

SERFF Tracking Number: MHPL-126793295 State: Arkansas
Filing Company: Mercy Health Plans State Tracking Number: 46682
Company Tracking Number: MHPL-126793295
TOI: H16I Individual Health - Major Medical Sub-TOI: H16I.005A Individual - Preferred Provider (PPO)
Product Name: ARINDIV PPACA-10
Project Name/Number: AR Indiv Health Reform Amendments/

Filing at a Glance

Company: Mercy Health Plans
Product Name: ARINDIV PPACA-10 SERFF Tr Num: MHPL-126793295 State: Arkansas
TOI: H16I Individual Health - Major Medical SERFF Status: Closed-Approved- State Tr Num: 46682
Closed
Sub-TOI: H16I.005A Individual - Preferred Provider (PPO) Co Tr Num: MHPL-126793295 State Status: Approved-Closed
Filing Type: Form Reviewer(s): Rosalind Minor
Author: Karen Hosack Disposition Date: 09/07/2010
Date Submitted: 09/01/2010 Disposition Status: Approved-Closed
Implementation Date Requested: 10/01/2010 Implementation Date:
State Filing Description:

General Information

Project Name: AR Indiv Health Reform 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: Individual
Submission Type: New Submission Group Market Size:
Overall Rate Impact: Group Market Type:
Filing Status Changed: 09/07/2010 Explanation for Other Group Market Type:
State Status Changed: 09/07/2010
Deemer Date: Created By: Karen Hosack
Submitted By: Karen Hosack Corresponding Filing Tracking Number: MHPL-126793295
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

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 Product Name: ARINDIV PPACA-10
 Project Name/Number: AR Indiv Health Reform Amendments/
 Little Rock, AR 72201-1904

RE: Health Reform Amendments to Individual Policies and Schedules
 NAIC: 11529

Dear Ms. Minor:

I am submitting these Amendments and Grandfather Plan Notice for your review and approval. The purpose of these documents 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 the Individuals only.

Documents are all NEW and do not replace any other forms. The Grandfathered Plan Notice will be used with the Individual Policies as needed. These Amendments will be used with the following forms:

Health Reform Amendment	Amends Form #	Name of Document
Approved on SERFF #		
PHI AR/INDIV AMEND5 (10-10)	PHI AR INDIV COC /LT-2010 2010	Individual Insurance Policy 2010 2/1/2010 MHPL-126444604
PHI AR/INDIVNB AMEND4 (10-10)	PHI AR INDIV COC (01/08) 2008-2009	Individual Insurance Policy 4/9/2008 MHPL-125487131
PHI AR AMEND/App v.3 (10/10)	AR INDIV APP/LT v.2 (2010)	Individual Application 2/1/2010 MHPL-126444604
PHI AR/INDIV AMEND6 (10-10)	PHI AR INDIV SCH v2 (01/08) and	
AR INDIV SCH/LT_2010 2008-2009	Schedule of Coverage & Benefits	And 2010 Schedule of Coverage 4/9/2008
And		
2/1/2010 MHPL-125487131		
MHPL-126444604		
PHI AR INDIV/GF Notice (10/10)	NEW Grandfathered Plan Notice.	

We have included the "Special Notices" in the Amendments to Policy (pages 1 and 2) that are also required under PPACA: "Notice of Special Opportunity to Enroll" covers those dependents who lost coverage due to previous limiting age; and, "Maximum Policy Benefit Special Notice" covers enrollees who lost coverage because they exhausted the Lifetime Maximum benefit.

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Additional Notes: We have included clarification on our "Extended Provider Network" in the Amendments to the Policy. 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 changes to Appeals review 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.

Since essential benefits have yet to be clarified by Federal regulations, on tehe Amendment to Schedule, we have changed the annual dollar limits to variables that will be removed as needed on these benefits: DME, orthotics, prosthetics, Mental Health. Osteoporosis, Immunizations fall under the \$0 copay preventive mandate for network benefits; \$0 copay Network will be included in the document and all other Network variables will be omitted.

Note that due to extraordinary circumstances, and the short ime for implementation of PPACA, we have submitted an Amendment to the Individual Application. It is anticipated that the entire Application may be re-filed later this year, if not early next year.

I have attached a completed PPACA Checklist under Supporting Documents. I look forward to your 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
Supervisor – Commercial Compliance

Company and Contact

Filing Contact Information

Karen Hosack, Compliance Analyst khosack@mhp.mercy.net
Mercy Health Plans 314-214-2342 [Phone]
14528 South Outer Forty Rd. 314-214-8103 [FAX]
Suite 300
Chesterfield, MO 63017

Filing Company Information

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

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Product Name: ARINDIV PPACA-10
Project Name/Number: AR Indiv Health Reform Amendments/
(314) 214-8100 ext. [Phone]

Filing Fees

Fee Required? Yes
Fee Amount: \$250.00
Retaliatory? No
Fee Explanation: 5 documents @ \$50 each
Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Mercy Health Plans	\$250.00	09/01/2010	39175432

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	09/07/2010	09/07/2010

Objection Letters and Response Letters

Objection Letters				Response Letters		
Status	Created By	Created On	Date Submitted	Responded By	Created On	Date Submitted
Pending Industry Response	Rosalind Minor	09/02/2010	09/02/2010	Karen Hosack	09/07/2010	09/07/2010

