

SERFF Tracking Number: MHPL-126776231 State: Arkansas
Filing Company: Mercy Health Plans State Tracking Number: 46544
Company Tracking Number: MHPL-126776231
TOI: H16G Group Health - Major Medical Sub-TOI: H16G.001A Any Size Group - PPO
Product Name: PPACA AMEND-10
Project Name/Number: PPACA Amendments/

Filing at a Glance

Company: Mercy Health Plans
Product Name: PPACA AMEND-10 SERFF Tr Num: MHPL-126776231 State: Arkansas
TOI: H16G Group Health - Major Medical SERFF Status: Closed-Approved- State Tr Num: 46544
Closed
Sub-TOI: H16G.001A Any Size Group - PPO Co Tr Num: MHPL-126776231 State Status: Approved-Closed
Filing Type: Form Reviewer(s): Rosalind Minor
Author: Karen Hosack Disposition Date: 08/31/2010
Date Submitted: 08/18/2010 Disposition Status: Approved-Closed
Implementation Date Requested: 10/01/2010 Implementation Date:
State Filing Description:

General Information

Project Name: PPACA Amendments Status of Filing in Domicile:
Project Number: Date Approved in Domicile:
Requested Filing Mode: Review & Approval Domicile Status Comments:
Explanation for Combination/Other: Market Type: Group
Submission Type: New Submission Group Market Size: Small and Large
Overall Rate Impact: Group Market Type: Employer
Filing Status Changed: 08/31/2010 Explanation for Other Group Market Type:
State Status Changed: 08/31/2010
Created By: Karen Hosack
Deemer Date: Corresponding Filing Tracking Number:
Submitted By: Karen Hosack
PPACA: Non-Grandfathered Immed Mkt Reforms, Grandfathered Immed Mkt Reforms
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: Health Reform Amendments to the COC and Schedules

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NAIC: 11529

Dear Ms. Minor:

I have attached these above-referenced Amendments and notices for your review and approval. The purpose of these Amendments is to be compliant with the recent "Patient Protection Act" regulations, which are effective for plan years beginning September 23, 2010. The anticipated effective date for this filing, however, is October 1, 2010, as all our plans begin or renew on the first of the month. This product will be marketed to both large and small employer groups. These Amendments will be used with Grandfathered and Non-Grandfathered plans.

The Grandfathered Plans Notices and the Supplemental Question to the Enrollment Application are NEW and do not replace any other forms. The Grandfathered Plan Notices will be used with the Certificates of Coverage as needed. Mercy Health Plans (MHP) already offers coverage for all the immediate reforms required by PPACA; therefore one Grandfathered Plan Notice was designed to accommodate our Group plans that will cover all the immediate reforms on or after October 1, 2010. We are filing a second Grandfathered Plan Notice which will be used only for Group plans that may have only the required reforms for Grandfathered Plans.

The Supplemental Question to the Enrollment Form, which is NEW, will be used with this Enrollment Forms: AR ENROLL v.4 (08) Approved on 5/16/2008 SERFF # MHPL-125641943

The Amendments will be used with the following forms:

Amendment Amends Form # Name of Document Approved on SERFF #

PHI AR AMEND9 (10/10) PHI AR COC (01/08) 2008 Certificate of Coverage 11/7/2007 PAPER FILING

AND PHI AR 2009COC v.2 (01/09) 2009 Certificate of Coverage 10/16/2008 MHPL 125852164

PHI AR AMEND10 (10/10) PHI AR COC/2010 2010 Certificate of Coverage 6/25/2009 MHPL-126157063

PHI AR AMEND8 (10/10) PHI AR SCHD (01/08) 2008 Schedule of Benefits 11/7/2007 PAPER FILING

AND PHI AR GRP SCHD v.2 (01/09) 2009 Schedule of Benefits 10/16/2008 MHPL 125852164

PHI AR AMEND7 (10/10) PHI AR GRP SCHD (2010) 2010 Schedule of Benefits 6/25/2009 MHPL-126157063

GRP AR GF-A Notice (10/10) NEW

GRP AR GFNotice (10/10) NEW

The Group Master Application had to be revised to accommodate changes in the Dependent Age 26. The GMA replaces: PHI AR GMA (2010) Approved on 6/30/2009 via SERFF # MHPL-126157063

We have included the "Special Notices" in the Amendments to COC (pages 1 and 2) that are also required under PPCA: "Notice of Special Opportunity to Enroll" covers those dependents who lost coverage due to previous limiting age; and,

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"Maximum Policy Benefit Special Notice" covers enrollees who lost coverage because they exhausted the Lifetime Maximum benefit.

Additional Notes: We have included clarification on our "Extended Provider Network" in the Amendments to the COCs. Additionally, it was necessary to align the Urgent Care/Expedited Appeals timeframes and the External Review deadline to appeal with PPACA regulations recently released. Other Appeals review changes mandated by PPACA are reflected in the Amendments to the COCs. Note also that we removed the \$500 dollar minimum required to submit an External Reviews in compliance with PPACA.

On the Amendment to 2008-2009 Schedule, we needed to insert the notice to the Hearing Aids Rider that the Group may reject coverage.

I have attached a completed PPACA Checklist under Supporting Documents. 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, MHP, CCP
Compliance Analyst

Company and Contact

Filing Contact Information

Karen Hosack, Compliance Analyst
Mercy Health Plans
14528 South Outer Forty Rd.
Suite 300
Chesterfield, MO 63017

khosack@mhp.mercy.net
314-214-2342 [Phone]
314-214-8103 [FAX]

Filing Company Information

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

SERFF Tracking Number: MHPL-126776231 State: Arkansas
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Fee Required? Yes
Fee Amount: \$400.00
Retaliatory? No
Fee Explanation: 8 documents x \$50 PER DOCUMENT
Per Company: No

| COMPANY | AMOUNT | DATE PROCESSED | TRANSACTION # |
|--------------------|----------|----------------|---------------|
| Mercy Health Plans | \$400.00 | 08/18/2010 | 38868482 |

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State: Arkansas

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TOI: H16G Group Health - Major Medical

Sub-TOI: H16G.001A Any Size Group - PPO

Product Name: PPACA AMEND-10

Project Name/Number: PPACA Amendments/

Correspondence Summary

Dispositions

| Status | Created By | Created On | Date Submitted |
|-----------------|----------------|------------|----------------|
| Approved-Closed | Rosalind Minor | 08/31/2010 | 08/31/2010 |

SERFF Tracking Number: *MHPL-126776231* *State:* *Arkansas*
Filing Company: *Mercy Health Plans* *State Tracking Number:* *46544*
Company Tracking Number: *MHPL-126776231*
TOI: *H16G Group Health - Major Medical* *Sub-TOI:* *H16G.001A Any Size Group - PPO*
Product Name: *PPACA AMEND-10*
Project Name/Number: *PPACA Amendments/*

Disposition

Disposition Date: 08/31/2010

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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| Schedule | Schedule Item | Schedule Item Status | Public Access |
|---------------------|---|----------------------|---------------|
| Supporting Document | Flesch Certification | Approved-Closed | Yes |
| Supporting Document | Application | Approved-Closed | Yes |
| Supporting Document | PPACA Uniform Compliance Summary | Approved-Closed | Yes |
| Supporting Document | Documents for Reference | Approved-Closed | Yes |
| Form | Health Reform Amendment to 2008-2009 COC | Approved-Closed | Yes |
| Form | Health Reform Amendment to the 2010 COC | Approved-Closed | Yes |
| Form | Health Reform Amendment to the 2008-2009 Schedule of Benefits | Approved-Closed | Yes |
| Form | Health Reform Amendment to the 2010 Schedule of Benefits | Approved-Closed | Yes |
| Form | Supplemental Question to Enrollment Form | Approved-Closed | Yes |
| Form | Group Master Application | Approved-Closed | Yes |
| Form | Grandfathered Plan Notice - All Reforms | Approved-Closed | Yes |
| Form | Grandfathered Plan Notice - Some Reforms | Approved-Closed | Yes |

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Form Schedule

Lead Form Number:

| Schedule Item | Form Number | Form Type | Form Name | Action | Action Specific Data | Readability | Attachment |
|-------------------------------|--------------------------------|------------------------------------|---|---------|----------------------|-------------|--|
| Approved-Closed 08/31/2010 | PHI AR AMEND9 (10/10) | Certificate | Health Reform Amendmen t, Insert Page, Endorseme nt or Rider | Initial | | | AR Group COC Health Reform Amendment 2008- 2009_(Eff 10.1.10).pdf |
| Approved-Closed 08/31/2010 | PHI AR AMEND10 (10/10) | Certificate | Health Reform Amendmen t, Insert Page, Endorseme nt or Rider | Initial | | | AR Group COC Health Reform Amendment 2010 (Eff 10.1.10).pdf |
| Approved-Closed 08/31/2010 | PHI AR AMEND8 (10/10) | Certificate | Health Reform Amendmen t, Insert Page, Endorseme nt or Rider | Initial | | | AR Group Health Reform AMENDMEN T to 2008- 2009 SCH (Eff 10.1.10).pdf |
| Approved-Closed 08/31/2010 | PHI AR AMEND7 (10/10) | Certificate | Health Reform Amendmen t, Insert Page, Endorseme nt or Rider | Initial | | | AR Group Health Reform AMENDMEN T to 2010 SCH (Eff 10.1.10).pdf |
| Approved-Closed 08/31/2010 | PHI AR ENROLL/S UPP (10- | Application/ Enrollment Form | Supplemental Question to Enrollment Form | Initial | | | AR Enrollment Form |

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 Product Name: PPACA AMEND-10
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10)

Approved- PHI AR Application/Group Master Initial
 Closed GMA Enrollment Application
 08/31/2010 (2010) Form

Approved- GRP AR Notice of Grandfathered Plan Initial
 Closed GF-A Coverage Notice - All Reforms
 08/31/2010 Notice
 (10/10)

Approved- GRP AR Notice of Grandfathered Plan Initial
 Closed GFNotice Coverage Ntoice - Some
 08/31/2010 (10/10) Reforms

Supplemental
 Question.pdf
 AR
 GMA_2010
 (AR-CO-028-
 0710)_7.19.1
 0.pdf
 NOTICE OF
 GF PLAN
 COVERAGE
 _all
 reforms.pdf
 NOTICE OF
 GF PLAN
 COVERAGE_
 req.pdf



**HEALTH REFORM
AMENDMENT**

This Amendment applies to the following

Certificates of Coverage:

**PHI AR 2009COC v.2 (01/09)
PHI AR COC (01/08)**

This document amends the Policies listed above. Except as modified or superceded by the coverage provided under this Amendment, all other terms, conditions, exclusions in these Policies remain unchanged and in full force and effect.

