act also limits the amount the Guaranty Association is obligated to cover: The Guaranty Association cannot pay more than what the insurance company would owe under a policy or contract. Also, for any one insured life, the Guaranty Association will pay a maximum of $300,000 — no matter how many policies and contracts there were with the same company, even if they provided different types of coverages. Within this overall $300,000 limit, the Association will not pay more than $300,000 in health insurance benefits, $300,000 in present value of annuity benefits, or $300,000 in life insurance death benefits or net cash surrender values — again, no matter how many policies and contracts there were with the same company, and no matter how many different types of coverages. There is a $1,000,000 limit with respect to any contract holder for unallocated annuity benefits, irrespective of the number of contracts held by the contract holder. These are limitations for which the Guaranty Association is obligated before taking into account either its subrogation and assignment rights or the extent to which those benefits could be provided out of the assets of the impaired or insolvent insurer.

SCHEDULE OF COVERAGE AND BENEFITS
for
[COMPANY NAME]

Effective Date of Coverage [MM/DD/YYYY]

With Mercy Health Plans' PPO, You can choose to receive either Network Benefits or Non-Network Benefits. To obtain Network Benefits You must see a Network Physician or other Network Provider. You must show Your identification card (ID card) every time You request health care services from a Network Provider. If You do not show Your ID card, Network Providers have no way of knowing that You are enrolled under a Mercy Health Plans' PPO Policy. As a result, they may bill You for the entire cost of the services You receive. Please refer to Your Certificate of Coverage for a detailed explanation of covered and non-covered services, as well as Prior Authorization requirements. Just because a Physician or other Health Care Professional has performed, prescribed or recommended a service does not mean it is Medically Necessary or that it is covered under this Schedule of Coverage and Benefits. All capitalized terms shall have the meaning assigned to them in Your Certificate of Coverage.

PAYMENT INFORMATION	AMOUNT	
	NETWORK	NON-NETWORK
MEDICAL SERVICES **[Annual] [Plan Year] Deductible** **[– Combined Medical & Pharmacy]** [The Deductible must be met before medical or pharmacy Benefits are payable, except for preventive health/wellness services, routine immunizations [and prescription drugs on the Preventive Drug list]. Coinsurances are not included in Your Deductible.]	[$0 – 10,000] per Covered Person per [Calendar] [Plan] Year, not to exceed [$0 – 30,000] for all Covered Persons in a family.	[$0 – 20,000] per Covered Person per [Calendar] [Plan] Year, not to exceed [$0 – 60,000] for all Covered Persons in a family.
Out-of-Pocket Maximum[– Combined Medical & Pharmacy] [Only Coinsurances apply towards Your Out-of-Pocket Maximum. Coinsurance is the amount You pay after You meet Your Deductible.] [Only Deductible and Coinsurances for Covered Services (medical and pharmacy combined) will count towards Your Out-of-Pocket Maximum. This includes Coinsurances for Covered Services provided under any Rider(s).]	[$0 – 10,000] per Covered Person per [Calendar] [Plan] Year, not to exceed [$0 – 30,000] for all Covered Persons in a family. Out-of-Pocket Maximum does not include the Annual Deductible. [No Out-of-Pocket Maximum]	[$0 – 20,000] per Covered Person per [Calendar] [Plan] Year, not to exceed [$0 – 60,000] for all Covered Persons in a family. Out-of-Pocket Maximum does not include the Annual Deductible. [No Out-of-Pocket Maximum]
Maximum Policy Benefit	[$1,000,000 – 5,000,000 per Covered Person.] [No Maximum Policy Benefit]	[$1,000,000 – 5,000,000 per Covered Person.] [No Maximum Policy Benefit]

SERVICES	MEMBER RESPONSIBILITY	
	NETWORK	NON-NETWORK
Allergy Services • Office Visits • Injections/Treatment	*Office Visit:* [[$0-$100 Copayment][0%-50% Coinsurance] [after Deductible]] per office visit for Primary care [[$0-$100 Copayment][0%-50% Coinsurance] [after Deductible]]per office visit for Specialist care *Injections/Treatment:* [[$0-$100 Copayment] [when no charge is made for Physician's services] [[0%-50%] Coinsurance after Deductible]	*Office Visit:* [[0% - 50%] Coinsurance after Deductible] *Injections/Treatment:* [[0% - 50%] Coinsurance after Deductible]
Ambulance Services - Emergency Only • Ground Transportation • Air Transportation ✹ Any combination of Network and Non-Network Benefit for ground and air ambulance services combined is limited to [$1,000 - $5,000].	*Ground Transportation:* [$25–$250 Copayment] per transport] [0%-50% Coinsurance after Deductible] [No Copayment] *Air Transportation:* [0%-50% Coinsurance after Deductible] [$50-$500 Copayment] per transport	*Ground Transportation:* [$25–$250 Copayment] per transport] [0%-50% Coinsurance after Deductible] [No Copayment] *Air Transportation:* [0%-50% Coinsurance after Deductible] [$50-$500 Copayment] per transport

✹ - Requires Prior Authorization. Refer to Your Certificate of Coverage for details.

SERVICES	MEMBER RESPONSIBILITY	
	NETWORK	NON-NETWORK
Dental - Anesthesia and Facility Charges ✸ Coverage is limited to: • A Dependent child under the age of seven who is determined by two (2) licensed dentists to require, without delay, necessary dental treatment in a hospital or ambulatory surgical center for a significantly complex dental condition; or • A Covered Person diagnosed with having a serious mental or physical condition; or • A Covered Person who has a significant behavioral problem as determined by the Covered Person's physician.	[[0% - 50%] Coinsurance after Deductible]	[[0% - 50%] Coinsurance after Deductible]
Dental Services – Accident Only ✸ Initial contact with a Physician or dentist must have occurred within seventy-two (72) hours of the accident. In no case will accidental dental coverage extend more than [6 – 12] months from the date of Injury. Any further visits for post-Emergency treatment must be pre-approved by the Plan.	[[0% - 50%] Coinsurance after Deductible]	[[0% - 50%] Coinsurance after Deductible]
Diabetes Services ✸ Medically appropriate and necessary equipment, supplies and self-management training for the management and treatment of diabetes. Services are provided for persons with gestational, type I or type II diabetes. Coverage for diabetes self-management training is limited to one (1) program during the entire time You are covered under this Policy.	[[0% - 50%] Coinsurance after Deductible] [Copayment/Coinsurance consistent with type of service received, but not subject to any DME limits.]	[[0% - 50%] Coinsurance after Deductible] [Copayment/Coinsurance consistent with type of service received, but not subject to any DME limits.]
Dialysis	[[$0-$100 Copayment] [[0%-50%] Coinsurance after Deductible]	[[0% - 50%] Coinsurance after Deductible]
DME/Orthotics/Prosthetics ✸ Any combination of Network and Non-Network Benefits for DME, Orthotics and Prosthetics is [[limited to [$750 - $10,000] per [Calendar] [Plan] Year combined Benefit][limited as follows: DME – [[$750 - $10,000]; Orthotics - [$750 - $10,000]; Prosthetics - [$750 - $10,000]]. The DME limitation is not applicable to any equipment, supplies or self-management training for the treatment of diabetes. The Prosthetics limitation does not apply to breast prostheses. Any DME, Orthotics, or Prosthetics purchase (or cumulative rental) in excess of $1,000 must be approved in advance by the Plan.	[[0%-50%] Coinsurance after Deductible]	[[0% - 50%] Coinsurance after Deductible]
Emergency Room Services [Physician charges may be applicable, if billed separately. See *Professional Fees for Surgical and Medical Services* below.]	[$0-$250 Copayment per visit, except Copayment charge will be waived when hospital inpatient or observation admission for the same condition occurs within 24 hours] [0% -50% Coinsurance][after Deductible][no Deductible]	[$0-$250 Copayment per visit, except Copayment charge will be waived when hospital inpatient or observation admission for the same condition occurs within 24 hours] [0% - 50% Coinsurance][after Deductible] [no Deductible]

✸ - Requires Prior Authorization. Refer to Your Certificate of Coverage for details.

SERVICES	MEMBER RESPONSIBILITY	
	NETWORK	NON-NETWORK
Eye Examinations (Routine Only) Expenses for one (1) routine eye exam [each] [every] [two - five] [Calendar][Plan] Year[s] by an Ophthalmologist or Optometrist.	[$0-$100 per visit] [[0% -50%] Coinsurance after Deductible]	[[0% -50%] Coinsurance after Deductible]
Hearing Screenings for Newborns	[[0% - 50%] Coinsurance after Deductible] [No Copayment]	[[0% - 50%] Coinsurance after Deductible]
Home Health Care ✸ Services received from a Home Health Agency that are ordered by a physician, provided by or supervised by a registered nurse in Your home, and You are Homebound or Your physical or mental condition pose a serious and significant impediment to receiving medically necessary services outside the home. Benefits are available only when the Home Health Agency services are provided on a part-time, intermittent schedule and when skilled care is required. Any combination of Network and Non-Network Benefits for home health care is limited to a maximum of [60 – 120] visits per [Calendar] [Plan] Year.	[$0-$100 Copayment per visit] [[0%-50%] Coinsurance after Deductible]	[[0%-50%] Coinsurance after Deductible]
Hospice/Palliative Care ✸ Benefit is available once (1) per lifetime for a terminally ill person with a life expectancy of less than six (6) months. Coverage is limited to one-hundred and eighty (180) days during the entire period of time You are covered under this Certificate of Coverage.	[$0 – $100 per day] [[0% - 50%] Coinsurance after Deductible]	[[0% – 50%] Coinsurance after Deductible]]
Immunization (Routine Only) (Received in Physician's Office) Applicable Copayment/Coinsurance for office visit(s) will apply.	[No Copayment and no Deductible] [*Birth – 18 yrs:* $0 Copayment *Children over 18 yrs. and Adults:* [0-50%] Coinsurance [after deductible][no Deductible] [$0-$100] Copayment]]	[No Copayment and no Deductible] [*Birth – 18 yrs:* $0 Copayment *Children over 18 yrs. and Adults:* [0-50%] Coinsurance [after deductible][no Deductible] [$0-$100] Copayment]]
Injectables/Infusions ✸ (received in a physician's office, infusion center or through home health) [Regardless of the place where these services are performed the cost-sharing for injectables/infusions will apply.] A list of injectables/infusions requiring Prior Authorization can be obtained at www.mercyhealthplans.com or by calling Our Customer Contact Center at the number listed on Your ID card.	[[0%-50%] Coinsurance [after deductible] [no Deductible] [$0-$100] Copayment per injectable/infusion]] [No Copayment] [No office visit Copayment applies when a Physician charge is not assessed]	[[0%-50%]] Coinsurance after Deductible per injectable/infusion
Inpatient Hospital Services ✸ Semi-Private Room covered.	[[0%-50%] Coinsurance after Deductible] [$0-$5000 per Inpatient Stay] [$0-$1,000] per day] [$0-$1,000] per day to a maximum of [$0-$5,000] per Inpatient Stay]	[[0% -50%] Coinsurance after Deductible]

✸ - Requires Prior Authorization. Refer to Your Certificate of Coverage for details.

SERVICES	MEMBER RESPONSIBILITY	
	NETWORK	NON-NETWORK
In-Vitro Fertilization ✸ Covered Health Services for In-Vitro Fertilization (IVF) include the following: • IVF associated labs; • Medication (covered under the pharmacy benefit); • Imaging and procedures including female and male pre-testing; • The IVF process, and; • Cryopreservation. Any combination of Network and Non-Network Benefits for in-vitro fertilization is limited to a lifetime maximum $15,000.	[[$0-$100] Copayment per visit] [[0%-50%] Coinsurance after Deductible] [Copayment/Coinsurance consistent with type of service received.] Member is responsible for the remaining 100% of the charges for infertility services over $15,000.	[[0% -50%] Coinsurance after Deductible] [Copayment/Coinsurance consistent with type of service received.] Member is responsible for the remaining 100% of the charges for infertility services over $15,000.
Maternity Services ✸ Covered maternity care includes the following services: • Physician services including pre-natal and post-partum office visits and delivery services; • Hospital services, including use of a delivery room and operating room. – Forty-eight (48) hours for the mother and newborn child following a normal vaginal delivery. – Ninety-six (96) hours for the mother and newborn child following a cesarean section delivery. • Medical services; • Anesthesia, x-rays, and laboratory services; • The routine charges of a healthy newborn until the mother or newborn is discharged, whichever comes first. Note: The number of prenatal visits or change in Physicians may affect your Copayment/Coinsurance. Ultrasounds in uncomplicated pregnancies are limited to two (2) per pregnancy. Any additional ultrasounds will require Prior Authorization. [When related outpatient diagnostic services are performed in a Physician's office, physician's charges may apply. See *Physician's Office Services* below.]	*Physician Office*: [No Copayment applies to Physician office visits for prenatal care after the first visit.] [In place of the Copayments for Physician's Office Services and Professional Fees, a global maternity Copayment of [$100-$500] applies at the time of delivery.] *Hospital Outpatient- Observation*: [[0% - 50%] Coinsurance] [after Deductible][per visit][[$[0-100] per visit] *Hospital Inpatient Services*: [[0% - 50%] Coinsurance] [after Deductible] For all related Maternity services, the Copayment/Coinsurance will be consistent with services received.	*Physician Office*: [[0% - 50%] Coinsurance] [after Deductible] *Hospital Outpatient- Observation*: [[0% - 50%] Coinsurance] [after Deductible] [[$[0-100] per visit] *Hospital Inpatient Services*: [[0% - 50%] Coinsurance] [after Deductible][per visit] For all related Maternity services, the Copayment/Coinsurance will be consistent with services received.
Mental Health and Substance Abuse Services – Outpatient ✸ Any combination of Network and Non-Network Benefits is limited to [20 – 30] visits per [Calendar] [Plan] Year.	[[0% - 50%] Coinsurance after Deductible] [[$[0-100] per visit]	[[0% - 50%] Coinsurance after Deductible]
Mental Health and Substance Abuse - Inpatient and Intermediate ✸ Any combination of Network and Non-Network Benefits is limited to [7 – 30] days per [Calendar] [Plan] Year.	[[0% - 50%] Coinsurance after Deductible] [$0-$1,000] per day to a maximum of [$0-$5,000] per Inpatient Stay]	[[0% - 50%] Coinsurance after Deductible]

✸ - Requires Prior Authorization. Refer to Your Certificate of Coverage for details.

SERVICES	MEMBER RESPONSIBILITY	
	NETWORK	NON-NETWORK
Neuropsychological Testing ✸ Covered only for an individual who has suffered a brain injury, dementia (including cognitive degeneration as seen in individuals with Alzheimer's), cerebrovascular disease, and who meet certain conditions as described in the Certificate of Coverage.	[[$0-$500] Copayment] [0%-50%] Coinsurance after Deductible][per test] [[$0-$100] Copayment per office visit for Specialist care]	[[0% - 50%] Coinsurance after Deductible]
Newborn Child Coverage ✸	[[0%-50%] Coinsurance after Deductible] [$0-$5000 per Inpatient Stay] [$0-$1,000] per day] [$0-$1,000] per day to a maximum of [$0-$5,000] per Inpatient Stay]	[[0% - 50%] Coinsurance after Deductible]
Nutritional Counseling Any combination of Network and Non-Network Benefits Up to three (3) visits per [Calendar] [Plan] Year for only certain conditions as limited in Your Certificate of Coverage.	[[0% - 50%] Coinsurance after Deductible] [[$[0-100] per visit]	[[0% - 50%] Coinsurance after Deductible]
Nutritional Supplements ✸ Covered benefit only when tube feeding (enteral administration) using nutritional supplements is the sole source of a member's nutrition for a permanent condition, or when parenteral (intravenous administration) nutritional requirements exists (i.e., hyperemesis of pregnancy) under certain conditions.	[[0% - 50%] Coinsurance after Deductible]	[[0% - 50%] Coinsurance after Deductible]
Observation Care ✸ Coverage for up to [23 –48] hours at the designated Copayment. We must pre-approve services that exceed one (1) day stay.	[[0% - 50%] Coinsurance after Deductible] [$0-$5000 Copayment per Observation Stay] [$0-$1,000 Copayment] per day] [$0-$1,000 Copayment] per day to a maximum of [$0-$5,000] per Observation Stay]	[[0% - 50%] Coinsurance after Deductible]
Osteoporosis Services/Bone Mineral Density (BMD) Testing ✸ Benefits under this section include only the facility charge and the charge for required services, supplies and equipment. Benefits for the professional fees related to outpatient surgery, diagnostic and therapeutic services are described under *Professional Fees for Surgical and Medical Services* below. [When these services are performed in a Physician's office, physician's charges may apply. See *Physician's Office Services* below.][Regardless of the place where these services are performed the applicable cost-sharing will apply.] A list of osteoporosis services requiring Prior Authorization can be obtained at www.mercyhealthplans.com or by calling Our Customer Contact Center at the number listed on Your ID card.	[[0 - 50]%] [Coinsurance] [after Deductible] [no Deductible][no Copayment]]	[[0 - 50]%] [Coinsurance after Deductible]]
Outpatient Diagnostics ✸ Covered health services received on an outpatient basis at a Hospital or Alternate Facility include: • Laboratory services • X-Ray/Imaging	*Laboratory Services:* [[0%-50%] [Coinsurance [after Deductible] [no Deductible] [No Copayment] *X-ray/Imaging:* [[0% - 50%] Coinsurance after Deductible][no Deductible][No Copayment]	*Laboratory Services:* [[0% - 50%] Coinsurance after Deductible] *X-ray/Imaging:* [[0% - 50%] Coinsurance after Deductible]

✸ - Requires Prior Authorization. Refer to Your Certificate of Coverage for details.

SERVICES	MEMBER RESPONSIBILITY	
	NETWORK	NON-NETWORK
• Other diagnostic & therapeutic services [When some lab and x-ray services are performed in a Physician's office, physician's charges may apply. See *Physician's Office Services* below.] [Regardless of the place where these services are performed the cost-sharing for outpatient diagnostics will apply.] The following services are subject to the outpatient diagnostic cost-sharing, regardless of the place of service: • MRA • MRI • CT Scan • PET Scan • Nuclear Cardiology Imaging studies A list of diagnostic/imaging services requiring Prior Authorization can be obtained at www.mercyhealthplans.com or by calling Our Customer Contact Center at the number listed on Your ID card.	*Other diagnostic/therapeutic services:* [[0% - 50%] Coinsurance after Deductible] The following services are subject to the outpatient diagnostic cost-sharing, regardless of the place of service: • [[0%-50%] Coinsurance after Deductible - MRA • [0%-50%] Coinsurance after Deductible - MRI • [0%-50%] Coinsurance after Deductible - CT Scan • [0%-50%] Coinsurance after Deductible - PET Scan • [0%-50%] Coinsurance after Deductible – Nuclear Cardiology Imaging studies]	*Other diagnostic/therapeutic services:* [[0% - 50%] Coinsurance after Deductible] The following services are subject to the outpatient diagnostic cost-sharing, regardless of the place of service: • [[0%-50%] Coinsurance after Deductible - MRA • [0%-50%] Coinsurance after Deductible - MRI • [0%-50%] Coinsurance after Deductible - CT Scan • [0%-50%] Coinsurance after Deductible - PET Scan • [0%-50%] Coinsurance after Deductible – Nuclear Cardiology Imaging studies]
Outpatient Surgery/Hospital Procedures ✸ Coverage includes surgical services and Hospital procedures received on an outpatient basis at a Hospital or Alternate Facility. Benefits under this section include only the facility charge and the charge for required services, supplies and equipment. Benefits for related professional fees are described under *Professional Fees for Surgical and Medical Services* below and may incur separate Copayment/Coinsurance in addition to the outpatient facility Copayment. [When these services are performed in a Physician's office, Benefits are described under *Physician Office Services* below.] [Regardless of the place where these services are performed the applicable cost-sharing will apply.] A list of outpatient surgical and hospital procedures requiring Prior Authorization can be obtained at www.mercyhealthplans.com or by calling Our Customer Contact Center at the number listed on Your ID card. • **Surgical Implants** Implants for cosmetic or psychological reasons are excluded, see Section 13, K. in Your Certificate of Coverage.	*Outpatient Surgery/Hospital Procedures*: [$0 – $1,000 Copayment] [per outpatient surgery or procedure] [No Copayment] [[0% - 50%] Coinsurance after Deductible] per outpatient surgery or procedure *Surgical Implants:* [Copayment consistent with type of service required.] [0% - 50%] Coinsurance after Deductible]	[[0% - 50%] Coinsurance after Deductible] *Surgical Implants:* [[0% - 50%] Coinsurance after Deductible] [Copayment consistent with type of service required.]
Physician's Office Services [For Preventive Health/Wellness care in a Physician's office, see *Preventive Health/Wellness Services* below.]	[$10-$100 per visit] [to a PCP] [to a Specialist] [No office visit Copayment applies when no Physician charge is assessed.] [[0% – 50%] Coinsurance after Deductible]	[[0% - 50%] Coinsurance after Deductible]

✸ - Requires Prior Authorization. Refer to Your Certificate of Coverage for details.

SERVICES	MEMBER RESPONSIBILITY	
	NETWORK	NON-NETWORK
PKU Formula/ Medical Foods for Metabolic Disorders Coverage for the treatment of phenylketonuria (PKU) or any inherited disease of amino and organic acids. To be eligible for coverage, the cost of the medical food or low protein modified food products for an individual or a family with a dependent person or persons must exceed two thousand four hundred dollars ($2,400)/year per person.	[[0% - 50%] Coinsurance after Deductible]	[[0% - 50%] Coinsurance after Deductible]
Preventive Health &Wellness Services Services may be performed in a Physician's Office or an Outpatient Facility and may incur both a professional fee and/or Outpatient facility charges. [Copayment will be consistent with type of service required.] [Benefits under this section include only the facility charge and the charge for required services, supplies and equipment. Benefits for the professional fees related to outpatient surgery, diagnostic and therapeutic services are described under *Professional Fees for Surgical and Medical Services* below.] [When these services are performed in a Physician's office, Benefits are described under *Physician Office Services* above.] [Regardless of the place where these services are performed the applicable cost-sharing will apply.]	*Cholesterol Tests:* [[0% – 50%] Coinsurance] [No][after] Deductible][when provided In-Network Only][No Copayment] *Colonoscopy:* [[0% – 50%] Coinsurance] [No][after] Deductible] [when provided In Network Only] [No Copayment] *Double-contrast Barium Enema:* [[0% – 50%] Coinsurance] [No][after] Deductible] [when provided In- Network Only][No Copayment] *Fecal Occult Blood Test:* [[0% – 50%] Coinsurance] [No][after] Deductible] [when provided In- Network Only][No Copayment] *Flexible Sigmoidoscopy:* [[0% – 50%] Coinsurance] [No][after] Deductible when provided In- Network Only][No Copayment *Pap/Pelvic:* [[0% – 50%] Coinsurance] [No][after] Deductible] [when provided In-Network Only] [$10-$100 per visit] [to a PCP] [to a Specialist][No Copayment] *Mammography:* [[0% – 50%] Coinsurance] [No][after] Deductible] [when provided In- Network Only][No Copayment] *Prostate Exam:* [[0% – 50%] Coinsurance] [No][after] Deductible] when provided In-Network Only][No Copayment] *PSA test:* [[0% – 50%] Coinsurance] [No][after] Deductible when provided In-Network Only][No Copayment] *[Preventive Health/Wellness care in a Physician's office, including:* [One (1) annual physical exam per [Calendar][Plan] Year - No Copayment[when provided In Network Only]] [Well-baby and well-child care - No Copayment [when provided In Network Only]][Hearing and vision screenings - No Copayment [when provided In Network Only]]	*Cholesterol Tests:* [[0% – 50%] Coinsurance] [after][no] Deductible] *Colonoscopy:* [[0% – 50%] Coinsurance] [after][no] Deductible] *Double-contrast Barium Enema:* [[0% – 50%] Coinsurance] [after][no] Deductible] *Fecal Occult Blood Test:* [[0% – 50%] Coinsurance] [after][no] Deductible] *Flexible Sigmoidoscopy:* [[0% – 50%] Coinsurance] [after][no] Deductible] *Pap/Pelvic:* [[0% – 50%] Coinsurance][no] [after] Deductible] *Mammography:* [[0% – 50%] Coinsurance] [after][no] Deductible] *Prostate Exam:* [[0% – 50%] Coinsurance [after][no] Deductible] *PSA test:* [[0% – 50%] Coinsurance][no] [after] Deductible] *[Preventive Health/Wellness care in a Physician's office, including:* [One (1) annual physical exam per [Calendar][Plan] Year - [0% – 50%] Coinsurance [after Deductible][no Deductible] [Well-baby and well-child care – [0% – 50%] Coinsurance [after Deductible][no Deductible]] [Hearing and vision screenings – [0% – 50%] Coinsurance [after Deductible][no Deductible]]

✸ - Requires Prior Authorization. Refer to Your Certificate of Coverage for details.

SERVICES	MEMBER RESPONSIBILITY	
	NETWORK	NON-NETWORK
Professional Fees for Surgical and Medical Services	[[0% - 50%] Coinsurance after Deductible]	[[0% - 50%] Coinsurance after Deductible]
Reconstructive Procedures ✸ See Your Certificate of Coverage for coverage description and limitations.	[[0% - 50%] Coinsurance after Deductible]	[[0% - 50%] Coinsurance after Deductible]
Rehabilitation Services • **Outpatient Rehabilitation Therapy** Any combination of Network and Non-Network Benefits is limited as follows: • Limited up to [60- 180] combined visits per [Calendar] [Plan] Year for Physical, Occupational and Speech Therapy. • 36 visits of Pulmonary Rehabilitation therapy within a [0-12]-week period per [Calendar] [Plan] Year. • 36 visits of Cardiac Rehabilitation therapy within a [0-12]-week period per [Calendar] [Plan] Year. • **Inpatient Rehabilitation Services** ✸ Any combination of Network and Non-Network Benefits is limited up to a maximum of [60 – 120] days per [Calendar] [Plan] Year.	*Outpatient Rehabilitation Therapy:* *PT/OT/ST:* [[$0-$100] Copayment per visit] [No Copayment][0% - 50%] Coinsurance after Deductible] *Pulmonary Rehabilitation:* [[$0-$100] Copayment per visit] [No Copayment][0% - 50%] Coinsurance after Deductible] *Cardiac Rehabilitation:* [[$0-$100] Copayment per visit] [No Copayment][0% - 50%] Coinsurance after Deductible] ***Inpatient Rehabilitation Services:*** [[0% – 50%] Coinsurance after Deductible] [$0 - $5,000] per Inpatient Stay. [No Copayment applies if You are transferred to an Inpatient Rehabilitation Facility directly from an acute facility.] [$0 - $1,000] per day] [$0 - $1,000] per day] to a maximum of [$0-$5,000] per Inpatient Stay. If You are transferred to an Inpatient Rehabilitation Facility directly from an acute facility, any combination of Copayments required for the Inpatient Stay in a Hospital and the Inpatient Stay in a Skilled Nursing Facility or Inpatient Rehabilitation Facility will apply to the stated maximum Copayment per Inpatient Stay.]	*Outpatient Rehabilitation Therapy:* *PT/OT/ST:* [[0% – 50%] Coinsurance after Deductible] *Pulmonary Rehabilitation:* [[0% - 50%] Coinsurance after Deductible] *Cardiac Rehabilitation:* [[0% - 50%] Coinsurance after Deductible] ***Inpatient Rehabilitation Facility Services:*** [[0% - 50%] Coinsurance after Deductible]
Skilled Nursing Facility (SNF) ✸ Any combination of Network and Non-Network Benefits is limited to a maximum of [60 – 120] days per [Calendar] [Plan] Year.	[[0% – 50%] Coinsurance after Deductible] [$0 - $5,000] per Inpatient Stay. No Copayment applies if You are transferred to a Skilled Nursing Facility or Inpatient Rehabilitation Facility directly from an acute facility.] [$0 - $1,000] per day] [$0 - $1,000] per day to a maximum of [$0-$5,000] per Inpatient Stay. If You are transferred to a Skilled Nursing Facility or Inpatient Rehabilitation Facility directly from an acute facility, any combination of Copayments required for the Inpatient Stay in a Hospital and the Inpatient Stay in a Skilled Nursing Facility or Inpatient Rehabilitation Facility will apply to the stated maximum Copayment per Inpatient Stay.]	[[0% - 50%] Coinsurance after Deductible]
Spinal Treatment The detection or correction by manual or mechanical means of subluxation(s) in the body to remove nerve interference or its effects. The interference must be the result of, or related to, distortion, misalignment or subluxation of, or in, the vertebral column. [Any combination of Network and Non-Network Benefits limited to [26 – 150] visits per [Calendar] [Plan] Year.]	[[$10-$100] Copayment per visit] [[0% – 50%] Coinsurance after Deductible]	[0% – 50%] Coinsurance after Deductible]

✸ - Requires Prior Authorization. Refer to Your Certificate of Coverage for details.

SERVICES	MEMBER RESPONSIBILITY	
	NETWORK	NON-NETWORK
Tobacco Cessation Education Program	[[$0-$75] Copayment] per program] [[0% – 50%] Coinsurance after Deductible] [No Copayment]	[[0% – 50%] Coinsurance after Deductible]
Transplant Services ✸ We have specific guidelines regarding Benefits for transplant services. Contact Us at the telephone number on Your ID card for information about these guidelines.	[[0% - 50%] Coinsurance after Deductible] [$0 - $5,000] per Inpatient Stay] [$[0 - 1,000] per day] [$0 - $1,000] per day to a maximum of [$0 – $5000], per Inpatient Stay]	[[0% - 50%] Coinsurance after Deductible] Note: You always have the option to receive Non-Network care; however, Non-Network transplant Benefits will be paid at the Usual and Customary global fee, which could result in much greater out-of-pocket costs.
Urgent Care Center Services Covered Health Services received at an Urgent Care Center that are required to prevent serious deterioration of Your health within twenty-four (24) hours of the onset of an unforeseen Sickness, Injury, or the onset of acute or severe symptoms. [If radiology and other diagnostics services are provided and billed separately from the Urgent Care Center, additional Copayments/Coinsurances may apply.] [When services to treat urgent health care needs are provided in a Physician's office, Benefits are available as described under *Physician's Office Services* above.] [When Urgent Care services are provided in a Physician's office, applicable Copayment/Coinsurance will be charged, regardless of the place where these services are performed.]	[[$0 – $250] Copayment per visit] [[0% - 50%] Coinsurance after Deductible] [No Copayment]	[[$0 – $250] Copayment per visit] [[0% - 50%] Coinsurance after Deductible]
[Acupuncture Services] [Any combination of Network and Non-Network Benefits is limited to [10 – 100] visits per [Calendar] [Plan] Year.]	[[$5 – $75] Copayment per visit] [[0% – 50%] Coinsurance after Deductible] [No Copayment]	[[0% – 50%] Coinsurance after Deductible]

RIDERS Note: [Deductibles, Copayments and Coinsurances for Covered Health Services available through an optional Rider are not included in Your Out-of-Pocket Maximum, except as noted below. Coinsurance is the amount You pay after You meet Your medical Deductible.] [Deductibles and Coinsurances for Covered Services provided under any Rider(s) will count towards Your Out-of-Pocket Maximum.]	
[Birth Control Services] [Required only if Prescription Drug Services covered.]	[Contraceptives (oral, topical, injectable), intrauterine devices (IUDs), and insertion and routine removal of implantable contraceptives (no more than once every 3 years, unless Medically Necessary.)] [Copayment/Coinsurance after Deductible consistent with type of service received.] [Only Coinsurances for medical services will be counted in Your Out-of-Pocket Maximum.]
[Craniomandibular and Temporomandibular Joint (TMJ) Disorder Rider]	[Medically necessary treatment of musculoskeletal disorders affecting any bone or joint in the face, neck or head, including the diagnosis and treatment of temporomandibular joint disorders (TMJ) and craniomandibular disorder.] [Copayment/Coinsurance consistent with type of service required]
[Employee Assistance Program (EAP)]	[Short-term counseling for a maximum of [three (3)][four (4)] [eight (8)][twelve (12)] counseling sessions in a [Calendar][Plan] Year. [$0-$50] Copayment] [0% -50% Coinsurance Deductible] for Network EAP Providers; [$0-$100] Copayment] [0% -50% Coinsurance after Deductible] for Non-Network EAP Providers.]
[Family Services]	[Tubal ligations and vasectomies.] [Copayment/Coinsurance after Deductible consistent with type of service received.] [Only Coinsurances will be counted in Your Out-of-Pocket Maximum.]
[Hearing Aid Services Rider]	[Hearing Aids and Testing: [Total maximum Benefit of [$1,000 - $3,000] net expense applicable toward the purchase of hearing aids from a Network Provider every [two – five] Calendar Years.] [[0% - 50%] Coinsurance after Deductible will apply for each purchase.] [Specialist Copayment for annual hearing test. If hearing test is done in conjunction with an office visit, only one Copayment applies]

✸ - Requires Prior Authorization. Refer to Your Certificate of Coverage for details.

RIDERS Note: [Deductibles, Copayments and Coinsurances for Covered Health Services available through an optional Rider are not included in Your Out-of-Pocket Maximum, except as noted below. Coinsurance is the amount You pay after You meet Your medical Deductible.] [Deductibles and Coinsurances for Covered Services provided under any Rider(s) will count towards Your Out-of-Pocket Maximum.]	
[Prescription Eyewear]	[[$ *] dollar benefit maximum toward the purchase of eyeglasses (lenses and frames) and/or contact lenses from a Network Provider during any consecutive [twenty-four (24) month][twelve (12) month] period.
[Outpatient Prescription Drug] [Your Annual Deductible noted above must be satisfied before Benefits are payable under this Rider [, except for expenses for drugs on the Preventive Drug List. Prescription Drugs on the Preventive Drug List will be covered as if you already met your Deductible, so you are only responsible for paying the appropriate Copayment or Coinsurance. For copy of the Preventive Drug List, please call the Customer Contact Center at the number listed on Your ID card].] [Only Deductibles and Coinsurances for Covered Services under this Rider will count towards Your Out-of-Pocket Maximum.]	**NETWORK:** • [[$0-$1,000] per Member [[$0-3,000] [per Family] Annual Drug Deductible per [Calendar][Plan] Year] • [[$0-$3,000] Annual Benefit Maximum] • [No Annual Drug Deductible] • [$0-$100 Copayment] [0%-50% Coinsurance] for up to a 30-day supply of Tier One drugs • [$0-$100 Copayment] [0%-50% Coinsurance] Copayment for up to a 30-day supply of Tier Two drugs • [[$0-$100 Copayment] [0%-5 Coinsurance 0%] Copayment for up to a 30-day supply of Tier Three drugs] • [[$0-$250 Copayment] [0%-50% Coinsurance][with a maximum of $75 - $250] for up to a thirty (30) day supply Tier Four drugs.] • [Mail order [0%-50% Coinsurance] [1x, 2x, 2.5x, 3x Copayment] for up to a 90-day supply.] • [90-day Retail Pharmacy [0%-50% Coinsurance] [1x, 2x, 2.5x, 3x Copayment for up to a 90-day supply.]] **Service Charge for Brand-Name Drugs When a Generic is Available** [If a Brand-name Drug is dispensed when a Generic equivalent that is subject to a Maximum Allowable Cost is available, the Member pays the Generic Copayment plus a Service Charge. A Service Charge is equal to the difference between the cost of the Brand-name drug and the cost of the Generic substitute, reflected by the Maximum Allowable cost. The Member pays a Service Charge whether he or she chooses to receive the Brand-name drug or the Prescriber requests that the Brand-name drug be dispensed when a Generic equivalent is available. (MAC A)] [If the Prescriber specifies a Brand-name drug must be dispensed when a Generic equivalent that is subject to a Maximum Allowable Cost is available, the Member pays the Brand-name Copayment, but does not pay a Service Charge. If the Member requests the Brand-name drug be dispensed when a Generic equivalent that is subject to a Maximum Allowable cost is available, the Member pays the Generic Copayment plus a Service Charge. A Service Charge is equal to the difference between the cost of the Brand-name drug and the cost of the Generic substitute, reflected by the Maximum Allowable Cost. (MAC B)] [If the Prescriber or the Member requests a Brand-name drug be dispensed when a Generic equivalent is available, the Member pays his or her Brand-name Copayment, but does not pay a Service Charge. (MAC C] **NON-NETWORK** The **greater** of 50% Coinsurance of the retail cost of a Prescription Drug *or* the Network Copayment/Coinsurance including any applicable service charge [subject to Plan Annual Drug Deductible] for up to a 30-day supply per Prescription Order or Refill.