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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	Health - Actuarial Justification	Approved-Closed	Yes
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Supporting Document	PPACA Uniform Compliance Summary	Approved-Closed	Yes
Form	Health Reform Amendment to 2010 Policy	Approved-Closed	Yes
Form	Health Reform Amendment to 2008-2009 Policy	Approved-Closed	Yes
Form	Health Reform Amendment of Application	Approved-Closed	Yes
Form	Health Reform Amendment to Schedule of Coverage & Benefits	Approved-Closed	Yes
Form	Notice of Grandfathered Plan	Approved-Closed	Yes

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(PPO)
Product Name: ARINDIV PPACA-10
Project Name/Number: AR Indiv Health Reform Amendments/

Objection Letter

Objection Letter Status Pending Industry Response
Objection Letter Date 09/02/2010
Submitted Date 09/02/2010

Respond By Date

Dear Karen Hosack,

This will acknowledge receipt of the captioned filing.

Objection 1

- Health Reform Amendment to 2010 Policy, PHI AR/INDIVNB AMEND4 (Form)
- Health Reform Amendment to 2008-2009 Policy , PHI AR/INDIV AMEND5 (10-10) (Form)
- Health Reform Amendment ot Application, PHI AR AMEND/App v.3 (10/10) (Form)
- Health Reform Amendment to Schedule of Coverage & Benefits, PHI AR/INDIV AMEND6 (10-10) (Form)
- Notice of Grandfathered Plan, PHI AR INDIV/GF Notice (10/10) (Form)

Comment:

Before final review is given to this submission, please advise if there will be any rate adjustments.

Please feel free to contact me if you have questions.

Sincerely,

Rosalind Minor

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Product Name: ARINDIV PPACA-10
Project Name/Number: AR Indiv Health Reform Amendments/

Response Letter

Response Letter Status Submitted to State
Response Letter Date 09/07/2010
Submitted Date 09/07/2010

Dear Rosalind Minor,

Comments:

I have verified and can confirm that there will not be any rate adjustments as a result of these PPACA Amendments scheduled to be effective October 1, 2010.

Response 1

Comments: There were no changes to the forms submitted.

Related Objection 1

Applies To:

- Health Reform Amendment to 2010 Policy, PHI AR/INDIVNB AMEND4 (Form)
- Health Reform Amendment to 2008-2009 Policy , PHI AR/INDIV AMEND5 (10-10) (Form)
- Health Reform Amendment of Application, PHI AR AMEND/App v.3 (10/10) (Form)
- Health Reform Amendment to Schedule of Coverage & Benefits, PHI AR/INDIV AMEND6 (10-10) (Form)
- Notice of Grandfathered Plan, PHI AR INDIV/GF Notice (10/10) (Form)

Comment:

Before final review is given to this submission, please advise if there will be any rate adjustments.

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Look forward to your review and approval.

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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 09/02/2010	PHI AR/INDIVN B AMEND4	Policy/Cont ract/Fratern al	Health Reform Amendment to 2010 Policy	Initial	Certificate: Amendmen t, Insert Page, Endorseme nt or Rider		AR INDIV 2010COC Health Reform Amendment_ Eff 10.1.10).pdf
Approved-Closed 09/02/2010	PHI AR/INDIV AMEND5 (10-10)	Policy/Cont ract/Fratern al	Health Reform Amendment to 2008- 2009 Policy	Initial	Certificate: Amendmen t, Insert Page, Endorseme nt or Rider		AR INDIV 2008COC Health Reform Amendment_ Eff 10.1.10).pdf
Approved-Closed 09/02/2010	PHI AR AMEND/Ap p v.3 (10/10)	Policy/Cont ract/Fratern al	Health Reform Amendment ot Application	Initial	Certificate: Amendmen t, Insert Page, Endorseme nt or Rider		AR INDIV AMENDMEN T to Application.pd f
Approved-Closed 09/02/2010	PHI AR/INDIV AMEND6	Policy/Cont ract/Fratern al	Health Reform Amendment to Schedule of	Initial			AR INDIV SCHEDULE Health

SERFF Tracking Number: MHPL-126793295 State: Arkansas
 Filing Company: Mercy Health Plans State Tracking Number: 46682
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Product Name: ARINDIV PPACA-10
 Project Name/Number: AR Indiv Health Reform Amendments/
 (10-10) Certificate: Coverage & Benefits
 Amendmen
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Reform
 AMENDMEN
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Approved- PHI AR Notice of Notice of Initial
 Closed INDIV/GF Coverage Grandfathered Plan
 09/02/2010 Notice
 (10/10)

Indiv NOTICE
 OF GF PLAN
 COVERAGE.
 pdf



**HEALTH REFORM
AMENDMENT**

**This Amendment applies to the following
Individual Comprehensive Health Insurance Policies:
PHI AR INDIV COC /LT-2010**

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

I. Section 2 (Eligibility), second paragraph under “Subscriber” is revised to read:
“To be eligible for this coverage, the primary domicile and residence of the Subscriber must be within Arkansas.”