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 the subscribers as defined in this Policy. Unless defined differently in this Amendment, all other capitalized terms shall have the meanings given them in Your Policy.

I. Section 1 (Eligibility), first paragraph under “Dependents” is revised to read:

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. Dependent children must be under twenty-six (26) years of age and not entitled to Medicare. Dependent children covered under a Grandfathered Health Plan must not be eligible for any other employer-sponsored group health plan or entitled to Medicare. For a complete definition of Dependent and Enrolled Dependent see Section 14 (Definitions of Terms).

II. Section 2 (When Coverage Begins), is amended by adding a new section as follows:

| | |
|--|--|
| Notice of Special Opportunity to Enroll | Dependents whose coverage ended, or who were denied coverage (or were not eligible for coverage) because the availability of Dependent coverage of children ended before attainment of age 26 are eligible to enroll in this Policy. Subscribers may request enrollment for such Dependents within 30 days of this Policy’s renewal date. Enrollment for such Dependents will be effective retroactively to the first renewal date on or after September 23, 2010. |
|--|--|

III. Section 3 (When Coverage Ends), “Fraud, Misrepresentation or False Information” is revised to read:

| Event | Description |
|--|---|
| Fraud, Misrepresentation or False Information | <p>When Your coverage is terminated because of fraud or intentional misrepresentation, We will provide You at least thirty (30) days advance written notice that coverage will be Rescinded.</p> <p>During the first three (3) years this Policy is in effect, if You provided Us with false information or intentional 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 three (3) years, We can only demand that You pay back these Benefits if the written application contained a fraudulent misstatement.</p> <p>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</p> |

| Event | Description |
|-------|--|
| | Group, all coverage may be Rescinded upon thirty (30) 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. |

IV. **Section 4 (How You Get Care), "Extended Provider Network"** is revised to read:

Mercy Health Plans has Network Providers that are either directly contracted or are part of our extended provider network. To find a Network Provider (including providers that are part of our extended provider network), call Our Customer Contact Center at the phone number listed on Your ID card, or visit our website at www.mercyhealthplans.com

V. **Section 5 (Your Cost for Covered Services), "Maximum Policy Benefit"** is revised to read:

| | |
|-------------------------------|--|
| Maximum Policy Benefit | <p>There is no Maximum Policy Benefit for this Policy. For a complete definition of Maximum Policy Benefit, see Section 14 (Definitions of Terms).</p> <p>Special Notice: Eligible Persons whose coverage ended because they reached the lifetime dollar limit (Maximum Policy Benefit) under this Policy are eligible to re-enroll within thirty (30) days from the renewal date of this Policy, beginning on or after September 23, 2010.</p> |
|-------------------------------|--|

VI. **Section 8 (Complaints, Grievances & Appeals)** is amended as follows:

"Expedited Grievance Procedure" – This paragraph is revised to read,

Expedited Appeal Procedure: When the standard time frames in the Complaint and appeal procedures 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 twenty-four (24) hours after receiving a request for an expedited review. This will be followed by written notification of that decision within three (3) calendar days of the notification of the determination.

"Ask Us for an External Independent Review..." – First Paragraph is revised to read,

Within four months of the date You or Your authorized representative receive written notice of an Adverse Determination, You or Your authorized representative may initiate an independent 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 are afforded an independent External Review.

"Ask Us for an External Independent Review..." – Second Paragraph is revised to read,

"Adverse Determination" required for an independent External Review 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, appropriateness of care, health care settings, level of care or effectiveness of a Covered Services, or

(b) The requested health care service has been found to be "experimental/investigational."

“Appeal Decisions”, #2. is revised to read:

2. Reference to the specific Plan provisions on which the denial is based, including the date of service, provider, claim amount (if applicable), diagnosis, treatment, denial codes, and explanation of those Benefit terms;

VII. Section 9 (Utilization Review), “Urgent Care Request”, # 1. (a) and (e), is amended as follows:

- (a) **Initial Determination** – We will make an initial decision as soon as possible, taking into account the medical exigencies, but no later than twenty-four (24) hours after receipt of the requested service.
- (e) **Appeal Determination** – We will make a determination on the appeal within twenty-four (24) hours after receipt of the You or Your provider’s request for review.

VIII. Section 12 (Covered Benefits) is amended as follows:

- **Durable Medical Equipment, Orthotics and Prosthetics** are combined and revised to read:

| 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.] |
|--|---|
| 7. DME, Orthotics, Prosthetics and Medical Supplies | <p><i>Durable Medical Equipment (DME)</i> and its associated supplies that meet each of the following criteria:</p> <ul style="list-style-type: none"> ■ 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; <p>Examples of Durable Medical Equipment include:</p> <ul style="list-style-type: none"> ■ 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.) <p>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. 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.</p> <p>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 Year. The Plan is not responsible for DME loss or damage that is that is the result of action of a third party (i.e., loss of luggage holding DME equipment by an airliner).</p> |

| BENEFIT | <p style="text-align: center;">DESCRIPTION</p> <p style="text-align: center;">See Schedule of Coverage and Benefits for Your cost-sharing Amount</p> <p style="text-align: center;">[Note: Copayments [and Deductibles] do not count towards Your Out-of-Pocket (OOP) Maximum; only Coinsurances [and Deductibles] apply to Your OOP Maximum.]</p> |
|---------|--|
| | <p><i>Orthotics</i></p> <p>Covered orthotic device/equipment is the Standard Basic Equipment necessary to continue Instrumental Activities of Daily Living (IADL). The following items are covered when ordered and provided by a Physician and obtained from an orthotic provider:</p> <ul style="list-style-type: none"> ■ 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 <ul style="list-style-type: none"> ■ Foot orthotics are a covered treatment only for neuropathy causing loss of protective reflexes, or severe vascular insufficiency due to diabetes, or vascular disease. <p>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.</p> <p>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 Plan is not responsible for orthotics loss or damage that is that is the result of action of a third party (i.e., loss of luggage holding orthotic devices by an airliner).</p> <p><i>Prosthetics</i></p> <p>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.</p> <p>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. The Plan is not responsible for prosthetic loss or damage that is that is the result of action of a third party (i.e., loss of luggage holding prosthetic devices by an airliner).</p> <p>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:</p> <ul style="list-style-type: none"> ■ All mechanical organs |

| BENEFIT | <p style="text-align: center;">DESCRIPTION</p> <p style="text-align: center;">See Schedule of Coverage and Benefits for Your cost-sharing Amount</p> <p style="text-align: center;">[Note: Copayments [and Deductibles] do not count towards Your Out-of-Pocket (OOP) Maximum; only Coinsurances [and Deductibles] apply to Your OOP Maximum.]</p> |
|---------|--|
| | <ul style="list-style-type: none"> ■ Computer assisted devices ■ Dental and TMJ appliances ■ Devices employing robotics ■ Electrical continence aids, anal or urethral ■ Investigational or obsolete devices and supplies ■ Remote control devices <p>See Section 13, K., Q., B., and C., for more details on related exclusions.</p> <p>Breast prosthesis as required by the Women's Health and Cancer Rights Act of 1998 is also covered. Breast prosthesis may follow a mastectomy at any time. Coverage includes a post-mastectomy brassiere.</p> <p style="text-align: center;"><u>Prior Authorization Required</u></p> <p>Some DME, orthotics and prosthetic devices require Prior Authorization, including DME, orthotics and prosthetic devices that cost more than \$1,000. 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 the services requiring Prior Authorization, or services that are over \$1,000, Network and Non-Network Benefits will be reduced by [50% - 100%] of Eligible Expenses.</p> <p><i>Medical Supplies</i></p> <p>Coverage includes Medically Necessary supplies only when prescribed by a Physician and supplied by a home care agency in conjunction with covered home health care services, or when dispensed and used by a Network Provider in conjunction with treatment of the member. The following medical supplies are covered:</p> <ul style="list-style-type: none"> ■ Diabetic supplies (see <i>Diabetes Services</i> above); ■ Standard ostomy supplies; ■ Catheters (urinary and respiratory) and associated supplies such as drainage bags and irrigation kits; ■ Sterile surgical wound supplies; ■ Jobst stockings or other support hose ordered by a physician and determined to be Medically Necessary, but only two (2) support stockings per [Calendar][Plan] Year are covered. <p>Coverage of medical supplies does not include items usually stocked in the home for general usage such as bandages, thermometers and petroleum jelly. Supplies that can be purchased over the counter without a physician's order are not covered. See Section 13, C., H., for related limitations and exclusions.</p> <p style="text-align: center;"><u>Prior Authorization Required</u></p> <p>Some medical supply services require Prior Authorization [including medical supplies that cost more than \$1,000]. 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%-100%] of Eligible Expenses.]</p> |

| 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.] |
|---------|--|
| | [Any combination of Network and Non-Network Benefits for DME, Orthotics, Prosthetics and Medical Supplies [(combined Benefit)] is limited according to Your Schedule of Coverage and Benefits.] |

