

SERFF Tracking Number: MHPL-126342531 State: Arkansas
Filing Company: Mercy Health Plans State Tracking Number: 43773
Company Tracking Number: MHPL-126342531
TOI: H16I Individual Health - Major Medical Sub-TOI: H16I.005A Individual - Preferred Provider (PPO)
Product Name: INDIVRATE2010
Project Name/Number: /

Filing at a Glance

Company: Mercy Health Plans
Product Name: INDIVRATE2010
TOI: H16I Individual Health - Major Medical
Sub-TOI: H16I.005A Individual - Preferred Provider (PPO)
Filing Type: Rate
Implementation Date Requested: 01/01/2010
State Filing Description:

SERFF Tr Num: MHPL-126342531 State: Arkansas
SERFF Status: Closed-Approved- Closed State Tr Num: 43773
Co Tr Num: MHPL-126342531 State Status: Approved-Closed
Reviewers: Rosalind Minor
Disposition Date: 10/14/2009
Authors: Karen Hosack, Wanda Thurman
Date Submitted: 10/14/2009 Disposition Status: Approved-Closed
Implementation Date:

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: 11/12/2009
Deemer Date:
Submitted By: Karen Hosack
PPACA: Pre-PPACA Submission
Filing Description:
Ms. Rosalind Minor
Senior Certified Rate and Form Analyst
Arkansas Insurance Department
Life and Health Division
1200 West Third Street

Status of Filing in Domicile:
Date Approved in Domicile:
Domicile Status Comments:
Market Type: Individual
Group Market Size:
Group Market Type:
Explanation for Other Group Market Type:
State Status Changed: 01/07/2010
Created By: Karen Hosack
Corresponding Filing Tracking Number:

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(PPO)

Product Name: INDIVRATE2010

Project Name/Number: /

Little Rock, AR 72201-1904

RE: RATE FILING for Individual Product

Dear Ms. Minor:

I have enclosed for your review and approval an Actuarial Memorandum and Certification of Rates for our Individual PPO and Conversion Plans. These rates will replace the Individual Rate Filing approved on 8/7/2007(paper filing), and the Conversion Rate Filing approved on 9/17/08 (SERFF #125742797).

This rate filing for the Individual PPO Product will be used with the Individual Application recently filed in SERFF #MHPL-126293991, that was approved on September 4, 2009; and these Schedules of Coverage:

PHI AR INDIV SCH (07/07) approved on 8/7/07 (paper filing)

PHI AR INDIV SCH v.2 (01/08) approved on 4/09/08 (SERFF #MHPL-125487131)

The rates for the Conversion Plans will be used with the Schedule, PHI AR CONV SCH (08) approved on 9/17/08 (SERFF # MHPL-125742797).

The related Certificates of Coverage were also filed and approved on the same filing as the Schedules mentioned above. I have attached all related Schedules under "Supporting Documents" for convenience with this review.

Please contact me at (314) 214-2342 or by email at khosack@mhp.mercy.net if you have any questions.

Sincerely,

Karen Hosack, MHP, CCP

Supervisor - Commercial Compliance

Company and Contact

Filing Contact Information

Karen Hosack, Compliance Analyst

khosack@mhp.mercy.net

Mercy Health Plans

314-214-2342 [Phone]

14528 South Outer Forty Rd.

314-214-8103 [FAX]

Suite 300

Chesterfield, MO 63017

Filing Company Information

SERFF Tracking Number: MHPL-126342531 State: Arkansas
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Product Name: INDIVRATE2010
 Project Name/Number: /

Mercy Health Plans
 14528 South Outer Forty Rd.
 Suite 300
 Chesterfield, MO 63017
 (314) 214-8100 ext. [Phone]

CoCode: 11529
 Group Code:
 Group Name:
 FEIN Number: 48-1262342

State of Domicile: Missouri
 Company Type: LAH/PPO
 State ID Number:

Filing Fees

Fee Required? Yes
 Fee Amount: \$50.00
 Retaliatory? No
 Fee Explanation: Rate Filing
 Per Company: No

CHECK NUMBER	CHECK AMOUNT	CHECK DATE
205179	\$50.00	10/13/2009

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	11/12/2009	11/12/2009
Approved-Closed	Rosalind Minor	10/14/2009	10/14/2009

Filing Notes

Subject	Note Type	Created By	Created On	Date Submitted
No changes made	Note To Reviewer	Karen Hosack	11/12/2009	11/12/2009
Reviewing regional figures	Note To Reviewer	Karen Hosack	11/11/2009	11/11/2009
reopened file	Note To Filer	Rosalind Minor	11/05/2009	11/05/2009

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Disposition

Disposition Date: 10/14/2009

Implementation Date:

Status: Approved-Closed

Comment:

Since no changes have been made to the rates, we are closing this submission with the original approval date of 10/14/09.

Company Name:	Overall % Indicated Change:	Overall % Rate Impact:	Written Premium Change for this Program:	# of Policy Holders Affected for this Program:	Written Premium for this Program:	Maximum % Change (where required):	Minimum % Change (where required):
Mercy Health Plans	10.000%	10.000%	\$871,027	3,968	\$8,710,268	10.000%	10.000%

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 TOI: H16I Individual Health - Major Medical Sub-TOI: H16I.005A Individual - Preferred Provider
 (PPO)

Product Name: INDIVRATE2010

Project Name/Number: /

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Health - Actuarial Justification	Approved-Closed	Yes
Supporting Document	Schedules	Approved-Closed	Yes
Rate	Exhibit 1A-Individual Rates 2010	Approved-Closed	Yes
Rate	Exhibit 1B-Individual Rates 2007-2008	Approved-Closed	Yes
Rate	Exhibit 1 A- Conversion Rates 010110	Approved-Closed	Yes
Rate	Exhibit 1B -Conversion Rates 080108	Approved-Closed	Yes
Rate	Exhibit 2- Expense Incurred	Approved-Closed	Yes

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 Product Name: INDIVRATE2010
 Project Name/Number: /

Disposition

Disposition Date: 10/14/2009

Implementation Date:

Status: Approved-Closed

Comment:

We have approved your request of a 10% level rate increase on this submission. The approval is subject to the following conditions:

1. Rate increases will not be given prior to the first annual anniversary date of any policy.
2. After the first annual anniversary date of any policy, increases will not be given more frequently than once in a twelve (12) month period.
3. All increases in rates, other than a change in age or an individual moving to another geographical area, must be submitted to our Department for approval.

Company Name:	Overall % Indicated Change:	Overall % Rate Impact:	Written Premium Change for this Program:	# of Policy Holders Affected for this Program:	Written Premium for this Program:	Maximum % Change (where required):	Minimum % Change (where required):
Mercy Health Plans	10.000%	10.000%	\$871,027	3,968	\$8,710,268	10.000%	10.000%

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Supporting Document	Schedules	Approved-Closed	Yes
Rate	Exhibit 1A-Individual Rates 2010	Approved-Closed	Yes
Rate	Exhibit 1B-Individual Rates 2007-2008	Approved-Closed	Yes
Rate	Exhibit 1 A- Conversion Rates 010110	Approved-Closed	Yes
Rate	Exhibit 1B -Conversion Rates 080108	Approved-Closed	Yes
Rate	Exhibit 2- Expense Incurred	Approved-Closed	Yes

SERFF Tracking Number: MHPL-126342531

State: Arkansas

Filing Company: Mercy Health Plans

State Tracking Number: 43773

Company Tracking Number: MHPL-126342531

TOI: H161 Individual Health - Major Medical

Sub-TOI: H161.005A Individual - Preferred Provider (PPO)

Product Name: INDIVRATE2010

Project Name/Number: /

Rate Information

Rate data applies to filing.