II. Section 2 (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 eligible for any employer-sponsored group health plan or entitled to Medicare. For a complete definition of Dependent and Enrolled Dependent, see Section 14 (Definitions of Terms).

III. Section 3 (When Coverage Begins), “Coverage for a disabled Child”, first paragraph and first sentence, is amended to read:

“Coverage for an Enrolled Dependent child who is Totally Disabled because of a mental or a physical disability will not end just because the child has reached a certain age.”

IV. Section 3 (When Coverage Begins), is amended by inserting the following at the end of this section:

Notice of Special Opportunity to Enroll	Individuals 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 prior to this Policy’s renewal date. Coverage for these Enrolled Dependents will be effective on the Policy’s renewal date.
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V. Section 4 (When Coverage Ends), “Full-Time Student Status Ends” is deleted in its entirety and not replaced.

VI. Section 4 (When Coverage Ends), “Fraud, Misrepresentation or False Information” is revised to read:

Event	Description
<p>Fraud, Misrepresentation or False Information</p>	<p>Your coverage ends on the date We identify in a notice that Your coverage is terminated because of fraud or intentional misrepresentation of material fact. We will provide You at least thirty (30) days written notice that coverage will be Rescinded.</p> <p>During the first three (3) years that 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>

VII. Section 5 (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.”

VIII. Section 6 (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: Individuals 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>
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IX. Section 9 (Complaints & 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 (4) 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,
- (b) The requested health care service was determined to be "experimental/investigational.", or
- (c) Your coverage was Rescinded.

“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;

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

Durable Medical Equipment – The **“Prior Authorization Required”** section is deleted in its entirety and replaced by the following:

“Some DME require Prior Authorization, including DME that costs 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.”

And, the **Medical Supplies, “Prior Authorization Required”**, is deleted in its entirety and replaced by the following:

“Some medical supplies 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 the services requiring Prior Authorization, Network and Non-Network Benefits will be reduced by [50% - 100%] of Eligible Expenses.”

Immunizations (Routine Only) – The entire section is revised to read:

“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.”

Mental Health and Substance Abuse Services (Outpatient) – The **“Prior Authorization Required”** section is deleted in its entirety and replaced by the following:

“Some mental health and substance abuse services require Prior Authorization. Please remember that You or Your Provider must call the Mental Health/Substance Abuse Designee at the number listed on Your ID card to get approval for those services that require Prior Authorization. Unless We pre-approve the services that require Prior Authorization, Network and Non-Network Benefits will be reduced by [50% -100%] of Eligible Expenses.”

Mental Health and Substance Abuse Services (Inpatient and Intermediate) – The **“Prior Authorization Required”** section is deleted in its entirety and replaced by the following:

“Some mental health and substance abuse services require Prior Authorization. Please remember that You or Your Provider must call the Mental Health/Substance Abuse Designee at the number

listed on Your ID card to get approval for those services that require Prior Authorization. Unless We pre-approve the services that require Prior Authorization, Network and Non-Network Benefits will be reduced by [50% -100%] of Eligible Expenses.”

Orthotics – The “**Prior Authorization Required**” section is deleted in its entirety and replaced by the following:

“Some orthotics devices require Prior Authorization, including orthotics 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.

Preventive Health Screenings (Routine Only) – The first paragraph is revised to read:

“Preventive Health Screenings in accordance with the American Cancer Society guidelines, Federal law and additional preventive Benefits provided by Mercy Health Plans. Any health screenings not listed here, or not required by Federal law, will be paid consistent with other services under the health benefit plan.”

Prosthetic Devices – the “**Prior Authorization Required**” section is deleted in its entirety and replaced by the following:

“Some prosthetic devices require Prior Authorization, including 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.

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

EXCLUSION	DESCRIPTION
M. 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;

XII. Section 13 (Definitions of Terms) is amended as follows:

- **Deleting** the term, “**Full-Time Student**”, and its definition;
- **Adding this new term:**

Term	Definition
<i>Rescinded</i>	Coverage that is retroactively cancelled or discontinued.

And –

■ Revising these terms to read:

Term	Definition
<i>Dependent</i>	<p>The Subscriber's legal Spouse or Dependent child. The term child includes any of the following:</p> <ul style="list-style-type: none"> • A biological 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 these conditions and limitations:</p> <ul style="list-style-type: none"> • Dependent children must be under twenty-six (26) years of age. • 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 must not be eligible for any employer-sponsored health plan or entitled to Medicare.
<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**

**This Amendment applies to the following
Individual Comprehensive Health Insurance Policies:
PHI AR INDIV 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 the Policy. Unless defined differently in this Amendment, all other capitalized terms shall have the meanings given them in the Policy.

I. CERTIFICATE OF COVERAGE, Cover Page, is amended by inserting the following at the end of the section entitled NOTICE:

“Please read the copy of the Application attached to this Policy. Carefully check the Application and write to Mercy Health Plans, First Security Center, 521 President Clinton Avenue, Suite 700, Little Rock, Arkansas 72201 within ten (10) days if any information shown on it is not correct and complete or if any past medical history has been left out of the Application. The Application is part of the Policy which was issued on the basis that answers to all questions and the information shown on the Application are correct and complete.”

II. Section 2 (Eligibility), second paragraph under “Subscriber” is revised to read:

“To be eligible for this coverage, the primary domicile and residence of the Subscriber must be within Arkansas.”