- **Immunizations and Preventive Health & Wellness Care** are deleted in their entirety and revised to read:

| 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.] |
|--|--|
| 13. Immunizations (Routine Only) | Routine immunizations for children and adults as recommended by the Plan and Federal law. 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. Note that applicable cost-share for office visit(s) may apply for all other medical services that are received during the same office visit. |
| 30. Preventive Health Screenings – Routine Only | <p>Preventive Health Screenings in accordance with the American Cancer Society guidelines, Federal law and additional preventive Benefits provided by Mercy Health Plans. Preventive Health Screenings include, but are not limited to, the services listed below. Any health screenings not listed here, or not required by Federal law, will be paid consistent with other services under the health benefit plan.</p> <p>These Preventive Health Screenings are limited to one (1) routine test of each of the following every Calendar Year, unless otherwise indicated:</p> <ul style="list-style-type: none"> ■ Cholesterol Tests ■ Colon Screening: <ul style="list-style-type: none"> <input type="checkbox"/> Fecal Occult Blood Test <input type="checkbox"/> Colonoscopy – one (1) routine screening every ten (10) [Calendar][Rolling] Years starting at age 50 <input type="checkbox"/> Double-contrast Barium Enema – one (1) routine screening every five (5) [Calendar][Rolling] Years starting at age 50 <input type="checkbox"/> Flexible Sigmoidoscopy – one (1) routine screening every five (5) [Calendar][Rolling] 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 Health Screening in a Physician’s office including one (1) annual physical exam per [Calendar] OR [Plan] Year for adults, and periodic visits for well-baby and well-child care as follows: <ul style="list-style-type: none"> <input type="checkbox"/> 10 visits, birth to 24 months; <input type="checkbox"/> 1 visit per Calendar Year for ages 2 – 18 years. <p>Any other Preventive Health Screenings not listed here may be covered, but would be paid consistent with other service(s) under the</p> |

| 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.] |
| | health benefit plan.” |

IX. Section 13 (Exclusions), L. Preexisting Conditions is deleted in its entirety and replaced by the following:

| EXCLUSION | DESCRIPTION |
|---------------------------|---|
| L. Preexisting Conditions | Benefits for the treatment of a Preexisting Condition are excluded until the date You have had Continuous Creditable Coverage for 12 months, <u>except</u> this waiting period will not apply to: <ul style="list-style-type: none"> ■ A newborn, if an application for coverage is filed within ninety (90) days of the birth of the child; ■ A child who is placed in a Member’s physical custody for purpose of adoption, if the petition for adoption is filed within sixty (60) days of placement of such a child; ■ A person who has had Continuous Creditable Coverage for at least 12 months without a break of sixty-three (63) days or more; ■ An Eligible Person under the age of 19 years; or ■ Pregnancy. |

X. Section 14 (Definitions of Terms) is amended as follows:

- Deleting the term, “Full-Time Student”, and its definition;
- Deleting the term, “Service Area”, and its definition;
- Adding these new terms:

| Term | Definition |
|----------------------------------|--|
| <i>Grandfathered Health Plan</i> | A major medical group health plan in which an individual was enrolled on March 23, 2010. |
| <i>Rescinded</i> | Coverage that is retroactively cancelled or discontinued. |

- Revising these terms to read:

| Term | Definition |
|------------------|--|
| <i>Dependent</i> | The Subscriber's legal Spouse, Dependent child or other Dependent as described in Your Schedule of Coverage and Benefits. The term child includes any of the following: <ul style="list-style-type: none"> ■ 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. ■ A child for whom health care coverage is required through a ‘Qualified Medical Child Support Order’ or other court or administrative order. The Enrolling Individual is responsible for determining if an order meets the criteria of a Qualified Medical Child Support Order. <p>The definition of Dependent is subject to the conditions and</p> |

| | |
|--|---|
| | <p>limitations as set forth in the Schedule of Coverage and Benefits. Additionally,</p> <ul style="list-style-type: none"> ■ Dependent children must be under twenty-six (26) years of age. ■ Dependent children must not be entitled to Medicare; ■ Dependent(s) do not include anyone who is enrolled as a Subscriber. ■ No one can be a Dependent of more than one Subscriber. ■ Dependent children covered under a Grandfathered Plan must not be eligible for any other employer-sponsored group health plan. ■ Dependent Children must reside within the United States. |
| <i>Preexisting Condition</i> | An Injury, Sickness or condition that was present before the Effective Date of coverage whether or not any medical advice, diagnosis, care, or treatment was recommended or received before the Effective Date. |
| <i>Preventive Health Screening(s)</i> | 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 are classified as diagnostic tests. |
| <i>Rolling Years</i> | A consecutive twelve (12) month period that begins on the date You receive a Covered Service and continues for each consecutive twelve (12) month period thereafter. A Rolling Year, for example, can be April 1 (of one year) to March 31 (of the following year); it is not the same as a Calendar Year. |



Charles S. Gilham, Secretary
Mercy Health Plans



**HEALTH REFORM
AMENDMENT
To the**

**2010 Certificate of Coverage
PHI AR COC/2010**

This document amends the Policy listed above. Except as modified or superceded by the coverage provided under this Amendment, all other terms, conditions, exclusions in this Policy remain unchanged and in full force and effect.

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 the subscribers as defined in the Policy. Unless defined differently in this Amendment, all other capitalized terms shall have the meanings given them in the Policy.

I. Section 1 (Eligibility), first paragraph under “Dependents” is revised to read:

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. Dependent children must be under twenty-six (26) years of age and not entitled to Medicare. Dependent children covered under a Grandfathered Health Plan must not be eligible for any other employer-sponsored group health plan or entitled to Medicare. For a complete definition of Dependent and Enrolled Dependent see Section 14 (Definitions of Terms).

II. Section 2 (When Coverage Begins), is amended by adding a new section as follows:

| | |
|--|--|
| Notice of Special Opportunity to Enroll | Dependents whose coverage ended, or who were denied coverage (or were not eligible for coverage) because the availability of Dependent coverage of children ended before attainment of age 26 are eligible to enroll in this Policy. Subscribers may request enrollment for such Dependents within 30 days of this Policy’s renewal date. Enrollment for such Dependents will be effective retroactively to the first renewal date on or after September 23, 2010. |
|--|--|

III. Section 3 (When Coverage Ends), “Fraud, Misrepresentation or False Information” is revised to read:

| Event | Description |
|--|--|
| Fraud, Misrepresentation or False Information | When Your coverage is terminated because of fraud or intentional misrepresentation, We will provide You at least thirty (30) days advance written notice that coverage will be Rescinded. During the first three (3) years this Policy is in effect, if You provided Us with false information or intentional misrepresentation of material facts |

| Event | Description |
|-------|---|
| | <p>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 three (3) years, We can only demand that You pay back these Benefits if the written application contained a fraudulent misstatement.</p> <p>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 Rescinded upon thirty (30) 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.</p> |

IV. **Section 3 (When Coverage Ends), “Full-Time Student Status Ends”** is deleted in its entirety and not replaced.

V. **Section 4 (How You Get Care), “Extended Provider Network”** is revised to read:

Mercy Health Plans has Network Providers that are either directly contracted or are part of our extended provider network. To find a Network Provider (including providers that are part of our extended provider network), call Our Customer Contact Center at the phone number listed on Your ID card, or visit our website at www.mercyhealthplans.com

VI. **Section 5 (Your Cost for Covered Services), “Maximum Policy Benefit”** is revised to read:

| | |
|--------------------------------------|--|
| <p>Maximum Policy Benefit</p> | <p>There is no Maximum Policy Benefit for this Policy. For a complete definition of Maximum Policy Benefit, see Section 14 (Definitions of Terms).</p> <p>Special Notice: Eligible Persons whose coverage ended because they reached the lifetime dollar limit (Maximum Policy Benefit) under this Policy are eligible to re-enroll within thirty (30) days from the renewal date of this Policy, beginning on or after September 23, 2010.</p> |
|--------------------------------------|--|

VII. **Section 8 (Complaints, Grievances & Appeals)** is amended as follows:

“**Expedited Grievance Procedure**” – This paragraph is revised to read,

Expedited Appeal Procedure: When the standard time frames in the Complaint and appeal procedures 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 twenty-four (24) hours after receiving a request for an expedited review. This will be followed by written notification of that decision within three (3) calendar days of the notification of the determination.

“Ask Us for an External Independent Review...” – First Paragraph is revised to read,

Within four months of the date You or Your authorized representative receive written notice of an Adverse Determination, You or Your authorized representative may initiate an independent 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 are afforded an independent External Review.

“Ask Us for an External Independent Review...” – Second Paragraph is revised to read,

“Adverse Determination” required for independent an External Review 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:

- The requested health care service does not meet the health benefit plan's requirements for medical necessity, appropriateness of care, health care settings, level of care or effectiveness of a Covered Services, or
- The requested health care service has been found to be "experimental/investigational."

“Appeal Decisions”, # 2. Is revised to read:

2. Reference to the specific Plan provisions on which the denial is based, including the date of service, provider, claim amount (if applicable), diagnosis, treatment, denial codes, and explanation of those Benefit terms;

VIII. Section 9 (Utilization Review), “Urgent Care Request”, first bullet, is amended as follows:

- Initial Determination: We will make an initial decision as soon as possible, taking into account the medical exigencies, but no later than twenty-four (24) hours after receipt of the requested service.