PLAN OPTIONS	
[MyChoice Wellness Benefit Plan]	[This program is offered under the proposed bona fide wellness program regulations of the Health Insurance Privacy and Accountability Act of 1996 (HIPAA). Eligible Subscriber and Dependent spouses (if applicable) who qualify for MyChoice will have Benefits as outlined in the Certificate Of Coverage. Dependent children will have the same Benefits. Qualification is based on *both* the eligible Subscriber and Dependent spouse (if applicable) agreeing to the requirements set forth in this Benefit Plan.]
[HSA/HDHP Amendment]	[Eligible Subscribers and Dependents who qualify for a Health Savings Account (HSA) will have High Deductible Health Plan (HDHP) Benefits as outlined in this Schedule of Coverage and Benefits, and the HSA Amendment. You may use Your HSA account to pay for non-qualified medical expenses, although withdrawals for such expenses are subject to federal, state, and local taxes, as applicable, and in most cases, a penalty tax. Any unused balance in your account at year-end is carried forward to the next Calendar Year.

✸ - Requires Prior Authorization. Refer to Your Certificate of Coverage for details.

PLAN OPTIONS	
	You are required both to determine whether withdrawals are used for qualified medical purposes and to report on Your annual tax return the amount withdrawn that is used for qualified medical expenses. Neither Mercy Health Plans nor its HSA banking partner will monitor this. Be sure to keep records (for example, receipts) so that You can prove to the IRS that the withdrawals are for qualified medical expenses that were not otherwise reimbursed. For examples of qualified medical expenses, see Your HSA Amendment.]
[HRA Amendment]	[Eligible Subscribers and Dependents who qualify for a Health Reimbursement Arrangement (HRA) will have Benefits as outlined in this Schedule of Coverage and Benefits, and the HRA Amendment.] [You may use Your HRA savings credit to pay for Qualified Medical Expenses. HRA reimbursements for medical expenses are not included in Your income. Unused funds are owned by Your employer and are not portable when You terminate Your employment.]

OTHER ELIGIBILITY REQUIREMENTS (As determined by the Enrolling Group)	
Dependent Eligibility ["Dependent" means the Subscriber's legal Spouse, or Domestic Partner*, or an unmarried Dependent Child of the Subscriber as described in the Certificate of Coverage.] ["Dependent" means the Subscriber's legal Spouse, or an unmarried Dependent Child of the Subscriber as described in the Certificate of Coverage.] [Other description of Dependent Eligibility as determined by Employer Group]	[A Dependent includes any unmarried dependent child under 19 years of age.] • [A Dependent includes any unmarried dependent child under [19-25] years of age.] • [A Dependent includes an unmarried dependent child who is between the ages of [19-25] and [20-25] [only if you furnish evidence upon our request, satisfactory to us, of all the following conditions: - The child must not be regularly employed on a full-time basis. - The child must be a Full-time Student. - The child must be primarily dependent upon the Subscriber for support and maintenance.] [A Dependent includes any unmarried dependent child who is between the ages of [19-25] and [20-25] [regardless of student status]]
[*Domestic Partner]	[An individual [of the [same] [or] [opposite] sex who signs an affidavit with a Subscriber, in which such individual and the Subscriber certify that they meet all of the following requirements: a) Such individual and Subscriber are both at least eighteen (18) years of age and mentally competent to consent to a contract; b) Such individual and Subscriber have lived together for the past [6 – 12] consecutive months and intend to remain so indefinitely; c) Such individual and Subscriber are in an exclusive, committed relationship with each other; d) Such individual and Subscriber are mutually responsible for each other's welfare on a continuing basis; e) Such individual and Subscriber are not related by blood; f) Such individual and Subscriber are not married to each other or anyone else; g) Such individual and Subscriber do not have a domestic partnership with anyone else; h) Such individual and Subscriber understand that providing deceptive or misleading information to the Plan or omitting information, may result in termination of employment, loss of Plan coverage, civil litigation, or criminal prosecution; and i) Such individual and Subscriber have provided proof of cohabitation and financial interdependence which means that they have provided proof of any two of the following items: 1. Joint least/mortgage of mutual residence; 2. Joint billing statements for residential utilities (e.g., gas, electric); 3. Joint bank account; 4. Joint insurance documents (e.g., property, life, auto); 5. Joint credit card accounts; 6. Joint loan agreements; 7. Joint car ownership; or 8. Other titles or deeds, which are jointly owned.]
Effective Date for Newly Hired Employees	[Varies by Employer]
Coverage Eligibility	[Varies by Employer]
Termination Effective Date	[Varies by Employer]

✸ - Requires Prior Authorization. Refer to Your Certificate of Coverage for details.

GROUP MASTER APPLICATION – ARKANSAS

[☐ New Group ☐ Renewal ☐ Plan Change ☐ Revisions]

GROUP INFORMATION

Effective Date:		Termination Date:			
Company Name:					
Billing Address:	City:		State:	Zip:	
Physical Address:	City:		State:	Zip:	
Phone:		Fax:			
Contact:		Title:		Email:	
Type of Business:		SIC Code:		# of Years in Business:	
Tax ID No.					

☐ Yes ☐ No In the past three years, has company filed for any form of bankruptcy?
☐ Yes ☐ No In the past three years, has any petition for bankruptcy been filed against company?

ELIGIBILITY INFORMATION

Total number of Eligible Employees:		Total number of Employees Applying for Coverage:	
Total number of Employees waiving (with Other Coverage)		Total number of Employees Waiving (without Other Coverage)	
Total number of Out-of-Area Employees:		Total number of COBRA participants:	
Total Number of Plan Employees:		Total number of Plan Members:	
States where Out-of-Area Employees Reside:		How many employees at each location?	

List any employee classes to be excluded from coverage: (i.e. part-time, seasonal, temporary)	
Annual Open Enrollment Period (date span)	
Effective Date for New Employees (CHOOSE ONE): NOTE: If Different for Different Classes, Please Specify.	☐ Date of Hire ☐ 30 ☐ 60 ☐ 90 Days ☐ 120 Days - After the Date of Hire First of the Month following: ☐ Date of Hire ☐ 30 ☐ 60 ☐ 90 ☐ 120 Days ☐ Other (Please Explain):_____
Number of Hours Worked per Week for Insurance Eligibility: (not to exceed 30 hours per week for Small Group Only):	
Termination Date of Plan Member:	☐ Date of Termination **OR** ☐ End of Month
Termination Date of Dependent Children:	☐ On [19-25] Birthday **OR** ☐ End of Month when turning [19-25] Full Time Student Age:_____ ☐ Date of Birth ☐ End of Month
[Domestic Partner Coverage: (Large Group Only):	☐ Yes ☐ No]

Employer Contribution:	Employee Only:	Dependent(s):

Group Name | Group Name

[Arkansas Region PPO Options available for Groups 2 to 25 eligible employees:]

Plan	Coinsurance	Deductible	Office Visit	Prescription Drug	Max. OOP (excluding deductible)
☐ **A**	80/60%	$2,500/$5,000	$25/50	$10/30/50	$4,000/$10,000
☐ **B**	80/60%	$2,000/$4,000	$25/50	$10/30/50	$4,000/$8,000
☐ **C**	80/60%	$1,500/$3,000	$25/50	$10/30/50	$3,000/$6,000
☐ **D**	90/70%	$1,000/$2,000	$15/30	$10/30/50	$2,000/$4,000
☐ **E**	80/60%	$1,000/$2,000	$20/40	$10/30/50	$2,000/$4,000
☐ **F**	80/60%	$1,000/$2,000	$20/40	$10/30/50	$4,000/$8,000
☐ **G**	70/50%	$1,000/$2,000	$25/40	$10/30/50	$4,000/$8,000
☐ **H**	90/70%	$500/$1,000	$15/25	$10/30/50	$1,000/$2,000
☐ **I**	80/60%	$500/$1,000	$15/30	$10/30/50	$1,000/$2,000
☐ **J**	80/60%	$500/$1,000	$20/40	$10/30/50	$2,000/$4,000
☐ **K**	70/50%	$500/$1,000	$25/40	$10/30/50	$4,000/$8,000
☐ **L**	80/60%	$250/$500	$20/40	$10/30/50	$1,000/$2,000
☐ **M**	80/60%	$250/$500	$25/50	$10/30/50	$2,000/$4,000
☐ **N**	80/60%	$0/$500	$15/25	$10/30/50	$1,000/$6,000

[Dual Option*: ☐ Yes (select 2 Plans above) ☐ No]

[*Only Groups with 10 or more covered.]

[Arkansas Region PPO Options available for Groups with 26+ eligible employees:]

Deductible (In-Network/ Out of Network)	Coinsurance (In-Network/Out of Network)	Maximum Out of Pocket (In-Network/ Out of Network)	Office Visit Copayments (PCP/ Specialist In-Network)	Prescription Drug (Tier 1/ Tier 2/ Tier 3/ Tier 4)
$_____/ $_____ ☐ 2x (family) ☐ 3x (family)	_____%/ _____%	$_____/ $_____ ☐ 2x (family) ☐ 3x (family)	$_____/ $_____	$_____/ $____/ $____/ ____%
$_____/ $_____ ☐ 2x (family) ☐ 3x (family)	_____%/ _____%	$_____/ $_____ ☐ 2x (family) ☐ 3x (family)]	$_____/ $_____	$_____/ $____/ $____/ ____%

Dual Option: ☐ **Yes** ☐ **No**

[Arkansas Region HDHP/HSA PPO Options available for Groups 26+ Eligible Employees: (TO BE USED FOR HDHP/HSA)]

Deductible (In-Network/ Out of Network)	Coinsurance (In-Network /Out of Network)	Maximum Out of Pocket (In Network/ Out of Network)	Prescription Drug (Tier 1/ Tier 2/ Tier 3/Tier 4)
$_____/ $_____	____%/ ____%	$_____/ $_____	$____/ $____/$____/[$] ____[%]
$_____/ $_____	____%/ ____%	$_____/ $_____	$____/ $____/$____/[$] ____[%]
Dual Option: ☐ **Yes** ☐ **No**			

PLAN OPTIONS: [NONE]

[☐ MyChoice Wellness Benefit Plan]	[This program is offered under the proposed bona fide wellness program regulations of the Health Insurance Privacy and Accountability Act of 1996 (HIPAA). Eligible Subscriber and Dependent spouses (if applicable) who qualify for MyChoice will have Benefits as outlined in the Certificate Of Coverage. Dependent children will have the same Benefits. Qualification is based on *both* the eligible Subscriber and Dependent spouse (if applicable) agreeing to the requirements set forth in this amendment.]
[☐ HSA/HDHP Amendment]	[Eligible Subscribers and Dependents who qualify for a Health Savings Account (HSA) will have high deductible health plan (HDHP) Benefits as outlined in this Schedule of Coverage and Benefits, and the HSA Amendment.]
[☐ HRA Amendment]	[Eligible Subscribers and Dependents who qualify for a Health Reimbursement Account (HRA) will have Benefits as outlined in this Schedule of Coverage and Benefits, and the HRA Amendment.]

RIDERS:

[☐ Family Services	• Tubal ligation and vasectomies.]
[☐ Birth Control Services *Required only if Outpatient Prescription Drug is covered.*	• Contraceptives, (oral, topical, injectable), intrauterine devices (IUDs), and insertion and routine removal of implantable contraceptives (no more than once every three (3) years, unless Medically Necessary.)]
[☐ Outpatient Prescription Drug]	• [Mail order [0%-50% Coinsurance] [1x, 2x, 2.5x, 3x Copayment] for up to a 90-day supply] • [90-day Retail Pharmacy [0%-50% Coinsurance] [1x, 2x, 2.5x, 3x Copayment] for up to a 90-day supply.]
CRANIOMANDIBULAR AND TEMPOROMANDIBULAR JOINT (TMJ) DISORDER RIDER	**Please check one:** ☐ I elect to provide coverage for craniomandibular and Temporomandibular Joint (TMJ) services. ☐ I elect not to provide coverage for craniomandibular and Temporomandibular Joint (TMJ) services.

HEALTH OVERVIEW

Answer "Yes" or "No" to the following questions. Please explain any "Yes" answers in the next section.

1. ☐ Yes ☐ No Have any Employees or Dependents incurred a medical expense exceeding $10,000 in the past 18 months?
2. ☐ Yes ☐ No Are any Employees or Dependents expected to have a major hospitalization or surgery in the next 6-month period?
3. ☐ Yes ☐ No Are any Employees or Dependents presently in a hospital or treatment facility?
4. ☐ Yes ☐ No Are any Employees on extended sick or injured leave?
5. ☐ Yes ☐ No Are any Employees or Dependents currently pregnant?
6. ☐ Yes ☐ No Are any Employees currently not at work performing their duties full-time due to illness or injury?

7. ☐ Yes ☐ No Are any Employees or Dependents undergoing regular or periodic treatment for a mental or physical disorder?

HEALTH OVERVIEW EXPLANATION

Please give details for any "Yes" answers from above. Please identify question above; give name and diagnosis.

_____

_____

_____

_____

_____

_____

_____

_____

PREVIOUS CARRIER INFORMATION

Please list the name of all insurance carriers in the last five years.

_____

_____

Please list the company's insurance rates for the past year.

	Employee	Employee + Spouse	Employee + Child(ren)	Family
Previous Year				
Current Rates				
Renewal Rates				

CURRENT BENEFITS:

Deductible	**Coinsurance**	**Maximum Out of Pocket**	**Office Visit Copayments**	**Prescription Drug**
$_____/ $_____ ☐ 2x (family) ☐ 3x (family)	_____%/ _____%	$_____/ $_____ ☐ 2x (family) ☐ 3x (family)	$_____/ $_____	$___/ $___/ $___/ ____%
$_____/ $_____ ☐ 2x (family) ☐ 3x (family)	_____%/ _____%	$_____/ $_____ ☐ 2x (family) ☐ 3x (family)	$_____/ $_____	$___/ $___/ $___/ ____%
Dual Option: ☐ **Yes** ☐ **No**				

READ THIS IMPORTANT INFORMATION

The applicant for this health coverage affirms that all information is complete and accurate to the best of their knowledge. Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. As changes occur, the applicant agrees to notify Mercy Health Plans (MHP) so that coverage premiums may be adjusted. This includes the addition or deletion of Plan Members, changes in company standards, or the installation of hazardous equipment. MHP will continue coverage based on the current information on hand at the time claims are filed.

The applicant agrees to allow MHP to use medical data for its own or a third party's research needs. MHP may use this information during or after coverage has been terminated. Confidentiality laws will govern the use of all information that pertains to individuals. At no time will confidential business information between the applicant and MHP be given to another party without first gaining written authorization.

Renewal rates may change periodically, and will be based on information that allows for projected future claims, as permitted by state law. If this application is approved in writing by MHP, and if a full monthly premium binder has been made, coverage will be effective on the agreed upon date. The applicant may use the canceled check as "proof of payment". Once coverage has been granted to the applicant, the premium binder will not be refunded if the applicant cancels coverage. All premium binders will be applied to the first premium payment or any outstanding balance due.

Applicant must have at least two (2) eligible employees. Applicant understands that if information becomes known after the effective date, which would have materially affected the Underwriting decision or rates offered the group by MHP, then MHP may terminate the coverage or increase the rates retroactively to the initial effective date. No statement voids the coverage or reduces the benefits after the coverage has been in force two (2) years from its effective date, unless the statement was material to the risk assumed and contained in a written statement.

☐ **The Group** is responsible for preparing and delivering all Certificates and Notices in accordance with and as required by **HIPAA**.

☐ **MHP** is responsible for preparing and delivering all Certificates and Notices in accordance with and as required by **HIPAA**.

Employer acknowledges that MHP does not cover medical care or treatment for an Illness or Injury arising out of or in the course of any occupation or employment for compensation, profit or gain, regardless of whether or not such Illness or Injury is covered by Workers' Compensation law, occupational disease law, or laws of a similar character.

[Employer understands that the coverage and rates contained in this Application are offered by MHP on an exclusive basis, and if Employer accepts the stated coverage and rates, agrees that MHP will be the exclusive health care plan offered to its employees. Failure by Employer to offer MHP on this exclusive basis prior to the effective date of coverage will result in immediate withdrawal of the proposed coverage and rates provided herein, without any further notification to Employer by MHP. MHP must approve exceptions to this agreement in writing.]

NOTICE OF GUARANTEED RENEWAL

This contract will be guaranteed renewable, subject to the group meeting underwriting rules of Mercy Health Plans (MHP), and making premiums payments as indicated in the Certificate of Coverage, unless MHP discontinues this product or discontinues offering all products in the small or large group markets, or both.

If MHP discontinues offering this product, the group will be given at least ninety (90) days notice prior to discontinuance and will be offered all remaining products, on a guaranteed basis by MHP.

If MHP discontinues offering all products in the small or large group markets or both, the group will be given at least one hundred eighty (180) days notice prior to discontinuance.

Applicant may terminate this Agreement on any anniversary date by giving MHP sixty (60) days advanced written notice. Any premiums due must be paid to MHP prior to termination.

Authorized Group Representative Name: _____ Title: _____

Authorized Group Representative Signature: _____ Date: _____

Authorized Producer Name: _____ _____

Authorized Producer Signature: _____ Date: _____

Agency Name: _____

Agency Address/Phone: _____

MHP Account Executive: _____ Date: _____

Before sending application please review the following:

- Answer questions in full and to the best of your knowledge.
- If replacing coverage, submit most recent premium notice with list of covered individuals.
- Do not cancel your coverage until your application is accepted in writing by MHP.
- Please submit current wage and tax statement.
- Include with this application a check for the first month's full payment.

ADDITIONAL RIDERS – FOR LARGE GROUPS ONLY:

[☐ Employee Assistance Program	• Short-term counseling for a maximum of [three (3)][four (4)][eight (8)][twelve (12)] counseling sessions in a Calendar Year. $0 Copayment for Participating EAP Providers.]
[☐ Hearing Aid Services	Hearing Aids and Testing: ▪ Maximum Benefit of [$1,000 - $3,000] allowable expense applicable toward the purchase of hearing aids every [two – five] Calendar Years. ▪ [[0% - 50%] Member Coinsurance] for each purchase. ▪ [Specialist Copayment for annual hearing test. If hearing test is done in conjunction with an office visit, only one Copayment applies]]
[☐ Prescription Eyewear	[[$ *] dollar benefit maximum toward the purchase of eyeglasses (lenses and frames) and/or contact lenses from a Participating Provider during any consecutive [twenty-four (24)] [twelve (12)] month period.]
[☐ Other	[Name of Rider:

[RATES (Initial Quote only, FINAL rates will be determined by Underwriting)]

4 Tier		**3 Tier**		**Age/ Gender**
Employee Only:		Employee Only:		See Attached Rate Proposal
Employee + Spouse:		Employee + One:		
Employee + Child(ren):		Employee + Two or More:		
Family:				

OUTPATIENT PRESCRIPTION DRUG RIDER

This Rider amends the Certificate of Coverage and the Schedule of Coverage and Benefits attached thereto (collectively, the "Policy"), and unless otherwise expressly stated in this Rider, is subject to all provisions, exclusions, and limitations set forth in the Policy. This Rider is issued to the enrolling group and provides benefits for Outpatient Prescription Drugs. Benefits are greater if received at a Participating Pharmacy. [The Annual Drug Deductible must be satisfied before We will begin paying for Benefits.] [Any applicable Deductible, Coinsurance and/or Copayment will not count towards any applicable Out-of-Pocket Maximum as set forth in the Schedule of Coverage and Benefits.] [Only Deductibles and Coinsurances for Covered Services under this Rider will count towards Your Out-of-Pocket Maximum. Your Annual Deductible as indicated on the Schedule of Coverage and Benefits must be satisfied before Benefits are payable under this Rider [, except for expenses for drugs on the Preventive Drug List. Prescription Drugs on the Preventive Drug List will be covered as if you already met your Deductible, so you are only responsible for paying the appropriate Copayment or Coinsurance].]

When We use the words "We", "Us", and "Our" in this document, We are referring to Mercy Health Plans When We use the words "You" and "Your" We are referring to Covered Persons as defined in the Policy. Unless defined differently in this Rider, all other capitalized terms shall have the meanings given them in the Policy.

I. GLOSSARY OF TERMS

This section:

- Defines the terms used throughout this Rider.
- Is not intended to describe benefits.

[**Annual Drug Deductible -** the amount You are required to pay for covered Prescription Drugs in a Calendar Year before We begin paying for Prescription Drugs[, except for expenses for Prescription Drugs on the Preventive Drug List].]

Brand-name – a Prescription Drug: (1) which is manufactured and marketed under a trademark or name by a specific drug manufacturer; or (2) that We identify as a Brand-name drug. We classify a Prescription Drug as Brand or Generic based on data provided to Our prescription claims processor by First DataBank or Medi-Span. First DataBank or Medi-Span will periodically change the classification of a drug based on many elements. Upon notification of a change in classification, the formulary list at www.mercyhealthplans.com will be updated. You may also obtain this information by calling Our Customer Contact Center telephone number on the back of Your identification card. A change in classification may affect Your applicable Copayment/Coinsurance for that drug.

Calendar Year – the period of twelve (12) months commencing on January 1st and each twelve (12) month period thereafter (or other period as indicated in the Group Master Policy), unless otherwise terminated as provided herein.

Copayment/Coinsurance – the fee, as set forth in the Schedule of Coverage and Benefits, to be paid directly by Covered Persons, for a Prescription Order or Refill.

Formulary – a list of Prescription Drugs that are approved by the Plan for coverage and are dispensed to Covered Persons. The Formulary is subject to periodic review and modification by the Plan without the consent of the Group or Covered Person. Prescription Drugs are given a status of Tier One (or "First Tier"), Tier Two (or "Second Tier"), Tier Three (or "Third Tier"), Tier Four (or "Fourth Tier"), or Not Covered by the Plan's Formulary Management Committee.

Generic – a Prescription Drug: (1) that is chemically equivalent to a Brand-name drug; or (2) that We identify as a Generic product. Classification of a Prescription Drug as a Generic is determined by Us and not by the manufacturer or pharmacy. We classify a Prescription Drug as Generic based on data provided to Our prescription claims processor by First DataBank or Medi-Span. Therefore, all products identified as a "generic" by the manufacturer or pharmacy may not be classified as a Generic by First DataBank or Medi-Span. First DataBank or Medi-Span will periodically change the classification of a drug based on many elements. Upon notification of a change in classification, the formulary list at www.mercyhealthplans.com will be updated. You may also obtain this information by calling Our Customer Contact Center telephone number on the back of Your identification card. A change in classification may affect Your applicable Copayment/Coinsurance for that drug.

Maximum Allowable Cost (MAC) – the upper limit cost paid to a Participating Pharmacy for specified Prescription Drugs. The MAC applies to Generic drugs, and when appropriate, Brand-name drugs included in the Formulary. We may modify the list at any time without the consent of any Group, Covered Person, or Participating Pharmacy. A change in the MAC status of a drug may affect the Copayment/Coinsurance You are required to pay for that drug.

National Drug Code (NDC) number - a number maintained by the Food and Drug Administration (FDA) that uniquely identifies all Prescription Drug products.

Non-Covered Drug – a drug or product for which coverage is not available through Mercy Health Plans. Non-Covered drugs or products include, but are not limited to, those specifically excluded by the Policy or this Rider.

Non-Participating Pharmacy (Non-Network Pharmacy) – a pharmacy that has **NOT**:
- Entered into an agreement with Us or Our designee to provide Prescription Drugs to Covered Persons.
- Agreed to accept specified reimbursement rates for dispensing Prescription Drugs.
- Been designated by Us as a Participating Pharmacy.

Participating Pharmacy – a pharmacy that has:
- Entered into an agreement with Us or Our designee to provide Prescription Drugs to Covered Persons.
- Agreed to accept specified reimbursement rates for dispensing Prescription Drugs.
- Been designated by Us as a Participating Pharmacy.

A Participating Pharmacy can be a retail, mail service, or specialty pharmacy.

Predominant Reimbursement Rate – the amount We will reimburse You for a Prescription Drug that is dispensed by a Non-Participating Pharmacy. The Predominant Reimbursement Rate for a particular Prescription Drug includes a dispensing fee and may include sales tax. We calculate the Predominant Reimbursement Rate using Our Prescription Drug Cost that applies to that Prescription Drug at most Participating Pharmacies.

Prescriber – A duly licensed health care provider who has issued a Prescription Order or Refill.

Prescription Drug – a medication that has been approved by the Food and Drug Administration (FDA) for use in the treatment of any indication provided the drug has been recognized as safe and effective for treatment of the specific type of indication in any of the following: (1) the National Comprehensive Cancer Network (NCCN) Drugs & Biologics Compendium drug evaluations; (2) The American Hospital Formulary Service drug information; (3) The United States Pharmocopoeia dispensing information; or (4) two articles from major peer-reviewed professional medical journals that have not had their effectiveness contradicted in another article from a major peer-reviewed professional medical journal. A Prescription Drug can, under federal or state law, be dispensed only pursuant to a Prescription Order or Refill. Prescription Drugs are given a status of Tier One (or "First Tier"), Tier Two (or "Second Tier"), Tier Three (or "Third Tier"), Tier Four (or "Fourth Tier"), or Not Covered by the Plan's Formulary Committee. A Prescription Drug includes a medication that, due to its characteristics, is appropriate for self-administration or administration by a non-skilled caregiver. For the purpose of this benefit, this definition also includes:
- Inhalers (with spacers)
- Insulin
- The following diabetic supplies:
  - insulin syringes with needles
  - blood testing strips – glucose
  - urine testing strips – glucose
  - ketone testing strips and tablets
  - lancets and lancet devices
  - glucose monitors

Prescription Drug Cost – the rate We have agreed to pay Our Participating Pharmacies, including a dispensing fee and any sales tax, for a Prescription Drug dispensed at a Participating Pharmacy.

Prescription Order – the directive to dispense a Prescription Drug issued by a duly licensed health care provider whose scope of practice permits issuing such a directive.

[Preventive Drug List – A list of drugs or medications that are considered preventive care because they are used solely by a person who has developed risk factors for a disease that has not yet manifested itself or not yet become clinically apparent (i.e., asymptomatic), or used solely to prevent the reoccurrence of a disease from which a person has recovered.]

Prior Authorization
Before certain Prescription Drugs are covered, Your Physician is required to obtain prior authorization from Us. There are several reasons for obtaining prior authorization, including determining whether the Prescription Drug, in accordance with Our approved guidelines, meets the definition of a Covered Service and is not Experimental, Investigational, or Unproven, or in some cases, simply to notify the Plan that a member may qualify for additional services such as case management.

The list of Prescription Drugs requiring prior authorization is subject to Our periodic review and modification. You may obtain a current list of Prescription Drugs that require prior authorization through the Internet at www.mercyhealthplans.com or by calling Our Customer Contact Center at the telephone number on Your ID card.

Quantity Limits
Benefits for Prescription Drugs are subject to the quantity limits that are stated in the "Description of Pharmacy Type and Supply Limits" column of the Benefit Information table in Section IV. For a single Copayment/Coinsurance, You may receive a Prescription Drug up to the stated quantity limit.

Note: Some Prescription Drugs are subject to additional quantity limits based on criteria that We have developed. The limit may restrict either the amount dispensed per Prescription Order or Refill, or the number of refills during a specified time frame.

You may obtain a current list of Prescription Drugs that have been assigned maximum quantity limits for dispensing through the Internet at www.mercyhealthplans.com or by calling Our Customer Contact Center at the telephone number on Your ID card. The list is subject to Our periodic review and modification.

Refill – A second or subsequent dispensation of a prescription drug as authorized by a Prescription Order.

Service Charge – a charge in addition to applicable Copayment/Coinsurance. A Service Charge is equal to the difference between the cost of the Prescription Drug as dispensed and the cost of the generic substitute reflected by the Maximum Allowable Cost.

Specialty Pharmaceutical – any Prescription Drug used to treat a complex, often chronic disease that requires complex care management. Specialty Pharmaceuticals include those drugs used to treat rheumatoid arthritis multiple sclerosis, hepatitis C and other chronic diseases. They are typically high-cost and often require special handling, and close monitoring of the patient's condition. Most Specialty Pharmaceuticals are subject to coverage limitations and may have limited distribution through certain specialty pharmacies. See Section IV. Benefit Information for more details.

Step Therapy
Step therapy is a program similar to prior authorization. It ensures use of clinically appropriate drugs in a cost effective manner. Step therapy protocols are based on current medical findings, FDA-approved drug labeling, and drug costs.

Step therapy drugs are considered either "first-line" or "second-line". A first-line drug and its corresponding second-line drug are both used to treat the same conditions. First-line drugs are drugs that are commonly prescribed, safe and effective in treating a given condition, and are typically less expensive than second-line drugs.

Second-line drugs are not covered unless You have tried a first-line therapy. If for some reason You cannot try the first-line drug, a Prescriber can request a medical exception to bypass the step therapy requirement.

Tier One – Tier One drugs will incur Your lowest Copayment/Coinsurance and are typically those drugs classified as Generic by First Databank or Medi-Span.

Tier Two – Tier Two drugs will incur a higher Copayment/Coinsurance than a Tier One Drug and a lower Copayment/Coinsurance than a Tier Three or Tier Four Drug. Tier Two drugs may be classified as either Generic or Brand by First Databank or Medi-Span.

Tier Three – Tier Three drugs will incur a higher Copayment/Coinsurance than a Tier One or Tier Two drug, and a lower Copayment/Coinsurance than a Tier Four drug. Tier Three drugs may be classified as either Generic or Brand by First Databank or Medi-Span.

Tier Four – Tier Four drugs incur Your highest Copayment/Coinsurance and are typically Specialty Pharmaceuticals. They may be classified as either Brand or Generic by First Databank or Medi-Span.

Usual and Customary Charge – the usual fee that a pharmacy charges individuals for a Prescription Drug without reference to reimbursement to the pharmacy by third parties.

II. INTRODUCTION

What's Covered - Outpatient Prescription Drug Benefits

We provide benefits under this Rider for Prescription Drugs designated as covered at the time the Prescription Order or Refill is dispensed by a Participating Pharmacy. Refer to exclusions in Your Policy and in Section V of this Rider.

Coverage Policies and Guidelines

Our Formulary Management Committee reviews all Prescription Drugs that are newly approved by the FDA. The committee objectively evaluates Prescription Drugs for therapeutic treatment, safety, and cost in order to establish coverage policies and guidelines, such as Quantity Limits, Step Therapy and Prior Authorization, that promote quality and cost-effective drug therapy. Prescription Drugs are given a status of Tier One (or "First Tier"), Tier Two (or "Second Tier"), Tier Three (or "Third Tier"), Tier Four (or "Fourth Tier"), or Non-Covered by the Plan's Formulary Committee. Drugs not added to the Formulary are considered Non-Covered.

Even after a Prescription Drug is included on the Formulary, this evaluation continues at least annually or as new information becomes available.

In the event that a Prescription Drug You are taking is removed from the Formulary, You will be notified electronically or in writing at least thirty (30) days prior to its removal and before it is considered a Non-Covered Drug.

Drug Cancellation Notification

Changes to the Formulary will be posted to the Plan's website at *www.mercyhealthplans.com.*

Identification Card (ID Card)

You will be required to show Your ID card at the time You obtain Your Prescription Drug at a Participating Pharmacy. If Your card is not available at that time, You must provide the Participating Pharmacy with identifying information that We can verify during regular business hours.

If the pharmacy is unable to verify Your coverage or if the Prescription Drug is dispensed by a Non-Participating Pharmacy, You will be required to pay 100% of the cost of the Prescription Drug at the pharmacy. Our contracted pharmacy reimbursement rates (Our Prescription Drug Cost) will not be available to You.

You may seek reimbursement from Us by submitting the paid pharmacy receipt(s) to Us as outlined in the section, What You Must Pay.

What You Must Pay

[If applicable, You may be responsible for paying an Annual Drug Deductible [in addition to Your Annual Deductible for the Certificate of Coverage] as described in the Schedule of Coverage and Benefits.]

You are responsible for paying the applicable [Deductible,]Copayment/Coinsurance, [Annual Drug Deductible] and any applicable Service Charge as described in the Schedule of Coverage and Benefits when Prescription Drugs are obtained from a retail, mail service, or specialty pharmacy. Your Annual Deductible as indicated on the Schedule of Coverage and Benefits must be satisfied before Benefits are payable under this Rider [, except for expenses for drugs on the Preventive Drug List. Prescription Drugs on the Preventive Drug List will be covered as if you already met your Deductible, so you are only responsible for paying the appropriate Copayment or Coinsurance].] The Prescription Drug Copayment/Coinsurance is in addition to any other place-of-service Copayment/Coinsurance (i.e., medical office, home care, etc.).

Mercy Health Plans negotiates with Participating Pharmacies on your behalf for a discounted rate for Prescription Drugs. This discount is passed on to You when You use Your Mercy Health Plans drug coverage.

If a Participating Pharmacy is unable to verify Your coverage or if the Prescription Drug is dispensed by a Non-Participating Pharmacy, You will be required to pay 100% of the cost of the Prescription Drug at the pharmacy. Our contracted pharmacy reimbursement rates (Our Prescription Drug Cost) will not be available to You. You may seek reimbursement from Us by submitting the paid pharmacy receipt(s) within 60 days to:

Mercy Health Plans
ATTN: Pharmacy Department
14528 South Outer 40 Road, Suite 300
Chesterfield, Missouri 63017

The receipt(s) must be submitted within sixty (60) days after the Prescription Drug is filled by the pharmacy. The receipt(s) must show the name of the Prescription Drug, the National Drug Code (NDC) number, the units dispensed, the days' supply, the prescription number, the amount You paid, and the date of purchase. Failure to furnish receipts within the time required will not invalidate any claim, if it was not reasonably possible to give notice within the time required.

When You request reimbursement for a Prescription Drug obtained at a Participating Pharmacy we will only reimburse You based on what We would have paid to the Participating Pharmacy less any required Copayment/Coinsurance, [Deductible,] [Annual Drug Deductible] and any applicable Service Charge. This means that You may not be refunded the full retail price that You originally paid. Any Quantity Limitations, Step Therapy, or Prior Authorization requirements will apply. We will not reimburse You for any Non-Covered Drug.

When You request reimbursement for a Prescription Drug obtained at a non-Participating Pharmacy, You will be responsible for the **greater** of 50% of the retail cost of the Prescription Drug *or* the in-Network [Deductible and] Copayment/Coinsurance amount including any applicable Service Charge. [The Annual Drug Deductible also applies.] This means that You may not be refunded the full retail price that You originally paid. Any Quantity Limitations, Step Therapy, or Prior Authorization requirements will apply. We will not reimburse You for any Non-Covered Drug.

The amount You pay for any of the following under this Rider will not be included in calculating any Out-of-Pocket Maximum stated in Your Policy:

- [Copayments][and Coinsurances] for Prescription Drugs]
- [Service Charges]
- [Annual Drug Deductible, if applicable]
- [The Annual Deductible]
- Any Non-Covered drug. You are responsible for paying 100% of the cost for any Non-Covered drug.

Medical Emergencies
When You obtain a Prescription Drug from a Non-Participating Pharmacy, as part of Emergency Care, You will be required to pay 100% of the cost for the Prescription Drug at the pharmacy. You may seek reimbursement from Us by submitting the paid pharmacy receipt(s) to Us as outlined in the section, What You Must Pay. Upon review of the relevant medical records and any other relevant information reasonably requested by Us, Our Chief Medical Officer or designee will determine whether the Prescription Drugs were in fact part of, or related to Emergency Care. If it is determined that the Prescription Drug was dispensed as part of Emergency Care, You will be reimbursed the cost incurred by You, less the appropriate [Deductible,]Copayment/Coinsurance, [Annual Drug Deductible], and any applicable Service Charge. If it is determined that the Prescription Drug was NOT dispensed as part of Emergency Care, You will pay the appropriate Non-Network [Deductible,]Coinsurance, [Annual Drug Deductible], and any applicable Service Charge.

When a Brand-name Drug Becomes Available as a Generic
When a Prescription Drug becomes available as a Generic, the Brand-name version may no longer be available on the Formulary or the Copayment/Coinsurance may change. See the Schedule of Coverage and Benefits for details.

Rebates and Other Payments to Us
We may receive rebates for certain Brand-name drugs included on Our Formulary. We do not consider these rebates in calculating any percentage Copayments/Coinsurances. We are not required to pass on to You, and We do not

pass on to You, amounts payable to Us under rebate programs or other such discounts.

Coupons and Incentives
At various times, We may offer coupons or other incentives for certain drugs on the Formulary. Only Your doctor can determine whether a change in Your Prescription Order or Refill is appropriate for Your medical condition.

Limitation on Selection of Pharmacies/Prescribers
If We determine that You are using Prescription Drugs in a harmful or abusive manner, or with harmful frequency, Your selection of Participating Pharmacies and Prescribers may be limited. If this happens, We will notify You and require You to select up to two Participating Pharmacies and Prescribers who will provide and coordinate all future pharmacy services. If You don't make a selection within ten (10) days of the date We notify You, We will select a Participating Pharmacy and Prescriber for You. If You fail to use the selected providers, benefits for covered Prescription Drugs will not be paid.