Filing Method:

SERFF

Rate Change Type:

Increase

Overall Percentage of Last Rate Revision:

0.000%

Effective Date of Last Rate Revision:

08/07/2007

Filing Method of Last Filing:

Paper

Company Rate Information

Company Name:	Overall % Indicated Change:	Overall % Rate Impact:	Written Premium Change for this Program:	# of Policy Holders Affected for this Program:	Written Premium for this Program:	Maximum % Change (where required):	Minimum % Change (where required):
Mercy Health Plans	10.000%	10.000%	\$871,027	3,968	\$8,710,268	10.000%	10.000%

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Supporting Document Schedules

	Item Status:	Status
Satisfied - Item: Schedules	Approved-Closed	11/12/2009

Comments:

Here are corresponding Schedules for convenience.

Attachments:

AR INDIV Schedule of Coverage FINAL (Effective 7.1.08).pdf

AR Conversion Schedule (08) .pdf

Individual_Schedule_of_Coverage.pdf



MERCY HEALTH PLANS
SCHEDULE OF COVERAGE AND BENEFITS
for

Effective Date of Coverage

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.

For a complete description of Benefits including exclusions [and Prior Authorization requirements] please refer to Your Policy. All capitalized terms shall have the same meaning given them in the Policy.

PAYMENT INFORMATION	AMOUNT	
	NETWORK	NON-NETWORK
Annual Deductible	[\$0 – 10,000] per Covered Person per Calendar Year, not to exceed [\$0 –30,000] for all Covered Persons in a family.]	[\$0 – 10,000] per Covered Person per Calendar Year, not to exceed [\$0 – 30,000] for all Covered Persons in a family.]
Out-of-Pocket Maximum <i>Only Coinsurances apply towards Your Out-of-Pocket Maximum. Coinsurance is the amount You pay after You meet Your Deductible.</i>	[\$0 – 10,000] per Covered Person per Calendar 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 – 10,000] per Covered Person per Calendar 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]
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]

MEDICAL SERVICES (As outlined in Your Policy)	YOUR COPAYMENT AMOUNT	
	NETWORK	NON-NETWORK
1. Allergy <ul style="list-style-type: none"> Office Visits Injections/Treatment 	<i>Office Visit:</i> [\$0-\$100 Copayment] [0%-50% Coinsurance] per office visit [after Deductible] for Primary care [\$0-\$100 Copayment] [0%-50% Coinsurance] per office visit [after Deductible] for Specialist care <i>Injections/Treatment:</i> [[\$0-\$100] Copayment] [when no charge is made for physician’s services.] [[0%-50%] Coinsurance after Deductible]	[0% - 50%] Coinsurance after Deductible [0% - 50%] Coinsurance after Deductible
2. Ambulance Services - Emergency Only <ul style="list-style-type: none"> Ground Transportation Air Transportation 	<i>Ground Transportation:</i> [\$25–250 Copayment] per transport] [0% - 50% Coinsurance after Deductible] [No Copayment] <i>Air Transportation:</i> [0% -50% Coinsurance after Deductible] [\$50-500 Copayment] per transport	<i>Ground Transportation:</i> [\$25–250 Copayment] per transport] [0%-50% Coinsurance after Deductible] [No Copayment] <i>Air Transportation:</i> [0% - 50% Coinsurance after Deductible] [\$50-500 Copayment] per transport

MEDICAL SERVICES (As outlined in Your Policy)	YOUR COPAYMENT AMOUNT	
	NETWORK	NON-NETWORK
3. Chiropractic Care Limited to 26 visits per [Calendar] [Plan] Year.	[\$0 - \$100 Copayment] [0% - 50% Coinsurance after Deductible] per visit][to a Specialist]	[\$0 - \$100 Copayment] [0% - 50% Coinsurance after Deductible] per visit][to a Specialist]
4. Dental Anesthesia and Facility Charges Please refer to Your Policy (Section 12: Covered Benefits) for limitations.	[0% - 50% Coinsurance after Deductible]	[0% - 50% Coinsurance after Deductible]
5. Dental Services - Accident only Initial contact with a Physician or dentist must have occurred within 72 hours of the accident. In no case will accidental dental coverage extend more than 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]	[% - 50% Coinsurance after Deductible]
6. 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. See Policy, (Section 12: Covered benefits).	[Copayment/Coinsurance consistent with type of service required.] [0% - 50% Coinsurance after Deductible]	[0% - 50% Coinsurance after Deductible] [Copayment/Coinsurance consistent with type of service required.]
7. Durable Medical Equipment We provide Benefits only for a single purchase (including repair/replacement) of a type of Durable Medical Equipment once [every][each] [two-five] Calendar Year[s]. Any combination of Network and Non-Network Benefits for Durable Medical Equipment is limited to [\$750-\$10,000] per [Calendar] [Plan] Year. This limitation is not applicable to any equipment, supplies or self-management training for the treatment of diabetes.	[0% - 50% Coinsurance after Deductible] [No Copayment]	[0% - 50% Coinsurance after Deductible]
8. Emergency Health Services [Physician charges may be applicable, if billed separately. See <i>Professional Fees for Surgical and Medical Services</i> below.]	[\$0-250 Copayment per visit, except Copayment charge will be waived when inpatient admission for the same condition occurs within 24 hours] [0% - 50% Coinsurance after Deductible]	[\$0-250 Copayment per visit, except Copayment charge will be waived when inpatient admission for the same condition occurs within 24 hours] [0% - 50% Coinsurance after Deductible]
9. Eye Examinations Benefits include one (1) routine vision exam, including refraction, to detect vision impairment [each] [every other] [2- 5] [Calendar] Year[s].	[\$5-75 Copayment per visit] [0% - 50% Coinsurance after Deductible]	[0% - 50% Coinsurance after Deductible]
10. Hearing Screenings for Newborns	[0% - 50% Coinsurance after Deductible] [No Copayment]	[0% - 50% Coinsurance after Deductible]

MEDICAL SERVICES (As outlined in Your Policy)	YOUR COPAYMENT AMOUNT	
	NETWORK	NON-NETWORK
<p>11. Home Health Care Services provided by a Home Health Agency must be:</p> <ul style="list-style-type: none"> • 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. <p>Any combination of Network and Non-Network Benefits for home health care is limited to 60 visits per [Calendar][Plan] Year.</p>	<p>[\$0-100 Copayment per visit] [0% - 50% Coinsurance after Deductible] [No Copayment]</p>	<p>[0% - 50% Coinsurance after Deductible]</p>
<p>12. Hospice/Palliative Care Any combination of Network and Non-Network Benefits is limited to 180 days lifetime maximum.</p>	<p>[\$0 – 100 Copayment per day] [0% - 50% Coinsurance after Deductible] [No Copayment]</p>	<p>[0% – 50% Coinsurance after Deductible]</p>
<p>13. Hospital - Inpatient Stay</p>	<p>[0% - 50% Coinsurance after Deductible] [\$0-\$5000 Copayment per Inpatient Stay] [\$0-1,000] Copayment per day [\$0-1,000] Copayment per day to a maximum of [\$0-5,000] Copayment per Inpatient Stay]</p>	<p>[0% - 50% Coinsurance after Deductible]</p>
<p>14. Immunization - Routine Only (Received in Physician’s Office)</p>	<p>[\$5-75] [Copayment per visit] [0% - 50% Coinsurance] [after Deductible] for adults over 18 yrs.] [per injection] [No Copayment] No Copayment, Coinsurance or Deductible for immunizations for children birth through age 18 yrs.</p>	<p>[0% - 50% Coinsurance] [after Deductible] [per injection] for adults over 18 yrs.] [Covered In Network Only] [No Copayment, Coinsurance or Deductible for immunizations for children birth through age 18 yrs.]</p>
<p>15. Injectables/Infusions (Received in a physician’s office, infusion center or through home health)</p>	<p>[[0% - 50%] Coinsurance [after deductible] [\$0-100] Copayment per injectable/infusion] [No Copayment] [No office visit Copayment applies when a Physician charge is not assessed]</p>	<p>[0% - 50%] Coinsurance after deductible per injectable/infusion</p>
<p>16. Medical Foods/PKU Please refer to Your Policy (Section 12: Covered Benefits) for limitations.</p>	<p>[0% - 50%] Coinsurance after deductible [No Copayment]</p>	<p>[0% - 50%] Coinsurance after deductible</p>
<p>17. Mental Health and Substance Abuse Services – Outpatient Any combination of Network and Non-Network Benefits is limited as indicated in Your Policy</p>	<p>[0% - 50% Coinsurance after Deductible] [No Copayment] [[0-100] per visit]</p>	<p>[0% - 50% Coinsurance after Deductible]</p>
<p>18. Mental Health and Substance Abuse Services – Inpatient and Intermediate Any combination of Network and Non-Network Benefits is limited as indicated in Your Policy</p>	<p>[0% - 50% Coinsurance after Deductible] [No Copayment] [\$0-1,000] per day to a maximum of [\$0-5,000] per Inpatient Stay]</p>	<p>[0% - 50% Coinsurance after Deductible]</p>