III. Section 2 (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 eligible for any employer-sponsored group health plan or entitled to Medicare. For a complete definition of Dependent and Enrolled Dependent, see Section 14 (Definitions of Terms).

IV. Section 3 (When Coverage Begins), “Coverage for a disabled Child”, first paragraph and first sentence, is amended to read:

“Coverage for an Enrolled Dependent child who is Totally Disabled because of a mental or a physical disability will not end just because the child has reached a certain age.”

V. Section 3 (When Coverage Begins), is amended by inserting the following at the end of this section:

Notice of Special Opportunity to Enroll	Individuals 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 prior to this Policy’s renewal date. Coverage for these Enrolled Dependents will be effective on the Policy’s renewal date.
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VI. Section 4 (When Coverage Ends), “Fraud, Misrepresentation or False Information” is revised to read:

Event	Description
<p>Fraud, Misrepresentation or False Information</p>	<p>Your coverage ends on the date We identify in a notice that Your coverage is terminated because of fraud or intentional misrepresentation of material fact. We will provide You at least thirty (30) days written notice that coverage will be Rescinded.</p> <p>During the first three (3) years that 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>

VII. Section 5 (How You Get Care), is amended by inserting the following at the end of this section:

Extended Provider Network

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

VIII. Section 6 (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: Individuals 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>
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IX. Section 9 (Complaints & 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,
- (b) The requested health care service was determined to be "experimental/investigational.", or
- (c) Your coverage was Rescinded.

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

Durable Medical Equipment – The fourth paragraph is deleted in its entirety and replaced by the following:

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 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:

- Diabetic supplies (see *Diabetes Services* benefit);
- 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 Year are covered. 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, B. and H., for information on medical supplies and equipment that We do not cover.”

And, the “**Prior Authorization Required**” section is deleted in its entirety and replaced by the following:

“Some DME and medical supplies require Prior Authorization, including DME and 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 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.”

Immunizations (Routine Only) – The entire section is revised to read:

“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.”

Mental Health and Substance Abuse Services (Outpatient) – The “**Prior Authorization Required**” section is deleted in its entirety and replaced by the following:

“Some mental health and substance abuse services require Prior Authorization. Please remember that You or Your Provider must call the Mental Health/Substance Abuse Designee at the number listed on Your ID card to get approval for those services that require Prior Authorization. Unless We pre-approve the services that require Prior Authorization, Network and Non-Network Benefits will be reduced by [50% -100%] of Eligible Expenses. See Section 13, I, K., and Q. for exclusions related to this Benefit.”

Mental Health and Substance Abuse Services (Inpatient and Intermediate) – The “**Prior Authorization Required**” section is deleted in its entirety and replaced by the following:

“Some mental health and substance abuse services require Prior Authorization. Please remember that You or Your Provider must call the Mental Health/Substance Abuse Designee at the number listed on Your ID card to get approval for those services that require Prior Authorization. Unless We pre-approve the services that require Prior Authorization, Network and Non-Network Benefits will be reduced by [50% -100%] of Eligible Expenses. See Section

13, I, K., and Q. for exclusions related to this Benefit.”

Orthotics – Third paragraph (referring to a dollar limitation) is deleted in its entirety and not replaced.

And, the “**Prior Authorization Required**” section is deleted in its entirety and replaced by the following:

“Some orthotics devices require Prior Authorization, including orthotics 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.

Preventive Health/Wellness Care – The first paragraph is revised to read:

“Preventive Health Screenings in accordance with the American Cancer Society guidelines, Federal law, and additional preventive Benefits provided by Mercy Health Plans.

Prosthetic Devices – Prosthetic Devices – Last paragraph (referring to dollar limitation) is deleted in its entirety and not replaced.

And the “**Prior Authorization Required**” section is deleted in its entirety and replaced by the following:

“Some prosthetic devices require Prior Authorization, including 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.

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

EXCLUSION	DESCRIPTION
M. 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;

XII. Section 13 (Definitions of Terms) is amended as follows:

- Deleting the term, “**Full-Time Student**”, and its definition;
- Adding this new term:

Term	Definition
Rescinded	Coverage that is retroactively cancelled or discontinued.

- Revising these terms to read:

Term	Definition
Dependent	The Subscriber's legal Spouse or Dependent child. The term child includes any of the following: <ul style="list-style-type: none"> • A biological child; • A stepchild; • A legally adopted child; • A child placed for adoption;

	<ul style="list-style-type: none"> • 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 these conditions and limitations:</p> <ul style="list-style-type: none"> • Dependent children must be under twenty-six (26) years of age. • 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 must not be eligible for any employer-sponsored health plan or entitled to Medicare.
<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.



Charles S. Gilham, Secretary
Mercy Health Plans

MERCY

Health Plans

AMENDMENT

To the

Individual Application for Comprehensive Health Insurance AR INDIV APP/LT v.2 (2010)

This document hereby amends the Individual Application for Comprehensive Health Insurance and form a part of this Policy upon issuance as if fully incorporated herein. Except for these Amendments, the terms of your Policy continues in full force and effect.