III. PAYMENT INFORMATION

Payment Term	Description	Amounts
[Annual Drug Deductible] **[Annual Deductible]**	[If applicable, the amount You pay for covered Prescription Drugs at a retail, mail service, or specialty pharmacy in a Calendar Year before We begin paying for Prescription Drugs.] [The amount as indicated on the Schedule of Coverage and Benefits that must be satisfied before Benefits are payable under this Rider [, except for expenses for drugs on the Preventive Drug List].]	***[If applicable, see the Annual Drug Deductible in the Schedule of Coverage and Benefits for amount.]*** *[See the Annual Deductible amount on the Schedule of Coverage and Benefits.]*
Copayment/Coinsurance	The amount You pay for covered Prescription Drugs. It can be either a specific dollar amount or a percentage of the Prescription Drug Cost. ***See Glossary of Terms for definition of Prescription Drug***.	[For Prescription Drugs at a Participating Pharmacy, You are responsible for paying the applicable [Deductible,] Copayment/Coinsurance, [Annual Drug Deductible] and any Service Charge.] [You do not have to meet the Annual Deductible before drugs on the Preventive Drug List are covered. For copy of the Preventive Drug List, please call the Customer Contact Center at the number listed on Your ID card.] For Prescription Drugs at a Non-Participating Pharmacy, You are responsible for paying the **greater** of 50% of the retail cost of the Prescription Drug *or* the Network [Deductible,]Copayment/Coinsurance amount including any applicable Service Charge. [The Annual Drug Deductible also applies.] (See Section IV. Benefit Information for more on obtaining Prescription Drugs from a Non-Participating Pharmacy).

IV. BENEFIT INFORMATION

Description of Pharmacy Type and Supply Limits	Your Copayment/Coinsurance Amount
Up to a 30-Day Supply of Prescription Drugs from a Participating Retail or Specialty Pharmacy As written by the Prescriber, *up to* a consecutive 30-day supply of a Prescription Drug, unless limited by the drug manufacturer's packaging size, or based on Quantity Limits, or	See Your applicable [Deductible,]

to the extent a Prescription Drug is normally prescribed in limited supplies in accordance with generally accepted medical practice. ***See Glossary of Terms for definition of Prescription Drug.***	Copayment/Coinsurance stated in the Schedule of Coverage and Benefits.
[A 31- to 90-Day Supply of Prescription Drugs from a Participating 90 Day Retail Pharmacy Some retail Participating Pharmacies have entered into an agreement with Us that allows them to dispense up to a 90-day supply of certain Prescription Drugs. You may obtain a list of 90-day retail Participating Pharmacies through the Internet at www.mercyhealthplans.com or by calling Our Customer Contact Center at the telephone number on Your ID card. As written by the Prescriber, a 31- to 90-consecutive day supply of a Prescription Drug, unless limited by the drug manufacturer's packaging size, or based on quantity limits, or to the extent a Prescription Drug is normally prescribed in limited supplies in accordance with generally accepted medical practice. **NOTE:** Specialty Pharmaceuticals are limited to *a maximum of* a thirty (30)-day supply per Prescription Order or Refill. ***See Glossary of Terms for definition of Prescription Drug.]***	[See Your applicable [Deductible,] Copayment/Coinsurance stated in the Schedule of Coverage and Benefits.]
Prescription Drugs from a Mail Service Participating Pharmacy The following supply limits apply: • As written by the provider, *up to* a consecutive 90-day supply of a Prescription Drug, unless limited by the drug manufacturer's packaging size, or based on quantity limits, or to the extent a Prescription Drug is normally prescribed in limited supplies in accordance with generally accepted medical practice. • **NOTE:** Specialty Pharmaceuticals are limited to *a maximum of* a thirty (30)-day supply per Prescription Order or Refill. It is not recommended, therefore, that You use a mail-order pharmacy to obtain Your Specialty Pharmaceutical. To receive the maximum Benefit, Your provider must write Your Prescription Order or Refill for the full 90-day supply. If You receive less than a 90-day supply from a Mail Service Pharmacy, You will still be required to pay the Mail Services Copayments/Coinsurances. ***See Glossary of Terms for definition of Prescription Drug.***	See Your applicable [Deductible,] Copayment/Coinsurance stated in the Schedule of Coverage and Benefits.
Prescription Drugs from a Non-Participating Pharmacy If the Prescription Drug is dispensed by a Non-Participating Pharmacy, You must pay for the Prescription Drug at the time it is dispensed and then file a claim for reimbursement with Us, as described in the Section II, *What You Must Pay.* In most cases, You will pay more if You obtain a Prescription Drug from a non-Network Pharmacy. The following supply limits apply: As written by the provider, up to a consecutive 30-day supply of a Prescription Drug Product, unless adjusted based on the	See Your applicable [Deductible,] Copayment/Coinsurance stated in the Schedule of Coverage and Benefits.

drug manufacturer's packaging size, or based on supply limits. Any Quantity Limitations, Step Therapy, or Prior Authorization requirements will apply. We will not reimburse You for any Non-Covered Drug.	

V. WHAT'S NOT COVERED - EXCLUSIONS

The Coordination of Benefits in Your Certificate of Coverage does not apply to Prescription Drugs covered by this rider. Except as modified or superseded by the coverage provided under this Rider, all other terms, conditions, exclusions in the Certificate of Coverage remain unchanged and in full force and effect. In addition, the following exclusions apply:

1. Coverage for Prescription Drugs for any amount dispensed in excess of the supply limits addressed above and/or any additional quantity limits as discussed in Section II.
2. Drugs that are prescribed, dispensed, or intended for use while You are an inpatient in a Hospital, Skilled Nursing Facility, or Alternate Facility.
3. Experimental, Investigational, or Unproven services and medications; medications not approved by the FDA; medications used for experimental or unproven indications ("off-label" uses) and/or dosage regimens determined by Us to be experimental.
4. Prescription Drugs furnished by the local, state, or federal government. Any Prescription Drug to the extent payment or benefits are provided or available from the local, state, or federal government (for example, Medicare) whether or not payment or benefits are received, except as otherwise provided by law.
5. Prescription Drugs for any condition, injury, sickness or mental illness arising out of, or in the course of, employment for which benefits are available under any Workers' Compensation law or other similar laws, whether or not a claim for such benefits is made or payment or benefits are received.
6. Any product dispensed for the purpose of appetite suppression or weight loss.
7. Compounded drugs that do not contain at least one ingredient that requires a Prescription Order.
8. Drugs available over-the-counter that do not require a Prescription Order by federal or state law before being dispensed.
9. Any drug that is therapeutically equivalent to an over-the-counter drug.
10. Durable Medical Equipment. Prescribed and non-prescribed outpatient supplies, other than the diabetic supplies and inhaler spacers specifically stated as covered.
11. Replacement Prescription Drugs resulting from lost, stolen, damaged, spilled, or destroyed medications.
12. General and injectable vitamins, except prenatal vitamins that require a Prescription Order and are prescribed for a Covered Person who is then pregnant or attempting to conceive.
13. Unit dose packaging of Prescription Drugs.
14. Medications used for cosmetic purposes.
15. New Prescription Drugs and/or new dosage forms until they are reviewed and approved by Our Formulary Management Committee.
16. Prescription Drugs or dosage forms that are determined to not be a Covered Service.
17. Prescription Drugs or devices to treat erectile dysfunction including, but not limited to, impotency.
18. Drugs that are determined to be Non-Covered by Our Formulary Management Committee for any reason, including but not limited to, safety, efficacy, cost, narrow therapeutic index, etc.
19. Medical foods or other products that are intended to meet the distinctive nutritional requirements of a person with a particular disease or condition for which nutritional requirements are established by recognized scientific principles and formulated to be consumed or administered enterally under the direction of a physician.
20. Prescription Drugs whose primary purpose or direct effect is the removal, destruction, or interference with the implantation of a fertilized ovum, embryo, or fetus.
21. Immunizations received through a Participating or Non-Participating pharmacy. See Your Certificate of Coverage for immunization services covered under Your medical Benefit.
22. A Specialty Pharmaceutical which, due to its characteristics as determined by Us, must typically be administered or supervised by a qualified provider or licensed certified health professional in an outpatient setting. This exclusion does not apply to Depo Provera and other injectable drugs used for contraception.
23. Growth hormone except as determined medically necessary by the Plan to treat diagnostically proven growth hormone deficiency. Growth hormone(s) to treat idiopathic short stature (ISS) is expressly excluded.
24. Contraceptive implant systems, diaphragms, and intrauterine devices (IUD).

[25. Prescription Drugs when prescribed to treat infertility, unless superseded by a Rider.]

[26. Prescription Drugs when prescribed to prevent conception, including but not limited to oral contraceptives, diaphragms, intrauterine devices, Nuva Ring, Depo Provera and other injectable drugs used for contraception, unless otherwise specified within this or other Plan documents, except when medically indicated for other than the purposes of preventing pregnancy, and pre-approved by the Plan's Chief Medical Officer or designee.]

Charles S. Gilham, Vice President
Mercy Health Plans

EMPLOYEE ASSISTANCE PROGRAM (EAP) RIDER

1. This Rider amends the Certificate of Coverage and the Schedule of Coverage and Benefits attached thereto (collectively, the "Policy") and, unless otherwise expressly stated in this Rider, is subject to all the provisions, exclusions and limitations set forth in the Policy.

2. Any exclusion(s) related to services specifically covered under this Rider is hereby deleted in its entirety.

3. For purposes of this Rider, capitalized terms shall have the meaning described below or, if not listed below, the meaning assigned to them in the Policy:

   "Counseling Session" means any in-person or telephone communication between a Member and an EAP Professional to discuss a personal problem that may have a negative impact on the Member's job performance. [Other persons living in the Member's immediate household may attend a Counseling Session.]

   ["Legal Consultation" means any in-person or telephone communication between a Member, persons in the Member's family, and an attorney to discuss a legal problem that may have a negative impact on the Member's job.**]**

   "Network EAP Provider" means any EAP Provider who has contracted with the Plan to provide care to Members under this Rider.

   "Non-Network EAP Provider" means an EAP Provider who is not contracted with the Plan to provide care to Members under this Rider.

   "Short-Term Counseling" means a maximum of EAP Counseling Sessions as indicated on the Schedule of Coverage and Benefits. Each EAP Counseling session lasts no more than one (1) hour for personal problems that may have a negative impact on the Member's job performance.

4. **Covered Services:**
   Member s shall be entitled to Short-Term Counseling from an EAP Provider for assistance with personal problems that may have a negative impact on the Member's job performance.

5. **Copayments:**
   For each employee assistance Counseling Session, the Member is responsible for paying a [Copayment*] [Deductible and Coinsurance*]. [The [Copayment] [Deductible and Coinsurance] described in this Rider shall not be counted against the applicable Out-of-Pocket Maximum as set forth in the Schedule of Coverage and Benefits.] [Only Deductibles and Coinsurances for Covered Services described in this Rider will count towards your Out-of-Pocket Maximum.]

6. **Exclusions:**
   Under no circumstances will coverage be provided for:
   (a) Services beyond the scope of the EAP Provider's license or certificate under a legally constituted professional association or other authority consistent with state laws.
   (b) More than the stated number of EAP Counseling Sessions described in this Rider in a Calendar Year.
   (c) Services not recognized as the standard of care by licensed state EAP Providers as determined by the Plan.
   [(d) Legal Consultations.]*

Charles S. Gilham, Vice President
Mercy Health Plans

** Depends on selection of Enrolling Group (See Schedule of Coverage and Benefits)*

PRESCRIPTION EYEWEAR RIDER

1. This Rider amends the Plan's Certificate of Coverage Agreement and all the relevant Schedules and Riders attached thereto (collectively, the "Policy"), and unless otherwise expressly stated in this Rider is subject to all the provisions, exclusions and limitations set forth in the Policy.

2. Any exclusion(s) related to services specifically covered under this Rider is hereby deleted in its entirety.

3. For purposes of this Rider, capitalized terms shall have the meaning described below, or if not listed below, the meaning assigned to them in the Policy:

4. **Covered Services:**

   Prescription Glasses/Contacts. A Member shall be entitled to a [*] dollar benefit applicable toward the purchase of eyeglasses and (lenses and frames) and/or contact lenses, and the fitting of contact lenses at the frequency listed in the Schedule of Coverage and Benefits.

   [Any [Copayment] [Deductible and Coinsurance] described in this Rider shall not be counted against the applicable Out-of-Pocket Maximum as set forth in the Schedule of Coverage and Benefits.] [Only Deductibles and Coinsurances for Covered Services described in this Rider will count towards your Out-of-Pocket Maximum.]

5. **Exclusions**:

   Under no circumstances will coverage be provided for:

   a) Keratoplasty, keratectomy, LASIK, laser surgery, or any other medical or surgical treatment of the eyes.
   b) Any cosmetic services.
   c) Non-prescription eyeglasses or contact lenses.
   d) Orthoptics, training, or any supplemental testing.
   e) Non-prescription safety lenses and frames.
   f) Eye exams and refractions.
   g) Services or eyewear provided as a result of Worker's Compensation law or any similar legislation, or if obtained through or required by any government agency or program, whether federal, state or any subdivision thereof.

Charles S. Gilham, Vice-President
Mercy Health Plans

** Dependent upon selection by Group (See Schedule of Coverage and Benefits)*

FAMILY SERVICES RIDER

1. This Rider amends the Certificate of Coverage and all the relevant Schedules and Riders attached thereto (collectively the "Policy") and, unless expressly stated in this Rider, is subject to all the provisions, exclusions and limitations set forth in the Policy.

2. Any exclusion(s) related to services specifically covered under this Rider is hereby deleted in its entirety.

3. **Covered Services**:

   Tubal ligations and vasectomies shall be covered under this Rider.

4. **Copayments**:

   The Covered Person shall be required to pay the same Copayment or Deductible and Coinsurance with respect to the health services described in this Rider as such Covered Person would be required to pay if the service were Medically Necessary and performed for the treatment of an illness or injury, including but not limited to the Copayment or Deductible and Coinsurance generally applicable to Inpatient Hospital Stay, Outpatient Surgery, and Physician's Office Services. [Coinsurance paid by a Covered Person for services covered under this Rider shall be counted for purposes of the applicable Out-of-Pocket Maximum, as set forth in the Schedule Coverage and Benefits. Deductibles do not apply to your Out-of-Pocket Maximum as set forth in the Policy.] [Only Deductibles and Coinsurances for Covered Services described in this Rider will count towards your Out-of-Pocket Maximum.]

5. **Exclusions**

   The reversal of any sterilization procedure is not a Covered Service.

Charles S. Gilham, Vice President
Mercy Health Plans

HEARING AID SERVICES RIDER

1. This Rider amends the Plan's Certificate of Coverage and the Schedule of Coverage and Benefits attached thereto (collectively the "Policy") and, unless expressly stated in this Rider, is subject to all the provisions, exclusions and limitations set forth in the Policy. All capitalized terms shall have the meanings given them in the Policy.

2. Except as modified or superceded by the coverage provided under this Rider, all other terms, conditions, exclusions in the Certificate of Coverage remain unchanged and in full force and effect.

3. **Covered Services:**
Members are entitled to coverage for up to one non-digital (analog), programmable hearing aid per ear during the time frame listed below. * Members may apply the "standard benefit" towards the purchase of additional functionality (i.e., digital). Coverage is provided for behind-the-ear (BTE) or in-the-ear (ITE) hearing aids and includes associated hearing aid fitting/dispensing fees. Members are responsible for any additional charges for functionality enhancements and/or components. **Coverage is limited to the Mercy Network only and requires Prior Authorization.**

   Members shall be entitled to a total maximum Benefit of * allowable expense applicable toward the purchase of hearing aids from a Network Provider every * Calendar Year(s) as indicated in the Schedule of Coverage and Benefits.

   * Coinsurance after Deductible will apply for each purchase.

   [Hearing Testing: Specialist Copayment for annual hearing test will apply. If hearing test is done in conjunction with an office visit, only one Copayment applies]

4. **Copayments:**

   [The Deductible and Coinsurance described in this Rider shall not be counted against the applicable Out-of-Pocket Maximum as set forth in the Schedule of Coverage and Benefits.] [Only Deductibles and Coinsurances for Covered Services described in this Rider will count towards your Out-of-Pocket Maximum.]

5. **Exclusions:**

   Under no circumstances will coverage be provided for:

   a) Charges for hearing aid batteries, listening devices and/or repairs, and any additional charges for functionality enhancements and/or components.
   b) Hearing aids when the device cannot assist the hearing loss.
   c) BAHA or osseointegrated hearing aids.

Charles S. Gilham, Vice-President
Mercy Health Plans

** As determined by the Enrolling Group (See Schedule of Coverage and Benefits)*

CRANIOMANDIBULAR AND
TEMPOROMANDIBULAR JOINT DISORDER RIDER

1. This Rider amends the Certificate of Coverage and all the relevant Schedules and Riders attached thereto (collectively the "Policy"), and unless otherwise expressly stated in this Rider is subject to all provisions, exclusions and limitations set forth in the Policy.

2. Except as modified or superseded by the coverage provided under this Rider, all other terms, conditions (including pre-existing), exclusions in the Certificate of Coverage remain unchanged and in full force and effect. For purposes of this Rider, capitalized terms shall have the meaning assigned to them in the Policy.

3. Covered Services:

   Coverage for the medically necessary treatment of musculoskeletal disorders affecting any bone or joint in the face, neck or head, including the diagnosis and treatment of temporomandibular joint disorders (TMJ) and craniomandibular disorder. Treatment shall include surgical and non-surgical procedures for medically necessary diagnosis and treatment, whether they are the result of accident, trauma, congenital defect, developmental defect, or pathology.

4. Copayments:

   The Covered Person shall be required to pay the same Copayment, or Deductible and Coinsurance with respect to the health services described in this Rider as such Covered Person would be required to pay if the service were Medically Necessary and performed for the treatment of an Illness or Injury, including (but not limited to) the Copayment, or Deductible and Coinsurance generally applicable to inpatient hospital and outpatient hospital services and office visits. [The Coinsurance described in this Rider shall not be counted against the applicable Out-Of-Pocket maximum as set forth in the Schedule of Coverage and Benefits. Deductibles do not apply to your Out-Of-Pocket Maximum as set forth in the policy.] [Only Deductibles and Coinsurances for Covered Services described in this Rider will count towards your Out-of-Pocket Maximum.]

5. Exclusions:

   Under no circumstances will coverage be provided for:

   a) Services for care of teeth including routine Preventive Care Services that would normally be covered under a dental plan, including but not limited to periodic oral exams, periapical or bitewing x-rays, and cleanings/prophylaxis.
   b) Services beyond the scope of the Physician's license to practice oral surgery.
   c) Services, including consultations that have not received Prior Authorization.

Prior Authorization Required

Unless We pre-approve these services, Network and Non-Network Benefits will be reduced by 100% of Eligible Expenses.

Charles S. Gilham, Vice-President
Mercy Health Plans

BIRTH CONTROL SERVICES RIDER

1. This Rider amends the Certificate of Coverage and all the relevant Schedules and Riders attached thereto (collectively the "Policy") and, unless expressly stated in this Rider, is subject to all the provisions, exclusions and limitations set forth in the Policy.

2. Any exclusion(s) related to services specifically covered under this Rider is hereby deleted in its entirety.

3. **Covered Services:**

The Member is entitled to the following temporary forms of prescribed birth controls set forth below:

- Insertion and removal of implantable contraceptive devices (but not more often than once every three (3) years, unless Medically Necessary)
- Insertion and removal of intrauterine device (IUD)
- Administration of contraceptive injections
- Diaphragms

These services are only covered under Mercy Health Plans' pharmacy benefit:

- Oral Contraceptives
- Topical contraceptives
- Contraceptive injections

4. **Copayments:**

The Covered Person shall be required to pay the same Copayment or Deductible and Coinsurance with respect to the health services described in this Rider as such Covered Person would be required to pay if the service were Medically Necessary and performed for the treatment of an Illness or Injury, including (but not limited to) the Copayment or Deductible and Coinsurance generally applicable to prescriptions and office visits.

[The Coinsurance for medical services described in this Rider shall be counted against the applicable Out-of-Pocket Maximum as set forth in the Schedule Coverage and Benefits. Deductibles do not apply to your Out-of-Pocket Maximum as set forth in the Policy. Charges that apply to the medical Deductible do not apply to any applicable pharmacy deductible.] [Only Deductibles and Coinsurances for Covered Services (medical **and** pharmacy) described in this Rider will count towards your Out-of-Pocket Maximum.]

5. **Exclusions:**

Under no circumstances will coverage be provided for:

1. Sterilization or the reversal of any sterilization procedure.
2. Medications or chemicals for which the primary purpose is the induction of an abortion.

Charles S. Gilham, Vice President
Mercy Health Plans

Rate Information

Rate data does NOT apply to filing.

Supporting Document Schedules

Satisfied -Name: Certification/Notice

Review Status: Approved-Closed 10/16/2008

Comments:

Please see attached Certifications.

Attachment:

AR 2009 PPO Group Certifications.PDF

Bypassed -Name: Application

Review Status: Approved-Closed 10/16/2008

Bypass Reason: Group Master Application is attached. The member Enrollment Application, AR ENROLL v.4 (08) was approved on 5/16/08.

Comments:

Satisfied -Name: Redlined Documents

Review Status: Approved-Closed 10/16/2008

Comments:

Please see Redlined documents attached. These documents were bundled as one document with tabs for your convenience.

Attachment:

Redlined Package1.pdf

CERTIFICATION

I, Charles S. Gilham, am a duly authorized officer of Mercy Health Plans and do hereby certify that, per Rule and Regulation 19 and 42, Section 5 (b), there will be no unfair discrimination with respect to the medical/lifestyle application questions and underwriting standards.

Charles S. Gilham, Vice President General Counsel
Mercy Health Plans
14528 S. Outer 40, Suite 300
Chesterfield, MO 63017
cgilham@mhp.mercy.net
(314) 214-8294

10-8-08
Date

STATE OF Missouri
COUNTY OF St. Louis

Subscribed and sworn to before me this 8th day of October, 2008.

Carol Nachtweih
Signature of Notary Public

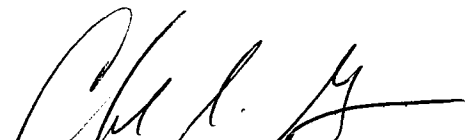
Carol Nachtweih
Printed Name of Notary Public

(NOTARY SEAL)

In and for the State of Missouri
My Commission expires: 3-15-09

CERTIFICATION

I, Charles S. Gilham, a duly authorized officer of Mercy Health Plans with the title of Secretary, do hereby certify that all benefits payable will comply with the Arkansas Bulletin 9-85 and that the difference between network and non-network deductibles, copays and coinsurances will not exceed 25%.



10-8-08

Charles S. Gilham, Vice President General Counsel
Mercy Health Plans
14528 S. Outer 40, Suite 300
Chesterfield, MO 63017
cgilham@mhp.mercy.net
(314) 214-8294

Date

Multiple files are bound together in this PDF Package.

Adobe recommends using Adobe Reader or Adobe Acrobat version 8 or later to work with documents contained within a PDF Package. By updating to the latest version, you'll enjoy the following benefits:

- Efficient, integrated PDF viewing
- Easy printing
- Quick searches

Don't have the latest version of Adobe Reader?

Click here to download the latest version of Adobe Reader

If you already have Adobe Reader 8, click a file in this PDF Package to view it.

Superseded Attachments

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Original Date:	Schedule	Document Name	Replaced Date	Attach Document
No original date	Form	PPO Certificate of Coverage	10/10/2008	AR COC_2009R_10.08.08 .pdf

Mercy Health Plans

[YEAR]

Your Certificate of Coverage

[(A High Deductible Health Plan (HDHP) [with a Health Savings Account (HSA) or Health Reimbursement Arrangement (HRA)]]

Issued by: Mercy Health Plans

www.mercyhealthplans.com

This Health Plan is underwritten by Mercy Health Plans
The Benefits and main points of coverage under the Plan are set forth in this Certificate.
The Benefits are effective only while You are covered by the Group Insurance Policy.

Mercy Health Plans
First Security Center
521 President Clinton Avenue, Suite 700
Little Rock, Arkansas 72201
866-647-5568

Certificate of Coverage

This Certificate of Coverage is part of the Group Policy that is a legal document between Mercy Health Plans **("The Plan", "We", "Us", "Our")** and the Group Policyholder to provide Benefits to Covered Persons **("You", "Your")**, subject to the terms, conditions, exclusions and limitations of this Policy. We issue this Policy based on the Enrolling Group's application and payment of the required Policy Charges.

In addition to this Certificate, the Policy includes:

- The Enrolling Group's application
- Any Amendments and Riders
- Schedule of Coverage and Benefits and any Inserts to the Certificate of Coverage

You can review this Policy at the office of the Group Policyholder during regular business hours.

Changes to the Document

We may from time to time modify this Certificate by attaching legal documents called Riders and/or Amendments that may change certain provisions of the Certificate. When that happens We will send You a new Certificate, Rider or Amendment pages.

No one has authority to make any changes to this Policy unless those changes are in writing and signed by an officer of Mercy Health Plans. No change will be valid until approved and made part of this Policy. Only the Plan has the right to change, interpret, modify, withdraw or add Benefits, or to terminate this Policy, as permitted by law, without Your approval.

Information You Should Have

This Certificate describes Benefits in effect as of Effective Date of Certificate Issuance.

On its Effective Date, this Certificate replaces and overrules any certificate that We may have previously issued to You. This Certificate will in turn be overruled by any Certificate We issue to You in the future.

This Policy will take effect on the date specified in the Group Policy. Coverage under this Policy will begin at 12:01 a.m. on the Effective Date and end at 12:00 midnight on the Termination Date. This Policy will remain in effect as long as the Policy Premiums are paid when they are due, subject to termination of this Policy.

We are delivering this Policy in the State of Arkansas. Unless otherwise prohibited by law, the Group Policyholder intends this Policy to be an employee welfare benefit plan as defined by ERISA. To the extent that state law applies, the laws of the State of Arkansas are the laws that govern this Policy.

The validity of this Policy will not be contested after this Policy has been in force for three (3) years from the date of issue. No statement relating to insurability made by any person covered under this Policy will be used to contest the validity of this Policy after it has been in force for a period of three (3) years. In addition, the statement must be contained in a written instrument signed by the person making the statement. The assertion, at any time, of defenses based upon the person's ineligibility for coverage under this Policy or upon other provisions in this Policy will not be precluded.

Table of Contents

Certificate of Coverage i

Changes to the Document i
Information You Should Have i

Table of Contents ii

Introduction to Your Certificate 1

We encourage You to read Your Certificate and any attached Riders and/or Amendments carefully. 1
Information about Defined Terms 1
Your Contribution to the Required Premiums 1
Don't Hesitate to Contact Us 1

Section 1: Eligibility 2

How to Enroll 2
If You Are Hospitalized When Your Coverage Begins 2
If You Are Eligible for Medicare 2
Who is Eligible for Coverage? 2

Section 2: When Coverage Begins 4

Section 3: When Coverage Ends 6

Section 4: How You Get Care 8

Identification cards 8
Where You get covered care: 8
- Network Providers 8
- Network Benefits 9
- Designated Facilities and Other Providers 9
- Non-Network Benefits 9

What You must do to get covered care 9
Care Management 9
Emergency Health Services 9

Section 5: Your Cost for Covered Services 11

Copayments 11
Coinsurance 11
Deductible 11
Eligible Expenses 11
Out-of-Pocket Maximum 11
Maximum Policy Benefit 12
[Carryover] 12

Section 6: How to File a Claim 13

Section 7: Coordinating Benefits with Other Coverage 15

When You have coverage under more than one plan 15
When You have other health coverage 16
When other Government agencies are responsible for Your care 16
Order of Benefit Determination Rules 16
General 16
Rules: 16
Effect on the Benefits of this Plan 18
Coordinating Benefit Payments 19
Right to Receive and Release Needed Information 19
Reconciliation of Payments 19
Right of Recovery 19

Section 8: Complaints, Grievances & Appeals 21

Section 9: Utilization Review 24

Section 10: Continuation of Coverage 27

Section 11: General Provisions 32

- Your Relationship with Us 32
- Our Relationship with Enrolling Groups 32
- Your Relationship with Providers and Enrolling Groups 32
- Administrative Services 33
- Amendments to the Policy 33
- Case Management 33
- Clerical Error 33
- Commission or Omission 33
- Entire Policy/Changes 33
- Examination of Covered Persons 34
- Incentives to Providers 34
- Incentives to You 34
- Incorporation by Reference 34
- Information and Records 34
- Interpretation of Eligibility and Benefits 35
- Legal Actions 35
- Medicare Eligibility 35
- Notice 35
- Policies, Identification Cards and Applications 35
- Statements by Enrolling Group or Subscriber 35
- Statement of ERISA Rights 35
- Time Limit on Certain Defenses 36
- Workers' Compensation not Affected 36

Section 12: Covered Benefits 37

Section 13: Exclusions – Things We Don't Cover 52

Section 14: Definitions of Terms 60

- NOTICE OF PRIVACY PRACTICES 72
- NOTICE CONCERNING COVERAGE LIMITATIONS AND EXCLUSIONS UNDER THE ARKANSAS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT 74

[HEALTH SAVINGS ACCOUNT (HSA) AMENDMENT]

[HEALTH REIMBURSEMENT ACCOUNT (HRA) AMENDMENT]

[SCHEDULE OF COVERAGE AND BENEFITS]

Introduction to Your Certificate

We encourage You to read Your Certificate and any attached Riders and/or Amendments carefully.

[This Plan has a [Health Savings Account (HSA)] [Health Reimbursement Arrangement (HRA)] component. HSAs and HRAs are governed by the Internal Revenue Code (IRC). It is important that You understand and follow the IRC rules in order to protect the tax-free status of Your account. Please refer to the attached HSA/HRA Amendment for more information.]

Information about Defined Terms

Because this Certificate is part of a legal document, We want to give You information about the document that will help You understand it. Certain capitalized words have special meanings. We have defined these words in Section 14 (Definitions of Terms). You can refer to Section 14 as You read this document to have a clearer understanding of Your Certificate of Coverage.

When We use the words **"The Plan"**, **"We", "Us",** and **"Our"** in this document, We are referring to **Mercy Health Plans** When We use the words **"You"** and **"Your"** We are referring to people who are **Covered Persons** as the term is defined in (14: Definitions of Terms).

This Certificate and the other Policy documents describe Your Benefits as well as Your rights and responsibilities under this Policy.

We especially encourage You to review the Benefit limitations of this Certificate by reading Section 12 (Covered Benefits) and Section 13 (Exclusions.) You should also carefully read Section 11 (General Provisions) in order to understand how this Certificate and Your Benefits work. You should call Us if You have questions about the coverage available to You.

Many of the sections of the Certificate are related to other sections of the document. You may not have all of the information You need by reading just one section. We also encourage You to keep Your Certificate and any attachments in a safe place for Your future reference.

Please be aware that Your Physician does not have a copy of Your Certificate of Coverage, and is not responsible for knowing or communicating Your Benefits.

Your Contribution to the Required Premiums

This Policy may require the Subscriber to contribute to the required Premiums. You can contact Your Enrolling Group for information about any part of the Premium cost You are responsible for paying.

Don't Hesitate to Contact Us

Throughout the document, You will find statements that encourage You to contact Us for further information. Whenever You have a question or concern regarding Your Benefits, please call Us using the telephone number for Our Customer Contact Center listed on Your ID card.

Section 1: Eligibility

How to Enroll

To enroll, You must complete an enrollment form. The Enrolling Group will give You the necessary forms. The Enrolling Group will then submit the completed forms to Us, along with any required Premium. We will not provide Benefits for health services that You receive before Your Effective Date of coverage.

If You Are Hospitalized When Your Coverage Begins

If You are a patient in a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility on the Effective Date of this Policy, We will pay Benefits for Covered Health Services related to that Inpatient Stay as long as You receive Covered Health Services in accordance with the terms of this Policy.

You should notify Us within forty-eight (48) hours of the day Your coverage begins, or as soon as is reasonably possible. Network Benefits are available only if You receive Covered Health Services from Network Providers.

If You Are Eligible for Medicare

[Your Benefits under this Policy may be reduced if You are eligible for Medicare but do not enroll in and maintain coverage under both Medicare Part A and Part B.]
[If you are eligible for Medicare, You are not eligible to participate in an HSA plan. Refer to Your HSA Amendment, section entitled, "Eligibility Requirements" for more information.]

Who is Eligible for Coverage?

Subscriber
When You enroll in the Plan, We refer to You as a Subscriber. For a definition of Eligible Person and Subscriber, see Section 14 (Definitions of Terms).

To be eligible for this coverage, You must reside within the United States and meet all the applicable eligibility requirements agreed upon by the Group Policyholder and the Plan [and as described in Your HSA Amendment]. If the Group elects, the number of hours worked per week may be waived to include coverage for retired employees.

If coverage is contributory, Subscriber must agree to make the required contributions. Any such coverage must be arranged by the Subscriber and the Group.

If both Spouses are Eligible to enroll, each may enroll as a Subscriber, or one Spouse may enroll as a Dependent of the other, but not both.

Except as We have described in Section 2 (When Coverage Begins), You may not enroll without Our written permission.

Dependents

Dependent generally refers to the Subscriber's Spouse and children. When a Dependent actually enrolls, We refer to that person as an Enrolled Dependent. Dependents may include Full-Time Students as determined by the Enrolling Group. For a complete definition of Dependent and Enrolled Dependent, or Full-Time Student, see Section 14 (Definitions of Terms).

Dependents of an Eligible Person may not enroll unless the Eligible Person is also covered under this Policy. If both parents of a Dependent child are enrolled as a Subscriber, only one parent may enroll the child as a Dependent.

Note: If the Subscriber's unmarried Dependent's infant child is eligible for coverage, such coverage will be available as described in this section, provided that appropriate notices and Premiums have been timely delivered to the Plan.

Enrollment of a Dependent child will not be denied for any of the following reasons:

- The child was born out of wedlock.
- The child is not claimed as a Dependent on Your Federal income tax return.
- The child does not reside with You.

The Subscriber must reimburse Us for any Benefits that We pay for a child at a time when the child did not satisfy these conditions. Except as We have described in Section 2 (When Coverage Begins), Dependents may not enroll without Our written permission.

Who is not Eligible to Enroll?

Persons not eligible for coverage include -

a) Those whose coverage was previously terminated for the following causes:
   - Fraud or misrepresentation in the Application
   - Abuse of services or facilities
   - Improper use of ID Card
   - Misconduct detrimental to Plan operations and the delivery of services

Refer to Section 3 (When Coverage Ends) for a detailed description of these causes that lead to termination.

b) Those who fail to enroll during the prescribed enrollment periods described in Section 2 (When Coverage Begins).

[Note: You must meet the eligibility requirements for an HSA/HRA plan as described in the HSA/HRA Amendment to enroll in an HSA/HRA plan.]

Notification of Change in Eligibility

It is the responsibility of both the Subscriber and the Group Policyholder to notify the Plan within fifteen (15) days of the date the Subscriber or Dependent(s) become ineligible. Failure to notify the Plan will make the Subscriber and the Group Policyholder jointly and severally liable to the Plan for expenses incurred and/or payment of services rendered by the Plan.

Coverage for a Disabled Child

Coverage for an unmarried Enrolled Dependent child who is totally disabled because of a mental or a physical disability will not end just because the child has reached a certain age. We will extend the coverage for the disabled child beyond the limiting age if both of the following are true:

- The disabled child is not able to be self-supporting because of a mental or physical disability; **and**
- The disabled child depends primarily on the Subscriber for support and maintenance due to the mental or physical disability.

Coverage will continue as long as the Enrolled Dependent is disabled and continues to satisfy both of these qualifying conditions, unless coverage is otherwise terminated in accordance with the terms of this Policy.

We will ask You to furnish Us with proof of the disabled child's incapacity and dependency. Before We agree to this extension of coverage for the child, We may require that a Physician chosen by Us examine the child. We will pay for that examination.

We may continue to ask You for proof that the disabled child still meets these two conditions, but will not ask more than once per year. The proof We ask for might include medical examinations at Our expense.

Section 2: When Coverage Begins

Initial Enrollment Period

When Your Enrolling Group purchases coverage under this Policy from Us, the Initial Enrollment Period is the first period of time when You can enroll. You may enroll yourself and Your dependents. Coverage begins on the Effective Date identified in Your Policy, when We receive the completed enrollment form and any required Premium within thirty-one (31) days of the date You are eligible to enroll. For a definition of Enrolling Group, see Section 14 (Definitions of Terms).

Open Enrollment Period

The Open Enrollment Period is the date identified by the Enrolling Group, if We receive the completed enrollment form and any required Premium within thirty-one (31) days of the date You are eligible to enroll. You may enroll yourself and Your Dependents.