MEDICAL SERVICES (As outlined in Your Policy)	YOUR COPAYMENT AMOUNT	
	NETWORK	NON-NETWORK
19. Newborn Child Coverage	[0% - 50% after Deductible] [\$0-\$5000 per Inpatient Stay] [\$0-1,000] Copayment per day [\$0-1,000] Copayment per day to a maximum of [\$0-5,000] per Inpatient Stay [No Copayment]	[0% - 50% Coinsurance after Deductible]
20. Nutritional Counseling Up to three (3) visits in a [Calendar] [Plan] Year for only certain conditions.	[0% - 50% Coinsurance after Deductible] [[\$0-100] Copayment per visit]	[0% - 50% Coinsurance after Deductible]
21. Observation Coverage for up to forty-eight (48) hours at the designated Copayment.	[0% - 50% Coinsurance after Deductible]	[0% - 50% Coinsurance after Deductible]
22. Orthotics [Benefits for orthotic devices are limited to the single purchase of each type of orthotic device [every][each][two-five] [Calendar] [Plan] Year(s).] Any combination of Network and Non- Network Benefits for prosthetic devices is limited to [\$2,500-\$10,000] per [Calendar] [Plan] Year.	[0% - 50% Coinsurance after Deductible]	[0% - 50% Coinsurance after Deductible]
23. Osteoporosis/Bone Density 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 <i>Professional Fees for Surgical and Medical Services</i> below.] [When these services are performed in a Physician's office, Benefits are described under <i>Physician Office Services</i> above.]	[[0% - 50%] [Coinsurance after Deductible] [Not Applicable]	[[0% - 50%] [Coinsurance after Deductible] [Not Applicable] [Covered In Network Only]
24. Outpatient Diagnostic When these services are performed in a Physician's office, physician's charges may apply. See <i>Physician's Office Services</i> below.	Lab Services (Not performed in a Physician's office): [0%-50% Coinsurance after Deductible] [No Copayment] Lab Services (Performed in a Physician's office): [No Copayment] [0%-50% Coinsurance after Deductible] X-ray (Not performed in a Physician's office) & all other Diagnostics: [0%-50% Coinsurance after Deductible] X-ray (Performed in a Physician's office): [No Copayment] [0%-50% Coinsurance after Deductible]	Lab Services (Not performed in a physician's office): [0%-50% Coinsurance after Deductible] Lab Services (Performed in a Physician's office): [No Copayment] [0%-50% Coinsurance after Deductible] X-ray (Not performed in a Physician's office) & all other Diagnostic's: [0%-50% Coinsurance after Deductible] X-ray (Performed in a Physician's office): [No Copayment] [0%-50% Coinsurance after Deductible]
25. Outpatient Surgery/Hospital Procedures	[\$0 - 1,000 Copayment] [per surgical procedure] for outpatient surgery.] [[0% - 50% Coinsurance after Deductible] [No Copayment]	[0% - 50% Coinsurance after Deductible]

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<ul style="list-style-type: none"> Surgical Implants Implants for cosmetic or psychological reasons are excluded, see Section 13, L. in Your Policy. <p>[Any combination of Network and Non-Network Benefits for surgical Implants is limited to [\$2,500-\$10,000] per [Calendar] [Plan] Year.]</p>	<p><i>Surgical Implants:</i> [Copayment consistent with type of service required.] [0% - 50% Coinsurance after Deductible]</p>	<p><i>Surgical Implants:</i> [Copayment consistent with type of service required.] [0% - 50% Coinsurance after Deductible]</p>
<p>26. Physician's Office Services</p>	<p>[\$10-100 Copayment per visit] [to a PCP] [to a Specialist] [No office visit Copayment applies when no Physician charge is assessed.] [0% – 50% Coinsurance after Deductible] [No Copayment for immunizations for children from birth to age eighteen.]</p>	<p>[0% - 50% Coinsurance after Deductible] [No Copayment for immunizations for children from birth to age eighteen.]</p>
<p>27. 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.]</p> <p>[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 <i>Professional Fees for Surgical and Medical Services</i> below.]</p> <p>[When these services are performed in a Physician's office, Benefits are described under <i>Physician Office Services</i> above.]</p>	<p><i>Cholesterol Tests:</i> [[0% – 50]% [No Deductible] [when provided In Network Only]] [No Copayment] [Not Applicable]</p> <p><i>Colonoscopy:</i> [[0% – 50]% [No Deductible] [when provided In Network Only]] [No Copayment][Not Applicable]</p> <p><i>Double-contrast Barium Enema:</i> [[0% – 50]% [No Deductible] [when provided In Network Only]] [No Copayment][Not Applicable]</p> <p><i>Fecal Occult Blood Test:</i> [[0% – 50]% [No Deductible] [when provided In Network Only]] [No Copayment][Not Applicable]</p> <p><i>Flexible Sigmoidoscopy:</i> [[0% – 50]% [No Deductible] [when provided In Network Only]] [No Copayment][Not Applicable]</p> <p><i>Mammography:</i> [[0% – 50]% [No Deductible] [when provided In Network Only]] [No Copayment][Not Applicable]</p> <p><i>Pap/Pelvic:</i> [[0% – 50]% [No Deductible] [when provided In Network Only] [\$10-100 per visit] [to a PCP] [to a Specialist] [No Copayment] [Not Applicable]</p> <p><i>Prostate Exam:</i> [[0% – 50]% [No Deductible] [when provided In Network Only]] [No Copayment] [Not Applicable]</p> <p><i>PSA Test:</i> [[0% – 50]% [No Deductible] [when provided In Network Only]] [No Copayment] [Not Applicable]</p>	<p>[[0% – 50]% Coinsurance after Deductible] [Not Applicable] [Covered In Network Only]</p> <p>[[0% - 50]%] [Coinsurance after Deductible] [Not Applicable] [Covered In Network Only]</p> <p>[[0% - 50]%] [Coinsurance after Deductible] [Not Applicable] [Covered In Network Only]</p> <p>[[0% - 50]%] [Coinsurance after Deductible] [Not Applicable] [Covered In Network Only]</p> <p>[[0% - 50]%] [Coinsurance after Deductible] [Not Applicable] [Covered In Network Only]</p> <p>[[0% - 50]%] [Coinsurance after Deductible] [Not Applicable] [Covered In Network Only]</p> <p>[[0 - 50]%] [Coinsurance after Deductible] [Not Applicable] [Covered In Network Only]</p> <p>[[0% - 50]%] [Coinsurance after Deductible] [Not Applicable] [Covered In Network Only]</p> <p>[[0 - 50]%] [Coinsurance after Deductible] [Not Applicable] [Covered In Network Only]</p> <p>[[0% - 50]%] [Coinsurance after Deductible] [Not Applicable] [Covered In Network Only]</p>