A. Page 1 – Third bullet is deleted in its entirety and replaced by the following:

- Obtain and send to Mercy Health Plans a copy of any Certificate of Creditable Coverage, if you have had prior health insurance coverage through another carrier. We will need a copy of this Certificate for individuals **over 19 years**, in order to grant you a waiver for any pre-existing conditions.

B. Page 2 – “Coverage and Benefit Selection” section, Option 1) Type of Coverage is revised to read:

<p>1) TYPE OF COVERAGE:</p>	<p><input type="checkbox"/> Applicant only (Ages 19-65 yrs.) <input type="checkbox"/> Child Only (Age 6 mos -18 yrs)</p> <p><input type="checkbox"/> Applicant & spouse</p> <p><input type="checkbox"/> Applicant, spouse & Dependent children*</p> <p><input type="checkbox"/> Applicant & Dependent children*</p> <p><i>*Dependent Children under age 26 may be added to the plan. Dependent children must be –</i></p> <ul style="list-style-type: none"> ■ 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.
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C. Page 3 – “Other Health Coverage” section, question 3) is revised to read:

- 3) Did you and/or your spouse and/or your eligible dependents age 19 and older have creditable coverage from a health insurance carrier within the past 63 days? (Creditable Coverage is any health insurance except a short term policy). If “yes”, and you are age 19 or older, you may be eligible for pre-existing credit. If applicable, submit a copy of the Certificate of Creditable Coverage for each person applying.

D. Page 6 –“Statements of Understanding”, # 5 and #6., are revised to read as follows:

- 5. I understand that if I, or any covered family members over age 19, am/are accepted for medical coverage, any pre-existing medical and/or mental health condition disclosed within this application will not be covered for up to 12 months after my effective date. Credit may be given for prior creditable coverage upon receipt of certificate of creditable coverage. I also understand that all applicants under age 19 will not be not subject to any pre-existing condition exclusion.

6. I understand that for applicants age 19 or older, if any pre-existing condition(s) is/are subsequently discovered that were not disclosed during the application process, benefits may be withheld for 12 months for that condition or the coverage may be rescinded in its entirety at MHP's discretion. For applicants under age 19, MHP has the right to re-underwrite the application using this new information, and the decision to provide coverage may change. Failure to disclose is construed as intentional misrepresentation.



Charles S. Gilham, Secretary
Mercy Health Plans



**HEALTH REFORM
AMENDMENT
To these
Individual Schedules of Coverage and Benefits:**

**PHI AR INDIV SCH v2 (01/08)
AR INDIV SCH/LT_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 the Individual Comprehensive Health Insurance Policies and Schedules of Coverage and Benefits listed above remain unchanged and in full force and effect.

The Schedules of Coverage and Benefits listed above are amended by deleting the benefits below in their entirety and replacing as follows:

SERVICES	MEMBER RESPONSIBILITY
<p>Durable Medical Equipment (DME) and Medical Supplies *</p> <p>Standard Basic Hospital-type medical Equipment (and its associated supplies) that meets the following criteria in addition to those described in our Certificate of Coverage:</p> <ul style="list-style-type: none"> ■ Ordered or provided by a Physician for outpatient use; ■ Used for medical purposes; ■ Not consumable or disposable; and ■ Not of use to a person in the absence of a disease or disability. <p>[Benefits only for a single purchase (including repair/replacement) of a type of Durable Medical Equipment [once] [every] [each] [two-five] Calendar Year[s]].</p> <p>[Any combination of Network and Non-Network Benefits for Durable Medical Equipment and Medical Supplies is limited to [\$750-\$10,000] per [Calendar][Plan] Year. This limitation is not applicable to any equipment, supplies or self-management training for the treatment of diabetes.]</p> <p>Durable Medical Equipment in excess of \$1,000.00 (either purchase price or cumulative rental of a single item) must be approved in advance by the Plan.</p> <p>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; <p>Jobst stockings or other support hose ordered by a physician and determined to be Medically Necessary, but only two (2) support stockings per Calendar Year are covered.</p> <p>Some DME and medical supply services require Prior Authorization, including DME and medical supplies that cost more than \$1,000 (either purchase price or cumulative rental of a single item). 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.</p>	<p>Network Providers: [0 - 50%] Coinsurance after Deductible</p> <p>Non-Network Providers: [0 - 50%] Coinsurance after Deductible</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>Immunizations (Routine Only)</p> <p>Routine immunizations for children and adults as recommended by the Plan and 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>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.</p>	<p>Network Providers: [No Copayment and no Deductible]</p> <p>Non-Network Providers: [No Copayment and no Deductible] OR [Birth – 18yrs: \$0 Copayment] [Children over 18yrs. and Adults:][0-50% Coinsurance] [after deductible][no Deductible] OR [\$0-\$100 Copayment]</p>
<p>Mental Health and Substance Abuse Services – Outpatient</p> <p>Any combination of Network and Non-Network Benefits is limited to [20 – 30] visits per [Calendar] [Plan] Year.</p> <p>[Any combination of Network and Non-Network Benefits for Mental Health and Substance Abuse Services for Outpatient is limited to [\$750-\$10,000] per [Calendar] [Plan] Year.]</p>	<p>Network Providers: [0% - 50% Coinsurance after Deductible] [No Copayment] [[\$0-100] per visit]</p> <p>Non-Network Providers: [0% - 50%] Coinsurance after Deductible</p>
<p>Mental Health and Substance Abuse Services – Inpatient and Intermediate</p> <p>Any combination of Network and Non-Network Benefits is limited to [7 – 30] days per [Calendar] [Plan] Year.</p> <p>[Any combination of Network and Non-Network Benefits for Mental Health and Substance Abuse Services – Inpatient and Intermediate is limited to [\$750-\$10,000] per [Calendar] [Plan] Year.]</p>	<p>Network Providers: [0% - 50% Coinsurance after Deductible] [No Copayment] [[\$0-1,000] per day to a maximum of [\$0-5,000] per Inpatient Stay]</p> <p>Non-Network Providers: [0% - 50%] Coinsurance after Deductible</p>
<p>Orthotics *</p> <p>Covered orthotic equipment is the Standard Basic Equipment necessary to continue the Instrumental Activities of Daily Living (IADL). The following items are covered when ordered and provided by a Participating Physician and obtained from a Participating 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 ■ 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>[Benefit for orthotic devices is limited to a single purchase of each type of orthotic device [every][each][two-five][Calendar][Plan] Year(s).]</p> <p>[Any combination of Network [and Non-Network Benefits] for orthotic devices is limited to [\$2,500-\$10,000] per [Calendar][Plan] Year.]</p> <p>Some orthotic devices require Prior Authorization, including orthotics in excess of \$1,000.00. 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]</p>	<p>Network Providers: [0 - 50% Coinsurance] [after Deductible]</p> <p>Non-Network Providers: [0 - 50% Coinsurance] [after Deductible] OR [Covered In Network Only]</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>Benefits will be reduced by 100% of the Eligible Expenses.</p>	
<p>Osteoporosis Services/Bone Mineral Density (BMD) Testing *</p> <p>Preventive Health Screening according to the USPSTF guidelines and Federal law. [Benefits under this section include only the facility charge and the charge for required services, supplies and equipment. Benefits for the professional fees related to outpatient diagnostic and therapeutic services are described under <i>Professional Fees for Surgical and Medical Services</i> in your Schedule of Coverage and Benefits.]</p> <p>Applicable cost-share for outpatient testing/procedures will apply for all Osteoporosis/BMD testing that is not considered Preventive Health Screening.</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: [No Copayment][No Deductible or Coinsurance] [0%-50% Coinsurance] [after Deductible] [No Deductible]</p> <p>Non-Network Providers: [0%-50% Coinsurance][after Deductible] [No Deductible] [No Copayment]</p> <p>Applicable cost-share for office visit(s) will apply for all other medical services that are received in the same office visit besides BMD Testing.</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. 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.]. Preventive Health Screenings include, but are not limited to, the services listed below.</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>	<p><i>Cholesterol Tests:</i> Network Providers: [0 % Coinsurance No Deductible][No Copayment] 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> Network Providers: [0 % Coinsurance No Deductible][No Copayment] Non-Network Providers: [0 – 50% Coinsurance] [after][no] [Deductible] [No Copayment]</p> <p><i>Mammography:</i> Network Providers: [0 % Coinsurance No Deductible][No Copayment] Non-Network Providers: [0 – 50% Coinsurance] [after][no] [Deductible] [No Copayment]</p> <p><i>Pap/Pelvic:</i> Network Providers: [0 % Coinsurance No Deductible][No Copayment] Non-Network Providers: [0 – 50% Coinsurance] [after][no] [Deductible] [No Copayment]</p> <p><i>Prostate Exam:</i> Network Providers: [0 % Coinsurance No Deductible][No Copayment]</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>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]</p> <p>Non-Network Providers: [0 – 50% Coinsurance] [after][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]</p> <p>Non-Network Providers: [0 – 50% Coinsurance] [after][no] Deductible] [No Copayment]No Copayment</p>
<p>Prosthetic Devices *</p> <p>Covered prosthetic equipment is the standard, basic equipment necessary to continue average daily activities. Breast prosthesis as required by the Women's Health and Cancer Rights Act of 1998 is also covered. No time limit will be imposed for the receipt of breast prosthesis and related reconstructive breast surgery following a mastectomy. Coverage also includes post-mastectomy brassiere.</p> <p>[Benefit for prosthetic devices is limited to a single purchase of each type of orthotic device [every][each][two-five] [Calendar] [Plan] Year(s).]</p> <p>[Any combination of Network [and Non-Network] Benefits for prosthetic devices is limited to [\$750 - \$10,000] per [Calendar][Plan] Year. Please note that this limitation does not apply to breast prostheses.]</p> <p>Some prosthetic services require Prior Authorization, including prosthetics 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.</p>	<p>Network Providers: [0 - 50% Coinsurance] [after Deductible]</p> <p>Non-Network Providers: [0 - 50% Coinsurance] [after Deductible] OR [Covered in Network Only]</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.



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 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.