IX. Section 13 (Exclusions), L. Preexisting Conditions is deleted in its entirety and replaced by the following:

| EXCLUSION | DESCRIPTION |
|---|---|
| <p>L. Preexisting Conditions</p> | <p>Benefits for the treatment of a Preexisting Condition are excluded until the date You have had Continuous Creditable Coverage for 12 months, <u>except</u> this waiting period will not apply to:</p> <ul style="list-style-type: none"> ■ A newborn, if an application for coverage is filed within ninety (90) days of the birth of the child; ■ A child who is placed in a Member’s physical custody for purpose of adoption, if the petition for adoption is filed within sixty (60) days of placement of such a child; ■ A person who has had Continuous Creditable Coverage for at least 12 months without a break of |

| | |
|--|--|
| | <p>sixty-three (63) days or more;</p> <ul style="list-style-type: none"> ■ An Eligible Person under the age of 19 years; or ■ Pregnancy. |
|--|--|

X. Section 14 (Definitions of Terms) is amended as follows:

- Deleting the term, “Full-Time Student”, and its definition;
- Deleting the term, “Service Area”, and its definition;
- Adding these new terms:

| Term | Definition |
|---|--|
| <i>Grandfathered Health Plan</i> | A major medical group health plan in which an individual was enrolled on March 23, 2010. |
| <i>Rescinded</i> | Coverage that is retroactively cancelled or discontinued. |

- Revising these terms to read:

| Term | Definition |
|-------------------------|--|
| <i>Dependent</i> | <p>The Subscriber's legal Spouse, Dependent child or other Dependent as described in Your Schedule of Coverage and Benefits. The term child includes any of the following:</p> <ul style="list-style-type: none"> • 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. • A child for whom health care coverage is required through a ‘Qualified Medical Child Support Order’ or other court or administrative order. The Enrolling Individual is responsible for determining if an order meets the criteria of a Qualified Medical Child Support Order. <p>The definition of Dependent is subject to the conditions and limitations as set forth in the Schedule of Coverage and Benefits. Additionally,</p> <ul style="list-style-type: none"> • Dependent children must be under twenty-six (26) years of age. • Dependent children must not be entitled to Medicare; • Dependent(s) do not include anyone who is enrolled as a Subscriber. • No one can be a Dependent of more than one Subscriber. • Dependent children covered under a Grandfathered |

| | |
|-------------------------------------|--|
| | <p>Plan must not be eligible for any other employer-sponsored group health plan.</p> <ul style="list-style-type: none"> • Dependent Children must reside within the United States. |
| <i>Preexisting Condition</i> | <p>An Injury, Sickness or condition that was present before the Effective Date of coverage whether or not any medical advice, diagnosis, care, or treatment was recommended or received before the Effective Date.</p> |



Charles S. Gilham, Secretary
 Mercy Health Plans



**HEALTH REFORM
AMENDMENT
to 2008 and 2009
SCHEDULES OF COVERAGE AND BENEFITS
PHI AR GRP SCHD v.2 (01/09)
PHI AR SCHD (01/08)**

This Amendment describes certain changes in Your Policy. Except as modified or superseded by the coverage provided under this Amendment, all other terms, conditions, exclusions in Your Certificate of Coverage and Schedule of Coverage and Benefits remain unchanged and in full force and effect.

I. The Schedule of Coverage and Benefit listed above is amended by deleting these benefits below in their entirety and replacing as follows:

| 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. 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.][for Subscribers plus one or more Covered Persons in a family per [Calendar][Plan] Year.] | [\$0 – 20,000] per Covered Person per [Calendar] [Plan] Year, not to exceed [\$0 – 60,000] [for all Covered Persons in a family.][for Subscribers plus one or more Covered Persons in a family per [Calendar][Plan] Year.] |
| 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.] [Copayments, 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.][for Subscribers plus one or more Covered Persons in a family per [Calendar][Plan] Year.] The 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.][for Subscribers plus one or more Covered Persons in a family per [Calendar][Plan] Year.] The Out-of-Pocket Maximum does not include the Annual Deductible. [No Out-of-Pocket Maximum] |
| Maximum Policy Benefit | No Maximum Policy Benefit | No Maximum Policy Benefit |

II. The Schedule of Coverage and Benefit listed above is amended by deleting the benefits below in their entirety and replacing as follows:

| SERVICES | MEMBER RESPONSIBILITY |
|---|--|
| Durable Medical Equipment (DME)/Orthotics/Prosthetics and Medical Supplies * Network and Non-Network Benefits for DME, Orthotics and Prosthetics and Medical Supplies is limited as follows: DME – Unlimited; Orthotics - [\$750 - \$10,000]; Prosthetics - Unlimited. Some DME, orthotics, prosthetics, and medical supply services require Prior Authorization, including those devices that cost more than \$1,000. 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 the services requiring Prior Authorization, or services that are over \$1,000, Network and Non-Network Benefits will be reduced by 100% of the Eligible Expenses. | Network Providers: [0 - 50% Coinsurance] [after Deductible] Non-Network Providers: [0 - 50% Coinsurance] [after Deductible] |

* - Prior Authorization required.

Prior Authorization can be found at www.mercyhealthplans.com, or by calling Our Customer Contact Center at the number listed on Your ID card.

| SERVICES | MEMBER RESPONSIBILITY |
|---|---|
| <p>Immunizations (Routine Only)</p> <p>Routine immunizations for children and adults as recommended by Federal law. Applicable cost-share for office visit(s) will apply for all other medical services besides immunization that are received in the same office visit.</p> | <p>Network Providers: [No Copayment and no Deductible]</p> <p>Non-Network Providers: [No Copayment and no Deductible] OR [Birth – 18 yrs: \$0 Copayment] [Children over 18 yrs. and Adults:] [0-50% Coinsurance] [after deductible][no Deductible] OR [\$0-\$100 Copayment]</p> |
| <p>Osteoporosis Services/Bone Mineral Density (BMD) Testing *</p> <p>Preventive Health Screening according to the USPSTF guidelines and Federal law.</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>Network Providers: [\$0 Copayment [0% Coinsurance] [after Deductible] [No Deductible]</p> <p>Applicable cost-share for office visit(s) will apply for all other medical services received in the same office visit besides BMD Testing.</p> <p>Applicable cost-share for outpatient testing/procedures will apply for all Osteoporosis Services/Bone Mineral Density (BMD) Testing that is not considered Preventive Health Screening.</p> <p>Non-Network Providers: [0%-50% Coinsurance][after Deductible] [No Deductible] [No Copayment]</p> |
| <p>Preventive Health Screenings – Routine Only</p> <p>Preventive Health Screenings in accordance with the American Cancer Society guidelines, Federal law and additional preventive Benefits provided by Mercy Health Plans. Preventive Health Screenings include, but are not limited to, the services listed below. Any health screenings not listed here, or not required by Federal law, will be paid consistent with other services under the health benefit plan. [The Plan pays 100% for these Preventive Health Screenings only when You use Network providers. Deductible and Coinsurance will apply to services received from Non-Network Providers.]</p> <p>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. [Applicable cost-share will be consistent with type of service received.]</p> <p>These Preventive Health Screenings are limited to one (1) routine test of each of the following every [Calendar] [Plan] Year, unless otherwise indicated:</p> <ul style="list-style-type: none"> ■ Cholesterol Tests ■ Colon Screening: <ul style="list-style-type: none"> <input type="checkbox"/> Fecal Occult Blood Test <input type="checkbox"/> Colonoscopy – one (1) routine screening every ten (10) [Calendar][Rolling] Years starting at age 50 <input type="checkbox"/> Double-contrast Barium Enema – one (1) routine screening every five (5) [Calendar][Rolling] Years starting at age 50 <input type="checkbox"/> Flexible Sigmoidoscopy – one (1) routine screening every five (5) [Calendar][Rolling] 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 Health Screening in a Physician’s office including one (1) annual physical exam per [Calendar] OR [Plan] Year for adults, and | <p><i>Cholesterol Tests:</i></p> <p>Network Providers: [0 % Coinsurance No Deductible][No Copayment]</p> <p>Non-Network Providers: [0 – 50% Coinsurance] [after][no] [Deductible] [No Copayment]</p> <p><i>Colon Screening(Fecal Occult Blood, Colonoscopy, Double-contrast Barium Enema, and Flexible Sigmoidoscopy):</i></p> <p>Network Providers: [0 % Coinsurance No Deductible][No Copayment]</p> <p>Non-Network Providers: [0 – 50% Coinsurance] [after][no] [Deductible] [No Copayment]</p> <p><i>Mammography:</i></p> <p>Network Providers: [0 % Coinsurance No Deductible][No Copayment]</p> <p>Non-Network Providers: [0 – 50% Coinsurance] [after][no] [Deductible] [No Copayment]</p> <p><i>Pap/Pelvic:</i></p> <p>Network Providers: [0 % Coinsurance No Deductible][No Copayment]</p> <p>Non-Network Providers: [0 – 50% Coinsurance] [after][no]</p> |

* - Prior Authorization required.

Prior Authorization can be found at www.mercyhealthplans.com, or by calling Our Customer Contact Center at the number listed on Your ID card.

| SERVICES | MEMBER RESPONSIBILITY |
|--|---|
| <p>periodic visits for well-baby and well-child care as follows:</p> <ul style="list-style-type: none"> <input type="checkbox"/> 10 visits, birth to 24 months <input type="checkbox"/> 1 visit per Calendar Year for ages 2 – 18 years <p>Note: All other Covered Services in a physician’s office will be covered under <i>Physician’s Office Services</i>.</p> | <p>Deductible] [No Copayment]</p> <p><i>Prostate Exam:</i> Network Providers: [0 % Coinsurance No Deductible][No Copayment] Non-Network Providers: [0 – 50% Coinsurance] [after][no Deductible] [No Copayment]</p> <p><i>PSA Test:</i> Network Providers: [0 % Coinsurance No Deductible][No Copayment] Non-Network Providers: [0 – 50% Coinsurance no Deductible] [No Copayment]</p> <p><i>Annual Physical Exam and well-child visits in a Physician’s office:</i> Network Providers: [0 % Coinsurance No Deductible][No Copayment] Non-Network Providers: [0 – 50% Coinsurance] [after][no Deductible] [No Copayment]</p> |

III. “Riders” section, the description of “Hearing Aid Services Rider” is revised to read as follows:

| OPTIONAL RIDER | |
|--|--|
| <p>Hearing Aid Services Rider [*]</p> <p>The group policy or contract holder may reject coverage offered under this rider.</p> | <p>[Hearing Aids including repair and replacement parts: [Total maximum Benefit of \$1,400 net expense per ear applicable toward the purchase of hearing aids from a Network or Non-Network Provider every three (3) [Calendar][Rolling] Years][thirty-six (36) consecutive months].] This mandated offer is not subject to any Deductible, Coinsurance or Copayment.</p> <p>[Specialist Copayment for annual hearing test will apply. If hearing test is done in conjunction with an office visit, only one Copayment applies] [Only][Deductibles,] [Coinsurances][and][Copayments] will be counted in Your Out-of-Pocket Maximum.]</p> <p>[Coverage not available]</p> |

IV. “Other Eligibility Requirements” section, the description of “Dependent Eligibility” is revised to read as follows:

| | |
|--|---|
| <p>Dependent Eligibility [“Dependent” means the Subscriber’s legal Spouse, or Domestic Partner*, or a Dependent Child of the Subscriber as described in the Certificate of Coverage.]</p> <p>[“Dependent” means the Subscriber’s legal Spouse, or an Dependent Child of the Subscriber as described in the Certificate of Coverage.]</p> | <p>Coverage for Dependent child terminates [at the end of the month] [on the date] that Your Dependent turns 26 years of age. However, coverage for a Dependent child who is disabled because of a mental or a physical disability will not end when the child has reached age 26, as long as the disabled child remains eligible as described in the Certificate of Coverage, and You furnish Us with proof of the disabled child's incapacity and dependency.</p> |
|--|---|

* - Prior Authorization required.