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	NETWORK	NON-NETWORK
28. Professional Fees for Surgical and Medical Services	[0% - 50% Coinsurance after Deductible]	[0% - 50% Coinsurance after Deductible]
29. Prosthetic Devices [Benefits for prosthetic devices are limited to a single purchase of each type of prosthetic device [every] [two-five] [Calendar] [Plan] Year(s). Any combination of Network and Non-Network Benefits for prosthetic devices is limited to [\$2,500-\$10,000] per [Calendar] [Plan] Year. Please note that this limitation does not apply to breast prostheses.	[0% - 50% Coinsurance after Deductible]	[0% - 50% Coinsurance after Deductible]
30. Reconstructive Procedures	[0% - 50% Coinsurance after Deductible]	[0% - 50% Coinsurance after Deductible]
31. Rehabilitation Services – Outpatient Therapy Any combination of Network and Non-Network Benefits is limited as indicated as follows: <ul style="list-style-type: none"> [10 – 100] visits of Physical Therapy per [Calendar] [Plan] Year. [10 – 100] visits of Occupational Therapy per [Calendar] [Plan] Year. [10 – 100] visits of Speech Therapy per [Calendar] [Plan] Year. [10 – 100] visits of Pulmonary Rehabilitation therapy within a 12-week period per [Calendar] [Plan] Year. [10 – 100] visits of Cardiac Rehabilitation therapy within a 12-week period per [Calendar] [Plan] Year. 	[\$0-100 Copayment per visit] [0% - 50% Coinsurance after Deductible] [No Copayment]	[0% – 50% Coinsurance after Deductible]
32. Skilled Nursing Facility / Inpatient Rehabilitation Facility Services Any combination of Network and Non-Network Benefits is limited to [40-180] 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]
33. Transplantation Services	[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] [Covered In Network Only except for corneal transplant]
34. Urgent Care Center Services	[\$0 –200] Copayment per visit] [0% - 50% Coinsurance after Deductible] [No Copayment]	[\$0 –200] Copayment per visit] [0% - 50% Coinsurance after Deductible]

MEDICAL SERVICES (As outlined in Your Policy)	YOUR COPAYMENT AMOUNT	
	NETWORK	NON-NETWORK
35. [Acupuncture Services] Any combination of Network and Non-Network Benefits is limited to [10 – 100] visits per [Calendar] [Plan] Year.]	[\$5 – 75] per visit] [0% – 50% Coinsurance after Deductible] [No Copayment]	[0% – 50% Coinsurance after Deductible]
36. [Tobacco Cessation Education Program]	[\$0-\$75] Copayment per program] [0% – 50% Coinsurance after Deductible] [No Copayment] [Not Covered]	[0% – 50% Coinsurance after Deductible] [Not Covered] [Covered In Network Only]

OPTIONAL RIDERS		
[Family Services]	[Tubal ligations and vasectomies.] [Copayment consistent with services received.]	
[In-Vitro Fertilization] Applies to Maternity Plan(s) only, however, Maternity waiting period does not apply. 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 the Policy.	NETWORK	NON-NETWORK
	[[0-100] Copayment per visit] [0%-50% after deductible.] Member is responsible for the remaining 100% of the charges for infertility services over \$15,000.	[0 - 50% Coinsurance after deductible] [Covered in-Mercy Network Only] Member is responsible for the remaining 100% of the charges for infertility services over \$15,000.
[Maternity Services] Maternity benefits apply only after twelve (12) months of continuous coverage.	NETWORK	NON-NETWORK
	<i>Physician Office:</i> [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.] <i>Hospital Outpatient- Observation:</i> [0% - 50% Coinsurance after Deductible][per visit] [[0-100] Copayment per visit] <i>Hospital Inpatient Services:</i> [0% - 50% Coinsurance after Deductible] <i>Outpatient Lab:</i> [0% - 50% Coinsurance after Deductible] <i>Outpatient X-ray:</i> [0% - 50% Coinsurance after Deductible]	<i>Physician Office:</i> [0% - 50% Coinsurance after Deductible] <i>Hospital Outpatient- Observation:</i> [0% - 50% Coinsurance after Deductible] [[0-100] Copayment per visit] <i>Hospital Inpatient Services:</i> [0% - 50% Coinsurance after Deductible][per visit] <i>Outpatient Lab:</i> [0% - 50% Coinsurance after Deductible] <i>Outpatient X-ray:</i> [0% - 50% Coinsurance after Deductible]
[Outpatient Prescription Drug]	NETWORK: <ul style="list-style-type: none"> • [[0-\$1,000] Annual Drug Deductible per Member per Calendar Year] [[0-\$3,000] per Family per Calendar Year] • [[0-\$3,000] [per Member] [per Family] annual Maximum] • [No Annual Drug Deductible] • [0-\$1,500 annual benefit maximum] • [0-\$100] [0-50%] Copayment for up to a 30-day supply of Tier One drugs • [0-\$100] [0-50%] Copayment for up to a 30-day supply of Tier Two drugs • [[0-\$100] [0-50%] Copayment for up to a 30-day supply of Tier Three drugs] • [[0-\$100] [0-50%] Coinsurance [with a maximum of \$100] per Prescription Order or Refill for Tier Four drugs up to a thirty (30) day supply per Prescription Order or Refill.] 	

OPTIONAL RIDERS

- **[Tobacco Cessation:** Copayment will be consistent with Your Prescription drug benefit for each month's purchase up to three (3) months of coverage per benefit year for certain tobacco cessation products.]
- [Mail order [1x, 2x, 2.5x, 3x] Copayment]
- [90-day Retail Pharmacy [1x, 2x, 2.5x, 3x] Copayment]
- [Formulary does not apply]
- **Birth Control Services:** Contraceptives (oral and injectable). All other physician-prescribed birth control services are covered under the medical plan.

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:

50% Coinsurance of the cost of a Prescription [subject to Plan deductible including a dispensing fee and sales tax] that We would pay at a Participating Pharmacy per Prescription Order or Refill. The cost of a brand name Prescription is based on its generic version if a generic is available.

<p>[Temporomandibular Joint Disorder (TMJ)] [When these services are performed in a Physician's office, Benefits are described under <i>Physician Office Services</i> above.]</p> <p>[Copayment/Coinsurance consistent with applicable inpatient hospital, outpatient, hospital or other services required.]</p>	<p>NETWORK</p>	<p>NON-NETWORK</p>
	<p>[0% - 50%] Coinsurance after Deductible [\$10-100 Copayment per visit] [to a Specialist] [Copayment/Coinsurance consistent with type of service required]</p>	<p>[0% - 50%] Coinsurance after Deductible [Copayment/Coinsurance consistent with type of service required]</p>



SCHEDULE OF COVERAGE AND BENEFITS
 for
 [NAME]
 Effective Date of Coverage [MM/DD/YYYY]

With Mercy Health Plans' conversion Policy, 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 Provider.

Please refer to Your Policy for a detailed explanation of covered and non-covered services In some cases, You must notify Us before receiving services.