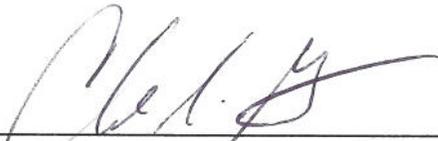
<i>SERFF Tracking Number:</i>	<i>MHPL-126793295</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Mercy Health Plans</i>	<i>State Tracking Number:</i>	<i>46682</i>
<i>Company Tracking Number:</i>	<i>MHPL-126793295</i>		
<i>TOI:</i>	<i>H16I Individual Health - Major Medical</i>	<i>Sub-TOI:</i>	<i>H16I.005A Individual - Preferred Provider (PPO)</i>
<i>Product Name:</i>	<i>ARINDIV PPACA-10</i>		
<i>Project Name/Number:</i>	<i>AR Indiv Health Reform Amendments/</i>		

Supporting Document Schedules

	Item Status:	Status Date:
<p>Satisfied - Item: Flesch Certification</p> <p>Comments: Certifications attached.</p> <p>Attachment: AR INDIV Certification.pdf</p>	Approved-Closed	09/02/2010
<p>Satisfied - Item: Application</p> <p>Comments: Application attached approved on 2/1/2010, SERFF # MHPL-126444604</p> <p>Attachment: AR Individual Application_ 2010_FINAL.pdf</p>	Approved-Closed	09/02/2010
<p>Bypassed - Item: Health - Actuarial Justification</p> <p>Bypass Reason: N/A no change in rate filing.</p> <p>Comments:</p>	Approved-Closed	09/02/2010
<p>Bypassed - Item: Outline of Coverage</p> <p>Bypass Reason: N/A - Schedule of Coverage is under "Form" tab</p> <p>Comments:</p>	Approved-Closed	09/02/2010
<p>Satisfied - Item: PPACA Uniform Compliance</p>	Approved-Closed	09/02/2010

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%.



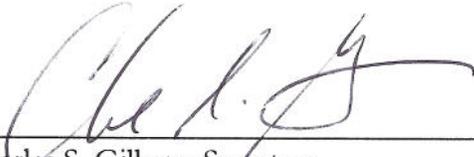
Charles S. Gilham, Secretary
Mercy Health Plans
14528 S. Outer 40, Suite 100
Chesterfield, MO 63017
cgilham@mhp.mercy.net
(314) 628-3696

8-30-10

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

8-30-10

Date

MercyOne Application Checklist

Please follow this checklist to ensure your application is complete and avoid unnecessary underwriting delays.

- Complete the General Member Information section (page *). Include the name, gender, height, weight, social security number, and date of birth for every person applying for coverage.
- Request an effective date on (page *). You may select either the 1st or 15th of the month.
- Obtain and send to Mercy Health Plans a copy of any Certificate of Creditable Coverage, if you have had prior health insurance coverage through another carrier. We will need a copy of this Certificate in order to grant you a waiver for any pre-existing conditions.
- Select the plan option for which you will be applying (page *).
- Answer all Health History questions (page * and *). Also, list all prescriptions and over-the-counter medications taken for each person applying for coverage. Failure to answer these questions will delay the underwriting of your application.
- Give us complete details in the attached *Secondary Health Questionnaire*, if you answered “yes” to any Health History conditions listed on page * (question # 6). The page number(s) listed next to the condition(s) in this section refer to corresponding questions in the *Secondary Health Questionnaire*.
- List the primary care physician, phone number, and date of last visit for each person applying for coverage (page*).
- Sign and date the Authorization to Use and Disclose Protected Health Information (page*). This applies to each enrolling Applicant age 18 or over. **If your application is dated more than 60 days before the requested effective date, you will be asked to re-apply.**
- Complete the Payment Information (page *). Payment for this policy can be made by automatic withdrawal from a checking or savings account. Mercy Health Plans also accepts Visa, MasterCard or American Express credit card payments.

If you need assistance in completing your application, please contact your agent. If you do not have an agent, please contact the MercyOne Sales Department (501) 372-0065 or (800) 330-8293, or email: mercystonearkansas@mercy.net.



Individual Application for Comprehensive Health Insurance

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



Please complete in black only.

Application Type										
Coverage Information (Select One): <input type="checkbox"/> New Coverage _____					Effective Date Requested: ___/___/___					
<input type="checkbox"/> Change to current plan			Member Number: _____		Effective Date of Change: ___/___/___					
<input type="checkbox"/> Add dependent (s) to current coverage			Member Number: _____		Effective Date of Change: ___/___/___					
Applicant Information										
Please enter the following applicant information: (If applying for <i>Child Only Coverage</i> , record the child's information in the following section. Please submit a separate application for each Child Only Applicant.)										
NAME: First Middle Last							Subscriber's Occupation:			
HOME ADDRESS: (Street & P.O. Box if applicable)				City		State		Zip	County	
Home Phone: (_____) _____			Best time to call: <input type="checkbox"/> Day <input type="checkbox"/> Evening			E-mail (this will not be shared with a 3rd party): _____				
Work Phone: (_____) _____			Cell Phone #: (_____) _____							
Are you a United States citizen? <input type="checkbox"/> Yes <input type="checkbox"/> No										
If "No", do you possess a Green Card (Permanent Resident Card) or a temporary U.S. visa? <input type="checkbox"/> Yes <input type="checkbox"/> No If "No", please explain: _____										
Are you a legal resident of the state of Arkansas? <input type="checkbox"/> Yes <input type="checkbox"/> No If "No", please explain: _____										
Have you resided in the United States for the past six (6) consecutive months? <input type="checkbox"/> Yes <input type="checkbox"/> No										
General Member Information										
Please complete information below for all family members applying for coverage (attach other pages, if needed).										
Name			Relationship to Applicant	Sex M/F	Height		Weight Lbs.	SSN#	Date of Birth	
First	MI	Last			Ft.	In.			(mm/dd/yyyy)	
			Self							
			Spouse							
			Child							
			Child							
			Child							
			Child							
			Child							
Will the Mercy Health Plans' coverage that you are applying for replace or change your current hospital, medical or major medical insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No										
Will any applicants be continuing any other health insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No If 'Yes', list name(s) : _____										