Prior Authorization can be found at www.mercyhealthplans.com, or by calling Our Customer Contact Center at the number listed on Your ID card.

| | |
|--|--|
| [Other description of Dependent Eligibility as determined by Employer Group] | |
|--|--|



Charles S. Gilham, Secretary
Mercy Health Plans

* - Prior Authorization required.

Prior Authorization can be found at www.mercyhealthplans.com, or
by calling Our Customer Contact Center at the number listed on Your ID card.



**HEALTH REFORM AMENDMENT
to the
SCHEDULE OF COVERAGE AND BENEFITS
PHI AR GRP SCHD (2010)**

This Amendment describes certain changes in Your Policy. Except as modified or superceded by the coverage provided under this Amendment, all other terms, conditions, exclusions in Your Certificate of Coverage and Schedule of Coverage and Benefits remain unchanged and in full force and effect.

- I. **The Schedule of Coverage and Benefit listed above is amended by deleting** the benefits below in their entirety and **replacing** as follows:

| MEMBER RESPONSIBILITY | DESCRIPTION |
|---|--|
| <p>DME, Orthotics, Prosthetics[*] and Medical Supplies [*] Network and Non-Network Benefits for DME, Orthotics and Prosthetics and Medical Supplies is limited as follows:</p> <ul style="list-style-type: none"> ■ DME – Unlimited ■ Orthotics - [\$750 – \$10,000] ■ Prosthetics – Unlimited <p>[There is no annual limit for Medical Supplies.]</p> <p>Network Providers: [[0-50%] Coinsurance after Deductible]</p> <p>Non-Network Providers: [[0 - 50%] Coinsurance after Deductible]</p> <p>[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.]</p> | <p><u>Durable Medical Equipment (DME)</u> and its associated supplies that meet each of the following criteria:</p> <ul style="list-style-type: none"> ■ 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; <p>Examples of Durable Medical Equipment include:</p> <ul style="list-style-type: none"> ■ 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.) <p>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. 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.</p> <p>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 Year. The Plan is not responsible for DME loss or damage that is that is the result of action of a third party (i.e., loss of luggage holding DME equipment by an airliner).</p> <p><u>Orthotics</u> Covered orthotic device/equipment is the Standard Basic Equipment necessary to continue Instrumental Activities of Daily Living (IADL). The following items are covered when ordered and provided by a Physician and obtained from an orthotic provider:</p> <ul style="list-style-type: none"> ■ 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 |

* - Prior Authorization required.

Prior Authorization can be found at www.mercyhealthplans.com, or by calling Our Customer Contact Center at the number listed on Your ID card.

| MEMBER RESPONSIBILITY | DESCRIPTION |
|-----------------------|---|
| | <ul style="list-style-type: none"> ■ Foot orthotics are a covered treatment only for neuropathy causing loss of protective reflexes, or severe vascular insufficiency due to diabetes, or vascular disease. <p>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.</p> <p>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 Plan is not responsible for orthotics loss or damage that is that is the result of action of a third party (i.e., loss of luggage holding orthotic devices by an airliner).</p> <p>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.</p> <p>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. The Plan is not responsible for prosthetic loss or damage that is that is the result of action of a third party (i.e., loss of luggage holding prosthetic devices by an airliner).</p> <p>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:</p> <ul style="list-style-type: none"> ■ All mechanical organs ■ Computer assisted devices ■ Dental and TMJ appliances ■ Devices employing robotics ■ Electrical continence aids, anal or urethral ■ Investigational or obsolete devices and supplies ■ Remote control devices <p>See Section 13, K., Q., B., and C., for more details on related exclusions.</p> <p>Breast prosthesis as required by the Women's Health and Cancer Rights Act of 1998 is also covered. Breast prosthesis may follow a mastectomy at any time. Coverage includes a post-mastectomy brassiere.</p> <p style="text-align: center;">[Prior Authorization Required]</p> <p>Some DME, orthotics and prosthetic devices require Prior Authorization, including those devices that cost more than \$1,000. 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 the services requiring Prior Authorization, or services that are over \$1,000, Network and Non-Network Benefits will be reduced by [50% - 100%] of Eligible Expenses.</p> <p>Medical Supplies Coverage includes Medically Necessary supplies only when prescribed by a Physician and supplied by a home care agency in conjunction with covered home</p> |

* - Prior Authorization required.

Prior Authorization can be found at www.mercyhealthplans.com, or by calling Our Customer Contact Center at the number listed on Your ID card.

| MEMBER RESPONSIBILITY | DESCRIPTION |
|---|---|
| | <p>health care services, or when dispensed and used by a Network Provider in conjunction with treatment of the member. The following medical supplies are covered:</p> <ul style="list-style-type: none"> ■ Diabetic supplies (see <i>Diabetes Services</i> above); ■ Standard ostomy supplies; ■ Catheters (urinary and respiratory) and associated supplies such as drainage bags and irrigation kits; ■ Sterile surgical wound supplies; ■ Jobst stockings or other support hose ordered by a physician and determined to be Medically Necessary, but only two (2) support stockings per [Calendar][Plan] Year are covered. <p>Coverage of medical supplies does not include items usually stocked in the home for general usage such as bandages, thermometers and petroleum jelly. Supplies that can be purchased over the counter without a physician's order are not covered. See Section 13, C., H., for related limitations and exclusions.</p> <p style="text-align: center;">[Prior Authorization Required]</p> <p>Some medical supply services require Prior Authorization [including medical supplies that cost more than \$1,000]. 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%-100%] of Eligible Expenses.]</p> |
| <p>Immunizations (Routine Only)</p> <p>Network Providers: [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]]</p> <p>Non-Network Providers: [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]]</p> <p>Note that applicable cost-share for office visit(s) will still apply for all other medical services that are received during the same office visit.</p> | <p>Routine immunizations for children and adults as recommended by the Plan and Federal law. 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.</p> |
| <p>Osteoporosis Services/Bone Mineral Density (BMD) Testing [*]</p> <p>Network Providers: [\$0 Copayment] [0% Coinsurance] [after Deductible][No Deductible]</p> <p>Applicable cost-share for office visit(s) will apply for all other medical services received in the same office visit besides BMD Testing.</p> <p>Applicable cost-share for outpatient testing/procedures will apply for all Osteoporosis Services/Bone Mineral Density (BMD) Testing that is not considered Preventive Health Screening.</p> <p>Non-Network Providers: [0%-50% Coinsurance][after Deductible] [No Deductible]</p> | <p>Preventive Health Screening according to the USPSTF guidelines and Federal law. [Coverage may be limited according to age and frequency of tests.]</p> <p style="text-align: center;">[Prior Authorization Required]</p> <p>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%-100%] of Eligible Expenses.]</p> |

* - Prior Authorization required.

Prior Authorization can be found at www.mercyhealthplans.com, or by calling Our Customer Contact Center at the number listed on Your ID card.

| MEMBER RESPONSIBILITY | DESCRIPTION |
|--|--|
| <p>[No Copayment]</p> <p>Preventive Health Screenings — Routine Only</p> <p><u>Cholesterol Tests:</u> Network Providers: [0 % Coinsurance No Deductible][No Copayment] Non-Network Providers: [0 – 50% Coinsurance] [after][no] [Deductible] [No Copayment]</p> <p><u>Colon Screening(Fecal Occult Blood, Colonoscopy, Double-contrast Barium Enema, and Flexible Sigmoidoscopy):</u> Network Providers: [0 % Coinsurance No Deductible][No Copayment] Non-Network Providers: [0 – 50% Coinsurance] [after][no] [Deductible] [No Copayment]</p> <p><u>Mammography:</u> Network Providers: [0 % Coinsurance No Deductible][No Copayment] Non-Network Providers: [0 – 50% Coinsurance] [after][no] [Deductible] [No Copayment]</p> <p><u>Pap/Pelvic:</u> Network Providers: [0 % Coinsurance No Deductible][No Copayment] Non-Network Providers: [0 – 50% Coinsurance] [after][no] Deductible] [No Copayment]</p> <p><u>Prostate Exam:</u> Network Providers: [0 % Coinsurance No Deductible][No Copayment] Non-Network Providers: [0 – 50% Coinsurance] [after][no] Deductible] [No Copayment]</p> <p><u>PSA Test:</u> Network Providers: [0 % Coinsurance No Deductible][No Copayment] Non-Network Providers: [0 – 50% Coinsurance No Deductible] [No Copayment]</p> <p><u>Annual Physical Exam and well-child visits in a Physician's office:</u> Network Providers: [0 % Coinsurance No Deductible][No Copayment] Non-Network Providers: [0 – 50% Coinsurance] [after][no] Deductible] [No Copayment]</p> | <p>Preventive Health Screenings in accordance with the American Cancer Society guidelines, Federal law and additional preventive Benefits provided by Mercy Health Plans. Preventive Health Screenings include, but are not limited to, the services listed below. Any health screenings not listed here, or not required by Federal law, will be paid consistent with other services under the health benefit plan. [The Plan pays 100% for these Preventive Health Screenings only when You use Network providers. Deductible and Coinsurance will apply to services received from Non-Network Providers.]</p> <p>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. [Applicable cost-share will be consistent with type of service received.]</p> <p>These Preventive Health Screenings are limited to one (1) routine test of each of the following every [Calendar] [Plan] Year, unless otherwise indicated:</p> <ul style="list-style-type: none"> ■ Cholesterol Tests ■ Colon Screening: <ul style="list-style-type: none"> <input type="checkbox"/> Fecal Occult Blood Test <input type="checkbox"/> Colonoscopy – one (1) routine screening every ten (10) [Calendar][Rolling] Years starting at age 50 <input type="checkbox"/> Double-contrast Barium Enema – one (1) routine screening every five (5) [Calendar][Rolling] Years starting at age 50 <input type="checkbox"/> Flexible Sigmoidoscopy – one (1) routine screening every five (5) [Calendar][Rolling] 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 Health Screening in a Physician's office including one (1) annual physical exam per [Calendar] OR [Plan] Year for adults, and periodic visits for well-baby and well-child care as follows: <ul style="list-style-type: none"> <input type="checkbox"/> 10 visits, birth to 24 months <input type="checkbox"/> 1 visit per Calendar Year for ages 2 – 18 years <p>Note: All other Covered Services in a physician's office will be covered under <i>Physician's Office Services</i>.</p> |