PAYMENT INFORMATION	AMOUNT	
	NETWORK	NON-NETWORK
MEDICAL SERVICES Annual Deductible	[\$500 - \$2,500] per Covered Person per Calendar Year, not to exceed \$3,000 for all Covered Persons in a family.	[\$1,000 - \$5,000] per Covered Person per Calendar Year, not to exceed \$6,000 for all Covered Persons in a family.
Out-of-Pocket Maximum <i>Coinsurance is the amount You pay after You meet Your Deductible. All Coinsurances apply towards Your Out-of-Pocket Maximum, except those related to Covered Health Service contained in an optional Rider.</i> Out-of-Pocket Maximum does not include the Annual Deductible.	<p align="center"><u>Network</u></p> [\$1,000 after Deductible per individual per Calendar Year, not to exceed \$3,000 for all Covered Persons in a family.] [No Out-of-Pocket Maximum]	<p align="center"><u>Non-Network</u></p> No Out-of-Pocket Maximum
Maximum Policy Benefit	Network and Non-Network Combined \$250,000 per Covered Person	

SERVICES	MEMBER RESPONSIBILITY	
	NETWORK	NON-NETWORK
1. Ambulance Services - Emergency Only <ul style="list-style-type: none"> Ground Transportation Air Transportation * 	<i>Ground Transportation:</i> 20% Coinsurance after Deductible <i>Air Transportation:</i> 45% Coinsurance after Deductible per transport	<i>Ground Transportation:</i> 45% Coinsurance after Deductible <i>Air Transportation:</i> 45% Coinsurance after Deductible
2. Dental Anesthesia and Facility Charges * Coverage is limited to: <ul style="list-style-type: none"> A Covered Person who is a child under the age of seven (7) who is determined by two (2) dentists to require necessary dental treatment; or A Covered Person who is severely disabled; or A Covered Person who has a medical or behavioral condition that requires hospitalization or general anesthesia when dental care is provided. 	20% Coinsurance after Deductible	45% Coinsurance after Deductible

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

SERVICES	MEMBER RESPONSIBILITY	
	NETWORK	NON-NETWORK
3. 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.	20% Coinsurance after Deductible Copayment/Coinsurance consistent with type of service required.	45% Coinsurance after Deductible
4. Emergency Room Services Physician charges may be applicable, if billed separately. See <i>Professional Fees for Surgical and Medical Services</i> below. Copayment/Coinsurance charge will be waived when hospital inpatient or observation admission for the same condition occurs within twenty-four (24) hours.	[\$0 - \$250 Copayment per visit] [20% Coinsurance after Deductible]	[\$0 - \$250 Copayment per visit] [45% Coinsurance after Deductible]
5. Hearing Screenings for Newborns	20% Coinsurance after Deductible	45% Coinsurance after Deductible
6. Immunization - Routine Only (Received in Physician's Office)	20% Coinsurance after Deductible for adults over 18 yrs. No Copayment, Coinsurance or Deductible for immunizations for children birth through age 18 yrs.	45% Coinsurance after Deductible. No Copayment, Coinsurance or Deductible for immunizations for children birth through age 18 yrs.
7. Inpatient Hospital Services * Semi-Private Room covered.	20% Coinsurance after Deductible	45% Coinsurance after Deductible
8. In-Vitro Fertilization * Covered Health Services for In-Vitro Fertilization (IVF) include the following: <ul style="list-style-type: none"> • IVF associated labs; • Medication; • Imaging and procedures including female and male pre-testing; • The IVF process, and; • Cryopreservation. <u>Any combination of Network and Non-Network Benefits for in-vitro fertilization is limited to a lifetime maximum \$15,000.</u>	20% Coinsurance after Deductible Member is responsible for the remaining 100% of the charges for infertility services over \$15,000.	45% Coinsurance after Deductible Member is responsible for the remaining 100% of the charges for infertility services over \$15,000.]
9. Maternity Services *	<i>Physician Office:</i> 20% Coinsurance after Deductible No Copayment applies to Physician office visits for prenatal care after the first visit. <i>Hospital Outpatient- Observation:</i> 20% Coinsurance after Deductible per visit <i>Hospital Inpatient Services:</i> 20% Coinsurance after Deductible <i>Outpatient Laboratory services:</i> 20% Coinsurance after Deductible <i>Outpatient X-ray/Imaging:</i> 20% Coinsurance after Deductible	<i>Physician Office:</i> 45% Coinsurance after Deductible <i>Hospital Outpatient- Observation:</i> 45% Coinsurance after Deductible <i>Hospital Inpatient Services:</i> 45% Coinsurance after Deductible <i>Outpatient Laboratory services:</i> 45% Coinsurance after Deductible <i>Outpatient X-ray/Imaging:</i> 45% Coinsurance after Deductible
10. Newborn Child Coverage *	20% Coinsurance after Deductible	45% Coinsurance after Deductible

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

SERVICES	MEMBER RESPONSIBILITY	
	NETWORK	NON-NETWORK
<p>11. Observation Care * If an Observation admission results in a conversion to an Inpatient Admission, the Observation Copayment will be waived. The alternate Copayment/Coinsurance will apply.</p>	20% Coinsurance after Deductible	45% Coinsurance after Deductible
<p>12. Osteoporosis Services/Bone Mineral Density (BMD) Testing * Diagnosis, treatment, and appropriate management of osteoporosis are covered for persons with a condition or medical history for which bone mass measurement is medically indicated.</p> <p>When these services are performed in a Physician's office, Physician's charges may apply. See <i>Physician's Office Services</i> below.</p> <p>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.</p>	<p><i>Laboratory Services:</i> 20% Coinsurance after Deductible</p> <p><i>X-ray/Imaging:</i> 20% Coinsurance after Deductible</p> <p><i>Other Diagnostic/Therapeutic Services:</i> 20% Coinsurance after Deductible</p>	<p><i>Laboratory Services:</i> 45% Coinsurance after Deductible</p> <p><i>X-ray/Imaging:</i> 45% Coinsurance after Deductible</p> <p><i>Other Diagnostic/Therapeutic Services:</i> 45% Coinsurance after Deductible</p>
<p>13. Outpatient Diagnostic Services * Covered Health Services received on an outpatient basis at a Hospital or Alternate Facility include:</p> <ul style="list-style-type: none"> • Laboratory services • X-Ray/Imaging • Other diagnostic & therapeutic services <p>The following services are subject to the outpatient diagnostic charges regardless of the place of service:</p> <ul style="list-style-type: none"> • MRA • MRI • CT Scan • PET Scan • Nuclear Cardiology Imaging studies. <p>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.</p>	<p>Laboratory Services : 20% Coinsurance after Deductible</p> <p>X-Ray/Imaging 20% Coinsurance after Deductible</p> <p>Other Diagnostic & therapeutic services: 20% Coinsurance after Deductible</p>	<p>Laboratory Services : 45% Coinsurance after Deductible</p> <p>X-Ray/Imaging : 45% Coinsurance after Deductible</p> <p>Other Diagnostic & therapeutic services: 45% Coinsurance after Deductible</p>
<p>14. Outpatient Surgery/Hospital Procedures * Coverage includes surgical services and hospital procedures received on an outpatient basis at a Hospital or Alternate Facility.</p> <p>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 <i>Professional Fees for Surgical and</i></p>	<p>Outpatient Surgery/Hospital Procedures:</p> <p>20% Coinsurance after Deductible per outpatient surgery or procedure</p>	45% Coinsurance after Deductible