Special Enrollment Period

An Eligible Person and/ or Dependent may also be able to enroll during a Special Enrollment Period. A Special Enrollment Period is not available to an Eligible Person and his or her Dependents if coverage under the prior plan was terminated for cause, or because Premiums were not paid on a timely basis.

A Special Enrollment Period applies to an Eligible Person and/or Dependent who did not enroll during the Initial Enrollment Period or Open Enrollment Period if the following are true:

- The Eligible Person and/or Dependent had existing health coverage under another plan at the time they had an opportunity to enroll during the Initial Enrollment Period or Open Enrollment Period; and
- Coverage under the prior plan ended because of any of the following:
  - Loss of eligibility.
  - The employer stopped paying the contributions.
  - In the case of COBRA continuation coverage, the coverage ended.

Coverage begins on the day immediately following the day coverage under the prior plan ends, if We receive the completed enrollment form and any required Premium within thirty-one (31) days of the date coverage under the prior plan ended.

A Special Enrollment Period also applies to an Eligible Person and any Dependents when one of the following events described below occurs. Subscribers may enroll Dependents who join their family because of any of the following events:

- Birth
- Legal adoption
- Placement for adoption
- Marriage
- Legal permanent general guardianship
- Court or administrative order

Newborn children of the Subscriber and/or Subscriber's Spouse, who are Members, will be covered for the lesser of: (a) 5 days from birth, or (b) mother's discharge, if family/Dependent coverage is available through the Subscriber's group plan on the date of birth, and the Subscriber elects Dependent coverage (if not previously elected) within ninety (90) days after the date of birth. Coverage will include necessary care and treatment of medically diagnosed Congenital defects and birth abnormalities, including premature birth.

Newly Acquired Eligible Dependent, other than a newborn child, who has an enrollment application submitted on his/her behalf within thirty-one (31) days of the events listed above, will be covered as of the date of the event. This includes a new Spouse, stepchild, or child placed by an authorized Federal or state governmental agent in the Subscriber's physical custody. Upon receiving notification of a new Dependent, We will provide You with an enrollment application and instructions necessary to enroll the new Dependent.

A newly adopted child, including a newborn, will be covered under the Plan effective from the date of birth, if We receive an application submitted on his/her behalf within sixty (60) days of the date You filed a petition for adoption of the child for which You have physical custody and who is under Your charge, care and control. Coverage will begin on the date of the filing of the petition for adoption, or from the moment of birth, if the petition is filed for adoption of a newborn within sixty (60) days after the birth of the child. Coverage will continue unless the placement is disrupted prior to legal adoption and the child is removed from placement. 'Placement' means in the physical custody of the adoptive parent. For coverage, You must notify the Plan, submit an application for Your new Dependent, and pay the required Premium.

Newly Eligible Dependents, including newborn children, not added to coverage within the Special Enrollment Period described above may not be added until the next Group Open Enrollment Period.

[HSA Plan]

[Eligible employees and their qualified family Dependent may enroll in an HSA plan anytime during the plan year if they are enrolled in a Mercy Health Plans High Deductible Health Plan. Please refer to Your HSA Amendment, or contact Your Benefits Administrator for more information about Your HSA Plan.]

Section 3: When Coverage Ends

General Information about When Coverage Ends:

- This Certificate of Coverage will continue in effect for the term agreed upon between the Group Policyholder and the Plan. The Certificate will automatically renew for one-year or other time periods, as determined by the Enrolling Group, unless it is terminated as described below. While coverage is renewable, Premium rates may change. The Plan may not terminate this Policy prior to the first Anniversary Date except for nonpayment of the required Premium or failure to meet continued underwriting standards.
- We may discontinue this Benefit plan and/or all similar benefit plans at any time for the reasons explained in this Policy, as permitted by law.
- Your entitlement to Benefits automatically ends on the date that coverage ends, unless You are hospitalized on that date, in which case Your coverage ends on the date of your inpatient confinement to the hospital.
- When Your coverage ends, We will still pay claims for Covered Health Services that You received before Your coverage ended. However, once Your coverage ends, We do not provide Benefits for health services that You receive for medical conditions that occurred after Your coverage ended.
- An Enrolled Dependent's coverage ends on the date the Subscriber's coverage ends.

Events Ending Your Coverage

Your coverage ends on the earliest of the dates specified in the following outline:

Event	Description
The Entire Group Policy Ends	Your coverage ends on the date the Group Policy ends. The Group may terminate this Policy on any Anniversary Date by providing written notice to the Plan at least sixty (60) days before such Anniversary Date. The Enrolling Group is responsible for notifying You that Your coverage has ended, except as follows: • If We terminate this Policy because We will no longer issue this particular type of group health benefit plan within the applicable market, We will provide at least ninety (90) days prior written notice to the Enrolling Group and all Covered Persons. • If We terminate this Policy because We will no longer issue any employer health benefit plan within the applicable market, We will provide at least one-hundred-eighty (180) days prior written notice to the applicable state authority, the Enrolling Group and all Covered Persons. The entire Group Policy ends when the Group fails to comply with the employer's contribution or Group participation rules, or if the Group membership in an association ceases and coverage terminates uniformly to all covered individuals.
You Lose Eligibility for Coverage	Your coverage ends on the date You are no longer eligible to be a Subscriber or Enrolled Dependent. Please refer to Section 1 (Eligibility) and Section 14 (Definition of Terms) for more information.
We Receive Notice to End Coverage	Your coverage ends on the date requested in a written notice. The Enrolling Group is responsible for providing written notice to Us to end Your coverage.

Event	Description
Subscriber Retires or Is Pensioned	Your coverage ends on the date the Subscriber is retired or pensioned under the Enrolling Group's plan. The Enrolling Group is responsible for providing written notice to Us to end Your coverage. This provision applies unless a specific coverage classification is designated for retired or pensioned persons in the Enrolling Group's application, and only if the Subscriber continues to meet any applicable eligibility requirements. The Enrolling Group can provide You with specific information about what coverage is available for retirees.
Fraud, Misrepresentation or False Information	When Your coverage is terminated because of fraud or misrepresentation, We will provide written notice to the Subscriber that coverage has ended on the date We identify in the notice. During the first two years this Policy is in effect, if You provided Us with false information or misrepresentation of material facts regarding Your application or coverage, We have the right to demand that You pay back all Benefits We paid to You, or paid in Your name, during the time You were incorrectly covered under this Policy. After the first two years, We can only demand that You pay back these Benefits if the written application contained a fraudulent misstatement. Fraud on the part of the Group: In the event of fraud concerning claims, employee verification, or other material misrepresentation on the part of the Group, all coverage may be canceled upon thirty-one (31) days written notice from the Plan to the Group. The Group will also be required to reimburse the Plan for all expenses incurred as a consequence of the fraud.
Abuse of Services or Facilities	In the event of abuse by a Covered Person in the use of services or facilities, that person's coverage may be restricted or canceled by the Plan upon at least thirty-one (31) days prior written notice to the Group and the Member.
Improper Use of ID Card	You permitted an unauthorized person to use Your ID card, or You used another person's card. When Your coverage is terminated because of improper use of Your ID card, We will provide written notice to the Subscriber that coverage has ended on the date We identify in the notice.
Misconduct	In the event Your misconduct is detrimental to the safe Plan operations and the delivery of services, Your coverage may be canceled immediately.
Death of Subscriber	Coverage ends for the Subscriber and his/her Dependents as of the date of the Subscriber's death. See Section 10 (Continuation of Coverage) for other options.
Default in Payment of Premiums	If any required Premium is not timely paid by You or on Your behalf, Your coverage may be canceled after not less than thirty-one (31) days written notice. The Plan will give notice to the Group at least ten (10) days prior to the date of termination of Benefits. The Group shall remain liable for all Premiums (and any interest accrued thereon) not paid prior to termination.

Notification of Members' Ineligibility

The Group and/or Subscriber must notify the Plan within fifteen (15) days after a Member ceases to be eligible for Benefits under this Policy. Failure to do so will make the Group and/or Subscriber jointly and severally liable for any expenses for Benefits or services incurred by the Plan, whether or not paid, due to the failure to notify the Plan pursuant to this provision. The Plan reserves the right to recover payments for Covered Health Services made on behalf of the Member after his/her Termination Date.

Section 4: How You Get Care

Identification cards

We will send You an identification (ID) card when You enroll. You should carry Your ID card with You at all times. You must show it whenever You receive services from a Network Provider, or fill a prescription at a Network pharmacy. If You do not show Your ID card, Network Providers have no way of knowing that You are enrolled under Our PPO Policy. As a result, they may bill You for the entire cost of the services You receive.

If You do not receive Your ID card within thirty (30) days after the Effective Date of Your enrollment, or if You need replacement cards, call Us at 866-647-5568. You may also request replacement cards through Our Web site: *www.mercyhealthplans.com.* You must show Your (ID) card every time You request Health Care Services from a Network Provider.

Where You get covered care:

You can choose to receive either Network Benefits or Non-Network Benefits. To obtain Network Benefits You must see a Network Physician or other Network Provider.

Benefits are available only if all of the following are true:

- Covered Health Services are received while the Group Policy is in effect;
- Covered Health Services are received prior to the date that any of the individual termination conditions listed in Section 3 (When Coverage Ends) occurs;
- The person who received Covered Health Services is a Covered Person and meets all eligibility requirements specified in this Policy.

You will only pay Copayments, Deductibles, and/or Coinsurances when receiving care from a Network Provider for a Covered Health Service. If You use Non-Network Providers, it will cost You more.

• Network Providers

Network Providers are physicians and other health care professionals that We contract with to provide Covered Services to Our Members. Network Providers are independent practitioners. They are not Our employees. It is Your responsibility to select Your provider. We credential Network Providers according to national standards. Our credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided.

You will be given a directory of Network Providers at no charge. However, before obtaining services You should always verify the Network status of a provider. A provider's status may change. You can verify the provider's status by calling Customer Contact Center.

We list Network Providers in the *Provider Directory*, which We update periodically. The list is also on Our Web site at www.mercyhealthplans.com.

It is possible that You might not be able to obtain services from a particular Network Provider. The network of providers is subject to change. You might find that a particular Network Provider may not be accepting new patients. If a provider leaves the Network or is otherwise not available to You, You must choose another Network Provider to get Network Benefits.

Do not assume that a Network Provider's agreement includes all Covered Health Services. Some Network Providers contract with Us to provide only certain Covered Health Services, but not all Covered Health Services. Some Network Providers choose to be a Network Provider for only some of Our products. Refer to Your provider directory or contact Us for assistance.

Extended Provider Network

Mercy Health Plans has an extended provider network **outside** of Our contracted Network called Private Healthcare Systems Preferred Provider Organization (PHCS PPO). This extended Provider Network is available to You as Network Benefits only when you are **outside** of Our contracted Network. To find a PHCS PPO provider, call Our Customer Contact Center or visit www.phcs.com and select the PPO Network.

PHCS PPO Network is not available when you receive services **within** Mercy Health Plans' contracted Network.

- **Network Benefits**

Network Benefits are generally paid at a higher level than Non-Network Benefits. Network Benefits are payable for Covered Health Services that are described as Network Benefits in Section 12 (Covered Benefits) and are any of the following:

- Provided by a Network Physician or other Network Provider
- Emergency Room Services

Please note that Mental Health/Substance Abuse Services must be authorized by the Mental Health/Substance Abuse Designee. Please see Section 12 (Covered Benefits) under the headings for Mental Health and Substance Abuse Services.

- **Designated Facilities and Other Providers**

If You have a medical condition that We believe needs special services, We may direct You to a Network Designated Facility or other Network provider chosen by Us. Network Benefits will only be paid if Your Covered Health Services for that condition are provided by, or arranged by the Network Designated Facility, or other Network provider chosen by Us. Non-Network Benefits will apply to any Non-Network facility or provider.

- **Non-Network Benefits**

Non-Network Benefits are generally paid at a lower level than Network Benefits. Non-Network Benefits are payable for Covered Health Services that are provided by Non-Network Physicians or Non-Network Providers.

What You must do to get covered care

You or Your Physician must notify Us and obtain **Prior Authorization** before getting certain Covered Health Services from either Network or Non-Network Providers. However, **You are responsible for ensuring that Your provider obtains any required Prior Authorization <u>before</u> You receive Covered Health Services.** A current list of those services and supplies requiring Prior Authorization is available by calling Our Customer Contact Center at the number listed on Your ID Card, or by visiting www.mercyhealthplans.com. Verify with your Physician, or Our Contact Center, the authorized date range, and the number and type of services.

We urge You to confirm with Us that the services You plan to receive are Covered Health Services. Prior Authorization does not mean Benefits are payable in all cases. That is because in some instances, certain procedures may not meet the definition of a Covered Health Service and, therefore, are excluded. In other instances, the same procedure may meet the definition of Covered Health Services. By calling *before* You receive treatment, You can check to see if the service is subject to limitations or exclusions including, but not limited to:

- The Cosmetic Procedures exclusion. Examples of procedures that may or may not be considered cosmetic include: breast reconstruction; vein stripping, ligation and sclerotherapy, and upper lid blepharoplasty.
- The Experimental, Investigational or Unproven Services exclusion.
- Any other contract limitation or exclusion.

Note: Mental Health and Substance Abuse services must be Prior Authorized by the Mental Health/Substance Abuse Designee. Please see Section 12 (Covered Benefits) under the headings for Mental Health and Substance Abuse services.

FAILURE TO PREAUTHORIZE CERTAIN BENEFITS MAY RESULT IN A REDUCTION OF ELIGIBLE EXPENSES.

Care Management

When You notify Us as described above, We will work together to implement the care management process and to provide You with information about additional services that are available to You, such as disease management programs, health education, pre-admission counseling and patient advocacy.

Emergency Room Services

We provide Benefits for Emergency Room Services when required for stabilization and initiation of treatment as provided by or under the direction of a Physician.

Network Benefits are paid for Emergency Room Services, even if a Non-Network Provider

provides the services. Emergency Services and any follow-up care rendered by a Non-Network Provider must be:

1) Of such immediate nature that Your health would be jeopardized if taken to a Network Hospital where the services of a Participating Physician would be available, or
2) Provided under circumstances under which You are unable, due to Your condition, to request treatment at a location where the services of a Participating Physician would be available.

- If You are admitted as an inpatient to a **Network** or **Non-Network Hospital** after You receive Emergency Room Services, We must be notified within two (2) business days or on the same day of admission, or as soon as reasonably possible, to receive authorization for continued services. Continuation of care as for any Inpatient Stay requires Prior Authorization and approval by the Plan.
- If You are admitted as an inpatient to a **Non-Network Hospital** after You receive Emergency Room Services, We may elect to transfer You to a Network Hospital as soon as it is medically appropriate to do so. If You choose to stay in the Non-Network Hospital after the date We decide a transfer is medically appropriate, Non-Network Benefits may be available if the continued stay is determined to be a Covered Health Service.
- If You are admitted as an inpatient to a **Network** or **Non-Network Hospital** within twenty-four (24) hours of receiving treatment for the same condition as an Emergency Health Service, You will not have to pay the Copayment/Coinsurance for Emergency Room Services. The Copayment/Coinsurance for an Inpatient Stay in a Network Hospital will apply instead.

Urgent Care Services

Covered Health Services that are required to prevent serious deterioration of Your health within twenty-four (24) hours of the onset of an unforeseen Sickness, Injury, or the onset of acute or severe symptoms. Urgent care is not the same as Emergency Care.

Special Note Regarding Medicare

If You are enrolled for Medicare on a primary basis (Medicare pays before We pay Benefits under this Policy), the notification requirements described in this Certificate of Coverage do not apply to You. Since Medicare is the primary payer, We will pay as secondary payer as described in (Section 7: Coordinating Benefits with Other Coverage). You are not required to notify Us before receiving Covered Health Services; however, You are required to follow any Provider participation guidelines and Prior Authorization requirements of Your primary Medicare carrier in order for Us to pay Benefits.

Section 5: Your Cost for Covered Services

This is what You will pay for covered care:

Copayments

A Copayment is a fixed amount of money You pay to the provider, facility, pharmacy, etc., when You receive *certain* services. **Copayments do not count towards Your Out-of-Pocket Maximum or Your Deductible.** Copayment amounts are listed on the Schedule of Coverage and Benefits next to the description for each Covered Health Service.

Coinsurance

Coinsurance is the percentage of Our Eligible Expenses that You must pay for Your care. Coinsurance does not begin until after You meet Your Deductible. **[Only] [Coinsurances count toward Your Out-of-Pocket Maximum[, including Coinsurances under any Rider(s), if applicable].].**

Deductible

A Deductible is a fixed expense You must incur within a [Calendar Year] [Plan Year] for certain Covered Services and supplies before We start paying Benefits for them. For a complete definition of [Annual] [Plan Year] Deductible, see Section14 (Definitions of Terms).

[NOTE: The Network Deductible applies to the Non-Network Deductible; however, the Non-Network Deductible does NOT apply to the Network Deductible.]

[NOTE: Charges that apply to one Deductible (e.g., Network Deductible) also apply to the other (e.g., Non-Network Deductible) and vice versa.]

[NOTE: Charges that apply to one Deductible (e.g., Network Deductible) do not apply to the other (e.g., Non-Network Deductible).]

[Deductibles do not apply to Your Out-of-Pocket Maximum.] [All Deductibles for Covered Health Services will count towards Your Out-of-Pocket Maximum.]

[You must meet Your Annual Deductible before [medical and pharmacy] Benefits are payable, except for preventive health/wellness services, [and] routine immunizations [and prescription drugs on the Preventive Drug list]. [Pharmacy Benefits are payable only under a Prescription Drug Rider and are not covered under Your medical Benefit.] Coinsurances are not included in Your Deductible**.]**

For Your [Annual][Plan Year] Deductible see Your Schedule of Coverage and Benefits.

Eligible Expenses

Eligible Expenses are the amount We determine that We will pay for Benefits minus any Copayment, Coinsurance or Deductible. We will pay a contracted rate for Network Providers. For Non-Network Providers, however, We will pay the Usual and Customary Rate (UCR) as determined by Us. For a complete definition of Eligible Expenses and UCR that describes how We determine payment, see Section 14 (Definitions of Terms).

Charges in Excess of UCR

Charges by a provider in excess of UCR will not be covered under this Policy and will not be counted toward Your Out-Of-Pocket Maximum limit or Deductible.

For Network Benefits, You are not responsible for any difference between the Eligible Expenses and the amount the provider bills, but You are responsible for all Copayments, Coinsurances or Deductibles.

For Non-Network Benefits, You are responsible to pay directly to the Non-Network Provider any difference between the amount the provider bills You and the UCR amount We will pay for Eligible Expenses. Please see Section 13 (Exclusions).

Out-of-Pocket Maximum

The maximum You pay out of Your pocket in a [Calendar] [Plan] Year for [Deductibles and] Coinsurances [for medical [and pharmacy] expenses]. [Pharmacy Benefits are payable only under a Prescription Drug Rider and are not covered under Your medical Benefit For a complete definition of Out-of-Pocket Maximum, see Section 14 (Definitions of Terms).

The Out-of-Pocket Maximum does **not** include any of the following:

- Any charges for non-Covered Health Services;
- [Copayments][and][Coinsurances] for Covered Health Services available by an optional Rider;
- The amount of any reduced Benefits if You do not obtain Prior Authorization as described in Section 12 (Covered Benefits) ;
- Charges that exceed Eligible Expenses;
- Any Copayments for Covered Health Services in Section 12 (Covered Benefits);
- [The Annual Deductible.]

For Your [Annual] [Plan Year] Out-of-Pocket Maximum see Your Schedule of Coverage and Benefits.

Maximum Policy Benefit

The maximum amount that We will pay for Benefits during the entire period of time You are enrolled under this Policy. For a complete definition of Maximum Policy Benefit, see Section 14 (Definitions of Terms).

For Your Maximum Policy Benefit see Your Schedule of Coverage and Benefits.

[Carryover]

[The fourth-quarter Deductible expenses incurred in a Calendar Year that is applied (or "carries over") to the next Calendar Year.]

Section 6: How to File a Claim

- **Network Provider** — We pay Network Providers directly for Your Covered Health Services. If a Network Provider bills You for any Covered Health Service, contact Us. However, You will be responsible for paying any Copayments or Coinsurance at the time of service.

- **Non-Network Provider** — When You receive Covered Health Services from a Non-Network Provider, You may be responsible for paying for all expenses up front and then requesting reimbursement from Us.

How to File a Claim

While You do not need to fill out a specific claim form, You must file the claim in a format that contains all of the information We require, as described below.

If a Subscriber provides written authorization to a Non-Network Provider for payment of medical Benefits for any Eligible Expenses, reimbursement may be paid directly to that Provider. If the subscriber did not sign authorization for payment of medical Benefits, the subscriber may be responsible for paying for all expenses up front and then requesting reimbursement from Us. We will not reimburse third parties who have purchased or been assigned Benefits by Physicians and other providers.

Required Information for Claims

When You request payment of Benefits from Us, You must provide Us with all of the following information:

1. The Subscriber's name and address;
2. The patient's name and age;
3. The number stated on Your ID card;
4. The name, address, phone number and Tax ID of the provider of the service(s);
5. A diagnosis from the Physician;
6. An itemized bill from the provider of service includes the Current Procedural Terminology (CPT) codes or a description of each charge;
7. The date the Injury or Sickness began;
8. A statement indicating whether You are, or You are not, enrolled for coverage under any other health insurance plan or program. If You are enrolled for other coverage You must include the name of the other carrier(s), the name and date of birth of the subscriber for that coverage, and the Effective Date of the coverage.

Proof of Loss

Written proof of loss and notice of claim must be provided to Us within ninety (90) days after the date of such loss. Failure to furnish such proof within such time will neither invalidate nor reduce any claim if it was not reasonably possible to furnish such proof within such time. In no event, except in the absence of legal capacity of the claimant, will a claim be valid later than one (1) year from the time proof is otherwise required. All Benefits payable under this Policy will be payable not more than thirty (30) days after receipt of proof. Written proofs of claim must be furnished to the Plan at P. O. Box 4568, Springfield, MO 65808.

Time of Payment of Claims

Eligible reimbursements payable under this Policy will be paid upon receipt of due written proof of such claim. All eligible reimbursement will be payable to Providers. We will send You an Explanation of Benefits form or letter. This will show You what services were paid, how much was paid, who was paid, when payment was made, or why payment for some services was not made or was made in part. There may be some circumstances for which We must seek additional information from You to process the claim. If this occurs, We will send You written notice within thirty (30) days after receipt of the claim. The notice will contain an explanation of the additional information that is required. We will suspend (pend) the claim until We receive the requested information from You. If You present the information after the thirty (30) days allocated, the claim will be reprocessed in accordance to the terms and Benefits of Your coverage. If We deny all or any part of Your claim, We will send You an Explanation of Benefits form or a letter telling You why it was denied. The form or letter may also tell You what other information, if any, We would need to

reconsider Our decision. If You do not agree with Our decision, You have the right to appeal Your claim. See Section 8 (Complaints, Grievances and Appeals). You may also call or write Us, or You may contact the Arkansas Insurance Department.

Action on Claims

If a claim is denied, We will send You a written notice that contains the reason for the denial and information on Your right to appeal. If You believe there is a discrepancy between the Benefits, the Certificate of Coverage, and the processing of such claim, or if You have a Grievance, You must notify the Plan no later than one-hundred and eighty (180) days from the date that written notice was sent from the Plan informing You of the event that gave rise to a Grievance. If a claim is denied, You may obtain a review of the denial through the Complaint and Grievance Procedure. See Section 8 (Complaints, Grievances and Appeals).

Release of Records

During the processing of Your claim, We might need to review Your health records. As a Covered Person, You hereby authorize the release to Us of all health records related to Your claim. This release constitutes authorization of any provision of law forbidding such disclosure. Your records will be maintained with strict confidentiality under the terms of applicable privacy laws. This authorization also applies to any Covered Dependent under this Policy.

Direct Payment to Public Hospitals

Benefits for Covered Health Services will be paid, with or without an assignment from You, to public hospitals or clinics for services and supplies provided to You if proper claim is submitted by the public hospital or clinic. No Benefits will be paid under this section to the public hospital or clinic, if such Benefits have been paid to You prior to Us receiving Your claim. Payment to the public hospital or clinic will discharge Us from all liability to You to the extent of the Benefits so paid.

Section 7: Coordinating Benefits with Other Coverage

When You have coverage under more than one plan

When You have coverage under more than one plan, Section 7 pertains to you. Please read this section carefully. This section describes how Benefits under this Policy will be coordinated with those of any other plan that provides Benefits to You.

The order of Benefit determination rules below determine which plan will pay as the Primary Plan. The Primary Plan is the plan that pays first without regard to the possibility that another Plan may cover some expenses. A Secondary Plan pays after the Primary Plan and may reduce the Benefits it pays, so that payment from all group plans do not exceed 100% of the Plan's Allowable Expenses.

Definitions

For purposes of this section, terms are defined as follows:

Other (Another) Plan

A Plan, or "other plan" is any of those which provides benefits or services for, or because of, medical or dental care or treatment:

(1) Group insurance or group-type coverage, whether insured or uninsured. This includes prepayment, group practice or individual practice coverage. It also includes coverage other than school accident-type coverage.

(2) Coverage under a governmental plan, or coverage required or provided by law. This does not include a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act). Each contract or other arrangement for coverage under (1) or (2) is a separate plan. In addition, if an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate plan.

This Plan

This Group contract that provides Benefits for health care expenses under Mercy Health Plans.

Primary Plan/Secondary Plan

The order of benefit determination rules state whether this plan is a Primary Plan or Secondary Plan. When this plan is a Primary Plan, its Benefits are determined *before* those of the other plan, and without considering the other plan's benefits. When this plan is a Secondary Plan, its Benefits are determined *after* those of the other plan, and may be reduced because of the other plan's benefits.

Allowable Expense

A necessary, customary and reasonable health care service or expense, including Copayments or Coinsurance that is covered, at least in part, by any of the Plans that provide benefits to You. The difference between the cost of a private hospital room and the cost of a Semi-Private Room is not considered an Allowable Expense under this definition, unless the patient's stay in a private hospital room is medically necessary, either in terms of generally accepted medical practice or as specifically defined in the plan.

When a plan provides benefit in the form of services, the reasonable cash value of each service rendered will be considered both an Allowable Expense and a benefit paid. When benefits are reduced under a Primary Plan because You do not comply with the plan provisions, the amount of that reduction will not be considered an Allowable Expense. Examples of these provisions are those related to second surgical opinions, precertification of admissions or services, and preferred provider arrangements.

Claim determination period

This period refers to a Calendar Year. However, it does not include any part of a year during which You have no coverage under this plan, or any part of a year before the date this COB provision or similar provision takes effect.

General Information:

When You have other health coverage

You must tell Us if You or a covered family member have coverage under any other health plan. This is called "double coverage."

When You have double coverage, one plan normally pays its benefits in full as the Primary payer and the other Plan pays a reduced benefit as the Secondary payer. We, like other insurers, determine which coverage is primary according to the National Association of Insurance Commissioners' guidelines.

When We are the Primary payer, We will pay the Benefits described in this Policy.

When We are the Secondary payer, We will determine Our allowance. After the primary plan pays, We will pay what is left of Our allowance, up to Our regular benefit. We will not pay more than Our allowance.

When other Government agencies are responsible for Your care

We do not cover services and supplies when a local, State, or Federal government agency directly or indirectly pays for them.

Order of Benefit Determination Rules

When coordination of benefits (COB) applies, the Order of Benefit Determination Rules should be looked at first. These rules determine whether the Benefits of this Plan are determined before or after those of another Plan. The Benefits of this Plan:

- Will not be reduced when, under the order of benefit determination rules, this Plan is the Primary payer; but
- May be reduced when, under the order of benefit determination rules, this Plan is the Secondary payer. This reduction is described later in this section.

General

When two or more Plans pay benefits, the rules for determining the order of payment are as follows:

This Plan is a Secondary Plan, which has its benefits determined after those of the other Plan, unless:

1. The other Plan has rules coordinating its benefits with those of this Plan; and
2. Both those rules and this Plan's rules require that this Plan's benefits be determined before those of the other Plan.

Rules:

This plan determines its order of benefits using the first of the following rules which applies:

1. Nondependent / Dependent

The Plan that covers You as a Subscriber (other than as a Dependent, for example, as an employee or Member) is the Primary Plan.

The benefits of the Primary Plan are determined *before* those of the Plan which covers You as a Dependent; **except**, if You are also a Medicare beneficiary and as a result of the rule established by Title XVII of the Social Security Act and implementing regulations, Medicare is:

a) Secondary to the Plan covering You as a Dependent; and
b) Primary to the Plan covering You as other than a Dependent (for example, a retired employee). The benefits of the Plan covering You as a Dependent are determined before those of the Plan covering You as other than a Dependent.

2. Dependent child whose parents are not separated or divorced

When this Plan and another Plan cover the same child as a Dependent, the order of benefits is the **"Birthday Rule"** described below:

a) The Primary Plan is the Plan of the parent whose birthday falls earlier in a year;
b) If both parents have the same birthday, the Plan that covered either of the parents longer is Primary. However, if the other Plan does not have this rule (#2) and if, as a result, the Plans do not agree on the order of benefits, the rule in the other Plan will

determine the order of benefits.

Note: The word, "birthday", refers only to the month and day in a Calendar Year, not the year in which the person was born.

3. Dependent child of unmarried (whether or not they ever have been married), separated, or divorced parents

When this Plan and another Plan cover the same child as a Dependent of divorced or separated parents, benefits for the child are determined in this order:

a) First, the Plan of the parent with custody of the child *(custodial parent)*; then
b) The Plan of the Spouse of the parent with custody of the child *(Spouse of the custodial parent)*; then
c) The plan of the parent not having custody of the child *(Non-custodial parent)*.
d) However, if the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses or health care coverage, and the Plan of that parent has actual knowledge of those terms, that Plan is Primary. The Plan of the other parent will be the Secondary Plan. This rule applies to claim determination periods or plan years beginning after the Plan is given notice of the court decree.

4. Joint Custody

If the specific terms of the court decree state that the parents will 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 will follow the "Birthday Rule" described above.

5. Active or inactive employee

The Plan that covers You as an employee is Primary, if You are neither laid off nor retired. The same would hold true if You are a Dependent of a person covered as a retiree and an employee. 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 (#5) is ignored.

6. Continuation coverage

If Your coverage is provided under a right of continuation provided by Federal or state law, and You are also covered under another Plan, the benefits of the Plan that covers You as an employee, retiree, Member or Subscriber (or as that person's Dependent) is Primary; and the continuation coverage is Secondary.

If the other Plan does not have the rule described here and if, as a result, the Plans do not agree on the order of the benefits, this rule (#6) is ignored.

7. Longer/Shorter length of coverage

If none of the previous rules determine the order of benefits, the benefits of the Plan that covered an employee, Member, Subscriber or retiree longer is Primary.

a) To determine length of time a person has been covered under a Plan, two Plans will be treated as one, if the Member was eligible under the second within twenty-four (24) hours after the first ended.
b) The start of a new Plan does not include
   i. A change in the amount or scope of a Plan's benefits;
   ii. A change in the entry which pays, provides or administers the Plan's benefits; or
   iii. A change from one type of plan to another (such as, from a single employer plan to that of a multiple employer plan).
c) The length of time You are covered under a Plan is measured from Your first date of coverage under that Plan. If that date is not readily available, the date You first became a Member of the Group will be used as the date from which to determine the length of time Your coverage under the present Plan has been in force.

8. Special Rules for Medicare Members

A. When You or Your covered Spouse are age 65 or over, have Medicare and…

1) You have coverage on Your own as an active employee, or

2) Through Your Spouse who is an active employee

This Plan is Primary for the individual with Medicare. This rule may vary Dependent upon the size of Group and status of Your employment. Please see Figure 1 below in this section.

B. When You or a covered family Member…

1) Have Medicare solely based on end stage renal disease (ESRD) and

- It is *within the first thirty (30) months* of eligibility for or entitlement to Medicare due

to ESRD (30-month coordination period) – This Plan is Primary;

- It is *beyond the thirty (30) month* coordination period and You or a family Member are still entitled to Medicare due to ESRD – Medicare is Primary;

2) Become eligible for Medicare due to ESRD while already a Medicare beneficiary and

- This Plan was the Primary payer before eligibility due to ESRD – This Plan is Primary (for the 30-month coordination period beginning on the date of Your first renal dialysis);
- Medicare was the Primary payer before eligibility due to ESRD – Medicare is Primary;

C. When either You or a covered family Member are eligible for Medicare solely due to disability and You…

- Have this Plan's coverage on Your own as an active employee, or through a family Member who is an active employee, Medicare or this Plan may be Primary depending upon the size of Group and status of Your employment. Please see Figure 1 below in this section.

When You are enrolled in Part A and Part B of Medicare, and Medicare is the Primary insurer, the Plan will pay all Medicare Deductible and Copayments/Coinsurances for services on Your behalf (as well as for Covered Services that are not covered by Medicare that meet the requirements set forth in this Policy), up to the total Allowable Expenses. You will still be responsible for Copayments/Coinsurances required under this Plan.

If You are eligible for Medicare and receive benefits from the Plan that would otherwise have been paid or reimbursed by Medicare, but You failed to enroll in Medicare's coverage, then the Plan will only pay for Benefits to the extent it would have paid had You enrolled under Medicare's coverage.

Medicare always makes the final determination as to whether they are the Primary payer. The following chart illustrates whether Medicare or this Plan should be the Primary payer for You according to Your employment status and other factors determined by Medicare. It is critical that You tell Us if You or a covered family Member has Medicare coverage so We can administer these requirements correctly.

GROUP SIZE	Medicare eligibility AGE 65	Medicare due to DISABILITY	Medicare due to ESRD ONLY
1 – 19	Medicare Primary	Medicare Primary	This Plan Primary (First 30 months)
20 – 99	This Plan Primary	Medicare Primary	This Plan Primary (First 30 months)
100 and over	This Plan Primary	This Plan Primary	This Plan Primary (First 30 months)

Figure 1. Coordination of Benefits with Medicare

Effect on the Benefits of this Plan When Plan is Secondary

When this Plan is Secondary, We may reduce Your Benefits so that the total Benefits paid or provided by all Plans during a claim determination period are no more that 100% of total Allowable Expenses.

a. **Reduction in this Plan's Benefits.** The Benefits of this Plan will be reduced when the sum of:

i. The Benefits that would be payable for the Allowable Expense under this Plan in the absence of this COB provision; and
ii. 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 COB provision (whether or not claim is made) exceeds those Allowable Expenses in a claim determination period. In that case, 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. When the Benefits of this plan are reduced as described previously, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of this Plan.

b. **When You become eligible for Medicare**, all Benefits for Covered Health Services otherwise payable will be reduced by any Benefits that We determine have been paid, or would be payable by Medicare. You will be deemed to have full Medicare coverage whether or not You are enrolled. Benefits under this Certificate will be reduced by any Benefits that would be payable, or the value of any services provided under Medicare for the same condition.

Coordinating Benefit Payments

The Plan will make every effort to expedite the exchange of COB information required to process Your claim (s) under these COB provisions. Eligible reimbursements payable under this Policy will be paid upon receipt of due written proof of such claim and any additional information requested including COB information. Payment will be made within 30 days after receipt of a completed claim form. See "Time Payment of Claims" in Section 6 for more information.

Right to Receive and Release Needed Information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine Benefits payable under this Plan. We may get the facts We need from, or give them to, other organizations or persons for the purpose of applying these rules and determining Benefits payable under this Plan.

By accepting Coverage under this Policy, You agree to:

1. Provide this Plan with information about other coverage and promptly notify Us of any coverage changes;
2. Give Us the right to obtain information as needed from others to coordinate Benefits;
3. Return any excess amounts paid to You if the Plan or Your provider gives You a credit or payment and later finds that the other Plan's coverage should have been primary.

We need not tell, or get the consent of, any person to do this. Each person claiming Benefits under this Plan must give Us any facts We need to apply these rules and determine Benefits payable. If You do not provide Us the information We need to apply these rules and determine the Benefits payable, Your claim for Benefits will be denied.

Reconciliation of Payments

A Primary payment made under another Plan may include an amount that should have been paid as Primary under this Plan. If this occurs, We may pay that amount to the organization that incorrectly made the payment. That amount will then be treated as though it were a benefit paid under this Plan. We will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

Right of Recovery

If the amount of the payments We made is more than We should have paid under this COB provision, We may recover the excess from one or more of:

1. The person We have paid or for whom We have paid;
2. Insurance companies; or
3. Other organizations.

The "amount of the payments made" includes the reasonable cash value of any Benefits provided in the form of services.

Right of Reimbursement

In consideration of the coverage provided by this Certificate of Coverage, We have the right to be reimbursed by You for the reasonable value of any services and benefits We provide to You, from any or all of the following listed below:

- Third parties, including any person alleged to have caused You to suffer injuries or damages;
- Your employer;
- Any person or entity who is or may be obligated to provide benefits or payments to You, including benefits or payments for underinsured or uninsured motorist protection, no-fault traditional auto insurance, medical payment coverage (auto, homeowners or otherwise), Workers' Compensation coverage, other insurance carriers or third party administrators;
- Any person or entity who is liable for payment to You on any equitable or legal liability theory.