* - Prior Authorization required.

Prior Authorization can be found at www.mercyhealthplans.com, or by calling Our Customer Contact Center at the number listed on Your ID card.

II. "Other Eligibility Requirements" section, the description of "Dependent Eligibility" is revised to read as follows:

| | |
|---|---|
| <p>Dependent Eligibility</p> <p>["Dependent" means the Subscriber's legal Spouse, or Domestic Partner*, or a Dependent Child of the Subscriber as described in the Certificate of Coverage.]</p> <p>["Dependent" means the Subscriber's legal Spouse, or a Dependent Child of the Subscriber as described in the Certificate of Coverage.]</p> <p>[Other description of Dependent Eligibility as determined by Employer Group]</p> | <p>Coverage for a Dependent child terminates [at the end of the month] [on the date] that Your Dependent turns 26 years of age. However, coverage for a Dependent child who is disabled because of a mental or a physical disability will not end when the child has reached age 26, as long as the disabled child remains eligible as described in the Certificate of Coverage, and You furnish Us with proof of the disabled child's incapacity and dependency.</p> |
|---|---|



Charles S. Gilham, Secretary
Mercy Health Plans

* - Prior Authorization required.

Prior Authorization can be found at www.mercyhealthplans.com, or by calling Our Customer Contact Center at the number listed on Your ID card.



Supplemental Question to the Enrollment Application Form

521 President Clinton Avenue • Suite 700
Little Rock, AR 72201
[(501) 372-0065] [800-330-8293]
www.mercyhealthplans.com

DEPENDENT COVERAGE

The Patient Protection and Affordable Care Act (the Affordable Care Act) requires that health plans cover certain consumer protections, including coverage of dependent children up to age 26. A dependent child, therefore, includes a child under the age of 26 who meets one of the following criteria:

- A biological child
- A stepchild
- A legally adopted child
- A child placed with you for adoption
- A child for whom permanent legal guardianship has been awarded to you or your spouse
- 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.

I hereby certify that the dependent child(ren) listed on page 1 of my Enrollment Form meets one of the criteria listed above. I understand that this supplemental question is attached to and becomes part of my Mercy Health Plans' Enrollment Application. I also understand that if I falsify information in a manner that is considered fraudulent or intentionally misleading, this may result in the cancellation or rescission of coverage based on the terms of my Policy. I agree to promptly repay any benefit payment(s) to which my covered dependent child(ren) was/were not entitled.

Subscriber's Printed Name

Employer Group Name

Subscriber's Signature

Date

[New Group Renewal Plan Change Revisions]

GROUP INFORMATION

Effective Date: _____ Renewal 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 Company Employees: | Total number of Eligible Employees: |
| Total number of Employees waiving (with Other coverage): | Total number of Employees Applying for Coverage: |
| Total number of Plan Employees: Total number of Plan Members: | Total number of Employees Waiving (without Other Coverage): |
| Total number of Out-of-Area Employees: | Total number of COBRA participants: |

For employers of fewer than *20 employees: Do you currently have an employee or dependent who is 65 years or older and is eligible for Medicare primary rates? No Yes If yes, please provide a copy of qualifying Medicare card(s).
 *20 or fewer employees (including full and part-time) on each working day of 20 calendar weeks of either the prior or the current calendar year.

COBRA: Is your group subject to COBRA? No Yes
 If you employed 20 or more employees for at least 50% of the business days of the previous calendar year you are subject to federal COBRA laws. To the degree permitted by those laws, part-time employees may be counted as a fraction of a full-time employee.

ERISA: Is your group subject to ERISA? No Yes
 Virtually all health plans of employers of any size (except church entities and government entities) are subject to the federal Employee Retirement Income Security Act of 1974.

States where Out-of-Area Employees Reside:

List any employee classes to be excluded from coverage:
 (i.e. part-time, seasonal, temporary, retirees)

Annual Open Enrollment Period (date span)

Number of Hours Worked per Week for Insurance Eligibility:
 (For Small Group Only: Not to exceed 30 hours per week):

| | |
|---|---|
| Effective Date for New Employees (CHOOSE ONE): NOTE: If different for different classes, please specify. | <input type="checkbox"/> Date of Hire <input type="checkbox"/> 30 <input type="checkbox"/> 60 <input type="checkbox"/> 90 Days |
| | <input type="checkbox"/> 120 Days - After the Date of Hire |
| | First of the Month following: |
| | <input type="checkbox"/> Date of Hire <input type="checkbox"/> 30 <input type="checkbox"/> 60 <input type="checkbox"/> 90 <input type="checkbox"/> 120 Days |
| | <input type="checkbox"/> Other (please explain): _____ |

| | |
|---|--|
| Termination Date of Plan Member (must follow Effective Date rules): | <input type="checkbox"/> Date of Termination OR <input type="checkbox"/> End of Month |
|---|--|

| | |
|---|---|
| Termination Date of Dependent Children: | <input type="checkbox"/> On 26 Birthday OR <input type="checkbox"/> End of Month when turning 26 |
|---|---|

| | |
|--|--|
| Domestic Partner Coverage: (Large Group Only): | <input type="checkbox"/> Yes <input type="checkbox"/> No |
|--|--|

| | |
|------------------------|---|
| Employer Contribution: | Employee Only: _____ Dependent(s): _____ |
|------------------------|---|

MANDATED OPTIONAL RIDERS

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.

HEARING AID SERVICES

Please check one:
 I elect to provide coverage for Hearing Aid Services.
 I elect not to provide coverage for Hearing Aid Services.

[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: | | |

HEALTH OVERVIEW

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

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

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

READ THIS IMPORTANT INFORMATION

The applicant for this health coverage affirms that all information is complete and accurate to the best of their knowledge. 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.]

FRAUD STATEMENT

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.

NOTICE OF GUARANTEED RENEWAL

This contract will be guaranteed renewable, subject to the group meeting underwriting rules of Mercy Health Plans and making premiums payments as indicated in the Group Policy, 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 premium due must be paid to MHP prior to termination.

Authorized Employer
Representative Name: _____ Title: _____

Authorized Employer
Representative Signature: _____ Date: _____

Authorized Producer Name: _____ Producer License #: _____

Authorized Producer Signature: _____ Date: _____

Agency Name: _____ Email: _____

Agency Address/ Phone: _____

Commission Paid To: _____ Fed. Tax I.D #: _____

Name (if applicable): _____

Address/Phone: _____

Is this Producer the Agent of
Record for the Group? Yes No

MHP Account Executive Name: _____

MHP Account Executive Signature: _____ 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.



NOTICE OF GRANDFATHERED PLAN COVERAGE

Mercy Health Plans believes this Policy is a “grandfathered health plan” under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your Policy may not include the consumer protection of the Affordable Care Act that apply to the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Although this notice is required by Federal Law, please note that this Mercy Health Plans’ Policy contains all the consumer protections under the Affordable Care Act, many of which were part of your core benefits on or before March 23, 2010.

You may contact the U.S. Department of Health and Human Services at <http://www.healthcare.gov/> with questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status.



NOTICE OF GRANDFATHERED PLAN COVERAGE

Mercy Health Plans believes this Policy is a “grandfathered health plan” under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. **Being a grandfathered health plan means that your Policy does not include the consumer protection of the Affordable Care Act that apply to the provision of preventive health services without any cost sharing.** However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

You may contact the U.S. Department of Health and Human Services at <http://www.healthcare.gov/> with questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status.