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

SERVICES	MEMBER RESPONSIBILITY	
	NETWORK	NON-NETWORK
<p><i>Medical Services</i> below and may incur separate Copayment/Coinsurance in addition to the outpatient facility Copayment.</p> <ul style="list-style-type: none"> Surgical Implants Implants for cosmetic or psychological reasons are excluded, see Section 12, L. in Your Policy. 	<p>Surgical Implants: [Copayment consistent with type of service received]. [20%] [45%] Coinsurance after Deductible]]</p>	<p>Surgical Implants: [Copayment consistent with type of service received]. [45% Coinsurance after Deductible]</p>
<p>15. Physician’s Office Services</p>	<p>20% Coinsurance after Deductible</p>	<p>45% Coinsurance after Deductible</p>
<p>16. PKU/Medical Foods and Low Protein Modified Food Products for Metabolic Disorders</p> <p>Please refer to Your Policy Section 11 (Covered Benefits) for limitations.</p>	<p>20% Coinsurance after Deductible</p>	<p>45% Coinsurance after Deductible</p>
<p>17. Preventive Health & Wellness Care 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. Coinsurance will be consistent with type of service received.</p> <p>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 diagnostic services are described under <i>Professional Fees for Surgical and Medical Services</i> below.</p> <p>When these services are performed in a Physician’s office, Physician’s charges may apply. See <i>Physician’s Office Services</i> above.</p>	<p><i>Cholesterol Tests:</i> [0% -45%] Coinsurance after Deductible</p> <p><i>Colon Screening:</i> [0% - 45%] Coinsurance after Deductible</p> <p><i>Well-Woman:</i> [0% - 45%] Coinsurance after Deductible</p> <p><i>Prostate Exam:</i> [0% - 45%] Coinsurance after Deductible</p> <p><i>PSA test:</i> [0% - 45%] Coinsurance after Deductible</p> <p><i>Diabetes A1C Test:</i> [0% - 45%] Coinsurance after Deductible</p> <p><i>Osteoporosis Services:</i> [0% - 45%] Coinsurance after Deductible</p>	<p>[Covered In-Network only]</p>
<p>18. Professional Fees for Surgical and Medical Services</p>	<p>20% Coinsurance after Deductible</p>	<p>45% Coinsurance after Deductible</p>
<p>19. Reconstructive Procedures * Please refer to Your Policy Section 11 (Covered Benefits) for limitations.</p>	<p>20% Coinsurance after Deductible</p>	<p>45% Coinsurance after Deductible</p>

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

SERVICES	MEMBER RESPONSIBILITY	
	NETWORK	NON-NETWORK
<p>20. Rehabilitation Services</p> <p><u>Outpatient Rehabilitation Therapy</u> Any combination of Network and Non-Network Benefits is limited as follows:</p> <ul style="list-style-type: none"> ▪ 60 Combined visits per Calendar Year for Physical, Occupational and Speech Therapy ▪ 36 Visits of Pulmonary Rehabilitation Therapy within a 12-week period per [Calendar] [Plan] Year. ▪ 36 Visits of Cardiac Rehabilitation Therapy within a 12-week period per [Calendar] [Plan] Year. <p><u>Inpatient Rehabilitation Services</u> * Any combination of Network and Non-Network Benefits is limited up to a maximum of [60 – 120] days per [Calendar] [Plan] Year.</p> <p>Rehabilitation Therapy services that are considered maintenance, developmental or educational in nature are not covered Benefits.</p>	<p><u>Outpatient Rehabilitation Therapy</u></p> <p>Physical Therapy/Occupational Therapy/Speech Therapy: 20% Coinsurance after Deductible</p> <p>Pulmonary Rehabilitation: 20% Coinsurance after Deductible</p> <p>Cardiac Rehabilitation: 20% Coinsurance after Deductible</p> <p><u>Inpatient Rehabilitation Services</u></p> <p>[0% - 45%] Coinsurance after Deductible] [\$0 - \$5,000] per Inpatient Stay] [\$0 - \$1,000] Copayment per day] [\$0 - \$1,000] Copayment per day to a maximum of [\$0 - \$5,000] Copayment per Inpatient Stay]</p>	<p><u>Outpatient Rehabilitation Therapy</u></p> <p>45% Coinsurance after Deductible</p> <p><u>Inpatient Rehabilitation Services</u></p> <p>[0% - 45%] Coinsurance after Deductible</p>
<p>21. Skilled Nursing Facility (SNF) *</p> <p>Any combination of Network and Non-Network Benefits is limited to [60-120] days per Calendar Year.</p>	<p>20% Coinsurance after Deductible</p>	<p>45% Coinsurance after Deductible</p>
<p>22. Urgent Care Center Services</p> <p>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 diagnostic services are provided and billed separately from the Urgent Care Center, additional Copayments/Coinsurances may apply.</p>	<p>[\$0 - \$250 Copayment] per visit] [No Copayment] [20% Coinsurance after Deductible]</p>	<p>[\$0 - \$250 Copayment] per visit] [0% - 45%] Coinsurance after Deductible</p>

OPTIONAL RIDERS		
	NETWORK	NON-NETWORK
<p>[Temporomandibular Joint Disorder (TMJ)]</p> <p>[When these services are performed in a Physician's office, Benefits are described under <i>Physician Office Services</i> above.]</p> <p>[Coinsurance consistent with applicable inpatient hospital, outpatient, hospital or other services required.]</p>	<p>[0% - 50%] Coinsurance after Deductible</p>	<p>[0% - 50%] Coinsurance after Deductible</p>

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



MERCY HEALTH PLANS

**SCHEDULE OF COVERAGE AND BENEFITS
for**

Effective Date of Coverage

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.

PAYMENT INFORMATION	AMOUNT	
	NETWORK	NON-NETWORK
Annual Deductible	[\$0 – 10,000] per Covered Person per Calendar Year, not to exceed [\$0 –30,000] for all Covered Persons in a family.]	[\$0 – 10,000] per Covered Person per Calendar Year, not to exceed [\$0 – 30,000] for all Covered Persons in a family.]
Out-of-Pocket Maximum <i>Only Coinsurances apply towards Your Out-of-Pocket Maximum. Coinsurance is the amount You pay after You meet Your Deductible.</i>	[\$0 – 10,000] per Covered Person per Calendar 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 – 10,000] per Covered Person per Calendar 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]
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 (As outlined in Individual PPO Policy)	YOUR COPAYMENT AMOUNT	
	NETWORK	NON-NETWORK
1. Allergy <ul style="list-style-type: none"> Office Visits Injections/Treatment 	<i>Office Visit:</i> [\$0-\$100] Copayment per office visit for Primary care [\$0-\$100] Copayment per office visit for Specialist care [[0%-50% Coinsurance per office visit] [after Deductible] <i>Injections/Treatment:</i> [[0-\$100] Copayment] [[0%-50%] Coinsurance after Deductible]	[0 - 50%] Coinsurance after Deductible [0 - 50%] Coinsurance after Deductible
2. Ambulance Services - Emergency Only <ul style="list-style-type: none"> Ground Transportation Air Transportation 	<i>Ground Transportation:</i> [\$25–250 Copayment] per transport] [0-50% Coinsurance after Deductible] [No Copayment] <i>Air Transportation:</i> [0-50% Coinsurance after Deductible] [\$50-500 Copayment] per transport	<i>Ground Transportation:</i> [\$25–250 Copayment] per transport] [0-50% Coinsurance after Deductible] [No Copayment] <i>Air Transportation:</i> [0-50% Coinsurance after Deductible] [\$50-500 Copayment] per transport