These third parties and persons or entities are collectively referred to as "Third Parties". You agree as follows:

- That You will cooperate with Us in protecting Our legal and equitable rights to subrogation and reimbursement, including, but not limited to:
  - Providing any relevant information requested by Us,
  - Signing and/or delivering such documents as We or Our agents reasonably request to secure the subrogation and reimbursement claim,
  - Responding to requests for information about any accident or injuries,
  - Making court appearances, and
  - Obtaining Our consent or Our agents' consent before releasing any party from liability or payment of medical expenses.
- That We have the sole authority and discretion to resolve all disputes regarding the interpretation of the language stated herein;
- That regardless of whether You have been fully compensated or made whole, We may collect from You the proceeds of any full or partial recovery that You or Your legal representative obtain, whether in the form of a settlement (either before of after any determination of liability) or an non-economic damage settlement or judgment;
- That benefits paid by Us may also be considered to be benefits advanced;
- That You will not accept any settlement that does not fully compensate or reimburse Us without Our written approval, nor will You do anything to prejudice Our rights under this provision;
- That, upon Our request, You will assign to Us all rights of recovery against Third Parties, to the extent of the tortfeasors for whom You are seeking recovery, to be paid before any other of Your claims are paid;
- That We may, at Our option, take necessary and appropriate action to preserve Our right under these subrogation provisions, including filing suit in Your name, which does not obligate Us in any way to pay Your part of any recovery We might obtain;
- That We shall not be obligated in any way to pursue this right independently or on Your behalf.

Section 8: Complaints, Grievances & Appeals

These procedures address all Complaints, Grievances, and appeals from Members concerning operation of the Plan, **except** any Complaints that allege or indicate possible professional liability. These procedures are designed to provide timely, thorough and fair review of determinations in utilization management and claims payment.

A Member, a Member's authorized representative, or a provider can make a Complaint or Grievance at any time. Complaints can be about anything, including: the Plan's service, Utilization Review, or a provider's service. A Complaint or Grievance can always be directed to the Arkansas Insurance Department at the following address and telephone number:

Arkansas Insurance Department
Consumer Services Division
1200 West Third Street
Little Rock, AR 72201
(501) 371-2640, (800) 852-5494
Fax: (501) 371-2749
Email: insurance.consumers@arkansas.gov
www.insurance.arkansas.gov

Step	Description
1	**What to do first. Contact Our Customer Contact Center. The telephone number is shown on Your ID card.** Customer Contact Center Representatives are available to take Your call during regular business hours, 8:00 a.m. – 5:00 p.m., Monday through Friday. At other times, You may leave a message on voicemail. A Customer Contact Center Representative will return Your call. If You would rather send Your Complaint to Us in writing at this point, You may write to Us at the address listed below. The Plan agrees to investigate and endeavor to resolve any and all Complaints received from Members with regard to the nature of professional services rendered or Benefits provided under this Policy. Oral Complaints or inquiries can be made to the Plan by telephone or an arranged appointment with the Customer Contact Center Representative at: Mercy Health Plans ATTN: Customer Contact Center 14528 S. Outer 40, Suite 300 Chesterfield, Missouri 63017-5743 (866)647-5568 The Customer Contact Center Representative will make every effort to resolve the concern to Your satisfaction during the initial telephone call or interview with the Plan. Resolution of Complaints through this process will not preclude Your rightful access to review through the formal Grievance Process.
2	**Ask Us in writing to reconsider Our initial decision.** ***Minimum Time to File a Grievance:*** You must file a Grievance no later than one hundred and eighty (180) days from the date that written notice was sent from the Plan informing You of the event that gave rise to the Grievance. ***Grievance Procedure:*** Ask Us in writing to reconsider Our initial decision. You, Your authorized representative, or Your Provider can submit a Grievance described below. a) Write to Us no later than one hundred and eighty (180) days from the date that written notice was sent from the Plan to You, informing You of the event that gave rise to the Grievance; and b) Send Your request to: Mercy Health Plans, Attn: Corporate Appeals, 14528 S. Outer 40, Suite 300, Chesterfield, Missouri 63017-5743. c) Include a statement about why You believe Our initial decision was wrong, based on specific benefit provisions in this brochure; and d) Include copies of documents that support Your claim, such as physician letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms.

The Plan will acknowledge receipt of Your Grievance in writing. A complete investigation of the Grievance will follow. Someone who is neither the individual who made the initial determination nor the subordinate of such individual will conduct the review. In the case of a Grievance involving a medical judgment, the Plan will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, and who is neither the individual who was consulted on the initial claim determination, nor the subordinate of such individual.

We will notify You of Our determination in writing as follows:

- Within thirty (30) calendar days for a service You have not yet received (pre-service); or
- Within sixty (60) calendar days for a service You have already received (post-service).

This written determination will include information about Your right to file request an External Independent Review (if We maintain Our denial of an Adverse Determination), and Your right to other voluntary alternative dispute resolution options including any rights You may have under ERISA.

3 ***Expedited Grievance Procedure***: When the standard time frames of the Grievance procedure would seriously jeopardize Your life or health, or would jeopardize Your ability to regain maximum function, a request for an expedited review can be submitted. An expedited review request may be made verbally or in writing. A decision will be made within seventy-two (72) hours after receiving a request for an expedited review. This will be followed by written notification of that decision.

4 ***Ask Us for an External Independent Review, only if Your appeal was related to an Adverse Determination.***

Within sixty (60) days of the date You or Your authorized representative receive written notice of an Adverse Determination, You or Your authorized representative may initiate an External Review. A request for a standard External Review must be made in writing or via electronic media, and should include any information or documentation to support Your request for the covered service. **Note: Only appeals that are related to an Adverse Determination and that involve treatment, services, equipment, supplies, or drugs that would require the health benefit plan to expend five hundred dollars ($500) or more of expenditures are afforded an external independent review.**

"Adverse Determination" means a determination by the Plan that an admission, availability of care, continued stay or other health care service has been reviewed and, based upon the information provided, the requested payment for the service is denied, reduced or terminated, because:

(a) The requested health care service does not meet the health benefit plan's requirements for medical necessity, or
(b) The requested health care service has been found to be "experimental/investigational."

The Plan will select an independent review organization from a list of independent review organizations approved by the Arkansas Insurance Department. The Plan shall be solely responsible for paying the fees of the external independent review organization selected to perform the review. For the purposes of this Section, an external Independent Reviewer shall: (a) be a clinical peer; (b) have no direct financial interest in connection with the case; and (c) have not been informed of the specific identity of the Member.

The independent review organization will complete its review within forty-five (45) calendar days after the receipt of the request for an External Review and will provide a written notice of its decision to You, or Your authorized representative and the Plan.

An expedited external independent review may be requested for a situation when a delay would significantly increase the risk to Your health or when extended health care services for a course of treatment that You are undergoing is at issue. Upon submission of a request for expedited external independent review, the Plan will immediately assign an independent review organization approved by the Arkansas Insurance Department. The independent review organization shall make a determination and verbally notify You, Your authorized representative, and the Plan of its decision within seventy-two (72) hours after receipt of all necessary information. The decision by the Independent Reviewer is final. Within two (2) calendar days, the independent review organization will follow up with a written notice of the determination via mail.

Nothing in this Section shall be construed to require the Plan to pay for a health care service not covered under this Policy.

5 At any time, You have the right to contact the Arkansas Insurance Department's consumer complaint hotline at: **1-800-852-5494** regarding Your Grievance, or write to the Arkansas Insurance Department at the following address: **Arkansas Insurance Department, Consumer Services Division, 1200 West Third Street, Little Rock, AR 72201**.

Grievance and Appeal Decisions

You will receive a decision from the Plan within the timeframes set forth above for the Grievance process. The decision will be provided in writing. However, in the case of an Expedited Grievance, the decision will be provided verbally and in writing. Any denial of Your Grievance will contain the following information:

a) The specific reason or reasons for the denial;
b) Reference to the specific Plan provisions on which the denial is based;
c) A statement that You are entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to Your claim for Benefits;
d) A statement of Your right to bring a civil action under ERISA;
e) Any specific guideline that was relied upon in issuing the denial, or a statement that such guideline will be provided to You free of charge upon request;
f) If the denial is based on medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to Your medical circumstances, or a statement that such explanation will be provided free of charge upon request; and
g) The following statement: "You and Your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact Your local U.S. Department of Labor Office and Your State insurance regulatory agency."

Section 9: Utilization Review

The following is information pertaining to utilization review decisions and procedures. Please note that in addition to utilization reviews, Mercy Health Plans practices care management and therefore may provide You with information about additional services that are available to You, such as disease management programs, health education, pre-admission counseling and patient advocacy.

Initial Determinations

For initial determinations, the Plan will make the determination within two (2) working days of obtaining all necessary information regarding a proposed admission, procedure or service requiring a review determination. For purposes of this section, "necessary information" includes the results of any face-to-face clinical evaluation or second opinion that may be required.

In the case of a determination to certify an admission, procedure or service, the Plan will notify the provider rendering the service by telephone within twenty-four (24) hours of making the initial certification.

In the case of an Adverse Determination, the Plan will notify the provider rendering the service by telephone within twenty-four (24) hours of making the Adverse Determination; and will provide written or electronic confirmation of the telephone notification to You and Your provider within one (1)working day of making the Adverse Determination.

Concurrent Review Determinations

For concurrent review determinations, the Plan will make the determination within one (1) working day of obtaining all necessary information.

In the case of a determination to certify an extended stay or additional services, the Plan will notify by telephone the provider rendering the service within one (1) working day of making the certification.

In the case of an Adverse Determination, the Plan will notify by telephone the provider rendering the services within twenty-four (24) hours of making the Adverse Determination, and provide written or electronic notification to You and Your provider within one (1) working day of the telephone notification. The services will be continued without liability to You until You have been notified of the determination.

Retrospective Review Determinations

For retrospective review determinations, the Plan will make the determination within thirty (30) working days of receiving all necessary information. The Plan will provide notice in writing of Our determination to You within ten (10) working days of making the determination.

Adverse Determination

A written notification of an Adverse Determination will include the principal reason or reasons for the determination, the instructions for initiating an appeal or reconsideration of the determination, and the instructions for requesting a written statement of the clinical rationale, including the clinical review criteria used to make the determination. The Plan will provide the clinical rationale in writing for an Adverse Determination, including the clinical review criteria used to make that determination, to any party who received notice of the Adverse Determination and who requests such information.

Reconsideration of an Adverse Determination

In a case involving an initial determination or a concurrent review determination, the Plan will give the provider rendering the service an opportunity to request on Your behalf a reconsideration of an Adverse Determination by the reviewer making the Adverse Determination.

The reconsideration will occur within one (1) working day of the receipt of the request and will be conducted between the provider rendering the service and the reviewer who made the Adverse Determination, or a clinical peer designated by the reviewer who made the Adverse Determination (if the reviewer who made the Adverse Determination is not available within one (1) working day).

If the reconsideration process does not resolve the difference of opinion, You or Your provider may appeal the Adverse Determination. Reconsideration is not a prerequisite to a standard appeal or an expedited appeal of an Adverse Determination.

Lack of Information

The Plan will have written procedures to address failure or inability of a provider or an enrollee to provide all necessary Information for review. In cases where the provider or an enrollee will not release necessary information, the Plan may deny certification of an admission, procedure or service.

Benefit Determinations and Appeal Procedures

Per the requirements of the Department of Labor Regulation Section 2560.503-1, the Plan establishes and maintains the following procedures to govern benefit determinations, Your claim for Benefits and the filing of appeals under the Plan. You are entitled to a full and fair review of Your benefit determination and the denial, which means:

(a) You may submit written comments, documents, records, and other information relating to the claim for Benefits;
(b) You may obtain upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to Your claim for Benefits;
(c) The review will take into account all comments, documents, records, and other information You submit, without regard to whether such information was submitted or considered with respect to the initial determination;
(d) Someone who is neither the individual who made the initial determination, nor the subordinate of such individual will conduct the review;
(f) Any medical or vocational experts whose advice was obtained in connection with the initial determination will be identified, regardless of whether the advice was relied upon in the initial determination; and
(g) In the case of an urgent care determination, the appeal may be submitted orally or in writing and all necessary information, including the decision on the appeal, will be transmitted between You and Mercy Health Plans by telephone, facsimile, or other available similarly expeditious method.

The timeframes within which You must submit appeals to Mercy Health Plans, and within which Mercy Health Plans must respond to such appeals, vary depending on whether Your claim for Benefits is an urgent care request, a pre-service request, a post-service request or a concurrent care request. If requested, the Plan will arrange for a referral to a Physician with the necessary expertise to provide a second opinion or consultation when You choose to seek a second medical opinion. You may select a physician in the same or a similar specialty for a second opinion, however You will be responsible for all Copayments, Coinsurances and/or Deductibles.

NOTE: SHOULD ANY CONFLICT ARISE BETWEEN ARKANSAS LAW AND THE DEPARTMENT OF LABOR REGULATIONS, THE RULE THAT PROVIDES YOU WITH THE BEST BENEFIT WILL PREVAIL.

The following is a description of each of these four types of benefit determinations:

1. Urgent Care Request

A request for medical care or treatment, which if a determination is not made expeditiously: (a) could seriously jeopardize Your life or health or Your ability to regain maximum function; or (b) in the opinion of a physician with the knowledge of Your medical condition, would subject You to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim for Benefits.

(a) **Initial Determination** – We will make an initial decision as soon as possible, taking into account the medical exigencies, but no later than seventy-two (72) hours after receipt of the requested service.
(b) **Insufficient Information to Process Request** – We will notify Your provider of insufficiency as soon as possible, but not later than twenty-four (24) hours. Your provider then has forty-eight (48) hours to provide the specified information.
(c) **Determination After Notice of Insufficiency** – As soon as possible, but no later than forty-eight (48) hours after the earlier of: (1) Our receipt of specified information; or (2) the end of the forty-eight (48) hour period afforded Your provider to submit additional information.
(d) **Time Within Which to Appeal Denial** – You or Your provider must appeal no later than one hundred and eighty (180) days after receipt of denial.
(e) **Appeal Determination** – We will make a determination on the appeal within seventy-two (72) hours after receipt of You or Your provider's request for review.

2. Pre-Service Request

A request for a benefit *in advance* of obtaining medical care.

(a) **Initial Determination** – We will make an initial decision within a reasonable period of time appropriate to the medical circumstances, but no later than fifteen (15) days after receipt of the requested service.

(b) **Extension of Time for Processing Request** – One additional period of fifteen (15) days from the end of the initial period, if the extension is necessary for reasons beyond the control of the Plan. If the reason for the extension is You or Your provider's failure to submit necessary information, the determination period is tolled from the date notice of insufficiency is given, until You or Your provider respond to the notice. You or Your provider have forty-five (45) days to respond to the notice.

(c) **Time Within Which to Appeal Denial** – You or Your provider must appeal no later than one hundred and eighty (180) days after receipt of denial.

(d) **Appeal Determination** – We will make a determination on the appeal within a reasonable time appropriate to the medical circumstances, but no later than thirty (30) days after request for review.

3. Post-Service Claim

A request for a benefit You have *already received*.

(a) **Initial Determination** – We will make an initial decision within a reasonable period of time appropriate to the medical circumstances, but no later than thirty (30) days after receipt of the claim.

(b) **Extension of Time for Processing Claim** – One additional period of fifteen (15) days from the end of the initial period, if the extension is necessary for reasons beyond the control of the Plan. If the reason for the extension is claimant's failure to provide necessary information, the determination period is tolled from the date notice of insufficiency is given, until You or Your provider respond to the notice. You or Your provider have forty-five (45) days to respond to the notice.

(c) **Time Within Which to Appeal Denial** – You or Your provider must appeal no later than one hundred and eighty (180) days after receipt of denial.

(d) **Appeal Determination** – We will make a determination on the appeal within a reasonable time appropriate to the medical circumstances, but no later than sixty (60) days after request for review.

4. Concurrent Care Review

If the Plan has approved an ongoing course of treatment to be provided over a period of time or number of treatments, any reduction or termination of the course of treatment will be treated as a benefit denial. We must notify You of the denial sufficiently in advance of the reduction or termination to allow You or Your provider to appeal and obtain a determination on review before the benefit is reduced or terminated. Any request by You or Your provider to extend the course of treatment beyond the period of time or number of treatments authorized must be decided as soon as possible, taking into account the medical exigencies, but no later than twenty-four (24) hours after receipt of the request, provided the request is made within twenty-four (24) hours prior to the expiration of the prescribed period or number of treatments.

Complaint and Grievance Procedures

These procedures address all Complaints, Grievances, and appeals concerning operation of Mercy Health Plans <u>except</u> any Complaints that allege or indicate possible professional liability. These procedures are designed to provide timely, thorough and fair review of determinations in utilization management and claims payment. The Grievance procedure is more fully described in Section 8 (Complaints, Grievances and Appeals).

Section 10: Continuation of Coverage

General Information about Continuation of Coverage:

- If Your coverage ends under this Policy, You may be entitled to elect continuation coverage (coverage that continues on in some form) in accordance with Federal or state law.
- Continuation coverage under COBRA (the Federal Consolidated Omnibus Budget Reconciliation Act) is available only to Enrolling Groups that are subject to the terms of COBRA. You can contact Your plan administrator to determine if Your Enrolling Group is subject to the provisions of COBRA.
- If You selected continuation coverage under a prior plan which was then replaced by coverage under this Policy, continuation coverage will end as scheduled under the prior plan or in accordance with the terminating events listed below, whichever is earlier.
- We are not the Enrolling Group's designated "plan administrator" as that term is used in Federal law, and We do not assume any responsibilities of a "plan administrator" according to Federal law.
- We are not obligated to provide continuation coverage to You if the Enrolling Group or its plan administrator fails to perform its responsibilities under Federal law. Examples of the responsibilities of the Enrolling Group or its plan administrator are:
  - Notifying You in a timely manner of the right to elect continuation coverage.
  - Notifying Us in a timely manner of Your election of continuation coverage.

Continuation Coverage under Federal Law (COBRA)

Much of the language in this section comes from the Federal law that governs continuation coverage. You should call Your Enrolling Group's plan administrator if You have questions about Your right to continue coverage.

In order to be eligible for continuation coverage under Federal law, You must meet the definition of a "Qualified Beneficiary". A Qualified Beneficiary is any of the following persons who was covered under this Policy on the day before a qualifying event:

- A Subscriber.
- A Subscriber's Enrolled Dependent, including with respect to the Subscriber's children, a child born to or placed for adoption with the Subscriber during a period of continuation coverage under Federal law.
- A Subscriber's Spouse.

Qualifying Events for Continuation Coverage under Federal Law (COBRA)

If the coverage of a Qualified Beneficiary would ordinarily terminate due to one of the following qualifying events, then the Qualified Beneficiary is entitled to continue coverage. The Qualified Beneficiary is entitled to elect the same coverage that she or he had on the day before the qualifying event (QE).

QE-1. Termination of the Subscriber from employment with the Enrolling Group, for any reason other than gross misconduct, or reduction of hours; or
QE-2. Death of the Subscriber; or
QE-3. Divorce or legal separation of the Subscriber; or
QE-4. Loss of eligibility by an Enrolled Dependent who is a child; or
QE-5. Entitlement of the Subscriber to Medicare benefits; or
QE-6. The Enrolling Group filing for bankruptcy, under Title XI, United States Code, on or after July 1, 1986, but only for a retired Subscriber and his or her Enrolled Dependents. This is also a qualifying event for any retired Subscriber and his or her Enrolled Dependents if there is a substantial elimination of coverage within one (1) year before or after the date the bankruptcy was filed.

Notification Requirements and Election Period for Continuation Coverage under Federal Law (COBRA)

The Subscriber or other Qualified Beneficiary must notify the Enrolling Group's designated plan administrator within sixty (60) days of the Subscriber's divorce, legal separation or an Enrolled Dependent's loss of eligibility as an Enrolled Dependent. If the Subscriber or other Qualified Beneficiary fails to notify the designated plan administrator of these events within the sixty (60) day period, the

Enrolling Group and its plan administrator are not obligated to provide continued coverage to the affected Qualified Beneficiary. If a Subscriber is continuing coverage under Federal Law, the Subscriber must notify the Enrolling Group's designated plan administrator within sixty (60) days of the birth or adoption of a child.

Continuation must be elected by the later of: (i) sixty (60) days after the qualifying event occurs, or (ii) sixty (60) days after the Qualified Beneficiary receives notice of the continuation right from the Enrolling Group's designated plan administrator.

In no event will an application for continuation coverage be accepted if filed more than sixty (60) days following the later of the date of the qualifying event or the date of the first notice of COBRA entitlement in connection with that qualifying event.

If the Qualified Beneficiary's coverage was terminated due to a qualifying event, then the initial Premium due to the Enrolling Group's designated plan administrator must be paid on or before the 45th day after electing continuation.

Terminating Events for Continuation Coverage under Federal Law (COBRA)

Continuation under this Policy will end on the earliest of the following dates:

A. Eighteen (18) months from the date of the qualifying event, if the Qualified Beneficiary's coverage would have ended because the Subscriber's employment was terminated or hours were reduced (QE-1). Refer to the Qualifying Events (QE) listed above.

   If a Qualified Beneficiary is determined to have been disabled by the Social Security Administration at anytime within the first sixty (60) days of continuation coverage under QE-1, then the Qualified Beneficiary may elect an additional eleven (11) months of continuation coverage (for a total of twenty-nine (29) months of continued coverage) subject to the following conditions: (i) notice of such disability must be provided within sixty (60) days after the date of determination of the disability, and in no event later than the end of the first eighteen (18) months; (ii) the Qualified Beneficiary must agree to pay any increase in the required Premium for the additional eleven (11) months; and (iii) if the Qualified Beneficiary entitled to the eleven (11) months of coverage has non-disabled family Members who are also Qualified Beneficiaries, then those non-disabled Qualified Beneficiaries are also entitled to the additional eleven (11) months of continuation coverage. Notice of any final determination that the Qualified Beneficiary is no longer disabled must be provided within thirty (30) days of such determination. Continuation coverage that was extended due to the disability may be terminated on the first day of the month that begins more than thirty (30) days after the date of that determination.

B. Thirty-six (36) months from the date of the qualifying event for an Enrolled Dependent whose coverage ended because of the death of the Subscriber, divorce or legal separation of the Subscriber, or loss of eligibility by an Enrolled Dependent who is a child (QE-2, QE-3, or QE-4).

C. For the Enrolled Dependents of a Subscriber who was entitled to Medicare (QE-5) prior to a qualifying event that was due to either the termination of employment or work hours being reduced, eighteen (18) months from the date of the qualifying event, or, if later, thirty-six (36) months from the date of the Subscriber's Medicare entitlement.

D. The date coverage terminates under this Policy for failure to make timely payment of the Premium.

E. The date, after electing continuation coverage, that coverage is first obtained under any other Group health plan. If such coverage contains a limitation or exclusion with respect to any pre-existing condition, continuation shall end on the date such limitation or exclusion ends. The other Group health coverage shall be primary for all health services except those health services that are subject to the pre-existing condition limitation or exclusion.

F. The date, after electing continuation coverage, that the Qualified Beneficiary first becomes entitled to Medicare, except that this shall not apply in the event that coverage was terminated because the Enrolling Group filed for bankruptcy, (i.e. QE-6).

G. The date the entire Policy ends.

H. The date coverage would otherwise terminate under this Policy as described in Section 3 under the heading, *Events Ending Your Coverage.*

If a Qualified Beneficiary is entitled to eighteen (18) months of continuation and a second qualifying event occurs during that time, the Qualified Beneficiary's coverage may be extended up to a maximum of thirty-six (36) months from the date coverage ended because employment was terminated or hours were reduced. If the Qualified Beneficiary was entitled to continuation because the Enrolling Group filed for bankruptcy, (i.e. QE-6.) and the retired Subscriber dies during the continuation period, then the other Qualified Beneficiaries shall be entitled to continue coverage for thirty-six (36) months from the date of the Subscriber's death. Terminating events B through G described in this section will apply during the extended continuation period.

Continuation coverage for Qualified Beneficiaries whose continuation coverage terminates because the Subscriber becomes entitled to Medicare may be extended for an additional period of time. Such Qualified Beneficiaries should contact the Enrolling Group's designated plan administrator for information regarding the continuation period.

Qualifying Event for Continuation Coverage Under Arkansas State Law

Covered Person whose coverage under the Group Policy are entitled to continue their Hospital, surgical or major medical coverage, including coverage for their eligible dependents, if such coverage would otherwise terminate because employment or membership ends. Such continuation is subject to the following terms and conditions:

- Continuation shall only be available to a Subscriber who has been continuously insured under the Group Policy, and for similar Benefits under any Group Policy which is replaced, during the entire three-month period ending with such termination. If employment is reinstated during the continuation period, then coverage under the Group Policy will be reinstated for the Subscriber and any Dependents who were covered under continuation.
- Continuation is not available for either of the following:
  - Any person covered under this Policy who is or could be covered by Medicare.
  - Any person who is or could be covered by any other insured or uninsured arrangement which provides Hospital, surgical or major medical coverage for individuals in a Group and under which the person was not covered immediately prior to such termination.
- Continuation need not include dental, vision care or prescription drug benefits or any other Benefits provided under this Policy in addition to its Hospital, surgical or major medical Benefits, but continuation must include maternity Benefits if those Benefits are provided under the Group Policy.

Notification Requirements and Election Period for Continuation Coverage Under Arkansas State Law

The Covered Person must do both of the following within ten (10) days of the date coverage would otherwise terminate:

- Request such continuation in writing.
- Pay the Enrolling Group, on a monthly basis, the amount of contribution required to continue coverage. Such Premium contribution shall not be more than the group rate of the insurance being continued on the due date of each payment; but, if any Benefits are omitted (such as dental, vision care, and prescription drug), such Premium contribution shall be reduced accordingly.

The Enrolling Group must notify Covered Persons, in writing, of its duties under this subdivision not later than the date on which coverage would otherwise terminate.

Terminating Events for Continuation Coverage Under Arkansas State Law

Continuation coverage under this Policy will end on the earliest of the following dates:

A. The date four (4) months after the date the Covered Person's Coverage under this Policy would have terminated because of termination of employment;

B. If the Covered Person fails to make timely payment of a required Premium contribution, the end of the period for which contributions were made;

C. The date this Policy is terminated or, in the case of a Subscriber, the date the Enrolling Group terminates participation under a Group Policy. However, if the Coverage ceasing by reason of termination is replaced by similar coverage under another Group Policy, then:

   1. The Covered Person shall have the right to become covered under that other policy for the balance of the period that the Covered Person would have remained covered under the prior policy in accordance with the conditions of this section;

   2. The minimum level of Benefits to be provided by the other policy shall be the applicable level of Benefits of the prior policy reduced by any Benefits payable under that prior policy; and

   3. The prior Group Policy shall continue to provide Benefits to the extent of its accrued liabilities and extensions of Benefits as if the replacement had not occurred.

Continuation of Coverage During a Military Leave

The Uniformed Service Employment and Reemployment Rights Act (USERRA) requires that an employer continue to provide coverage during this Plan during a military leave that is covered by the Act for You or Your dependents. The coverage provided must be identical to the coverage provided under the employer's plan to similarly situated, active employees and dependents. This means that if the coverage for similarly situated, active employees and dependents is modified, coverage for the individual on military leave will be modified. The cost of such coverage will be:

1. For military leaves of thirty (30) days or less, the same as the employee contribution required for active employees.

2. For military leaves of thirty-one (31) days or more, up to 102% of the full cost of the coverage, e.g., the employee and employer share.

Continuation coverage rights apply to medical, dental, prescription drugs and other health coverage. Short and long term disability and life Benefits are not subject to continuation rights.

Continued coverage provided under USERRA will reduce any continuation provided under COBRA.

Maximum Period of Coverage During Military Leave

Continued coverage under this provision will terminate on the earlier of the following events:

1. The date You fail to return to Employment with the Company following completion of Your military leave. Employees must return to employment within:
   - The first full business day after completing military service, for leaves of thirty (30) days or less. A reasonable amount of travel time will be allowed for returning from such military service.
   - Fourteen (14) days after completing military service for leaves of thirty-one (31) to one hundred and eighty (180) days.
   - Ninety (90) days after completing military service, for leave of more than one hundred and eighty (180) days; or
2. Eighteen (18) months from the date Your leave began.

Reinstatement of Coverage Following Military Leave

The law also requires, regardless of whether continuation coverage as stated above was elected, that Your coverage and Your Dependent coverage be reinstated immediately upon Your honorable discharge from military service and return to employment, if You return within:

1. The first full business day after completing military service, for leaves of thirty (30) days or less. A reasonable amount of travel time will be allowed for returning from such military service;
2. Fourteen (14) days after completing military service for leaves of thirty-one (31) to one hundred and eighty (180) days;
3. Ninety (90) days after completing military service, for leave of more than one hundred and eighty (180) days; or

If due to sickness or Injury caused or aggravated by Your military service, You cannot return to work within the times stated above, You may take up to a period of two (2) years, or as soon as reasonably possible if for reasons beyond Your control You cannot return within two (2) years, to recover from such sickness or Injury and return to employment within the times stated above.

If Your coverage under the Plan is reinstated, all provisions and limitations of the Plan will apply to the extent that they would have applied if You had not taken military leave and Your coverage had been continual under the Plan. The eligibility period will be waived and the Pre-Existing Condition Limitation will be credited as if You had been continually covered under the Plan from Your original Effective Date.

This waiver of limitations does not provide coverage for any sickness or Injury caused or aggravated by Your military services, as determined by the Secretary of Veterans Affairs.

Conversion Coverage

If Your coverage terminates for one of the reasons described below, You may apply for conversion coverage without furnishing evidence of insurability.

Reasons for termination:

- The Subscriber is retired or pensioned;
- You cease to be eligible as a Subscriber or Enrolled Dependent;
- Continuation coverage ends;
- The entire Policy ends and is not replaced.

A converted Policy need not be made available if termination occurred for any of the following reasons:

- You failed to make timely payment of any required contribution, or were terminated for any reason (s) listed in Section 3 (When Coverage Ends);
- For any other reasons, and You have not been continuously covered under the Group Policy, and for similar Benefits under any group policy which it replaced, during the entire three-month period ending with such termination;
- The Group Policy terminated or a Group's participation terminated, and the insurance is replaced by similar coverage under another Group Policy within thirty-one (31) days of the date of termination.

Application and payment of the initial Premium must be made within thirty (30) days after coverage ends under this Policy. Conversion coverage will be issued in accordance with the terms and conditions in effect at the time of application. Conversion coverage may be substantially different from coverage provided under this Policy.

The converted Policy shall cover the employee or Member and his/her dependents who were covered by the Group Policy on the date of termination of insurance. At the option of the insurer, a separate converted Policy may be issued to cover any Dependent.

We are not required to issue a converted Policy covering any person if such person is or could be covered by Medicare. Furthermore, We shall not be required to issue a converted Policy covering any person if:

- Such person is or could be covered for similar Benefits by another individual Policy; such person is or could be covered for similar Benefits under any arrangement of coverage for individuals in a Group, whether insured or uninsured; or similar Benefits are provided for or available to such person, by reasons of state or Federal law; and
- The Benefits under sources of the kind referred to above for such person, or Benefits provided or available under sources of the kind referred to above for such person, together with the converted Policy's Benefits would result in over-insurance according to the insurer's standards for over-insurance.

Section 11: General Provisions

Your Relationship with Us

In order to make choices about Your health care coverage and treatment, We believe that it is important for You to understand how We interact with Your Enrolling Group's benefit plan and how it may affect You. We help finance or administer the Enrolling Group's benefit plan in which You are enrolled. We do not provide medical services or make treatment decisions. This means:

- We communicate to You decisions about whether the Enrolling Group's benefit plan will cover or pay for the health care that You may receive. The plan pays for certain medical costs, which are more fully described in this Certificate. The plan may not pay for all treatments You or Your Physician may believe are necessary. If the plan does not pay, You will be responsible for the cost.
- We do not decide what care You need or will receive. You and Your Physician make those decisions.

We may use individually identifiable information about You to identify for You (and You alone) procedures, products or services that You may find valuable. We will use individually identifiable information about You as permitted or required by law, in Our operations and in Our research. We will use de-identified data for commercial purposes including research.

Our Relationship with Enrolling Groups

The relationship between Enrolling Groups and Us is solely a contractual relationship between independent contractors. Enrolling Groups are not Our agents or employees. Neither We, nor any of Our employees, are agents or employees of the Enrolling Groups.

We do not provide Health Care Services or supplies, nor do We practice medicine. We are **not** liable for any act or omission of any provider.

We are not considered to be an employer for any purpose with respect to the administration or provision of Benefits under the Enrolling Group's benefit plan. We are not responsible for fulfilling any duties or obligations of an employer with respect to the Enrolling Group's benefit plan.

The Enrolling Group is solely responsible for all of the following:

- Enrollment and classification changes (including classification changes resulting in Your enrollment or the termination of Your coverage).
- The timely payment of the Policy Charge to Us.
- Notifying You of the termination of this Policy.

When the Enrolling Group purchases a Policy to provide coverage under a benefit plan governed by the Employee Retirement Income Security Act ("ERISA"), 29 U.S.C. §1001 et seq., We are not the plan administrator or named fiduciary of the benefit plan, as those terms are used in ERISA. If You have questions about Your welfare benefit plan, You should contact the Enrolling Group. If You have any questions about this statement or about Your rights under ERISA, contact the nearest area office of the Pension and Welfare Benefits Administration, U. S. Department of Labor.

Your Relationship with Providers and Enrolling Groups

The relationship between You and any provider is that of provider and patient.

- You are responsible for choosing Your own provider.
- You must decide if any provider treating You is right for You.

This includes providers You choose and providers to whom You have been referred.

- You must decide with Your provider what care You should receive.
- Your provider is solely responsible for the quality of the services provided to You.

The relationship between You and the Enrolling Group is that of employer and employee, Dependent or other classification as deemed in this Policy.

Administrative Services

We may, in Our sole discretion, arrange for various persons or entities to provide administrative services in regard to this Policy, such as claims processing. The identity of the service providers and the nature of the services they provide may be changed from time to time in Our sole discretion. We are not required to give You prior notice of any such change, nor are We required to obtain Your approval. You must cooperate with those persons or entities in the performance of their responsibilities.

Amendments to this Policy

To the extent permitted by law, We reserve the right, in Our sole discretion and without Your approval, to change, interpret, modify, withdraw or add Benefits or terminate this Policy.

Any provision of this Policy that on its Effective Date is in conflict with the requirements of state or Federal statutes or regulations (of the jurisdiction in which this Policy is delivered) is hereby amended to conform to the minimum requirements of such statutes and regulations.

No other change may be made to this Policy unless it is made by an Amendment or Rider that has been signed by one of Our officers. All of the following conditions apply:

- Amendments to this Policy are effective thirty-one (31) days after We send a written notice to the Enrolling Group.
- Riders are effective on the date We specify.
- No agent has the authority to change this Policy or to waive any of its provisions.
- No one has authority to make any oral changes or amendments to this Policy.

Case Management

Case Management is a service that assists individuals with treatment needs that extend beyond the acute care setting. The goal of Case Management is to ensure that patients receive appropriate care in the most effective setting possible, whether at home, as an outpatient, or an inpatient in a hospital or specialized facility. Should the need for Case Management arise, a Case Management professional will work closely with the patient, his or her family and the attending physician to determine appropriate treatment options that will best meet the patient's needs and keep costs manageable. The case manager will help coordinate the treatment program and arrange for necessary resources. Case managers are also available to answer questions and provide ongoing support for the family in times of medical crisis.

Case managers are Registered Nurses (RNs) and other credentialed health care professionals, each trained in a clinical specialty area such as trauma, high risk Pregnancy and neonates, oncology, mental health, rehabilitation or general medicine and surgery. A case manager trained in the appropriate clinical specialty area will be assigned to You or Your dependent. In addition, case managers are supported by a panel of physician advisors, who offer guidance on up-to-date treatment programs and medical technology. While the case manager recommends alternate treatment programs and helps coordinate needed resources, the patient's attending physician remains responsible for the actual medical care.

Clerical Error

If a clerical error or other mistake occurs, that error will not deprive You of Benefits under this Policy, nor will it create a right to Benefits. If the Enrolling Group makes a clerical error (including, but not limited to, sending Us inaccurate information regarding Your enrollment for coverage or the termination of Your coverage under this Policy) We will not make retroactive adjustments beyond a sixty (60) day time period.

Commission or Omission

No Hospital, Physician or other Provider of service will be liable for any act of commission or omission by Us. We will not be liable for any act of commission or omission by (1) any Hospital or Hospital's agent or employee; (2) any Physician or Physician's agent or employee; (3) any other Providers or services or their agent or employee; or (4) You.