SERFF Tracking Number: MHPL-126776231 State: Arkansas
 Filing Company: Mercy Health Plans State Tracking Number: 46544
 Company Tracking Number: MHPL-126776231
 TOI: H16G Group Health - Major Medical Sub-TOI: H16G.001A Any Size Group - PPO
 Product Name: PPACA AMEND-10
 Project Name/Number: PPACA Amendments/

Supporting Document Schedules

| | Item Status: | Status Date: |
|---|---------------------|-------------------------|
| Satisfied - Item: Flesch Certification | Approved-Closed | 08/31/2010 |
| Comments: See attached forms. | | |
| Attachment: AR Certifications.pdf | | |

| | Item Status: | Status Date: |
|--|---------------------|-------------------------|
| Satisfied - Item: Application | Approved-Closed | 08/31/2010 |
| Comments: See Cover Letter for information on Enrollment Application and Group Master Application. | | |

| | Item Status: | Status Date: |
|---|---------------------|-------------------------|
| Satisfied - Item: PPACA Uniform Compliance Summary | Approved-Closed | 08/31/2010 |
| Comments: See attached completed form. | | |
| Attachment: PPACA Checklist.pdf | | |

| | Item Status: | Status Date: |
|---|---------------------|-------------------------|
| Satisfied - Item: Documents for Reference | Approved-Closed | 08/31/2010 |
| Comments: For convenience in your review, I've attached copies of the COC's and Schedules referenced in the Amendments. Copies of the GMA and Enrollment Application are also attached. | | |
| Attachments: COC-Schedules being Amended.pdf AR ENROLL v.4 (08).pdf AR GMA_2010 (eff 1.1.2010).pdf | | |

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 to a Network and Non-Network Provider comply with the requirements outlined in Arkansas Bulletin 9-85 and that the difference between network and non-network deductibles, copays and coinsurances will not exceed 25%.



Charles S. Gilham, Secretary
Mercy Health Plans
14528 S. Outer 40, Suite 100
Chesterfield, MO 63017
cgilham@mhp.mercy.net
(314) 628-3696

8-18-10

Date

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, Secretary
Mercy Health Plans
14528 S. Outer 40, Suite 100
Chesterfield, MO 63017
cgilham@mhp.mercy.net
(314) 628-3696

8-18-10

Date

PPACA Uniform Compliance Summary

Please select the appropriate check box below to indicate which product is amended by this filing.

- INDIVIDUAL HEALTH BENEFIT PLANS (Complete SECTION A only)
- SMALL / LARGE GROUP HEALTH BENEFIT PLANS (Complete SECTION B only)

This form filing compliance summary is to be submitted with your [endorsement][contract] to comply with the immediate market reform requirements of the Patient Protection and Affordable Care Act (PPACA). These PPACA requirements apply only to policies for health insurance coverage referred to as “major medical” in the statute, which is comprehensive health coverage that includes PPO and HMO coverage. This form includes the requirements for grandfathered (coverage in effect prior to March 23, 2010) and non-grandfathered plans, and relevant statutes. Refer to the relevant statute to ensure compliance. Complete each item to confirm that diligent consideration has been given to each. (*If submitting your filings electronically, bookmark the provision(s) in the form(s) that satisfy the requirement and identify the page/paragraph on this form.*)

***For all filings, include the Type of Insurance (TOI) in the first column.**

Check box if this is a paper filing.

COMPANY INFORMATION

| Company Name | NAIC Number | SERFF Tracking Number(s) *if applicable | Form Number(s) of Policy being endorsed | Rate Impact |
|--------------------|-------------|---|---|---|
| Mercy Health Plans | 11529 | See Cover Letter | See Cover Letter | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |

PPACA Uniform Compliance Summary

SECTION B – Group Health Benefit Plans (Small and Large)

| TOI | Category | Statute/Section | Grandfathered | Non-Grandfathered |
|-----|----------|-----------------|---------------|-------------------|
|-----|----------|-----------------|---------------|-------------------|

| | | | | |
|-----------------------------------|---|--|---|---|
| H16G Group Health - Major Medical | Eliminate Pre-existing Condition Exclusions for Enrollees Under Age 19 | <i>[Sections 2704 of the PHSA/Section 1201 of the PPACA]</i> | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If no, please explain. | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If no, please explain. |
| | Explanation: Page Number: Pg 3 Amend to 2010 COC; pg 7 Amend to 08/09 COC | | | |
| H16G Group Health - Major Medical | Eliminate Annual Dollar Limits on Essential Benefits – Except allows for “restricted” annual dollar limits for essential benefits for plan years prior to January 1, 2014. | <i>[Section 2711 of the PHSA/Section 1001 of the PPACA]</i> | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If no, please explain. | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If no, please explain. |
| | Explanation: Benefit specific annual limits for DME, Orthotics & Prosthetics have been filed as variables to be removed in compliance with PPACA; however, if these are NOT essential benefits, limits may be used as determined by federal regulations on “Essential Benefits”. Page Number: See Amendments to Schedules. | | | |
| H16G Group Health - Major Medical | Eliminate Lifetime Dollar Limits on Essential Benefits | <i>[Section 2711 of the PHSA/Section 1001 of the PPACA]</i> | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If no, please explain. | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If no, please explain. |
| | Explanation: 2010 Schedule already filed with “No Benefit maximum” variable which will be used. Page Number: Pg 1 Amend to 08/09 Schedule; | | | |
| H16G Group Health - Major Medical | Prohibit Rescissions – Except for fraud or intentional misrepresentation of material fact. | <i>[Section 2712 of the PHSA/Section 1001 of PPACA]</i> | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If no, please explain. | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If no, please explain. |
| | Explanation: Page Number: Pg 1 on both Amendments to COC | | | |

PPACA Uniform Compliance Summary
SECTION B – Group Health Benefit Plans (Small and Large)

| TOI | Category | Statute Section | Grandfathered | Non-Grandfathered |
|-----|----------|-----------------|---------------|-------------------|
|-----|----------|-----------------|---------------|-------------------|

| | | | | |
|-----------------------------------|--|--|---|---|
| H16G Group Health - Major Medical | <p>Preventive Services – Requires coverage and prohibits the imposition of cost-sharing for specified preventative services</p> <p>Explanation:</p> <p>Page Number: pg 6 Amend to 08/09 COC; pg 2 Amend to 08/09 Schedule; pg 3-4 Amend to 2010 Schedule</p> | [Section 2713 of the PHSA/Section 1001 of the PPACA] | N/A | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If no, please explain. |
| | <p>Extends Dependent Coverage for Children Until age 26 – If a policy offers dependent coverage, it must include dependent coverage until age 26. ◊</p> <p>Explanation:</p> <p>Page Number: page 1 of Amend to COC; pg 5 Amend to 2010 Schedule; pg 3-4 Amend to 08/09 Schedule</p> | [Section 2714 of the PHSA/Section 1001 of the PPACA] | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If no, please explain. | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If no, please explain. |
| H16G Group Health - Major Medical | <p>Appeals Process – Requires establishment of an internal claims appeal process and external review process.</p> <p>Explanation: Minor changes to External Review required due to PPACA.</p> <p>Page Number: pg 2-3 Amend 2010 COC; pg 2-3 Amend 08/09 COC</p> | [Section 2719 of the PHSA/Section 1001 of the PPACA] | N/A | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If no, please explain. |

◊ For plan years beginning before January 1, 2014, grandfathered group plans are not required to extend coverage to a child until the age of 26 if such child is eligible to enroll in another employee-sponsored plan

PPACA Uniform Compliance Summary

SECTION B – Group Health Benefit Plans (Small and Large)

| TOI | Category | Statute Section | Grandfathered | Non-Grandfathered |
|-----|----------|-----------------|---------------|-------------------|
|-----|----------|-----------------|---------------|-------------------|

| | | | | |
|-----------------------------------|---|--|-----|---|
| H16G Group Health - Major Medical | <p>Emergency Services – Requires plans that cover emergency services to provide such coverage without the need for prior authorization, regardless of the participating status of the provider, and at the in-network cost-sharing level.</p> <p>Explanation: MHP already in compliance. No change needed.</p> <p>Page Number:</p> | [Section 2719A of the PHSA/Section 10101 of the PPACA] | N/A | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If no, please explain. |
| | <p>Access to Pediatricians – Mandates that if designation of a PCP for a child is required, the person be permitted to designate a physician who specialized in pediatrics as the child's PCP if the provider is in-network.</p> <p>Explanation: No PCP/gatekeeper. Already in compliance</p> <p>Page Number: N/A</p> | [Section 2719A of the PHSA/Section 10101 of the PPACA] | N/A | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If no, please explain. |
| H16G Group Health - Major Medical | <p>Access to OB/GYNs – Prohibits authorization or referral requirements for obstetrical or gynecological care provided by in-network providers who specialize in obstetrics or gynecology.</p> <p>Explanation: PPO Plan, no limitations on access to providers. Already in compliance</p> <p>Page Number: N/A</p> | [Section 2719A of the PHSA/Section 10101 of the PPACA] | N/A | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If no, please explain. |

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ENROLLMENT APPLICATION FORM

521 President Clinton Avenue • Suite 700 • Little Rock, AR 72201 • 866-647-5568 • mercyhealthplans.com

INCOMPLETE INFORMATION WILL DELAY PROCESSING YOUR APPLICATION AND PRODUCTION OF YOUR MEMBER ID CARD(S)