SERVICES (As outlined in Individual PPO Policy)	YOUR COPAYMENT AMOUNT	
	NETWORK	NON-NETWORK
3. Dental Anesthesia and Facility Charges Please refer to Your Policy (Section 11: Covered Benefits) for limitations.	[0 - 50% Coinsurance after Deductible] [No Copayment]	[0 - 50% Coinsurance after Deductible]
4. Dental Services - Accident only	[0 - 50% Coinsurance after Deductible] [No Copayment]	[0 - 50% Coinsurance after Deductible] [No Copayment]
5. Diabetes Services Coverage for diabetes self-management training is limited to one (1) program during the entire time You are covered under this Policy. See Policy, (Section 11: Covered benefits).	[Copayment/Coinsurance consistent with type of service required.] [0 - 50% Coinsurance after Deductible]	[0 - 50% Coinsurance after Deductible] [Copayment/Coinsurance consistent with type of service required.]
6. Durable Medical Equipment We provide Benefits only for a single purchase (including repair/replacement) of a type of Durable Medical Equipment once every [two-five] Calendar Year[s]. Any combination of Network and Non-Network Benefits for Durable Medical Equipment is limited to [\$750-\$10,000] per [Calendar] [Plan] Year. This limitation is not applicable to any equipment, supplies or self-management training for the treatment of diabetes.	[0-50% Coinsurance after Deductible] [No Copayment]	[0 - 50% Coinsurance after Deductible]
7. Emergency Health Services [Physician charges may be applicable, if billed separately. See <i>Professional Fees for Surgical and Medical Services</i> below.]	[\$0-250 Copayment per visit, except Copayment charge will be waived when inpatient admission for the same condition occurs within 24 hours] [0-50% Coinsurance after Deductible] [No Copayment]	[\$0-250 Copayment per visit, except Copayment charge will be waived when inpatient admission for the same condition occurs within 24 hours] [0-50% Coinsurance after Deductible] [No Copayment]
8. Eye Examinations Benefits include one (1) routine vision exam, including refraction, to detect vision impairment [each] [every other] [Calendar] [Plan] Year.	[\$5-75 Copayment per visit] [0-50% Coinsurance after Deductible]	[0-50% Coinsurance after Deductible]
9. Family Planning	[[0-\$100] Copayment per office visit] [[0%-50%] Coinsurance per office visit] [after Deductible]	[0 - 50%] Coinsurance after Deductible
10. Hearing Screenings for Newborns	[0 - 50% Coinsurance after Deductible] [No Copayment]	[0 - 50% Coinsurance after Deductible]
11. Home Health Care Any combination of Network and Non-Network Benefits for home health care is limited to 60 visits per [Calendar][Plan] Year.	[\$0-100 Copayment per visit] [0 - 50% Coinsurance after Deductible] [No Copayment]	[0 - 50% Coinsurance after Deductible]

SERVICES (As outlined in Individual PPO Policy)	YOUR COPAYMENT AMOUNT	
	NETWORK	NON-NETWORK
12. Hospice/Palliative Care Any combination of Network and Non-Network Benefits is limited to 180 days lifetime maximum.	[\$0 – 100 Copayment per day] [0 - 50% Coinsurance after Deductible] [No Copayment]	[0 – 50% Coinsurance after Deductible]]
13. Hospital - Inpatient Stay	[0-50% Coinsurance after Deductible]] [\$0-\$5000 Copayment per Inpatient Stay] [\$0-1,000] Copayment per day [\$0-1,000] Copayment per day to a maximum of [\$0-5,000] Copayment per Inpatient Stay [No Copayment]	[0-50% Coinsurance after Deductible]]
14. Immunization - Routine Only (Received in Physician’s Office)	[\$5-75] [Copayment per visit] [0-50% Coinsurance after Deductible for adults over 18 yrs.] [per injection] [No Copayment] No Copayment, Coinsurance or Deductible for immunizations for children birth through age 18 yrs.	[0-50% Coinsurance] [after Deductible] [per injection] for adults over 18 yrs.] [Covered In-Mercy Network Only] [No Copayment, Coinsurance or Deductible for immunizations for children birth through age 18 yrs.]
15. Injectables/Infusions (Received in a physician’s office, infusion center or through home health)	[[0-50%] Coinsurance [after 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
16. In-Vitro Fertilization <u>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 the Policy.</u>	[[[\$0-100] Copayment per visit] [0%-50% after deductible.] Member is responsible for the remaining 100% of the charges for infertility services over \$15,000.	[0 - 50% Coinsurance after deductible] [Covered in-Mercy Network Only] Member is responsible for the remaining 100% of the charges for infertility services over \$15,000.
17. Medical Foods/PKU Please refer to Your Policy (Section 11: Covered Benefits) for limitations.	[0 - 50%] Coinsurance after deductible [No Copayment]	[0 - 50%] Coinsurance after deductible
18. Mental Health and Substance Abuse Services – Outpatient Any combination of Network and Non-Network Benefits is limited as indicated in Your Policy	[0 - 50% Coinsurance after Deductible] [No Copayment] [[[\$0-100] per visit]	[0 - 50% Coinsurance after Deductible]
19. Mental Health and Substance Abuse Services – Inpatient and Intermediate Any combination of Network and Non-Network Benefits is limited as indicated in Your Policy	[0 - 50% Coinsurance after Deductible] [No Copayment] [\$0-1,000] per day to a maximum of [\$0-5,000] per Inpatient Stay]	[0 - 50% Coinsurance after Deductible]
20. Newborn Child Coverage	[0-50% after Deductible] [\$0-\$5000 per Inpatient Stay] [\$0-1,000] Copayment per day [\$0-1,000] Copayment per day to a maximum of [\$0-5,000] per Inpatient Stay] [No Copayment]	[0 - 50% after Deductible]
21. Nutritional Counseling Any combination of Network and Non-Network Benefits is limited as indicated in Your Policy.	[0 - 50% Coinsurance after Deductible] [[[\$0-100] Copayment per visit]	[0 - 50% Coinsurance after Deductible]

SERVICES (As outlined in Individual PPO Policy)	YOUR COPAYMENT AMOUNT	
	NETWORK	NON-NETWORK
22. Observation	[0 - 50% Coinsurance after Deductible]	[0 - 50% Coinsurance after Deductible]
23. Orthotics	[0 - 50% Coinsurance after Deductible] [No Copayment]	[0 - 50% Coinsurance after Deductible]
24. Osteoporosis [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 <i>Professional Fees for Surgical and Medical Services</i> below.] [When these services are performed in a Physician's office, Benefits are described under <i>Physician Office Services</i> above.]	[[0 - 50%] [Coinsurance after Deductible] [No Copayment] [Not Applicable]	[[0 - 50%] [Coinsurance after Deductible] [Not Applicable] [Covered In-Mercy Network Only]
25. Outpatient Diagnostic When these services are performed in a Physician's office, physician's charges may apply. See <i>Physician's Office Services</i> below.	Lab: [0%-50% Coinsurance after Deductible] [performed in a office] X-ray or Other: [0% - 50% Coinsurance after Deductible] [performed in office] [[0 - 50% Coinsurance after Deductible] [No Copayment]	[0 - 50% Coinsurance after Deductible]
26. Outpatient Surgery • Surgical Implants Implants for cosmetic or psychological reasons are excluded, see Section 14, L. in Your Policy.	[\$0 – 1,000 Copayment] [per surgical procedure] for outpatient surgery.] [[0 - 50% Coinsurance after Deductible] [No Copayment] <i>Surgical Implants:</i> [Copayment consistent with type of service required.] [0 - 50% Coinsurance after Deductible]	[0 - 50% Coinsurance after Deductible] [0 - 50% Coinsurance after Deductible]
27. Physician's Office Services	[\$10-100 Copayment per visit] [to a PCP] [to a Specialist] [No office visit Copayment applies when no Physician charge is assessed.] [0% – 50% Coinsurance after Deductible] [No Copayment for immunizations for children from birth to age eighteen.]	[0 - 50% Coinsurance after Deductible] [No Copayment for immunizations for children from birth to age eighteen.]