Entire Policy/Changes

This Policy issued to the Enrolling Group, including this Certificate of Coverage, the Enrolling Group's application, Amendments and Riders, constitutes the entire Policy. No change in this Policy will be valid until approved by one of Our executive officers and unless

such approval be endorsed hereon or attached hereto. No agent has authority to change this Policy or waive any of its provisions.

Examination of Covered Persons

In the event of a question or dispute regarding Your right to Benefits, We may require that a Network Physician of Our choice examine You at Our expense.

Incentives to Providers

We pay certain providers through various types of contractual arrangements, some of which may include financial incentives to promote the delivery of health care in a cost efficient and effective manner. These financial incentives are not intended to affect Your access to health care.

Examples of financial incentives for providers are bonuses for performance based on factors that may include quality, Member satisfaction, and/or cost effectiveness.

We use various payment methods to pay specific providers. From time to time, the payment method may change. If You have questions about whether Your provider has a contract with Us and if that contract includes any financial incentives, We encourage You to discuss those questions with Your provider.

Incentives to You

Sometimes We may offer coupons or other incentives to encourage You to participate in various wellness programs or certain disease management programs. The decision about whether or not to participate is yours alone, but We recommend that You discuss participating in such programs with Your Physician. These incentives are not Benefits and do not alter or affect Your Benefits. Contact Us if You have any questions.

Incorporation by Reference

Unless otherwise stated therein, the Schedule of Coverage and Benefits, the schedule of rates and Premiums, any riders, the application, the member handbook, and any amendments to any of the foregoing, form a part of this Policy as if fully incorporated herein.

Information and Records

At times, We may need additional information from You. You agree to furnish Us with all information and proofs that We may reasonably require regarding any matters pertaining to this Policy. If You do not provide this information when requested, We may delay or deny payment of Your Benefits.

By accepting Benefits under this Policy, You authorize and direct any person or institution that has provided services to You to furnish Us with all information or copies of records relating to the services provided to You. We have the right to request this information at any reasonable time. This applies to all Covered Persons, including Enrolled Dependents, whether or not they have signed the Subscriber's enrollment form. We agree that such information and records will be considered confidential.

We have the right to release any and all records concerning Health Care Services that are necessary to implement and administer the terms of this Policy for appropriate medical review, quality assessment, or as We are required to do by law or regulation. During and after the term of this Policy, We and Our related entities may use and transfer the information gathered under this Policy in a de-identified format for commercial purposes, including research and analytic purposes.

For complete listings of Your medical records or billing statements We recommend that You contact Your health care provider. Providers may charge You reasonable fees to cover their costs for providing records or completing requested forms.

If You request medical forms or records from Us, We also may charge You reasonable fees to cover costs for completing the forms or providing the records.

In some cases, We will designate other persons or entities to request records or information from or related to You, and to release those records as necessary. Our designees have the same rights to this information as We have.

Interpretation of Eligibility and Benefits

Mercy Health Plans (MHP) has sole discretion to determine eligibility or interpret Plan Benefits. This function is the responsibility of MHP. We may delegate this authority to other persons or entities that provide services in regards to the administration of this Policy. Note: You have the right to appeal the decision, file a Grievance, seek relief through the Department of Insurance, or seek legal action to enforce the contract.

In certain circumstances, for purposes of overall cost savings or efficiency, We may, in Our sole discretion, offer Benefits for services that would otherwise not be Covered Health Services. The fact that We do so in any particular case will not in any way be deemed to require Us to do so in other similar cases.

Legal Actions

You may not bring any action of law or in equity concerning a claims payment until sixty (60) days after written proof of claim for Benefit payment has been furnished in accordance with the requirement of this Policy. Any such action must begin within three (3) years of the date a claim is required to be sent to Us.

Medicare Eligibility

Benefits under this Policy are not intended to supplement any coverage provided by Medicare. In some circumstances, Covered Persons who are eligible for or enrolled in Medicare may also be enrolled under this Policy.

If You are eligible for or enrolled in Medicare, please read the following information carefully.

If You are eligible for Medicare, and Medicare would be Your Primary payer (Medicare pays before Benefits under this Policy), You **should** enroll in and maintain coverage under both Medicare Part A and Part B. If You don't enroll and maintain that coverage, and if We are the Secondary payer as described in Section 7 (Coordinating Benefits with Other Coverage), We will pay Benefits under this Policy as if You were covered under both Medicare Part A **and** Part B. As a result, You will be responsible for the costs that Medicare would have paid and You will incur a larger out-of-pocket cost.

Notice

When We provide written notice regarding administration of this Policy to an authorized representative of the Enrolling Group, that notice is deemed notice to all affected Subscribers and their Enrolled Dependents. The Enrolling Group is responsible for giving notice to You.

Policies, Identification Cards and Applications

We will furnish You with identification cards, copies of this Policy, and applications.

Statements by Enrolling Group or Subscriber

Except for fraudulent statements, all statements made by the Enrolling Group or by a Subscriber will be deemed representations and not warranties and that no statement made for the purpose of effecting insurance shall void the insurance or reduce benefits, unless contained in a written instrument signed by the policyholder of the insured person, a copy of which has been furnished to the policyholder or to the person or his or her beneficiary.

Statement of ERISA Rights

As a participant in the Plan, You are entitled to certain rights and protection under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Members shall be entitled to:

Receive Information About Your Plan and Benefits

– Examine, without charge, at the Plan Administrator's office and at other locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U. S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.

- Obtain, upon written request to the Plan Administrator, copies of documents governing the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated *Summary Plan Description*. The Plan Administrator may make a reasonable charge for the copies.

- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of the summary annual report.

Continue Group Health Plan Coverage

- Continue health care coverage for yourself, Spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or Your dependents may have to pay for such coverage. Review this *Summary Plan Description* and the document governing the Plan on the rule governing Your COBRA continuation coverage rights.
- Reduction or elimination of exclusionary periods of coverage for preexisting conditions under Your Group health plan, if You have Continuous Creditable Coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from Your Group health plan or health insurance issuer when You lose coverage under the Plan, when You become entitled to elect COBRA continuation coverage, when Your COBRA continuation coverage ceases, if You request it before losing coverage, or if You request it up to twenty-four (24) months after losing coverage. Without evidence of Continuous Creditable Coverage, You may be subject to preexisting condition exclusion for twelve (12) months after Your enrollment date in Your coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit Plan. The people who operate the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of You and other Plan participants and beneficiaries. No one, including Your employer, Your union, or any other person may fire You or otherwise discriminate against You in any way to prevent You from obtaining a welfare benefit or exercising Your rights under ERISA.

Enforce Your Rights

If a claim for a welfare benefit is denied or ignored, in whole or in part, You have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any steps You can take to enforce the above rights. For instance, if You request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, You may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay You up to $110 a day until You receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If You have a claim for Benefits which is denied or ignored, in whole or in part, You may file suit in a state or Federal court. If it should happen that Plan fiduciaries misuse the Plan's money or if You are discriminated against for asserting Your rights, You may seek assistance from the U. S. Department of Labor, or You may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If You are successful, the court may order the person You have sued to pay these costs and fees. If You lose, the court may order You to pay these costs and fees, for example, if it finds Your claim is frivolous.

Assistance With Your Questions

If You have any questions about Your Plan, You should contact the Plan administrator. If You have any questions about this statement or about Your rights under ERISA, or if You need assistance in obtaining document from the Plan Administrator, You should contact the nearest office of the Pension and Welfare Benefits Administration, United States Department of Labor listed in Your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. You may also obtain certain publications about Your rights and responsibilities under ERISA by calling the publication hotline of the Pension and Welfare Benefits Administration.

Time Limit on Certain Defenses

1. After three (3) years from the date of issue of this Policy, no misstatements, except fraudulent misstatements, made by the applicant in the application for such Policy shall be used to void this Policy or to deny a claim for charges incurred after the expiration of such three (3) year period.
2. The time limits of this Policy for charges incurred due to a Preexisting Condition, if applicable, are set forth in Section 13 (M).

Workers' Compensation not Affected

Benefits provided under this Policy do not substitute for and do not affect any requirements for coverage by Workers' Compensation insurance.

Section 12: Covered Benefits

Benefit	Description **See Schedule of Coverage and Benefits for Your cost-sharing Amount** [Note: Copayments [and Deductibles] do not count towards Your Out-of-Pocket (OOP) Maximum; only Coinsurances [and Deductibles] apply to Your OOP Maximum.]
1. Allergy Services	• Office visits • Injections and serum, treatment, or testing (when no charge is made for physician services)
2. Ambulance Services-Emergency Only	Medically Necessary ambulance service (either by a licensed ambulance service - ground or air ambulance) to the most appropriate Hospital where Emergency Care can be provided in the case of a Medical Emergency Condition; however, use of air ambulance must be approved in advance or as soon as reasonable possible by the Plan. Ambulance services do not include safety evacuation or medical transportation from foreign countries, even in Emergency situations. See Section 13, R., for related exclusions.
3. Dental -Anesthesia and Facility Charges	Administration of general anesthesia and Hospital charges for dental care if: • The Covered Person is a child under the age of seven (7) who is determined by two (2) licensed dentists to require, without delay, necessary dental treatment in a hospital or ambulatory surgical center for a significantly complex dental condition; or • The Covered Person is diagnosed with a serious mental or physical condition; or • The Covered Person has a significant behavioral problem as determined by the Covered Person's Physician. Limitations and Exclusions are described in Section 13, C. **Prior Authorization Required** Unless We pre-approve these services, Network and Non-Network Benefits for dental anesthesia and related facility charges will be reduced by 50% of Eligible Expenses.
4. Dental Services - Accident only	Dental services when all of the following are true: • Treatment is necessary because of accidental damage • Dental services are received from a Doctor of Dental Surgery, "D.D.S." or Doctor of Medical Dentistry, "D.M.D." • The dental damage is severe enough that initial contact with a Physician or dentist occurred within seventy-two (72) hours of the accident Benefits are available only for treatment of a sound, natural tooth. Sound, natural teeth means teeth and tissue that are viable, functional, and free of disease. The Physician or dentist must certify that the injured tooth was: • A virgin or unrestored tooth • A tooth that has no decay, no filling on more than two surfaces, no gum disease associated with bone loss, no root canal therapy, is not a dental implant and functions normally in chewing and speech. Dental services for final treatment to repair the damage must be completed within the timeframe described in Your Schedule of Coverage and Benefits. Dental x-rays and narrative report for independent dental consultant review may be required. Coverage does not include Benefits for the repair or replacement of dental prosthetics, including but not limited to bridges, dentures, crowns, implants, braces, and retainers. Please note that dental damage that occurs as a result of normal activities of daily living or extraordinary use of the teeth other than for normal biting or chewing is not considered an "accident". Benefits are not available for repairs to teeth that are injured as a result of such activities, or specifically excluded in Section 13, C.

Benefit	Description **See Schedule of Coverage and Benefits for Your cost-sharing Amount** [Note: Copayments [and Deductibles] do not count towards Your Out-of-Pocket (OOP) Maximum; only Coinsurances [and Deductibles] apply to Your OOP Maximum.]
	Prior Authorization Required You do not have to notify Us before the initial Emergency treatment. However, You must obtain Prior Authorization as soon as possible and before follow-up (post-Emergency treatment) begins. Unless We pre-approve post-emergency treatment, coverage for accidental dental services will be reduced by 50% of Eligible Expenses.
5. Diabetes Services	Medically appropriate and necessary equipment, supplies and self-management training for the management and treatment of diabetes. Services are provided for persons with gestational, type I or type II diabetes. Coverage is provided for insulin infusion devices, insulin pumps, and associated supplies. Services for **diabetes self-management training**: Covered Health Services are limited to a program that complies with the National Standards for Diabetes Self-Management Education Program as developed by the American Diabetes Association. Diabetes self-management training shall be provided only upon prescription by a licensed physician and a licensed health care professional must certify that the Covered Person successfully completed the training program. Coverage is limited to one (1) program during the entire time a Covered Person is Covered under this Certificate. However, a Physician may prescribe additional training, due to a significant change in the Covered Person's symptoms or condition. A provider licensed, registered, and/or certified in the state to provide appropriate Health Care Services must provide diabetes self-management training program. Training is to be provided upon the initial diagnosis of diabetes, where there is a significant change in the Member's symptoms and when the Food and Drug Administration for the treatment of diabetes approve new techniques and treatments. **Prior Authorization Required** You must obtain Prior Authorization before receiving services for insulin pumps. Diabetes services are not subject to any durable medical equipment (DME) limits. Unless We pre-approve these services, Network and Non-Network Benefits will be reduced by 50% of Eligible Expenses
6. Dialysis	Medically Necessary dialysis is a covered Benefit.
7. DME, Orthotics and Prosthetics	***Durable Medical Equipment (DME)*** and its associated supplies that meet each of the following criteria: • Ordered or provided by a Physician for outpatient use; • Standard Basic Hospital-type Equipment that meets the medical need; • It can withstand repeated use; • Used for medical purposes; • Not consumable or disposable; • Not of use to a person in the absence of a disease or disability; • It is not primarily a device for enhancing the environmental setting in which the patient is placed or altering air quality or temperature; • It is not used for exercising or training; and • It is not used for monitoring health conditions. If more than one piece of Standard Basic Hospital-type Equipment can meet Your functional needs, Benefits are available only for the most cost effective piece of equipment. Examples of DME include: • Equipment to assist mobility, such as a standard wheelchair. • A standard Hospital-type bed. • Oxygen and the rental of equipment to administer oxygen (including tubing, connectors and masks.)

Benefit	Description **See Schedule of Coverage and Benefits for Your cost-sharing Amount** [Note: Copayments [and Deductibles] do not count towards Your Out-of-Pocket (OOP) Maximum; only Coinsurances [and Deductibles] apply to Your OOP Maximum.]
	We will decide if the equipment should be purchased or rented. If more than one piece of Standard Basic Hospital-type Equipment can meet Your functional needs, Benefits are available only for the most cost effective piece of equipment. DME is not modified, repaired, or replaced unless necessitated by the Member's medical condition. The Plan may replace an item because of severe damage or loss through no intentional act of the Member; however, an item is generally not replaced more than once per [Calendar][Plan] Year. Please note that any DME limitation is not applicable to any equipment, supplies or self-management training for the treatment of diabetes. In no event shall orthodontic braces, humidifiers, air conditioners, dehumidifiers or similar personal comfort items be treated as DME for purposes of this Plan. See Section 13, B. and G., for information on medical supplies and equipment that We do not cover. ***Orthotics*** Covered orthotic device/equipment is the Standard Basic Equipment necessary to continue average daily activities. The Plan may replace an item because of severe damage or loss through no intentional act of the Member; however, an item is generally not replaced more than once per [Calendar][Plan] Year. The following items are covered when ordered and provided by a Physician and obtained from an orthotic provider: • Braces/support including necessary adjustments to shoes to accommodate braces. Braces that stabilize an Injured body part are considered Durable Medical Equipment and are a Covered Health Service. • Trusses • Splints • Collars • Foot orthotics are a covered treatment for neuropathy or severe vascular insufficiency due to diabetes, or vascular disease. Braces that straighten or change the shape of a body part are orthotic devices, and are covered only for Instrumental Activities of Daily Living. Orthotics for sports-related activities are not covered. Dental braces are also excluded from coverage. See Section 13, C., F. and G. for mechanical equipment, medical supplies and other related services that are not covered. ***Prosthetics*** The purchase, fitting, necessary adjustment of prosthetic devices which replace or repair all or part of a limb including tissue, or replace all or part of the function of a permanently inoperative or malfunctioning body organ is a covered benefit. Supplies, adjustments, and repair or replacement of these devices, necessary to maintain their effective use, is provided when needed due to irreparable damage, normal wear or a change in the patient's condition, and deemed necessary by the Plan. As long as the device remains Medically Necessary, it will be covered even if the device has been in use prior to the user's enrollment; however an item is generally not replaced more than once per [Calendar] [Plan] Year. Covered prosthetic equipment is the Standard Basic Equipment necessary to continue average daily activities. If more than one prosthetic device can meet Your functional needs, Benefits are available only for the most cost-effective prosthetic device. The following devices and related services are not covered as prosthetic equipment: a. All mechanical organs b. Computer assisted devices c. Dental and TMJ appliances d. Devices employing robotics e. Electrical continence aids, anal or urethral f. Investigational or obsolete devices and supplies g. Remote control devices See Section 13, K., Q., B and C., for more details on related exclusions. Breast prosthesis as required by the Women's Health and Cancer Rights Act of 1998 is also

Benefit	Description **See Schedule of Coverage and Benefits for Your cost-sharing Amount** [Note: Copayments [and Deductibles] do not count towards Your Out-of-Pocket (OOP) Maximum; only Coinsurances [and Deductibles] apply to Your OOP Maximum.]
	covered. Breast prosthesis may follow a mastectomy at any time. Coverage includes a post-mastectomy brassiere. Please note that any limitation for prosthetics does not apply to breast prostheses. **Note:** The Plan is not responsible for any DME/Orthotics/Prosthetics loss or damage that is that is the result of action of a third party (i.e., loss of luggage containing DME equipment or orthotic/prosthetic devices by an airliner). [Any combination of Network and Non-Network Benefits for DME, Orthotics and Prosthetics [(combined Benefit)] is limited according to Your Schedule of Coverage and Benefits.] **Prior Authorization Required** We must pre-approve any single item of DME, orthotics or prosthetics that costs more than $1,000 (either purchase price or cumulative rental of a single item). Unless We pre-approve services over $1,000, You will be responsible for paying 100% of the charges and no Benefits will be paid.
8. Emergency Room Services	Emergency Services that are required to stabilize or initiate treatment in an Emergency. Emergency Room Services must be received on an outpatient basis at a Hospital or Alternate Facility. You will find more information about Benefits for Emergency Health Services in Section 4 (How You Get Care). Please remember that if You are admitted to a Hospital as a result of an Emergency, You must notify Us within two (2) business days or the same day of admission, or as soon as reasonably possible to receive authorization for continued services related to post-stabilization as needed. If You don't notify Us, Benefits for the Hospital Inpatient Stay will be reduced by 50% of Eligible Expenses. Benefits will not be reduced for the outpatient Emergency Room Services. Please refer to *Inpatient Hospital Services* below. If an Emergency Room admission results in a conversion to an Inpatient Stay or Observation Care for the same condition within 24 hours, the Emergency Room Copayment/Coinsurance will be waived. The alternate higher level Copayment/Coinsurance will apply.
9. Eye Examinations	Expenses for one (1) routine eye examinations per [Calendar] [Plan] Year by an Ophthalmologist or Optometrist at the frequency listed in Your Schedule of Coverage and Benefits. Please note that Benefits are not available for charges connected to the purchase or fitting of eyeglasses or contact lenses. See Section 13, S., for more information on limitations and exclusions related to vision care.
10. Hearing Screenings for Newborns	Newborn hearing screenings, necessary rescreening, audiological assessment and follow-up, and initial amplification.
11. Home Health Care	Services received from a Home Health Agency that are: • Ordered by a physician; • Provided by or supervised by a registered nurse in Your home; and • You are Homebound or Your physical or mental condition pose a serious and significant impediment to receiving medically necessary services outside the home. Benefits are available only when the Home Health Agency services are provided on a part-time, intermittent schedule and when skilled care is required. Skilled care is skilled nursing, skilled teaching and skilled rehabilitation services when all of the following are true: • It must be delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome, and provide for the safety of the patient. • It is ordered by a Physician.

Benefit	Description **See Schedule of Coverage and Benefits for Your cost-sharing Amount** [Note: Copayments [and Deductibles] do not count towards Your Out-of-Pocket (OOP) Maximum; only Coinsurances [and Deductibles] apply to Your OOP Maximum.]
	• It is not delivered for the purpose of assisting with activities of daily living, including but not limited to dressing, feeding, bathing, or transferring from a bed to a chair. • It requires clinical training in order to be delivered safely and effectively. • It is not Custodial Care. We will decide if skilled care is required by reviewing both the skilled nature of the service and the need for Physician-directed Medical management. A service will not be determined to be "skilled" simply because there is not an available caregiver. Certain extended home infusion services may be more appropriately performed in the home even if You are not Homebound. Any combination of Network and Non-Network Benefits is limited according to Your Schedule of Coverage and Benefits. Services primarily for hygiene, feeding, exercising, moving the patient, homemaking, companionship or giving oral medication are excluded. See Section 13,.J. for related exclusions. **Prior Authorization Required** Unless We pre-approve home health services, Network and Non-Network Benefits will be reduced by 50% of Eligible Expenses.
12. Hospice/Palliative Care	Hospice/Palliative care that is recommended by a Physician. Hospice/Palliative care is an integrated program that provides comfort and support services for the terminally ill. An individual is considered to be terminally ill if the medical prognosis for the life expectancy of that individual is six (6) months or less. A written or oral certification of the terminal illness must be provided to the hospice agency no later than two (2) calendar days after hospice care is initiated. Hospice care includes physical, psychological, social and spiritual care for the terminally ill person, and short-term grief counseling for immediate family members. Services can be provided either on an inpatient or on an outpatient basis. Benefits are available when hospice care is received from a licensed hospice agency. Discharge from a hospice may occur because You: • Revoke the hospice benefit; • Move away from the geographic area serviced by the hospice agency; • Transfer to another hospice; • Your condition improves and You are no longer considered terminally ill; or • You are deceased. Please contact Us for more information regarding Our guidelines for hospice care. You can contact Us at the telephone number on Your ID card. Any combination of Network and Non-Network Benefits is limited to one hundred and eighty (180) days during the entire period of time You are covered under this Policy. **Prior Authorization Required** Unless We pre-approve hospice/palliative care services, Network and Non-Network Benefits will be reduced by 50% of Eligible Expenses.
13. Immunizations (Routine Only)	Routine immunizations as defined by the Plan. Coverage limitations may apply but only for adults over eighteen (18) years of age. Immunizations required for international travel are excluded. A list of routine immunizations can be obtained at www.mercyhealthplans.com or by calling Our Customer Contact Center at the number listed on Your ID card.Applicable [Copayment] [Deductible] [and] [Coinsurance] for office visit(s) will apply.
14. Injectables/Infusions	Benefits are available for injections/infusions received in a Physician's office, infusion center or through home health, when no other health service is received. Some injectables and infusions received in the locations listed above may incur a [Copayment] [or] [Deductible and][Coinsurance] for the injectable/infusion, in addition to any cost-sharing for the Physician's

Benefit	Description **See Schedule of Coverage and Benefits for Your cost-sharing Amount** [Note: Copayments [and Deductibles] do not count towards Your Out-of-Pocket (OOP) Maximum; only Coinsurances [and Deductibles] apply to Your OOP Maximum.]
	office visit, infusion center or home health service, regardless of whether other health services are received. [Regardless of the place where these services are performed, the cost-sharing for injectables/infusions will apply.] **Prior Authorization Required** Some injectables/infusions require Prior Authorization. A list of injectables/infusions requiring Prior Authorization can be obtained at www.mercyhealthplans.com or by calling Our Customer Contact Center at the number listed on Your ID card. Unless We pre-approve injectable/infusions that require Prior Authorization, Network and Non-Network Benefits will be reduced by 100% of Eligible Expenses.
15. Inpatient Hospital Services	Inpatient Stay in a Hospital. Benefits are available for: • Services and supplies received during the Inpatient Stay. • Room and board in a Semi-Private Room (a room with two or more beds), or • A private room only when medically necessary and approved in advance by the Plan. **Prior Authorization Required** Please remember that You must notify Us as follows: • For elective admissions; and • For Emergency admissions: within two (2) business days or the same day of admission, or as soon as is reasonably possible. Unless We pre-approve inpatient Hospital services, Network and Non-Network Benefits will be reduced by 50% of Eligible Expenses.

16. In-Vitro Fertilization	Covered Health Services for In-Vitro Fertilization (IVF) include the following charges:
	
	• IVF associated lab;
	• Medication (covered under the pharmacy benefit);
	• Imaging and procedures including female and male pre-testing;
	• The IVF process, and;
	• Cryopreservation.
	
	Benefits are provided for in-vitro fertilization if the following conditions are met:
	• The patient's oocytes are fertilized with the sperm of the patient's Spouse, and
	• The patient and the patient's Spouse have a history of unexplained infertility of at least two (2) years' duration; or
	• The infertility is associated with one or more of the following medical conditions:
	  • Endometriosis;
	  • Exposure in utero to Diethylstilbestrol, commonly known as DES;
	  • Blockage of or removal of one or both fallopian tubes (lateral or bilateral salpingectomy) not a result of voluntary sterilization; or
	  • Abnormal male factors contributing to the infertility, and
	• The in-vitro fertilization procedures are performed at a medical facility, licensed or certified by the Arkansas Department of Health, those performed at a facility certified by the Arkansas Department of Health which conform to the American College of Obstetricians and Gynecologists' guidelines for in vitro fertilization clinics, or those performed at a facility certified by the Arkansas Department of Health which meet the American Fertility Society's minimal standards for programs of in vitro fertilization.
	
	Any combination of Network and Non-Network Benefits is limited to a lifetime maximum benefit of $15,000 during the entire period of time You are covered under this Policy. See Section 13, N. for related exclusions.
	
	Prior Authorization Required

Benefit	Description **See Schedule of Coverage and Benefits for Your cost-sharing Amount** [Note: Copayments [and Deductibles] do not count towards Your Out-of-Pocket (OOP) Maximum; only Coinsurances [and Deductibles] apply to Your OOP Maximum.]
	Unless We pre-approve these services, Network and Non-Network Benefits will be reduced by 50% of Eligible Expenses.
17. Maternity Services	Benefits for Pregnancy will be paid at the same level as Benefits for any other condition, Sickness or Injury. This includes all maternity related medical services for prenatal care, postnatal care, delivery, and any Complications of Pregnancy. Laboratory, x-ray and other diagnostic testing services such as ultrasounds related to a Pregnancy are also covered. Ultrasounds in uncomplicated Pregnancies are limited to two (2) per Pregnancy. We will pay Benefits for an Inpatient Stay of: • Forty-eight (48) hours for the mother and newborn child following a normal vaginal delivery. • Ninety-six (96) hours for the mother and newborn child following a cesarean section delivery. • Five (5) full days in a hospital nursery or until the mother is discharged from the hospital following the birth of the child, whichever is the lesser period of time. If the mother agrees, the attending provider may discharge the mother and/or the newborn child earlier than these minimum time frames. Early discharge requires that both of the following requirements are met: • The discharge complies with the guidelines of the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists. • The mother and child are provided post-discharge care as determined by the attending physician. Post-discharge care shall consist of a minimum of two (2) visits, at least one (1) of which shall be in the home, in accordance with accepted maternal and neonatal physical assessments, by a registered professional nurse with experience in maternal and child health nursing or a physician; and includes parent education, training in breast or bottle-feeding, and appropriate testing of the mother and child. Copayments/Coinsurances and Deductible requirements apply to normal newborn admissions and both the mother and newborn will incur separate inpatient Copayments/Deductible as follows: • If the mother and newborn are discharged from the same hospital on the same day, applicable Copayments/Coinsurances and Deductible will apply separately for the mother and the newborn; however, the Deductible will be waived for the newborn; • If the mother and newborn are *not* discharged from the same hospital on the same day, both the mother and newborn will each incur applicable Copayments/Coinsurances and Deductibles for their inpatient hospital stay. The newborn's inpatient hospital Copayment/Coinsurance and Deductible will cover the dates of service *after* the mother's discharge, or dates of service at a different hospital. • If the newborn remains hospitalized after the mother's discharge date, an inpatient authorization is required for the dates of service after the mother's discharge date, and vice versa. See "Prior Authorization Required" below. **Note:** The number of prenatal visits or change in Physicians may affect your Copayment or Coinsurance. Maternity care Benefits will be extended to a Subscriber's unmarried Dependent child. The Subscriber provides no Benefits for the infant child of the Subscriber's unmarried Dependent child, unless the infant child of the unmarried Dependent is otherwise eligible for coverage. **Prior Authorization Required** Please remember that You must notify Us as soon as reasonably possible if the Inpatient Stay for the mother and/or the newborn will be more than the time frames described above. Unless We pre-approve any extended inpatient Hospital services beyond labor and delivery for either You or Your newborn, Your Network and Non-Network Benefits for the extended stay will be reduced

Benefit	Description **See Schedule of Coverage and Benefits for Your cost-sharing Amount** [Note: Copayments [and Deductibles] do not count towards Your Out-of-Pocket (OOP) Maximum; only Coinsurances [and Deductibles] apply to Your OOP Maximum.]
	by 50% of Eligible Benefits.
18. Mental Health and Substance Abuse Services - Outpatient	Mental Health, Substance Abuse and a Chemical Dependency evaluations and assessment prescribed by a licensed professional. • Diagnosis • Treatment planning • Referral services • Medication management • Short-term individual, family and group therapeutic services (including Intensive Outpatient Program) • Crisis intervention For Network Benefits, referrals to a mental health/substance abuse provider are at the sole discretion of the Mental Health/Substance Abuse Designee, who is responsible for coordinating all of Your care. Contact the Mental Health/Substance Abuse Designee regarding Network Benefits for outpatient Mental Health and Substance Abuse Services. Any combination of Network and Non-Network Benefits for these outpatient Mental Health Services and/or Substance Abuse Services is limited according to Your Schedule of Coverage and Benefits. See Section 13, J., P. for exclusions related to this Benefit. **Prior Authorization Required** Please remember that You must call and get authorization to receive these Benefits in advance of any treatment through the Mental Health/Substance Abuse Designee. The Mental Health / Substance Abuse Designee phone number appears on Your ID card. Unless We pre-approve these services, Network and Non-Network Benefits will be reduced by 100% of Eligible Expenses.
19. Mental Health and Substance Abuse Services – Inpatient and Intermediate	Mental Health and Substance Abuse Services received on an inpatient or intermediate care basis in a Hospital or an Alternate Facility. Benefits include detoxification from abusive chemical or substances that is limited to physical detoxification when necessary to protect Your physical health and well-being. The Mental Health/Substance Abuse Designee, who will arrange for the service, will determine the appropriate setting for the treatment. If an Inpatient Stay is required, it is covered on a Semi-Private Room basis. At the discretion of the Mental Health/Substance Abuse Designee, two (2) sessions of intermediate care (such as Partial Hospital Treatment Program) may be substituted for one (1) inpatient day. Network Benefits for Mental Health Services and Substance Abuse Services must be provided by or under the direction of the Mental Health/Substance Abuse Designee. For Network Benefits, referrals to a mental health/substance abuse provider are at the sole discretion of the Mental Health/Substance Abuse Designee, who is responsible for coordination all of Your care. Contact the Mental Health/Substance Abuse Designee regarding Benefits for inpatient/intermediate Mental Health Services and Substance Abuse Services. Any combination of Network and Non-Network Benefits for these inpatient and intermediate Mental Health Services and Substance Abuse is limited according to Your Schedule of Coverage and Benefits. Residential treatment services are not covered. See Section 13, J., P. for exclusions related to this Benefit. **Prior Authorization Required** Please remember that You must call and get authorization to receive these Benefits in advance of any treatment through the Mental Health/Substance Abuse Designee. The Mental Health / Substance Abuse Designee phone number appears on Your ID card. Unless We pre-approve these

Benefit	Description **See Schedule of Coverage and Benefits for Your cost-sharing Amount** [Note: Copayments [and Deductibles] do not count towards Your Out-of-Pocket (OOP) Maximum; only Coinsurances [and Deductibles] apply to Your OOP Maximum.]
	services, Network and Non-Network Benefits will be reduced by 100% of Eligible Expenses.
20. Neuropsychological Testing	Neuropsychological Testing is a covered benefit for an individual who has suffered a brain injury, dementia (including cognitive degeneration as seen in individuals with Alzheimer's), cerebrovascular disease, and is covered when: ▪ Results of the assessment will significantly alter the treatment plan; and ▪ This type of assessment is the least intrusive, as well as most time and resource efficient method of meeting treatment goals for; and ▪ The testing is not used to confirm previous testing/diagnostic results; ▪ There are only mild or questionable deficits on standard mental status testing, and more precise evaluation is needed to establish the presence of abnormalities or distinguish them from changes that may occur with normal aging or the expected progression of other disease processes; or ▪ There is a need to quantify the patient's deficits, particularly when the information will be useful in determining a prognosis; or ▪ There is a need to characterize the strengths and weaknesses of a patient, as a guide to treatment or rehabilitation planning; or ▪ Neuropsychological data can provide a more comprehensive profile of function that, when combined with clinical, laboratory, and imaging data, may assist in determining a diagnosis; or ▪ The patient is being considered for epilepsy surgery; and ▪ Will affect medical treatment choices. **Note:** Neuropsychological Testing to assist in planning educational and vocational programs, for the purpose of disability determinations, and/or for forensic determinations is not a covered benefit. See Section 13, P. for exclusions related to this Benefit. **Prior Authorization Required** Unless We pre-approve these services, Network and Non-Network Benefits will be reduced by 50% of Eligible Expenses.
21. Newborn Child Coverage	Coverage for newborn children begins from the moment of birth. Benefits include coverage for illness, injury, congenital defects, premature birth, tests for hypothyroidism, phenylketonuria, galactosemia, sickle-cell anemia, all other disorders of metabolism, and routine nursery care and pediatric charges for a well newborn child for up to five (5) full days in a hospital nursery or until the mother is discharged from the hospital following the birth of the child, whichever is the lesser period. **Prior Authorization Required** We must be notified within ninety (90) days of birth, or Your next Premium due date, whichever is greater. If You don't notify Us, You will be responsible for paying 100% of the charges incurred after the lesser of five (5) days, or the mother's discharge date.
22. Nutritional Counseling	Nutritional counseling that is appropriately included as part of the course of treatment based on the efficacy of the diet and lifestyle and treatment of the disease states, in accordance with Plan policies and procedures, which are subject to change. Expenses for nutritional counseling for up to three (3) visits in a [Calendar] [Plan] Year are covered. Coverage is provided for only certain conditions such as diabetic education, congestive heart failure, malnutrition and nutritional deficiencies. See Section 13, I. and K., for related limitations or exclusions to this benefit.