- Base Plan
- Buy Up
- Conversion
- Coverage Waived

| SUBSCRIBER INFORMATION | | | | |
|---|--|-----------------------|---|--------|
| SOCIAL SECURITY NUMBER | SEX <input type="checkbox"/> M <input type="checkbox"/> F | LAST NAME | FIRST NAME | M.I. |
| DATE OF BIRTH (M/D/Y) / / | | STREET ADDRESS | | |
| CITY | | STATE | ZIP | COUNTY |
| HOME PHONE () () | BUSINESS PHONE () () | FAX NUMBER () () | MARITAL STATUS <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED | |
| PREFERRED METHOD OF COMMUNICATION <input type="checkbox"/> EMAIL <input type="checkbox"/> PHONE <input type="checkbox"/> MAIL <input type="checkbox"/> FAX | | EMAIL ADDRESS | | |
| EMPLOYER NAME | | EMPLOYER ADDRESS | | |

| CONTRACT TYPE | |
|----------------|---|
| COVERAGE: | <input type="checkbox"/> PPO IN AREA <input type="checkbox"/> ASO <input type="checkbox"/> PPO OUT OF AREA <input type="checkbox"/> HDHP <input type="checkbox"/> COBRA <input type="checkbox"/> HSA <input type="checkbox"/> CONVERSION <input type="checkbox"/> MYCHOICE |
| CONTRACT TYPE: | <input type="checkbox"/> EMPLOYEE <input type="checkbox"/> EMPLOYEE/CHILDREN <input type="checkbox"/> EMPLOYEE/SPOUSE <input type="checkbox"/> FAMILY |

| RELEASE OF INFORMATION |
|---|
| To obtain a Release of Information Form, contact Member Services (phone no. on back of ID card) or go to www.mercyhealthplans.com . |

| FAMILY INFORMATION | | | | | | | | | | |
|---|-----------|------------|------|--------------|---------------|--|--|--|-----------------------------------|----------------------|
| ALL AREAS BELOW MUST BE FILLED OUT FOR EACH OF YOUR DEPENDENTS OR PROCESSING YOUR APPLICATION WILL BE DELAYED. If dependent is a full-time student over age 19, has a last name different from that of the subscriber, or if dependent is disabled, please attach appropriate documentation from school, courts or physician. | | | | | | | | | | |
| S.S. # | LAST NAME | FIRST NAME | M.I. | RELATIONSHIP | DATE OF BIRTH | SEX | ENROLLED IN MEDICARE? | OTHER COVERAGE? | PRIMARY CARE PHYSICIAN (PROVIDER) | PROVIDER I.D. NUMBER |
| | | | | SELF | / / | <input type="checkbox"/> M <input type="checkbox"/> F | <input type="checkbox"/> YES <input type="checkbox"/> NO | <input type="checkbox"/> YES <input type="checkbox"/> NO | | |
| | | | | SPOUSE | / / | <input type="checkbox"/> M <input type="checkbox"/> F | <input type="checkbox"/> YES <input type="checkbox"/> NO | <input type="checkbox"/> YES <input type="checkbox"/> NO | | |
| | | | | CHILD | / / | <input type="checkbox"/> M <input type="checkbox"/> F | <input type="checkbox"/> YES <input type="checkbox"/> NO | <input type="checkbox"/> YES <input type="checkbox"/> NO | | |
| | | | | CHILD | / / | <input type="checkbox"/> M <input type="checkbox"/> F | <input type="checkbox"/> YES <input type="checkbox"/> NO | <input type="checkbox"/> YES <input type="checkbox"/> NO | | |
| | | | | CHILD | / / | <input type="checkbox"/> M <input type="checkbox"/> F | <input type="checkbox"/> YES <input type="checkbox"/> NO | <input type="checkbox"/> YES <input type="checkbox"/> NO | | |

| EMPLOYER MUST COMPLETE |
|---|
| GROUP # _____ |
| EMPLOYEE HIRE DATE _____ |
| EFFECTIVE DATE OF COVERAGE _____ |
| REASON FOR ENROLLMENT: <input type="checkbox"/> NEW EMPLOYEE <input type="checkbox"/> OPEN ENROLLMENT <input type="checkbox"/> COBRA <input type="checkbox"/> TERMINATION DATE _____ <input type="checkbox"/> QUALIFYING EVENT EXPLAIN: _____ |
| EMPLOYEE CLASSIFICATION: <input type="checkbox"/> HOURLY <input type="checkbox"/> SALARY <input type="checkbox"/> OTHER <input type="checkbox"/> ACTIVE <input type="checkbox"/> RETIRED |
| APPROVED BY: _____ |
| DATE: _____ |

| OTHER HEALTH INSURANCE INFORMATION |
|---|
| OTHER GROUP COVERAGE INSURANCE EFFECTIVE DATE _____ MEDICARE EFFECTIVE DATE _____ |
| NAME OF OTHER INSURANCE CARRIER FOR EACH PERSON LISTED ABOVE _____ POLICY HOLDER _____ |
| OTHER CARRIER'S CLAIMS ADDRESS _____ OTHER CARRIER'S PHONE NUMBER _____ |

| MHP USE ONLY |
|--------------------|
| ENTERED BY _____ |
| DATE ENTERED _____ |

| IMPORTANT INFORMATION | |
|--|--|
| <p>Please read the following information. It is part of the agreement between you and Mercy Health Plans.</p> <ol style="list-style-type: none"> This may be considered my full and complete authorization to any physician, hospital or other necessary entity to allow full disclosure to Mercy Health Plans, of medical information relevant to persons covered by this application. This application is not in force until approved by Mercy Health Plans. Untruthful or misleading information provided on this application may render this application void and subject to cancellation within the first two (2) years. Any changes in eligibility must be reported to Mercy Health Plans immediately. If applying for an HSA, I agree to have Bank of America contact me to open an account. | <p>Please note: 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.</p> <p>Employee: _____ Date: _____</p> |

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

NOTE:

It is required that this Authorization to Use and Disclose Protected Health Information be completed and submitted with the application. The application is not complete without this authorization form.

Each person age 18 or over who is to be covered by this policy is requested to sign at the bottom of this form. Failure to receive signatures for each person age 18 or over who is to be covered may affect premium issued by MHP, as permitted by law.

I authorize Mercy Health Plans (MHP) or its affiliates to obtain necessary individually identifiable health information, including but not limited to claims, medical records, reports, pharmaceutical records, diagnostic tests, and lab reports from physicians, hospitals or other health care providers pertaining to my care or the care of any other dependent(s) listed on the application for insurance. I understand that this information can be used to determine my/our eligibility for insurance, and that those records can be requested as far back as the past ten years.

I authorize MHP to share necessary information with my Producer (Broker or Agent). I understand that Mercy Health Plans may disclose individually identifiable health information, including but not limited to claims, medical records, reports, pharmaceutical records, diagnostic tests, and lab reports to other entities in the course of its business operations or as required or permitted by law or as set out in the Mercy Health Plans Notice of Privacy Practices and authorize such disclosure. I also understand that there is a possibility of re-disclosure of any information disclosed pursuant to this authorization and that information, once disclosed, may no longer be protected by federal rules governing privacy and confidentiality.

This authorization is valid for the duration of my coverage with Mercy Health Plans. I understand that this authorization is voluntary and that I may revoke this authorization at any time; however, if I do so before I am enrolled in the policy(ies), my application for coverage may be denied. A revocation request must be sent in writing to MHP's home address, or via e-mail. I also understand that my revocation will not affect the rights of any individual who has acted in reliance on the authorization prior to receiving notice of my revocation.

All listed applicants 18 years of age and older are requested to agree to the terms of this authorization. Signing this document confirms agreement. I understand and agree to the release of information for the purpose described above in this document.

Signature:

Printed Name:

Relationship to Applicant:

Date:

| | | | | |
|--------------------|--|--|--|--|
| Applicant | | | | |
| Applicant's Spouse | | | | |
| Dependent Child 1 | | | | |
| Dependent Child 2 | | | | |
| Dependent Child 3 | | | | |
| Dependent Child 4 | | | | |
| Dependent Child 5 | | | | |
| Dependent Child 6 | | | | |



Group Master Application — Arkansas

[New Group Renewal Plan Change Revisions]

GROUP INFORMATION

Effective Date: _____ Renewal 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 Company Employees: | Total number of Eligible Employees: |
| Total number of Employees waiving (with Other coverage): | Total number of Employees Applying for Coverage: |
| Total number of Plan Employees: | Total number of Employees Waiving (without Other Coverage): |
| Total number of Out-of-Area Employees: | Total number of COBRA participants: |
| States where Out-of-Area Employees Reside: | Total number of Plan Members: |
| List any employee classes to be excluded from coverage: (i.e. part-time, seasonal, temporary, retirees) | |
| Annual Open Enrollment Period (date span) | |
| Number of Hours Worked per Week for Insurance Eligibility: (For Small Group Only: Not to exceed 30 hours per week): | |
| Effective Date for New Employees (CHOOSE ONE): NOTE: If different for different classes, please specify. | <input type="checkbox"/> Date of Hire <input type="checkbox"/> 30 <input type="checkbox"/> 60 <input type="checkbox"/> 90 Days <input type="checkbox"/> 120 Days - After the Date of Hire First of the Month following: <input type="checkbox"/> Date of Hire <input type="checkbox"/> 30 <input type="checkbox"/> 60 <input type="checkbox"/> 90 <input type="checkbox"/> 120 Days <input type="checkbox"/> Other (please explain): _____ _____ _____ |
| Termination Date of Plan Member (must follow Effective Date rules): | <input type="checkbox"/> Date of Termination OR <input type="checkbox"/> End of Month |
| Termination Date of Dependent Children: | <input type="checkbox"/> On [19-25] Birthday OR <input type="checkbox"/> End of Month when turning [19-25] Full Time Student Age: ____ <input type="checkbox"/> Date of Birth <input type="checkbox"/> End of Month |
| Domestic Partner Coverage: (Large Group Only): | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Employer Contribution: | Employee Only: _____ Dependent(s): _____ |

MANDATED OPTIONAL RIDERS

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.

HEARING AID SERVICES

Please check one:
 I elect to provide coverage for Hearing Aid Services.
 I elect not to provide coverage for Hearing Aid Services.

[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: | | |

HEALTH OVERVIEW

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

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

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

READ THIS IMPORTANT INFORMATION

The applicant for this health coverage affirms that all information is complete and accurate to the best of their knowledge. 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.]

FRAUD STATEMENT

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.



NOTICE OF GUARANTEED RENEWAL

This contract will be guaranteed renewable, subject to the group meeting underwriting rules of Mercy Health Plans and making premiums payments as indicated in the Group Policy, 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 premium due must be paid to MHP prior to termination.

Authorized Employer Representative Name: _____ Title: _____

Authorized Employer Representative Signature: _____ Date: _____

Authorized Producer Name: _____ Producer License #: _____

Authorized Producer Signature: _____ Date: _____

Agency Name: _____ Email: _____

Agency Address/ Phone: _____

Commission Paid To: _____ Fed. Tax I.D #: _____

Name (if applicable): _____

Address/Phone: _____

Is this Producer the Agent of Record for the Group? Yes No

MHP Account Executive Name: _____

MHP Account Executive Signature: _____ 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.