SERVICES (As outlined in Individual PPO Policy)	YOUR COPAYMENT AMOUNT	
	NETWORK	NON-NETWORK
<p>28. 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.]</p> <p>[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 <i>Professional Fees for Surgical and Medical Services</i> below.]</p> <p>[When these services are performed in a Physician's office, Benefits are described under <i>Physician Office Services</i> above.]</p>	<p><i>Cholesterol Tests:</i> [[0 – 50]% no Deductible when provided In-Mercy Network Only] [No Copayment] [Not Applicable]</p> <p><i>Colon Screening:</i> [[0 – 50]% no Deductible when provided In-Mercy Network Only] [No Copayment] [Not Applicable]</p> <p><i>Well-Woman:</i> [[0 – 50]% no Deductible when provided In-Mercy Network Only] [\$10-100 per visit] [to a PCP] [to a Specialist] [No Copayment] [Not Applicable]</p> <p><i>Prostate Exam:</i> [[0 – 50]% no Deductible when provided In-Mercy Network Only] [No Copayment] [Not Applicable]</p> <p><i>PSA test:</i> [[0 – 50]% no Deductible when provided In-Mercy Network Only] [No Copayment] [Not Applicable]</p> <p><i>Diabetes A1C Test:</i> [[0 – 50]% no Deductible when provided In-Mercy Network Only] [No Copayment] [Not Applicable]</p>	<p>[[0 – 50]% Coinsurance after Deductible] [Not Applicable] [Covered In-Mercy Network Only]</p> <p>[[0 - 50]%) [Coinsurance after Deductible] [Not Applicable] [Covered In-Mercy Network Only]</p> <p>[[0 - 50]%) [Coinsurance after Deductible] [Not Applicable] [Covered In-Mercy Network Only]</p> <p>[[0 - 50]%) [Coinsurance after Deductible] [Not Applicable] [Covered In-Mercy Network Only]</p> <p>[[0 - 50]%) [Coinsurance after Deductible] [Not Applicable] [Covered In-Mercy Network Only]</p>
<p>29. Professional Fees for Surgical and Medical Services</p>	<p>[0 - 50% Coinsurance after Deductible] [No Copayment]</p>	<p>[0 - 50% Coinsurance after Deductible]</p>
<p>30. Prosthetic Devices Benefits for prosthetic devices are limited to a single purchase of each type of prosthetic device every [two-five] [Calendar] [Plan] Year(s).</p> <p>Any combination of Network and Non-Network Benefits for prosthetic devices is limited to [\$2,500-\$10,000] per [Calendar] [Plan] Year. Please note that this limitation does not apply to breast prostheses.</p>	<p>[0 - 50% Coinsurance after Deductible] [No Copayment]</p>	<p>[0 - 50% Coinsurance after Deductible]</p>
<p>31. Reconstructive Procedures</p>	<p>[0 - 50% Coinsurance after Deductible] [No Copayment]</p>	<p>[0 - 50% Coinsurance after Deductible]</p>
<p>32. Rehabilitation Services – Outpatient Therapy Any combination of Network and Non-Network Benefits is limited as indicated in the Policy</p>	<p>[\$0-100 Copayment per visit] [0 - 50% Coinsurance after Deductible] [No Copayment]</p>	<p>[0 – 50% Coinsurance after Deductible]</p>
<p>33. Skilled Nursing Facility / Inpatient Rehabilitation Facility Services Any combination of Network and Non-Network Benefits is limited to [40-180] days per [Calendar] [Plan] Year.</p>	<p>[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</p>	<p>[0 - 50% Coinsurance after Deductible]</p>

SERVICES (As outlined in Individual PPO Policy)	YOUR COPAYMENT AMOUNT	
	NETWORK	NON-NETWORK
	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.] [No Copayment]	
34. Transplantation Services	[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] [No Copayment]	[0 - 50% Coinsurance after Deductible] [Benefits are limited to [\$30,000] per transplant. Please note that this limitation does not apply to dose intensive chemotherapy or bone marrow Transplants.].
35. Urgent Care Center Services	[\$0 –200] Copayment per visit] [0 - 50% Coinsurance after Deductible] [No Copayment]	[\$0 –200] Copayment per visit] [0 - 50% Coinsurance after Deductible]
36. [Acupuncture Services] Any combination of Network and Non-Network Benefits is limited to [10 – 100] visits per [Calendar] [Plan] Year.]	[\$5 – 75] per visit] [0 – 50% Coinsurance after Deductible] [No Copayment]	[0 – 50% Coinsurance after Deductible]
37. [Smoking Cessation Education Program]	[\$0-\$75] Copayment per program] [0 – 50% Coinsurance after Deductible] [No Copayment] [Not Covered]	[0 – 50% Coinsurance after Deductible] [Not Covered]
38. Chiropractic Care Limited to 26 visits per [Calendar] [Plan] Year.	Specialist [Copayment] [Coinsurance after deductible] applies	Specialist [Copayment] [Coinsurance after deductible] applies

OPTIONAL RIDERS

[Outpatient Prescription Drug]	<p>NETWORK:</p> <ul style="list-style-type: none"> • [[\$0-\$1,000] Annual Drug Deductible per Member per Calendar Year] [[\$0-1,500][per Member] [per Family] annual Maximum] • [No Annual Drug Deductible] • [\$0-\$1,500 annual benefit maximum] • [\$0-\$100] [0-50%] Copayment for up to a 30-day supply of Tier One drugs • [\$0-\$100] [0-50%] Copayment for up to a 30-day supply of Tier Two drugs • [[\$0-\$100] [0-50%] Copayment for up to a 30-day supply of Tier Three drugs] • [[\$0-\$100] [0%-50%] Coinsurance [with a maximum of \$100] per Prescription Order or Refill for Tier Four drugs up to a thirty (30) day supply per Prescription Order or Refill.] • [Smoking Cessation: Copayment will be consistent with Your Prescription drug benefit for each month’s purchase up to three (3) months of coverage per benefit year for certain smoking cessation products.] • Mail order [1x, 2x, 2.5x, 3x] Copayment • [90-day Retail Pharmacy [1x, 2x, 2.5x, 3x] Copayment] • [Formulary does not apply]
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OPTIONAL RIDERS

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:

50% Coinsurance of the cost of a Prescription [subject to Plan deductible including a dispensing fee and sales tax] that We would pay at a Participating Pharmacy per Prescription Order or Refill. The cost of a brand name Prescription is based on its generic version if a generic is available.

[Maternity Services]	NETWORK	NON-NETWORK
<p>Maternity benefits apply only after twelve (12) months of continuous coverage.</p>	<p><i>Physician Office:</i> [No Copayment applies to Physician office visits for prenatal care after the first visit.]</p> <p>[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.]</p> <p><i>Hospital Outpatient- Observation:</i> [0 - 50% Coinsurance after Deductible][per visit] [[\$[0-100] Copayment per visit]</p> <p><i>Hospital Inpatient Services:</i> [0 - 50% Coinsurance after Deductible]</p> <p><i>Outpatient Lab:</i> [0 - 50% Coinsurance after Deductible]</p> <p><i>Outpatient X-ray:</i> [0 - 50% Coinsurance after Deductible]</p>	<p><i>Physician Office:</i> [0 - 50% Coinsurance after Deductible]</p> <p><i>Hospital Outpatient- Observation:</i> [0 - 50% Coinsurance after Deductible] [[\$[0-100] Copayment per visit]</p> <p><i>Hospital Inpatient Services:</i> [0 - 50% Coinsurance after Deductible][per visit]</p> <p><i>Outpatient Lab:</i> [0 - 50% Coinsurance after Deductible]</p> <p><i>Outpatient X-ray:</i> [0 - 50% Coinsurance after Deductible]</p>
<p>[Temporomandibular Joint Disorder (TMJ)] [When these services are performed in a Physician's office, Benefits are described under <i>Physician Office Services</i> above.]</p> <p>[Copayment/Coinsurance consistent with applicable inpatient hospital, outpatient, hospital or other services required.]</p>	<p>[0 - 50%] Coinsurance after Deductible [\$10-100 Copayment per visit] [to a Specialist] [Copayment/Coinsurance consistent with type of service required]</p>	<p>[0 - 50%] Coinsurance after Deductible [Copayment/Coinsurance consistent with type of service required]</p>