Benefit	Description **See Schedule of Coverage and Benefits for Your cost-sharing Amount** [Note: Copayments [and Deductibles] do not count towards Your Out-of-Pocket (OOP) Maximum; only Coinsurances [and Deductibles] apply to Your OOP Maximum.]
23. Nutritional Supplements	Nutritional supplements are covered Benefits only when tube feeding (enteral administration) using nutritional supplements is the sole source of a member's nutrition for a permanent condition, or when parenteral (intravenous administration) nutritional requirements exists (i.e., hyperemesis of pregnancy). Coverage is only provided when the following conditions exist: (a) A permanent non-function or disease of the structures that normally permit food to reach the small bowel; or (b) Disease of the small bowel which impairs digestion and absorption of an oral diet, leading to insufficient nutrition to maintain weight and strength commensurate with the member's overall health status; or (c) Because the member is taking medication or undergoing treatment that is depleting the body's normal supply of nutrients. Oral nutrition (including Medical Foods) is not considered a covered benefit, except for PKU formula, or low protein modified food products described below. See Section 13, I for limitations and exclusions related to this benefit. **Prior Authorization Required** Unless We pre-approve these services, Network and Non-Network Benefits will be reduced by 50% of Eligible Expenses.
24. Observation Care	Observation Care are those services furnished by a hospital on the hospital's premises, including use of a bed and periodic monitoring by a hospital's nursing or other staff, that are reasonable and necessary to evaluate an outpatient's condition or determine the need for a possible admission to the Hospital as an inpatient. Most Observation services do not exceed one (1) day. Some patients, however, may require a second day of outpatient Observation services. Members may be admitted as Observation status to beds in the Emergency room, an Observation unit, the intensive care unit, or a regular floor. If an Observation admission results in a conversion to an Inpatient Admission for the same condition within 24 hours, the Observation Copayment/Coinsurance will be waived. The alternate Copayment/Coinsurance will apply. **Prior Authorization Required** Unless We pre-approve services that exceeds one (1) day, Network and Non-Network Benefits will be reduced by 50% of Eligible Expenses.
25. Osteoporosis Services/Bone Mineral Density (BMD) Testing	Diagnosis, treatment, and appropriate management of osteoporosis for Covered Persons with a condition or medical history for which bone mass measurement is medically indicated. **Prior Authorization Required** Coverage limitations may apply. Some services require Prior Authorization. A list of services requiring Prior Authorization can be obtained at www.mercyhealthplans.com or by calling Our Customer Contact Center at the number listed on Your ID card. Unless We pre-approve BMD testing that requires Prior Authorization, Network and Non-Network Benefits will be reduced by 50% of Eligible Expenses.
26. Outpatient Diagnostic Services	Covered Health Services received on an outpatient basis at a Hospital or Alternate Facility for laboratory and medical diagnostic services. • Laboratory services • X-ray/Imaging services • Other diagnostic tests and therapeutic treatments (including cancer Chemotherapy or intravenous infusion therapy) The following services are subject to the outpatient diagnostic cost-sharing, regardless of the

Benefit	Description **See Schedule of Coverage and Benefits for Your cost-sharing Amount** [Note: Copayments [and Deductibles] do not count towards Your Out-of-Pocket (OOP) Maximum; only Coinsurances [and Deductibles] apply to Your OOP Maximum.]
	place of service: • MRA • MRI • CT Scan • PET Scan • Nuclear Cardiology Imaging studies [Benefits under this section include only the facility charge and the charge for required services, supplies and equipment. When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services* below.] [Regardless of the place where these services are performed the applicable cost-sharing will apply.] **Prior Authorization Required** Some services require Prior Authorization. A list of services requiring Prior Authorization can be obtained at www.mercyhealthplans.com or by calling Our Customer Contact Center at the number listed on Your ID card. Unless We pre-approve these services, Network and Non-Network Benefits will be reduced by 50% of Eligible Expenses.
27. Outpatient Surgery/Hospital Procedures	Covered surgical services and other medical care received on an outpatient basis at a Hospital or Alternate Facility. Benefits under this section include only the facility charge and the charge for required services, supplies and equipment. Benefits for related professional fees are described under *Professional Fees for Surgical and Medical Services* below and may incur separate Copayment/Coinsurance in addition to the outpatient facility Copayment/Coinsurance. [Regardless of the place where these services are performed, the applicable cost-sharing will apply.] **Surgical Implants**, whether inserted in the inpatient, outpatient, or office setting, including pacemakers, stents, and other implantable devices or treatments. Copayment/Coinsurance is consistent with type of service required. Implants for cosmetic or psychological reasons are excluded, see Section 13, K. **Prior Authorization Required** Some services require Prior Authorization. A list of services requiring Prior Authorization can be obtained at www.mercyhealthplans.com or by calling Our Customer Contact Center at the number listed on Your ID card. Unless We pre-approve these services, Network and Non-Network Benefits will be reduced by 50% of Eligible Expenses.
28. Physician's Office Services	Covered Health Services received in a Physician's office including: • Treatment of a Sickness or Injury; • Preventive medical care; • Well-baby and well-child care including children's preventive health care services for children from birth through 18 years of age; • Routine physical examinations; • Vision and hearing screenings. (Vision screenings do not include refractive examinations to detect vision impairment. See *Eye Examination* earlier in this Section.) • Testing for lead poisoning; • Second opinion rendered by a specialist in that specific diagnosis area, including but not limited to when a patient with a newly diagnosed cancer is referred to such specialist by his or her attending physician. Coverage for this second opinion is subject to the same conditions as any other benefit when the specialist is not a Network Physician. [For Preventive Health/Wellness care in a Physician's office, see *Preventive Health/Wellness Services* below.]

Benefit	Description **See Schedule of Coverage and Benefits for Your cost-sharing Amount** [Note: Copayments [and Deductibles] do not count towards Your Out-of-Pocket (OOP) Maximum; only Coinsurances [and Deductibles] apply to Your OOP Maximum.]
29. PKU Formula and Medical Foods for Metabolic Disorders	Benefits are provided for PKU formula Medical Foods and Low Protein Modified Food Products if the following are met: • The Medical Food or Low Protein Modified Food Products are prescribed as medically necessary for the therapeutic treatment of phenylketonuria, galactosemia, organic acidemias, and disorders of amino acid metabolism; • The products are administered under the direction of a physician licensed; and • The cost of the Medical Food or Low Protein Modified Food Products for an individual or a family with a Dependent person or persons exceeds $2,400 per year per person. See Section 13, I. for limitations and exclusions related to this Benefit.
30. Preventive Health & Wellness Care	Preventive Health Screenings in accordance with the American Cancer Society guidelines and additional preventive Benefits provided by Mercy Health Plans. [Preventive Health Screenings listed in this section below are not subject to the Deductible. The Plan pays 100% for the Preventive Health Screenings only when you use Network providers.] Preventive Health Screenings include one (1) routine test of each of the following every [Calendar] [Plan] Year, unless otherwise indicated: • Cholesterol Tests • Colon Screening: – Fecal Occult Blood Test – Colonoscopy – one (1) routine screening every ten (10) years starting at age 50 – Double-contrast Barium Enema one (1) routine screening every five (5) years starting at age 50 – Flexible Sigmoidoscopy one (1) routine screening every five (5) years starting at age 50 • Mammography starting at age 35 and older • Pap Test • Pelvic Exam • Prostate Exam • PSA test starting at age 40 • [Preventive care in a Physician's office including: One (1) annual physical exam per [Calendar] [Plan] Year, periodic visits for well-baby and well-child care, hearing and vision screenings.] [Preventive Health Screenings are covered in-Network with no Deductible. Deductible and Coinsurances will apply to services received from a Non-Network Provider.] [Regardless of the place where these services are performed the applicable cost-sharing will apply.]
31. Professional Fees for Surgical and Medical Services	Professional fees for surgical procedures and other medical care provided in an outpatient facility. You may incur a separate Copayment/Coinsurance in addition to the outpatient facility charge. When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services* above.
32. Reconstructive Procedures	Services for reconstructive procedures, when a physical impairment exists and the primary purpose of the procedure is to improve or restore physiologic function. Reconstructive procedures include surgery or other procedures which are associated with an Injury, Sickness or Congenital Anomaly. The fact that physical appearance may change or improve as a result of a reconstructive procedure does not classify such surgery as a Cosmetic Procedure when a physical impairment exists, and the surgery restores or improves function. Cosmetic Procedures are excluded from coverage. Procedures that correct an anatomical Congenital Anomaly without improving or restoring physiologic function are considered

Benefit	Description **See Schedule of Coverage and Benefits for Your cost-sharing Amount** [Note: Copayments [and Deductibles] do not count towards Your Out-of-Pocket (OOP) Maximum; only Coinsurances [and Deductibles] apply to Your OOP Maximum.]
	Cosmetic Procedures. The fact that a Covered Person may suffer psychological consequences or socially avoidant behavior as a result of an Injury, Sickness or Congenital Anomaly does not classify surgery or other procedures done to relieve such consequences or behavior as a reconstructive procedure. See Section 13, K. for related limitations and exclusions. Please note that Benefits for reconstructive procedures include breast reconstruction following a mastectomy related to breast disease, and reconstruction of the non-affected breast to achieve symmetry. Reconstructive surgery for breast reconstruction and the receipt of related prosthetic devices may follow a mastectomy at any time. Other services required by the Women's Health and Cancer Rights Act of 1998, including breast prostheses and treatment of complications, are provided in the same manner and at the same level as those for any other Covered Health Service. You can contact Us at the telephone number on Your ID card for more information about Benefits for mastectomy-related services. **Prior Authorization Required** You must notify Us before receiving services. When You notify Us, We can verify that the service is a reconstructive procedure rather than a Cosmetic Procedure. Cosmetic Procedures are always excluded from coverage. Unless We pre-approve a Covered reconstructive Service, Network and Non-Network Benefits for reconstructive procedures will be reduced by 100% of Eligible Expenses.
33. Rehabilitation Services	***Outpatient Rehabilitation Therapy*** Short-term outpatient rehabilitation services for: • Physical Therapy • Occupational Therapy • Speech Therapy • Pulmonary Rehabilitation therapy • Cardiac Rehabilitation therapy Also includes covered Health Services received on an outpatient basis at a Hospital or Alternate Facility for treatment for loss or impairment of speech or hearing. "Short-term" means rehabilitation services that are expected to result in significant physical improvement in Your condition within two (2) months of the start of treatment. Rehabilitation services must be performed by a licensed therapy provider, under the direction of a Physician. Home rehabilitation services are limited to the Homebound patient and considered separately under the home health Benefit. Please note that We will pay Benefits for speech therapy only when the speech impediment or speech dysfunction results from Injury, stroke or a Congenital Anomaly. Exclusions are described in Section 13, P. Any combination of Network and Non-Network Benefits is limited according to Your Schedule of Coverage and Benefits. ***Inpatient Rehabilitation Services*** Medically Necessary services for an Inpatient Stay in an Inpatient Rehabilitation Facility. Benefits are available for: • Services and supplies received during the Inpatient Stay • Room and board in a Semi-Private Room Any combination of Network and Non-Network Benefits is limited according to Your Schedule of Coverage and Benefits. Please note that Benefits are available only for the care and treatment of an Injury or Sickness that would have otherwise required an Inpatient Stay in a Hospital.

Benefit	Description **See Schedule of Coverage and Benefits for Your cost-sharing Amount** [Note: Copayments [and Deductibles] do not count towards Your Out-of-Pocket (OOP) Maximum; only Coinsurances [and Deductibles] apply to Your OOP Maximum.]
	Prior Authorization Required We must pre-approve services for an elective or non-elective inpatient rehabilitation admission. Unless We pre-approve inpatient rehabilitation services, Network and Non-Network Benefits will be reduced by 50% of Eligible Expenses. For Emergency Admission, You must notify Us within two (2) business days or as soon as reasonably possible.
34. Skilled Nursing Facility(SNF)	Medically Necessary services for an Inpatient Stay in a Skilled Nursing Facility. Benefits are available for: • Services and supplies received during the Inpatient Stay • Room and board in a Semi-Private Room (a room with two or more beds) Any combination of Network and Non-Network Benefits is limited according to Your Schedule of Coverage and Benefits. Please note that Benefits are available only for the care and treatment of an Injury or Sickness that would have otherwise required an Inpatient Stay in a Hospital. **Prior Authorization Required** We must pre-approve services for an elective or non-elective SNF admission. Unless We pre-approve these services, Network and Non-Network Benefits will be reduced by 50% of Eligible Expenses. For emergency admission, You must notify Us within two (2) business days or as soon as reasonably possible.
35. Spinal Treatment	Benefits for Spinal Treatment when provided by a licensed Spinal Treatment provider in the provider's office. Benefits for Spinal Treatment are limited to one (1) visit and treatment per day. Any combination of Network and Non-Network Benefits for Spinal Treatment is limited according to Your Schedule of Coverage and Benefits.
36. Tobacco Cessation Education Program	Education Benefits are available for up to one (1) tobacco cessation group support program per year. Providers generally offer up to five (5) American Lung Association certified sessions per program. One Copayment/Coinsurance applies to each program. Tobacco cessation products are available only through a prescription drug Rider.
37. Transplant Services	Covered Health Services for the following organ and tissue transplants when ordered by a Physician. For Network Benefits, transplant services must be received at an approved facility in the designated transplant Network. Benefits are available for the transplants listed below when the transplant is Medically Necessary and is not an Experimental, Investigational or Unproven Service: • Bone marrow transplants (either from You or from a compatible donor) and peripheral stem cell transplants, with or without high dose Chemotherapy. Not all bone marrow transplants meet the definition of a Covered Health Service. Benefits include the treatment of breast cancer by dose-intensive Chemotherapy bone marrow transplants or stem cell transplants, when performed pursuant to nationally accepted peer review protocols. • Heart transplants • Heart/lung transplants • Lung transplants • Kidney transplants • Kidney/Pancreas transplants • Kidney/Liver • Liver transplants • Liver/small bowel transplants • Pancreas transplants • Small bowel transplants

Benefit	Description **See Schedule of Coverage and Benefits for Your cost-sharing Amount** [Note: Copayments [and Deductibles] do not count towards Your Out-of-Pocket (OOP) Maximum; only Coinsurances [and Deductibles] apply to Your OOP Maximum.]
	Benefits are also available for cornea transplants that are provided by a Physician at a Hospital. We do not require that cornea transplants be performed at a Designated Facility in order for You to receive Network or Non-Network Benefits. Corneal transplant does not require Prior Authorization. We have specific guidelines regarding Benefits for transplant services and there are related limitations in Section 13, Q. Contact Us at the telephone number on Your ID card for information about these guidelines. Note: You always have the option to receive Non-Network care; however, Non-Network transplant Benefits will be paid at the Usual and Customary global fee, which could result in much greater out-of-pocket costs. **Prior Authorization Required** You must notify Us as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). Unless We pre-approve these services (and before a pre-transplantation evaluation is performed at a transplant center), Network and Non-Network Benefits for transplant will be reduced by 100% of Eligible Expenses.
38. Urgent Care Center Services	Covered Health Services received at an Urgent Care Center. If radiology and other diagnostics services are provided and billed separately from the Urgent Care Center, additional Copayments/Coinsurances may apply. [When services to treat urgent health care needs are provided in a Physician's office, Benefits are available as described under *Physician's Office Services*above.] [When Urgent Care services are provided in a Physician's office, applicable Copayment/Coinsurance will be charged, regardless of the place where these services are performed.]
39. [Acupuncture Services]	[Acupuncture services for pain therapy when both of the following are true: • Another method of pain management has failed. • The service is performed by a provider in the provider's office. • Prior Authorization is required. Any combination of Network and Non-Network Benefits is limited to according to Your Schedule of Coverage and Benefits.]

Section 13: Exclusions – Things We Don't Cover

This section contains information about Medical services that are not covered. We call these Exclusions. It is important for You to know what services and supplies are not covered under this Policy.

We do not pay Benefits for exclusions or any related complications.

We will not pay Benefits for any of the services, treatments, items or supplies described in this section, even if any of the following is true:

- It is recommended or prescribed by a Physician.
- It is the only available treatment for Your condition.

The services, treatments, items or supplies listed in this section are not Covered Health Services, except as may be specifically provided for in Section 12 (Covered Benefits) or through a Rider to this Policy.

Category	Description
A. Alternative Treatments	We do not cover alternative treatments, including but not limited to: 1. Acupressure **[**and Acupuncture.**]** 2. Aromatherapy. 3. Hypnotism. 4. Massage Therapy. 5. Rolfing. 6. Herbal remedies. 7. Ayurvedic therapies. 8. Reflexology. 9. Biofeedback and neurofeedback therapy. 10. Other forms of alternative treatment as defined by the Office of Alternative Medicine of the National Institutes of Health.
B. Comfort or Convenience	1. Television. 2. Telephone. 3. Beauty/Barber service. 4. Guest service. 5. Automated travel devices (motor scooters). 6. Supplies, equipment and similar incidental services and supplies for personal comfort or convenience. Examples include: - Air conditioners - Batteries and battery chargers - Electrostatic machines - Portable room heaters, grab bars, etc. - Tanning booths, - Breast pumps unless newborn is in NICU - Raised or regular toilet seats - Air purifiers and filters - Dehumidifiers and Humidifiers - Lights/lighting - Vaporizers - Bath chairs - Exercise equipment - Whirlpools, saunas, and hot tubs 7. Devices and computers to assist in communication and speech. Augmentative communication devices, including but not limited to computer assisted speech devices, speech teaching machines, telephones, TDD equipment, Braille teaching texts, computers, and telephone alert systems. Exceptions include basic, Non-digital voice systems, such as the Electro-Larynx, after post-radical neck or other invasive surgery that interferes with laryngeal function. 8. Personal hygiene items and hygienic items, including but not limited to shower chairs, commodes (unless the individual is confined to room or bed), incontinence pads, bed baths, etc.

Category	Description
	9. Devices that are primarily non-medical in nature or used primarily for comfort, including but not limited to: - Bed boards - Elevators - Foam pads - Heating pads - Beds other than standard single hospital beds - Carafes - Emesis basins - Maternity belts - Bathtub seats - Standing tables - Overbed tables 10. Chair lifts, bathtub lifts, bed lifter, and other similar devices. 11. Exercise equipment including but not limited to parallel bars, weights, bicycles, rowing machines, and treadmills.
C. Dental	1. Dental care except as described in Section 12 (Covered Benefits) under the heading, "Dental Services Accident Only" and "Dental – Anesthesia and Facility Charges". 2. Preventive care, diagnosis, treatment of or related to the teeth, jawbones or gums, whether the services are considered to be medical or dental in nature. Examples include all of the following: – Extraction, restoration and replacement of teeth; – Medical or surgical treatments of dental conditions; – Services to improve dental clinical outcomes; – Services for overbite or underbite; – Services related to surgery for cutting through the lower or upper jaw bone; – Maxillary and mandibulary osteotomies 3. Dental implants and associated oral surgery and supplies, even if associated with Accidental Dental Services. This includes but is not limited to any enabling procedures for implants, as well as placement, maintenance, restoration, and removal of dental implants. Any prosthetic superstructure fabricated upon a dental implant is also excluded. 4. Dental braces and occlusal splints, even if associated with Accidental Dental Services. 5. Dental X-rays, supplies and appliances and all associated expenses, including hospitalizations and anesthesia. The only exceptions to this are for any of the following: – Transplant preparation; – Initiation of immunosuppressives; – The direct treatment of acute traumatic Injury; – The direct treatment of cancer (i.e., injury to teeth as a direct effect of cancer treatment); – Cleft palate; – Covered Persons with conditions outlined in Section 12(Covered Benefits) under Dental – Anesthesia and Facility Charges; 6. Treatment of congenitally missing, malpositioned, or super numerary teeth, even if part of a Congenital Anomaly. 7. Orthodontic services. 8. Services for the evaluation and treatment of temporomandibular joint syndrome (TMJ), whether the services are considered to be medical or dental in nature. 9. Upper and lower jawbone surgery except as required for direct treatment of acute traumatic injury or cancer. 10. Orthognathic surgery, jaw alignment and treatment for the temporomandibular joint syndrome, except as a treatment of obstructive sleep apnea.
D. Drugs	1. Prescription drug products for outpatient use (including self-injectables) that are filled by a prescription order or refill. 2. Non-injectable medications given in a Physician's office except as required in an Emergency. 3. Over the counter drugs and treatments.

Category	Description
	4. Charges for supplies for use beyond the first twenty-four (24) hours following discharge from the Hospital as an Inpatient or following the provision of Emergency Care, including any prescription drugs intended primarily for home use.
E. Experimental, Investigational or Unproven Services	1. Experimental, Investigational or Unproven Services are excluded. The fact that an Experimental, Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Benefits if the procedure is considered to be Experimental, Investigational or Unproven in the treatment of that particular condition.
F. Foot Care	1. Routine foot care (including the cutting or removal of corns and calluses). 2. Nail trimming, cutting, or debriding, unless the charges are for the removal of a nail or root in connection with the treatment of a metabolic or peripheral-vascular disease or infection. 3. Hygienic and preventive maintenance foot care. Examples include the following: – Cleaning and soaking the feet; – Applying skin creams in order to maintain skin tone; – Other services that are performed when there is not a localized illness, Injury or symptom involving the foot. 4. Treatment of flat feet, painful feet, fallen arches, metatarsalgia, plantar fasciitis, neuromas, tendonitis, bursitis, varus or valgus deformities, and other conditions of the feet unless otherwise noted in this document. 5. Treatment of subluxation of the foot. 6. Shoe orthotics, orthopedic shoes and other supportive appliances for feet, except as otherwise noted in this document.
G. Medical Supplies and Appliances	1. Devices used specifically as safety items or to affect performance in sports-related activities. 2. Prescribed or Non-prescribed medical supplies and disposable supplies. Examples include: – Elastic stockings – Ace bandages – Gauze and dressings – Disposable sheets and bags – Fabric supports – Surgical face masks – Incontinent pads, including diapers – Irrigating kits – Pressure leotards – Surgical leggings and support hose Exceptions include diabetic supplies covered under the medical benefit and ostomy supplies and supplies associated with equipment and home care services that have been provided in accordance with Plan policies and procedures. 3. Orthotic and prosthetic appliances for sports-related activities. 4. Tubings and masks are not covered except when used with Durable Medical Equipment as described in Section 12 (Covered Benefits). 5. Devices and equipment that are not normally appropriate outside of a hospital (or other provider) setting, including but not limited to: – Home monitoring devices and supplies, except Medically Necessary cardiac monitoring devices (such as holter monitors and event recorders) – Home prenatal monitoring and associated nursing support 6. The following are not covered under the medical benefit: – Insulin syringes with needles – Lancets and lancet devices – Glucometers, test strips and related supplies. 7. Lift Seats.

Category	Description
H. Mental Health/Substance Abuse	1. Services performed in connection with conditions not classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. 2. Services utilizing methadone treatment as maintenance, L.A.A.M (1-Alpha-Acetyl-Methadol), Cyclazocine, or their equivalents. 3. Psychosurgery. 4. Vagus nerve stimulation (VNS) for depression. 5. Treatment provided in connection with or to comply with involuntary commitments, police detentions and other similar arrangements unless medically necessary and authorized by the Mental Health/Substance Abuse Designee. Medically Necessary care may include any of the following: a. Not consistent with prevailing national standards of clinical practice for the treatment of such conditions including but not limited to Mental Health Services and Substance Abuse Services that extend beyond the period necessary for short term evaluation, diagnosis, treatment or crisis intervention. b. Not consistent with prevailing professional research demonstrating that the services or supplies will have a measurable and beneficial health outcome. c. Typically do not result in outcomes demonstrably better than other available treatment alternatives that are less intensive or more cost effective. d. Not consistent with the Mental Health/Substance Abuse Designee's level of care guidelines or best practices as modified from time to time. 6. Services or supplies for the diagnosis or treatment of Mental Illness, alcoholism or substance abuse disorders that, in the reasonable judgment of the Mental Health/Substance Abuse Designee, are any of the following: a. Not consistent with prevailing national standards of clinical practice for the treatment of such conditions including but not limited to Mental Health Services and Substance Abuse Services that extend beyond the period necessary for short term evaluation, diagnosis, treatment or crisis intervention. b. Not consistent with prevailing professional research demonstrating that the services or supplies will have a measurable and beneficial health outcome. c. Typically do not result in outcomes demonstrably better than other available treatment alternatives that are less intensive or more cost effective. d. Not consistent with the Mental Health/Substance Abuse Designee's level of care guidelines or best practices as modified from time to time. 7. Mental Health Services and Substance Abuse Services that extend beyond the period necessary for short-term evaluation, diagnosis, treatment or crisis. Intervention. 8. Mental Health Services as treatment for insomnia and other sleep disorders, neurological disorders and other disorders with a known physical basis. 9. Treatment or services, except for the initial diagnosis, for a primary diagnosis of Mental Retardation, Learning, Motor Skills, and Communication Disorders, Pervasive Developmental Disorder, Conduct Disorder, Dementia, Sexual, Paraphilia, and Gender Identity Disorders, and Personality Disorders, as well as other Mental Illnesses that will not substantially improve beyond the current level of functioning, or that are not subject to modification or management according to prevailing national standards of clinical practice, as reasonably determined by the Mental Health/Substance Abuse Designee. 10. Residential treatment services. The Mental Health/Substance Abuse Designee may consult with professional clinical consultants, peer review committees or other appropriate sources for recommendations and information regarding whether a service or supply meets any of these criteria.
I. Nutrition	1. Megavitamin and nutrition based therapy (for any purpose). 2. Vitamins (other than those prenatal vitamins prescribed for a Member who is then pregnant). 3. Nutritional counseling and other hospital-based educational programs for either individuals or groups, except for treatment of Diabetes or certain illnesses or

Category	Description
	conditions. 4. Medical foods and other nutritional and electrolyte supplements taken orallyor enterally regardless of the disease state, including infant formula and donor breast milk. This exclusion does not apply to the treatment of Phenylketonuria or any inherited disease of amino or organic acids, or nutritional supplements ordered by a Physician in connection with home care, which requires the Member to have a feeding tube as a sole source of nutrition.
J. Personal	1. Physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments that are otherwise covered under this Policy when: a. Required solely for purposes of career, education, sports or camp, travel, recreation, employment, insurance, marriage or adoption. b. Related to judicial or administrative proceedings or orders. c. Conducted for purposes of medical research. d. Required to obtain or maintain a license of any type. 2. Custodial Care. See Section 14 (Definitions of Terms). 3. Domiciliary care or any nursing care on full-time basis in Your home. 4. Private Duty Nursing. See Section 14 (Definitions of Terms). 5. Respite care. 6. Rest cures. 7. Medical and surgical treatment of excessive sweating (hyperhidrosis). 8. Medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea. 9. Oral appliances for snoring. 10. Care for an Injury or Illness resulting from participation in, or in consequence of having participated in an illegal occupation or the commission of an assault or felony. 11. Work place evaluations and work hardening treatment.
K. Physical Appearance	1. Cosmetic Procedures. See the definition in Section 14 (Definitions of Terms). Examples include: – Pharmacological regimens, nutritional procedures or treatments; – Scar, keloid or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures); – Skin abrasion procedures performed as a treatment for acne; – Liposuction; – Hair transplant for baldness; – Correction of asymmetric breasts or abnormal nipple-areolar complexes and protruding ears; – All other cosmetic services **except** if medically necessary to: i. Repair a functional disorder caused by a disease or an accidental injury suffered while insured by the Plan; ii. Restore or improve function for a structurally abnormal Congenital or developmental defect or anomaly in a Member under age nineteen (19). Anomaly is defined as a marked deviation beyond the range of normal human variation; or iii. Reconstructive breast surgery performed post-mastectomy; 2. Replacement of an existing breast implant if the earlier breast implant was performed as a Cosmetic Procedure. 3. Physical conditioning programs such as athletic training, bodybuilding, exercise, fitness, flexibility, and diversion or general motivation. 4. Weight loss programs whether or not they are under medical supervision. Weight loss programs for medical reasons are also excluded. 5. Wigs, regardless of the reason for the hair loss, except as otherwise provided by law. 6. Treatment of benign gynecomastia (abnormal breast enlargement in males). 7. Surgical and Non-surgical treatment of obesity, including morbid obesity. Treatment includes but is not limited to, stomach stapling, jaw wiring, gastric banding, gastric balloon or bypass surgery, dietary/nutritional supplements, behavioral/community support programs, exercise programs, and medical testing, medications, and office

Category	Description
	visits associated with any weight loss program. 8. Growth hormone except as determined medically necessary by the Plan to treat diagnostically proven growth hormone deficiency. Growth hormone(s) to treat idiopathic short stature (ISS) is expressly excluded. 9. Sex transformation operations. 10. Breast Reduction Surgery (Reduction Mammoplasty).
L. Preexisting Conditions	Benefits for the treatment of a Preexisting Condition are excluded until the date You have had Continuous Creditable Coverage for twelve (12) months except this waiting period will not apply to: a) A child who is placed in a Member's physical custody for purposes of adoption if the petition for adoption is filed within sixty (60) days of placement of such child; or b) A newborn if an application for coverage is filed within ninety (90) days of the birth of the child. c) A person who has had creditable coverage for eighteen (18) months without a break of sixty-three (63) days or more.
M. Providers	1. Services performed by a provider who is a family member by birth or marriage, including Spouse, brother, sister, parent or child. This includes any service the provider may perform on himself or herself. 2. Services performed by a provider with Your same legal residence. 3. Services provided at a freestanding or Hospital-based diagnostic facility without an order written by a Physician or other provider. Services that are self-directed to a free-standing or Hospital based diagnostic facility. Services ordered by a Physician or other provider who *is* an employee or representative of a free-standing or Hospital-based diagnostic facility, when that Physician or other provider: a. Has not been actively involved in Your medical care prior to ordering the service, or b. Is not actively involved in Your medical care after the service is received. This exclusion does not apply to mammography testing. 4. Charges Incurred for broken appointments with a Participating Physician.
N. Reproduction	1. Health services and associated expenses for Infertility treatments including, but not limited to, medical care or prescription drugs used to stimulate ovulation, or assisted reproductive technology (ART). ART includes any combination of chemical and/or mechanical means of obtaining a mature male or female reproductive cell and placing it into a medium (whether internal or external to the human body) to enhance the chance reproduction will occur. Examples of ART include, but are not limited to, artificial insemination, gametic intra fallopian transfer, zygote intra fallopian transfer, pronuclear state tubal transfer and surrogate Pregnancy. **ART does not include in-vitro fertilization.** 2. Surrogate parenting. 3. Voluntary sterilization or the reversal of voluntary sterilization. 4. Health services and associated expenses for elective abortion. Elective abortion means an abortion for any reason other than a spontaneous abortion or loss of the fetus as a result of the only treatment available to save the life of the mother. 5. Contraceptive supplies and services. 6. Fetal reduction surgery. 7. Health services associated with the use of non-surgical or drug induced Pregnancy termination. 8. Services (including pharmaceuticals) provided in connection with treatment or surgery to change gender or restore sexual function, unless otherwise covered in this Policy.
O. Services Provided under Another Plan	1. Health service for which other coverage is required by Federal, state or local law to be purchased or provided through other arrangements. 2. Health services for treatment of Injury, Sickness or Mental Illness arising out of or in the course of, any employment, whether or not covered by Workers' Compensation or

Category	Description
	similar law. If coverage under Workers' Compensation or similar legislation is optional for You because You could elect it, or could have it elected for You, Benefits will not be paid for any Injury, Sickness or Mental Illness that would have been covered under Workers' Compensation or similar legislation if that coverage had been elected. 3. Health services for treatment of military service-related disabilities, when You are legally entitled to other coverage and facilities are reasonably available to You. 4. Health services while on active military duty. 5. Injury or Illness incurred while incarcerated in any local, municipal, state or Federal facility.
P. Therapies/Psychological Testing	1. Speech, physical, occupational, and other rehabilitative services solely for speech/language delay or articulation disorders or other developmental delay, regardless of origin (unless otherwise covered under this policy, or by law). Speech therapy for central processing disorders, dyslexia, attention deficit disorder or other learning disabilities, stammering, stuttering, conceptual handicap, psychosocial speech delay, and voice therapy for vocational or avocational singers, and procedures that may be carried out effectively by the patient, family, or caregivers are not covered Benefits. Speech, physical, occupational, and other rehabilitative services are not covered except as required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke, or a Congenital Anomaly. 2. Cognitive therapy as a medical treatment (Non-mental health) unless provided for acute brain injury. 3. Psychological testing for services that are considered primarily educational or training in nature or related to improving academic or work performance, except when authorized in advance by the Mental Health/Substance Abuse designee. 4. Neuropsychological Testing to assist in planning educational, training, and vocational programs, for the purpose of disability determinations, and/or for forensic determinations including Neuropsychological Testing for any of the following diagnosis, except as otherwise provided by law: ▪ Attention-deficit/hyperactivity disorder (ADHD) ▪ Developmental disability, developmental delay ▪ Learning disability ▪ Mental retardation ▪ Tourette's syndrome ▪ Autism Spectrum Disorder 5. All Educational Services, including treatment of learning disorders and acquired cognitive deficits. 6. Water exercise and other exercises not under the supervision of a physical therapist. 7. Services or supplies that cannot reasonably be expected to lessen a Member's disability, and enable him/her to live outside an institution. 8. Therapy for conditions such as developmental delay, ADHD, and autism.
Q. Transplants	1. Health services for organ and tissue transplants, except those described in Section 12 (Covered Benefits). 2. Health services connected with the removal of an organ or tissue from You for purposes of a transplant to another person. (Donor costs for removal are payable for a transplant through the organ recipient's Benefits under this Policy). 3. Health services for transplants involving mechanical or animal organs. 4. Any multiple organ transplant not listed as a Covered Health Service under the heading *Transplantation Health Services* in Section 12 (Covered Benefits).
R. Travel	1. Health services provided in a foreign country, unless required as Emergency Services. 2. Travel or transportation expenses, even though prescribed by a Physician, except for medically necessary ambulance services. Some travel expenses related to covered transplantation services may be reimbursed at Our direction. 3. Air Ambulance Services outside the continental United States for any reason.

Category	Description
S. Vision and Hearing	1. Purchase cost of eye glasses, contact lenses (except for eyeglasses or contact lenses prescribed following cataract surgery, up to a maximum of a $300.00 dollar benefit per lifetime), or hearing aids. 2. Fitting charge for hearing aids, eye glasses or contact lenses. 3. Eye exercise therapy (orthoptics or pleoptic training). 4. Surgery that is intended to allow You to see better without glasses or other vision correction including radial keratotomy, laser, and other refractive eye surgery.
T. General/ Administrative	1. Health services and supplies that are not included in Section 12 (Covered Benefits), or that do not meet the definition of a Covered Health Service - see the definition in Section 14 (Definitions of Terms). 2. Health services received as a result of any catastrophic act or incident of war, whether declared or undeclared or caused during service in the armed forces of any country. 3. Health services received after the date Your coverage under this Policy ends, including health services for medical conditions arising before the date Your coverage under this Policy ends. This exclusion does not apply if You are eligible for and choose continuation coverage. For more information, see Section 10 (Continuation of Coverage) under Qualifying Events for Continuation Coverage under State Law. 4. Health services for which You have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under this Policy. 5. Charges in excess of the Usual and Customary Rate or in excess of any specified limitation. 6. Complications of Health Care Services that are not Covered Health Services. 7. Charges made for completion of forms and/or filing of claims in connection with the Benefits provided under this Plan. 8. Autopsies (post-mortem exams)

Section 14: Definitions of Terms

[Plan Year]

[Means the period of twelve (12) months commencing on the Effective Date of this Policy and each twelve (12) month period thereafter (or other periods as indicated in the Group Enrollment Policy), unless otherwise terminated as provided herein.]

Adverse Determination

A decision by Mercy Health Plans that an admission, availability of care or continued stay has been reviewed and, based upon the information provided, does not meet the Plan's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness (or is considered experimental or investigational) leading to a decision that coverage for the requested service is denied, reduced or terminated.

Allowable Expense

The necessary, reasonable and customary item of expense for health care when the item is covered at least in part under any of the plans involved in coordination of Benefits.

Alternate Facility

A health care facility that is not a Hospital or a facility that is attached to a Hospital and that is designated by the Hospital as an Alternate Facility. This facility provides one or more of the following services on an outpatient basis, as permitted by law:

- Pre-scheduled surgical services
- Emergency Room Services
- Pre-scheduled rehabilitative, laboratory or diagnostic services

Amendment

Any attached written description of additional or alternative provisions to this Policy. Amendments are effective only when signed by Us. Amendments are subject to all conditions, limitations and exclusions of this Policy, except for those that are specifically amended.

Anniversary Date

The annual anniversary of the Effective Date of this Policy.

Annual Deductible/Deductible

[If applicable, the amount You must pay for Covered Health Services in a [Calendar] [Plan] Year before We will begin paying for Benefits in that [Calendar] [Plan] Year.] [Deductible amounts are separate from and not reduced by Copayments. Deductible and Copayments are in addition to any Coinsurance You pay.] The Annual Deductible is included with any Coinsurance You pay to calculate Your total Out-of-Pocket Maximum.]

Benefits

Your right to payment for Covered Health Services that are available under this Policy. Your right to Benefits is subject to the terms, conditions, limitations and exclusions of this Policy, including this Certificate of Coverage and any attached Riders and Amendments.

Calendar Year

January 1 through December 31 of the same year.

Cardiac Rehabilitation

A comprehensive program to rehabilitate the heart.

Case Management

A coordinated set of activities conducted for individual patient management of serious, complicated, protracted or other health Conditions. Case Management may include:

1. Assessment of the Your individual benefit needs;
2. Formulation and modification of a comprehensive benefit plan of action;
3. Coordination of Benefits;
4. Evaluation of the effectiveness of the plan of action; and
5. Negotiation of extra-contractual services, if necessary.

Certificate of Coverage

This document including all riders, Amendments and Schedule of Coverage.

Chemical Dependency

The psychological or physiological dependence upon and abuse of drugs, including alcohol, characterized by drug tolerance or withdrawal and impairment of social or occupational role functioning or both.

Chemotherapy Treatment of disease by FDA-approved anti-neoplastic agents.

Chief Medical Officer(CMO) or Designee A licensed Physician under the employment of the Plan and/or such other licensed Physician or Health Professional as the Chief Medical Officer may designate, who shall be responsible for monitoring the quality of medical care rendered to Members.

Coinsurance Coinsurance is the percentage of Our allowance that You must pay for Your care. You may also be responsible for other costs for Your care such as a Deductible. See Section 5 (Your Cost for Covered Services).

Complaint Any communication primarily expressing a Grievance to the Plan by, or on behalf of the Member, or by the health care Provider. For purposes of this definition, communication is a written notice relating to the Plan's determinations, procedures, and administration and written or oral notice filed under the expedited Health Care Services appeal process or under the Utilization Review process.

Complications of Pregnancy Any complications associated with Pregnancy, i.e., conditions requiring hospital confinement (when pregnancy is not terminated), whose diagnoses are distinct from pregnancy but are affected by pregnancy, including but not limited to acute nephritis, nephrosis, cardiac decompensation, missed abortion, and similar medical and surgical conditions of comparable severity, but shall not included false labor, occasional spotting, physician prescribed rest period during the period of pregnancy, morning sickness, hyperemesis gravidarum, pre-eclampsia and similar conditions associated with the management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy; and non-elective cesarean section, termination of ectopic pregnancy, and spontaneous termination of pregnancy occurring during a period of gestation in which a viable birth is not possible.

Congenital Existing or dating from birth; acquired through development while in the uterus.

Congenital Anomaly A physical developmental defect that is present at birth, and is identified within the first twelve months of birth.

Continuous Creditable Coverage Health care coverage under any of the types of plans listed below, during which there was a break in coverage of no more than sixty-three (63) consecutive days, and provided there were eighteen (18) continuous months of eligible coverage:

- A Group health plan;
- Health insurance coverage;
- Medicare;
- Medicaid;
- Medical and dental care for Members and certain former Members of the uniformed services, and for their dependents;
- A medical care program of the Indian Health Services Program or a tribal organization;
- A state health benefit's risk pool;
- The Federal Employees Health Benefits Program;
- Any public health benefit program provided by a state, county, or other public subdivision of a state;
- A health benefit plan under the Peace Corps Act.

A waiting period for health care coverage will be included in the period of time counted as Continuous Creditable Coverage.

Copayment A Copayment is a fixed amount of money You pay when You receive Covered Services. See Section 5 (Your Cost for Covered Services).

Cosmetic Procedures Procedures or services that change or improve appearance without significantly improving physiological function, as determined by Us.

Covered Health Service(s)/Covered Service

A Covered Health Service is a Health Care Service or supply described in Section 12 (Covered Benefits) as a Covered Health Service. A Covered Health Service is a Health Care Service or supply which is not excluded under Section 13 (Exclusions) and meets the following conditions:

1) Prescribed by a Physician for the therapeutic treatment of Injury, Illness or Pregnancy;
2) Deemed Medically Necessary and appropriate in type, level, setting, and length of service; and if required by the Plan, is authorized on a prospective and timely basis by the Plan.
3) Rendered in accordance with generally accepted medical practice and professionally recognized standards;
4) Provided on or after the Effective Date and before Your coverage terminates in accordance with Section 3 (When Coverage Ends) and at a time when You met all applicable requirements for eligibility set forth in Section 2 (When Coverage Begins).
5) Not considered to be Experimental, Investigational, or which are performed for research purposes;
6) Services that are specifically included and not excluded or limited, or not specifically excluded by the Plan.

Covered Person

Either the Subscriber or an Enrolled Dependent, but this term applies only while the person is enrolled under this Policy. References to "You" and "Your" throughout this Certificate are references to a Covered Person.

Custodial Care

Services that:

- Are Non-health related services, such as assistance in activities *of* daily living (including but not limited to feeding, dressing, bathing, transferring and ambulating); *or*
- Are health-related services which do not seek to cure, or which are provided during periods when the medical condition of the patient who requires the service is not changing; or
- Do not require continued administration by trained medical personnel in order to be delivered safely and effectively.

Dependent

The Subscriber's legal Spouse or an unmarried Dependent child of the Subscriber. The term child includes any of the following:

- A natural child.
- A stepchild.
- A legally adopted child.
- A child placed for adoption.
- A child for whom permanent legal guardianship has been awarded to the Subscriber or the Subscriber's Spouse.

To be eligible for coverage under this Policy, a Dependent must reside within the United States. The definition of Dependent is subject to the conditions and limitations as set forth in the Schedule of Coverage and Benefits.

A Dependent also includes a child for whom health care coverage is required through a 'Qualified Medical Child Support Order' or other court or administrative order. The Enrolling Group is responsible for determining if an order meets the criteria of a Qualified Medical Child Support Order.

A Dependent does not include anyone who is enrolled as a Subscriber. No one can be a Dependent of more than one Subscriber.

Designated Facility

A Hospital that We name as a Designated Facility. A Designated Facility has entered into an agreement with Us, or with an organization contracting on Our behalf, to render Covered Health Services for the treatment of specified diseases or conditions. A Designated Facility may or may not be located within Our geographic area.

Durable Medical Equipment

Medical equipment that is all of the following:

- Can withstand repeated use;
- Is not disposable;
- Is used to serve a medical purpose with respect to treatment of a Sickness, Injury or their symptoms;
- Is generally not useful to a person in the absence of a Sickness, Injury or their symptoms;
- Is appropriate for use in the home.

Educational Service

A service provided as a means of training Members through formal instruction and supervised practice. Educational Services include those services designed to assist Members who do not currently meet maturation expectations in making progress towards those goals.

Effective Date

The Effective Date of coverage for the Group as specified in the Group Insurance Policy, or the separate Effective Date specified under any Rider, or for any particular individual as determined in accordance with Section 2 of this Policy.

Eligible Expenses

The amount We will pay for Covered Health Services, incurred while this Policy is in effect, are determined as stated below:

Eligible Expenses are determined solely in accordance with Our reimbursement policy guidelines. We develop Our reimbursement policy guidelines, in Our discretion, following evaluation and validation of all provider billings in accordance with one or more of the following methodologies:

- As indicated in the most recent edition of the Current Procedural Terminology (CPT), a publication of the American Medical Association;
- As reported by generally recognized professionals or publications;
- As used for Medicare;
- As determined by medical staff and outside medical consultants pursuant to other appropriate source or determination that We accept.

Eligible Person

An employee of the Enrolling Group or other person whose connection with the Enrolling Group meets the eligibility requirements specified in both the application and this Certificate of Coverage. An Eligible Person must reside within the United States.

Emergency

The sudden and, at the time, unexpected onset of a health condition that manifests itself by symptoms of sufficient severity that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that immediate medical care is required, which may include, but will not be limited to any of the following:

- Placing the person's health in significant jeopardy;
- Serious impairment to a bodily function;
- Serious dysfunction of any bodily organ or part;
- Inadequately controlled pain;
- With respect to a pregnant woman who is having contractions, either of the following:
  - Inadequate time to affect a safe transfer of a pregnant woman to another hospital before delivery;
  - The transfer to another hospital may pose a threat to the health or safety of the woman or unborn child.

Emergency Care/Emergency Room Services

Health Care Services and supplies necessary for the treatment of an Emergency.

Enrolled Dependent

A Dependent who is properly enrolled under this Policy.

Enrolling Group

The employer, or other defined or otherwise legally established Group, to whom this Policy is issued.

Experimental or Investigational Services

Medical, surgical, diagnostic, psychiatric, substance abuse or other Health Care Services, technologies, supplies, treatments, procedures, drug therapies or devices that, at the time We make a determination regarding coverage in a particular case, are determined to be any of the following:

- Not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service or the United States Pharmacopoeia Dispensing Information as appropriate for the proposed use.
- Subject to review and approval by any institutional review board for the proposed use.
- The subject of an ongoing clinical trial that meets the definition of a Phase 1 clinical trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight.

External Independent Reviewer

A clinical peer with no direct financial interest in connection with the Grievance/appeal in question and who has not been informed of the specific identity of the Enrollee.

External Review

A process, independent of all affected parties, to determine if a health care service is medically necessary or experimental/investigational.

Full-Time Student

An unmarried Dependent child who meets all the following conditions:

- The child must not be regularly employed on a full-time basis.
- The child must be primarily dependent upon the Subscriber for support and maintenance.
- The child must be attending, fulltime, a recognized course of study or training at one of the following:
  - An accredited high school;
  - An accredited college or university;
  - A licensed vocational school, technical school, beautician school, automotive school or similar training school.

Full-time Student status is determined in accordance with the standards set forth by the educational institution. You are no longer a Full-time Student on the date You graduate or otherwise cease to be enrolled and in attendance at the institution on a full-time basis.

You continue to be a Full-time Student during periods of regular vacation established by the institution. If You do not continue as a Full-time Student immediately following the period of vacation, the Full-time Student designation will end as described above.

Grievance

A written Complaint submitted by or on behalf of a Member regarding the a) availability, delivery or quality of Health Care Services, including a Complaint regarding an Adverse Determination made pursuant to Utilization Review; b) claims payment, handling or reimbursement for Health Care Services; or c) matters pertaining to the contractual relationship between a Member and the Company.

Group Policyholder/Group

The employer, labor union, trust, association, partnership, government agency, or other organization to which this Policy is issued and through which as agent for Subscriber only, and not for the Plan, a Subscriber and his/her Dependents become entitled to the coverage described in this Policy.

Health Care Service(s)

Those health services provided for cosmetic or other Non-medical purposes, or for the purpose of preventing, diagnosing or treating a Sickness, Injury, Mental Illness, substance abuse, or their symptoms, but do not include prescription drug benefits.

[Health Reimbursement Arrangement (HRA)]

[Tax-free health plan deposits provided by Your employer that allows You to accumulate savings for tax-free withdrawals for Qualified Medical Expenses. HRA reimbursements for medical expenses are not included in Your income. Unused funds are owned by Your

employer and are not portable when You terminate Your employment.]

[Health Savings Account (HSA)] [An HSA is a special, tax-advantaged account where money goes in tax-free, earns interest tax-free and is not taxed when it is withdrawn to pay for Qualified Medical Expenses under a High Deductible Health Plan. Either the employee or the employer can make contributions to the HSA. Unused funds are owned by the employee, can be rolled over annually, and are portable when You terminate Your employment, change health plan options, or change health plan carriers.]

[High Deductible Health Plan (HDHP)] [An HDHP is a plan with a Deductibles that meet the requirements established by the Internal Revenue Code making this plan eligible to coordinate with either an HSA or an HRA.]

Homebound Homebound means an individual who is confined to the home as a result of their physical or mental condition and that leaving home is a major effort and normally requires assistance. Leaving home is done to receive medical care or for short, infrequent non-medical reasons such as a trip to the grocery store, beauty parlor or barbershop, or to attend religious services.

Home Health Agency A program or organization authorized by law to provide Health Care Services in the home.

Hospital A legally constituted institution, having organized facilities for the care and treatment of sick and injured persons on a resident or inpatient basis, including facilities for diagnosis and surgery under supervision of a staff of one or more licensed physicians and which provides 24-hour nursing services by registered nurses on duty or call. It does not mean convalescent, nursing, rest or extended care facilities or facilities operated exclusively for treatment of the aged, drug addict or alcoholic, even though such facilities are operated as a separate institution by a hospital.

Implant(s) That which is implanted such as a piece of tissue, a pellet of medicine, or a tube or needle containing radioactive substance, a graft or an insert. Also included are liquid and solid materials used to augment tissues or to fill in areas traumatically or surgically removed. An object or material partially or totally inserted or grafted in to the body for prosthetic, therapeutic, or diagnostic purpose. Examples of surgical implants include stents, artificial joints, shunts, grafts, pins, plates, screws, anchors and radioactive seeds.

Infertility The inability to conceive after one year of unprotected sexual intercourse or the inability to sustain a successful Pregnancy. (Sexual intercourse means the sexual union between a male and female). Infertility does not include individuals unable to conceive post-sterilization.

Initial Enrollment Period The initial period of time, as We agree with the Enrolling Group, during which Eligible Persons may enroll themselves and their Dependents under this Policy.

Injury Bodily damage other than Sickness, including all related conditions and recurrent symptoms.

Inpatient Rehabilitation Facility A Hospital (or a special unit of a Hospital that is designated as an Inpatient Rehabilitation Facility) that provides rehabilitation health services (physical therapy, occupational therapy and/or speech therapy) on an inpatient basis, as authorized by law.

Inpatient Mental Health An acute care facility for psychiatric treatment where a psychiatric physician supervises care. The patient receives care twenty-four (24) hour per day and may be on a locked unit and/or on psychiatric precautions (e.g., suicide, homicide, close observation precautions).

Inpatient Stay An uninterrupted confinement, following formal admission to a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility.

Intensive Outpatient Program Active therapeutic programming 3 ½ hours or less per session. Therapy sessions are usually two to three times per week and are a combination of individual and group work.

Instrumental Activities of Daily Living (IADL)

Activities related to independent living including preparing meals, managing money, shopping for groceries or personal items, performing light or heavy housework, and using the telephone.

Low Protein Modified Food Products

Food products specifically formulated to have less than one gram of protein per serving and intended for the dietary treatment of an inherited metabolic disease under the direction of a Physician.

Maximum Policy Benefit

The maximum amount that We will pay for Benefits during the entire period of time that You are enrolled under this Policy issued to the Enrolling Group. The Maximum Policy Benefit includes any amount that We have paid for Benefits under a former policy issued to the Enrolling Group that is replaced by the current Policy, as well as any amount that We may pay under a later Policy that replaces the Enrolling Group's current Policy. When the Maximum Policy Benefit applies, it is described in Section 5 (Your Cost for Covered Services).

Medical Emergency/Medical Emergency Condition

The sudden and, at the time, unexpected, onset of a health condition that manifests itself by symptoms of sufficient severity that would lead a prudent layperson, possessing an average knowledge of health and medicine, to believe that immediate medical care is required, which may include, but is not limited to:

a. Placing the Member's health in significant jeopardy;
b. Serious impairment to a bodily function;
c. Serious dysfunction of any bodily organ or part;
d. Inadequately controlled pain; or
e. With respect to a pregnant woman who is having contractions, when
    i. There is inadequate time to effect a safe transfer to another Hospital before delivery; or
    ii. Transfer to another Hospital may pose a threat to the health or safety of the woman or unborn child.

Medical Foods

Products that are intended to meet the distinctive nutritional requirements of a person with a particular disease or condition for which nutritional requirements are established by recognized scientific principles and formulated to be consumed or administered enterally under the direction of a physician.

Medically Necessary

Health Care Services that are ordered by a health provider, without which there would be significant risk of a serious deterioration and/or a significant impairment that, if not treated, could seriously affect one's ability to function within his or her normal environment. Although some Health Care Services are medically acceptable, they may not be medically necessary. Health Care Services need to be (1) medically appropriate and necessary to meet the basic health needs of the Member; (2) rendered in the most cost-efficient manner and type of setting appropriate for the delivery of the Covered Service; (3) consistent in type, frequency and duration of treatment with scientifically-based guidelines of national medical, research, or health care coverage organizations or governmental agencies that are accepted by the Plan; (4) consistent with the diagnosis of the conditions; and (5) of demonstrated medical value. Medically Necessary does not include care that is provided primarily for the convenience of the Member or a health provider, or care that is rendered more frequently than that accepted as medically appropriate by the medical profession.

Medicare

Parts A, B, C and D of the insurance program established by Title XVIII, United States Social Security Act, as amended by 42 U.S.C. Sections 1394, et seq. and as later amended.

Member

A Member means any Subscriber or Dependent.

Mental Health Services

Covered Health Services for the diagnosis and treatment of Mental Illnesses. The fact that a condition is listed in the current Diagnostic and Statistical Manual of the American Psychiatric Association does not mean that treatment for the condition is a Covered Health Service.

Mental Health/Substance Abuse Designee Refers to St. John's Mercy Managed Behavioral Health or other applicable designated agent that provides and manages Mental Health Services for the Plan.

Mental Illness Those Conditions classified as mental disorders in the American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders, except mental retardation.

Network Benefits Benefits for Covered Health Services that are provided by (or directed by) a Network Physician or other Network Provider in the provider's office or at a Network or Non-Network facility.

Network/Network Provider When used to describe a provider of Health Care Services, this means a provider that has a participation agreement in effect with Us or with Our affiliate (directly or through one or more other organizations) to provide Covered Health Services to Covered Persons.

A provider may enter into an agreement to provide only certain Covered Health Services, but not all Covered Health Services, or to be a Network Provider for only some of Our products. In this case, the provider will be a Network Provider for the Health Services and products included in the participation agreement, and a Non-Network Provider for other Health Services and products. The participation status of providers will change from time to time.

Neuropsychological Testing Neuropsychological testing is a quantitative, comprehensive evaluation of cognitive, motor and behavioral functional abilities related to developmental, degenerative and acquired brain disorders

Non-Network Benefits Benefits for Covered Health Services that are provided by a Non-Network Physician or other Non-Network Provider.

Non-Network Provider A Provider who is not contracted with Mercy Health Plans.

Observation Care Care in the Hospital to monitor evaluate or stabilize a patient in order to determine the need for further treatment or an inpatient admission. Such Care is not considered Inpatient Care, even though the patient may be confined to a Hospital bed.

Occupational Therapy Treatment of a physically or mentally disabled person through constructive activities designed to restore the ability to accomplish satisfactorily the ordinary activities of daily living. Activities of daily living include feeding, dressing, bathing and other types of self-care.

Open Enrollment Period A period of time that follows the Initial Enrollment Period during which Eligible Persons may enroll themselves and Dependents under this Policy. The Enrolling Group and Us will agree upon the period of time that is the Open Enrollment Period.

Out-of-Pocket Maximum If applicable, the maximum amount of [Deductible and] Coinsurance You pay every [Calendar] [Plan] Year [for Eligible Expenses]. If You use both Network Benefits and Non-Network Benefits, two separate Out-of-Pocket Maximums apply. Once You reach the Out-of-Pocket Maximum for Network Benefits, those Benefits are payable at 100% of Eligible Expenses during the rest of that [Calendar] [Plan] Year. Once You reach the Out-of-Pocket Maximum for Non-Network Benefits, those Benefits are payable at 100% of Eligible Expenses during the rest of that [Calendar] [Plan] Year. See Section 5 (You Cost for Covered Services).

Outpatient Mental Health Visits Psychotherapy and other mental health services provided in an individual practitioner office. Psychotherapy may be provided by a medical doctor (MD), clinical psychologist (Ph.D.), or Master's level licensed therapist.

Palliative Care Care provided to patients with progressive and advanced disease with little or no prospect of cure. A comprehensive approach to treating life-threatening illness that focuses on the physical, psychological, spiritual and existential needs of the patient. It is applicable early in the course of illness, in conjunction with other therapies that are intended to prolong life, such as Chemotherapy or radiation therapy, and includes investigations needed to evaluate

and treat clinical complications. Palliative care is meant to maintain the quality of life of patients and their families coping with the problems associated with life-threatening illness.

Partial Hospital Treatment Program Active therapeutic mental health programming and care given to a patient for 3 ½ hours or more per day in a facility setting. Mental health professionals have assessed that the patient can maintain safety outside of the hospital environment during Non-program hours. During this program, the patient may or may not see psychiatrist daily depending on condition.

Physical Therapy Treatment by physical means including hydrotherapy, heat, physical agents, and biomechanical and neurophysiological principles and devices that relieve pain or restore maximum bodily function. Physical Therapy does not include Cardiac Rehabilitation, Pulmonary Rehabilitation or Manipulation/Adjustment.

Physician Any Doctor of Medicine, "M.D.", or Doctor of Osteopathy, "D.O.", who is properly licensed and qualified by law.

Please Note: Any podiatrist, dentist, psychologist, chiropractor, optometrist, or other provider who acts within the scope of his or her license will be considered on the same basis as a Physician. The fact that We describe a provider as a Physician does not mean that Benefits for services from that provider are available to You under this Policy.

Plan (the Plan) The Plan refers to Mercy Health Plans.

Policy The entire agreement issued to the Enrolling Group, that includes all of the following:

- The Group Policy;
- This Certificate of Coverage;
- The Enrolling Group's application;
- Amendments;
- Riders.

These documents make up the entire agreement that is issued to the Enrolling Group.

Policy Charge The sum of the Premiums for all Subscribers and Enrolled Dependents enrolled under this Policy.

Preexisting Condition An Injury or Sickness that was diagnosed or treated, or for which prescription medications or drugs were prescribed or taken within the six (6) month period ending on the person's enrollment date. (The enrollment date is the date the person became covered under this Policy or, if earlier, the first day of any waiting period under this Policy.) A Preexisting Condition does not include Pregnancy. Genetic information is not an indicator of a Preexisting Condition, if there is not a diagnosis of a condition related to the genetic information. Preexisting Conditions do not apply for Covered Persons with Continuous Creditable Coverage.

Pregnancy Includes all of the following:

- Prenatal care
- Postnatal care
- Childbirth
-

Premium The periodic fee required for each Subscriber and each Enrolled Dependent, in accordance with the terms of this Policy.

Preventive Health Screening(s) Routine tests performed on a healthy individual who has no signs or symptoms of disease, or history of the disease being screened. Preventive Health Screenings are for the purpose of detecting abnormalities or malfunctions of bodily systems and parts according to accepted medical practice. Tests performed on a symptomatic patient or a patient previously diagnosed with the disease being screened are classified as diagnostic tests.

[Preventive Drug List] [A list of drugs or medications that are considered preventive care because they are used solely by a person who has developed risk factors for a disease that has not yet manifested itself or not yet become clinically apparent (i.e., asymptomatic), or used solely to prevent the reoccurrence of a disease from which a person has recovered.]

Prior Authorization Precertification review by the Plan, before services and treatment are rendered, to determine if the service meets the criteria as a Covered Health Service.

Private Duty Nursing Private Duty Nursing is defined as one-on-one care provided on an individual basis either in an institution or in a patient's home. Private duty skilled nursing care can be considered custodial after Non-professional personnel repetitively performs the care, making continuous attention by a health professional no longer necessary, and is therefore not a covered benefit.

Pulmonary Rehabilitation A comprehensive program to manage patients with substantial chronic lung disease. Includes diagnostic testing, monitored dynamic exercise and education under the direct supervision of a qualified Physician.

[Qualified Medical Expenses] [Those eligible expenses paid for care that qualifies for a tax-free withdrawal from your HSA as described in Section 213 and 223 of the Internal Revenue Code. For guidelines on Qualified Medical Expenses under Internal Revenue Code (IRC) Section 213, see IRS Publication 502. However, some items listed in this publication are not reimbursable under the HSA (e.g. premiums, except for certain premiums at age 65 or older). For HSA specific requirements under IRC Section 223, see IRS Publication 969.

As an HSA owner, You are responsible to keep records (for example, receipts) so that You can prove to the IRS that the withdrawals are for Qualified Medical Expenses that were not otherwise reimbursed.]

Rider Any attached written description of additional Covered Health Services not described in this Certificate. Covered Health Services provided by a Rider may be subject to payment of additional Premiums. Riders are effective only when signed by Us and are subject to all conditions, limitations and exclusions of this Policy except for those that are specifically amended in the Rider.

Semi-Private Room A room with two or more beds. When an Inpatient Stay in a Semi-Private Room is a Covered Health Service, the difference in cost between a Semi-Private Room and a private room is a Benefit only when a private room is necessary in terms of generally accepted medical practice, or when a Semi-Private Room is not available.

Sickness Physical illness, disease or Pregnancy. The term Sickness as used in this Certificate does not include Mental Illness or substance abuse, regardless of the cause or origin of the Mental Illness or substance abuse.

Skilled Nursing Facility A Hospital or nursing facility that is licensed and operated as required by law. A Skilled Nursing Facility is not, other than incidentally, a place that provides minimal Care, Custodial Care, ambulatory Care, part-time Care, or Care for Mental Illness and Substance Abuse, pulmonary tuberculosis or venereal disease.

Special Enrollment Period Any additional period of enrollment required by state and Federal law, in addition to the Open Enrollment Period.

Speech Therapy Treatment for loss or impairment of speech or hearing, including communicative disorders resulting from genetic defects, birth defects, injury, illness, disease, developmental disabilities or delays or other causes, whether of organic or non-organic etiology and whether or not the person suffering from that loss or impairment had the capacity for speech, language or hearing before the loss or impairment occurred.

Spinal Treatment — The detection or correction by manual or mechanical means of subluxation(s) in the body to remove nerve interference or its effects. The interference must be the result of, or related to, distortion, misalignment or subluxation of, or in, the vertebral column.

Spouse — One who is legally married to an Eligible Employee in a ceremony legally solemnized by a third party duly authorized by law to perform marriages.

Standard Basic Equipment — Equipment that is the usual or most common and simplest form that possesses the most fundamental level of function required to meet the needs of the member in performing Instrumental Activities of Daily Living.

Subscriber — An Eligible Person who is properly enrolled under this Policy. The Subscriber is the person (who is not a Dependent) on whose behalf this Policy is issued to the Enrolling Group.

Substance Abuse Services — Covered Health Services for the diagnosis and treatment of alcoholism and substance abuse disorders that are listed in the current Diagnostic and Statistical Manual of the America Psychiatric Association, unless those services are specifically excluded. The fact that a disorder in listed in the Diagnostic and Statistic Manual of the American Psychiatric Association does not mean that treatment of the disorder is a Covered Health Service.

Termination Date — Means:

a. For the Member, the last date on which the Member is eligible for coverage; or

b. For the Group, the last date on which this Policy is in force.

Unemancipated — A Dependent that is unmarried, relies on the Member for his/her major support, and is not eligible for Group health Benefits on his/her behalf. Dependent children must live with a parent, adult family Member, or someone appointed by an agency with legal jurisdiction, unless the Dependent is a student in an accredited school or institution of higher learning.

Unproven Services — Services that are not consistent with conclusions of prevailing medical research which demonstrate that the health service has a beneficial effect on health outcomes and that are not based on trials that meet either of the following designs:

- Well-conducted randomized controlled trials. (Two or more treatments are compared to each other, and the patient is not allowed to choose which treatment is received).
- Well-conducted cohort studies. (Patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group).

Decisions about whether to cover new technologies, procedures and treatments will be consistent with conclusions of prevailing medical research, based on well-conducted randomized trials or cohort studies, as described.

Urgent Care Center — A facility, other than a Hospital, that provides Covered Health Services that are required to prevent serious deterioration of Your health, within twenty-four (24) hours of the onset of an unforeseen Sickness, Injury, or the onset of acute or severe symptoms

Us/We/Our — Us/We/Our refers to Mercy Health Plans.

Usual and Customary Rate — Charges for Covered Services that do not exceed the fees and prices generally approved for cases of comparable nature and severity at the time and place when such Covered Services are rendered or received. In determining the Usual and Customary Rate (UCR), one or more of the following guidelines shall be taken into consideration:

a) The rate allowed by Medicare for the particular service or supply;
b) The prevailing rate of fees charged for identical or similar services in the same geographical area by health professionals of similar training and experience;
c) Unusual circumstances or complications that require additional time, skill and

experience in connection with the provided service or supply;

d) The actual charge by the provider (if less than Our UCR charge);
e) The frequency of the determination of the usual and customary fee;
f) A general description of the methodology used to determine usual and customary fees;
g) The percentile that determines the maximum benefit the Plan will pay for any Accidental Injury dental procedure, if the usual and customary fee is determined by taking a sample of fees submitted on actual claims from licensed dentists and then making the benefit by selecting a percentile of those fees.

Utilization Review A set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency, of Health Care Services, procedures or settings. Utilization Review may include Ambulatory Review, Prospective Review, second opinion, Certification, Concurrent Review, Case Management, discharge planning or Retrospective Review, but will not include elective requests for clarification of Coverage.

You/Your You/Your refers to the Subscriber and each Enrolled Dependent.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Mercy Health Plans by and on behalf of its wholly-owned subsidiaries, including Mercy Health Plans of Missouri, Inc., Mercy Health Plans, and Premier Benefits, Inc. (Collectively referred to as "the Plan"), respects the privacy of its Members and former Members and protects the security and confidentiality of their nonpublic personal information. We have instituted internal policies to: insure the security and confidentiality of Your personal and financial healthcare information; protect against any anticipated threats or hazards to the security or integrity of such records; and protect against unauthorized access to or use of information which could result in substantial harm or inconvenience to You. We are required by law to provide You with this Notice of Our legal duties and privacy practices. This Notice explains Your rights, Our legal duties, and Our privacy practices. To fulfill Our responsibilities to You, the Plan may use and disclose Your protected health information for treatment, payment, and healthcare operations, or when We are otherwise required or permitted to do so by law. Below is further detail explaining these situations.

Treatment. We may use and disclose protected health information with Your healthcare providers (physicians, pharmacies, hospitals and others) to assist in the diagnosis and treatment of Your injury or illness. For example, We may disclose Your protected health information to suggest treatment alternatives.

Payment. We may use and disclose protected health information to pay for Your covered health expenses. For example, We may use protected health information to process claims. We may also ask a healthcare provider for details about Your treatment so that We may pay the claim for Your care.

Healthcare Operations. We may use and disclose protected health information for Our healthcare operations. For example, We may use or disclose protected health information to perform quality assessment activities or provide You with Case Management services.

Business Associates. We may at times need to use the services of other companies in lieu of Our own staff, such as outsourcing data entry services, or, as part of Our routine business, We may require that outside entities, such as auditors perform operations that require access to Our healthcare information. In order for Us to share confidential information with these organizations, We must enter into agreements that require them to comply with the privacy regulations of the Plan.

Plan Sponsor. If You participate in a self-funded group health plan through Your employer (plan sponsor), We may share limited health information with Your employer as necessary to perform administrative functions. Plan sponsors that receive this information are required by law to have safeguards in place to protect against inappropriate use or disclosure of Your information.

You or Your Personal Representative. We must disclose Your health information to You as described in the Patient Rights section below. If You have a legally assigned personal representative or are an Unemancipated minor, We will release the information to Your personal representative or parent(s) as required by law.

Family/Friends. We may disclose Your health information to a family member or friend to the extent necessary to help with Your healthcare or with payment for Your healthcare if You agree that We may do so. If You wish to designate a person(s) to whom We may discuss Your healthcare, You may submit a request to the address listed below. If You are physically or mentally unable to participate in decisions regarding Your healthcare, We may need to communicate with a family member; however, only to the extent necessary to insure that You receive appropriate healthcare treatment.

Permitted or Required by Law. We must disclose protected health information about You when required to do so by law. Information about You may be used or disclosed to regulatory agencies, such as Medicare and Medicaid; for administrative or judicial hearings; public health authorities; or law enforcement officials, such as to comply with a court order or subpoena.

Member Authorization

Other uses or disclosures of Your protected health information will be made only with Your written authorization, unless otherwise permitted or required by law. You may revoke an authorization at any time in writing, except to the extent that We have already taken action on the information disclosed or if We are permitted by law to use the information to contest a claim or coverage under the Plan.

RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION

You have the following rights regarding protected health information that the Plan maintains about You. If You wish to exercise any of these rights, You may submit Your request in writing.

Right to Access Your Protected Health Information. You have the right to inspect and/or obtain a copy of individual protected health information that We maintain about You. We may charge a fee for the costs of producing, copying and mailing Your requested information, but We will tell You the cost in advance.

Right to Amend Your Protected Health Information. You have the right to request an amendment of individual protected health information that We maintain about You. All requests must be in writing and must include the reason for the change.

Right to an Accounting of Disclosures by the Plan. You have the right to request an accounting of disclosures of individual protected health information made by the Plan on or after the compliance date of April 14, 2003. All requests must be in writing and must state the period of time for which You want the accounting. We may charge for providing the accounting, but We will tell You the cost in advance.

Right to Request Restrictions on the Use and Disclosure of Your Protected Health Information. You have the right to request that the Plan restrict the use and disclosure of Your protected health information for treatment, payment, or healthcare operations. The Plan is not required to agree to the requested restriction; however, if the Plan does agree to the restriction, it must comply with Your request unless the information is needed for an emergency.

Right to Receive Confidential Communications. You have the right to request to receive communication of protected health information from the Plan through an alternative procedure (other than the standard means of communicating protected health information). All requests must be in writing and are subject to technical reasonability for the Plan.

Right to a Paper Copy of This Notice. You have the right at any time to receive a paper copy of this Notice, even if You had previously agreed to receive an electronic copy.

Changes

The Plan reserves the right to change the terms of this Notice at any time, effective for protected health information that We already have about You as well as any information that We receive in the future. We are required by law to comply with whatever Notice is currently in effect. We will communicate changes to Our Notice through subscriber newsletters, direct mail and/or Our Internet website (www.mercyhealthplans.com).

Complaints

If You believe Your privacy rights have been violated, You have the right to file a Complaint with the Plan and/or with the Federal Government. Complaints to the Plan may be directed to the appropriate Customer Contact Center listed at the end of this Notice or by calling the Customer Contact Center number listed on the back of Your ID card. You may also file a Complaint anonymously by calling the Plan's Fraud and Abuse Hotline at 1-877-349-5997. Complaints to the government may be sent to: Secretary of the Department of Health and Human Services, 200 Independence Avenue, S.W., Washington, D.C. 20201. You will not be penalized for filing a Complaint.

Contact The Plan

If You want more information about this Notice, how to exercise Your rights, or how to file a Complaint, please direct Your correspondence to the appropriate Customer Contact Center listed at the end of this Notice or call the Customer Contact Center phone number listed on the back of Your ID card. You can also contact Us through Our Internet website: www.mercyhealthplans.com

Mercy Health Plans
ATTN: Customer Contact Center
14528 S Outer 40, Suite 300,
Chesterfield, MO 63017-5743
(866) 647-5568

NOTICE CONCERNING COVERAGE LIMITATIONS AND EXCLUSIONS UNDER THE ARKANSAS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT

Residents of this state who purchase life insurance, annuities or health and accident insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the Arkansas Life and Health Insurance Guaranty Association ("Guaranty Association"). The purpose of the Guaranty Association is to assure that policy and contract owners will be protected, within certain limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the claims of policy owners who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by the member insurers through the Guaranty Association is not unlimited, however. And, as noted in the box below, this protection is not a substitute for consumers' care in selecting insurance companies that are well managed and financially stable.

DISCLAIMER

The Arkansas Life and Health Insurance Guaranty Association ("Guaranty Association") may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions and require continued residency in this state. You should not rely on coverage by the Guaranty Association in purchasing an insurance policy or contract.

Coverage is NOT provided for Your policy or contract or any portion of it that is not guaranteed by the insurer or for which You have assumed the risk, such as non-guaranteed amounts held in a separate account under a variable life or variable annuity contract.

Insurance companies or their agents are required by law to provide You with this notice. However, insurance companies and their agents are prohibited by law from using the existence of the Guaranty Association to induce You to purchase any kind of insurance policy.

The Arkansas Life and Health Insurance Guaranty Association
c/o The Liquidation Division
1023 West Capitol
Little Rock, Arkansas 72201

Arkansas Insurance Department
1200 West Third Street
Little Rock, Arkansas 72201-1904

The state law that provides for this safety-net is called the Arkansas Life and Health Insurance Guaranty Association Act ("Act"). Below is a brief summary of the Act's coverages, exclusions and limits. This summary does not cover all provisions of the Act; nor does it in any way change anyone's rights or obligations under the Act or the rights or obligations of the Guaranty Association.

COVERAGE

Generally, individuals will be protected by the Guaranty Association if they live in this state and hold a life, annuity or health insurance contract or policy, or if they are insured under a group insurance contract issued by a member insurer. The beneficiaries, payees or assignees of policy or contract owners are protected as well, even if they live in another state.

EXCLUSIONS FROM COVERAGE

However, persons owning such policies are NOT protected by the Guaranty Association if:

- They are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);
- The insurer was not authorized to do business in this state;
- Their policy or contract was issued by a nonprofit hospital or medical service organization, an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policy or contract owner is subject to future assessments, or by an insurance exchange.

The Guaranty Association also does NOT provide coverage for:

- Any policy or contract or portion thereof which is not guaranteed by the insurer or for which the owner has assumed the risk, such as non-guaranteed amounts held in a separate account under a variable life or variable annuity contract;
- Any policy of reinsurance (unless an assumption certificate was issued);
- Interest rate yields that exceed an average rate;
- Dividends and voting rights and experience rating credits;
- Credits given in connection with the administration of a policy by a group contract holder;
- Employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);
- Unallocated annuity contracts (which give rights to group contract holders, not individuals);

- Unallocated annuity contracts issued to/in connection with benefit plans protected under Federal Pension Benefit Corporation ("FPBC")(whether the FPBC is yet liable or not);
- Portions of an unallocated annuity contract not owned by a benefit plan or a government lottery (unless the owner is a resident) or issued to a collective investment trust or similar pooled fund offered by a bank or other financial institution);
- Portions of a policy or contract to the extent assessments required by law for the Guaranty Association are preempted by State or Federal law;
- Obligations that do not arise under the policy or contract, including claims based on marketing materials or side letters, riders, or other documents which do not meet filing requirements, or claims for policy misrepresentations, or extra-contractual or penalty claims;
- Contractual agreements establishing the member insurer's obligations to provide book value accounting guarantees for defined contribution benefit plan participants (by reference to a portfolio of assets owned by a nonaffiliate benefit plan or its trustees).

LIMITS ON AMOUNT OF COVERAGE

The Act also limits the amount the Guaranty Association is obligated to cover: The Guaranty Association cannot pay more than what the insurance company would owe under a policy or contract. Also, for any one insured life, the Guaranty Association will pay a maximum of $300,000 — no matter how many policies and contracts there were with the same company, even if they provided different types of coverages. Within this overall $300,000 limit, the Association will not pay more than $300,000 in health insurance benefits, $300,000 in present value of annuity benefits, or $300,000 in life insurance death benefits or net cash surrender values — again, no matter how many policies and contracts there were with the same company, and no matter how many different types of coverages. There is a $1,000,000 limit with respect to any contract holder for unallocated annuity benefits, irrespective of the number of contracts held by the contract holder. These are limitations for which the Guaranty Association is obligated before taking into account either its subrogation and assignment rights or the extent to which those benefits could be provided out of the assets of the impaired or insolvent insurer.