Producer Information

If you have a Producer (Broker or Agent) that will be assigned to your account, HAVE HIM/HER COMPLETE THIS SECTION.

Note: Mercy Health Plans (MHP) may share medical information with the Producer concerning you or your covered dependents that is contained in this application or discovered in the course of processing the application. The writing (and any assisting) Producer's current Arkansas health insurance license must be on file with MHP prior to acceptance of this application.

Do you know of any significant medical information relating to the applicant or any of his dependents that has not been reported on this form?
Yes No

For purposes of processing commission, please provide the following information*:

Agency Name: _____ Broker's Name: _____
 Broker's Telephone #: _____ Broker's Email: _____
 Broker's Signature: _____ Date: _____

Notification: Broker Only (Broker to receive policy)
 Broker and Subscriber (Member to receive policy, Broker to receive copy by email)

* Please fill out this information as it appears on your W-9 form.

Coverage and Benefit Selection

To choose the type of coverage that you would like, select ONE option from EACH of the sections numbered 1, 2, 3 and 4 below.

- 1) **TYPE OF COVERAGE:** Applicant only (Ages 19-65 yrs.) Child Only (Age 6 mos -18 yrs) Applicant & spouse
 Applicant & unmarried children* Applicant, spouse & unmarried children*

**Unmarried children under age 19, or who are full time students (FTS) through the date on which they turn 23 may be added to the plan. FTS documentation must accompany application. Call us for details on FTS documentation at [(501) 372-0065] [or] [800-330-8293].*

- 2) **EFFECTIVE DATE REQUESTED:** ____/____/____ [1st or 15th of the month only]

Note: The actual effective date will be determined by Mercy Health Plans, and if approved, you will be notified of the effective date for your policy.

- 3) **OPTIONAL RIDERS:** **Family Services Rider** [(tubal ligations & vasectomies)] – Additional \$ ____ /month (per family) (Applies only to Applicant and enrolled spouse) Yes No

Temporomandibular Joint Disorder (TMJ) Rider – Additional \$ ____ /month/per applicant Yes No

- 4) **PLAN SELECTION: Plan Option** – Choose ONLY ONE Plan option

Plan	In network deductible Individual/Family	In network co-insurance after Deductible	Office Visit PCP/Specialist	Prescription Copay
<input type="checkbox"/> ARK - A - 10	\$1,000/\$2,000	20%	\$30/\$60	\$10/\$35/\$70
<input type="checkbox"/> ARK - B - 10	\$2,500/\$5,000	20%	\$30/\$60	\$10/\$35/\$70
<input type="checkbox"/> ARK - C - 10	\$5,000/\$10,000	20%	\$30/\$60	\$10/\$35/\$70
<input type="checkbox"/> ARK - D - 10	\$1,500/\$3,000	20%	\$30/\$60	\$10/\$35/\$70
<input type="checkbox"/> ARK - E - 10	\$1,000/\$2,000	20%	\$30/\$60	\$10/\$35/\$70
<input type="checkbox"/> ARK - F - 10	\$2,500/\$5,000	20%	\$30/\$60	\$10/\$35/\$70
<input type="checkbox"/> ARK - G - 10	\$5,000/\$10,000	20%	20% after deductible	\$10/\$35/\$70

Other Health Coverage		Yes	No												
Answer "Yes" or "No" and list and/or submit additional information as requested below.															
1) Are you or anyone that is applying for coverage currently eligible for Medicare? If "yes", please list name(s): _____ _____		<input type="checkbox"/>	<input type="checkbox"/>												
Note: Anyone who is eligible for Medicare is not eligible for coverage under this Policy.															
2) Have you ever had your coverage through Mercy Health Plans terminated for failure to pay premiums? If "yes", please list name(s): _____ If your coverage was terminated by Mercy Health Plans for non-payment of premiums, you must wait 12 months before applying for coverage and one month's advance premium may be required.		<input type="checkbox"/>	<input type="checkbox"/>												
3) Did you and/or your spouse and/or your eligible dependents have creditable coverage from a health insurance carrier within the past 63 days? (Creditable Coverage is any health insurance except a short term policy) If "yes", you may be eligible for pre-existing credit. If applicable, submit a copy of the Certificate of Creditable Coverage for each person applying.		<input type="checkbox"/>	<input type="checkbox"/>												
Lifestyle		Yes	No												
Answer "Yes" or "No" and list additional information as requested below.															
1) Have you or any family member(s) who are applying for coverage smoked tobacco within the last 12 months? If "yes", list name(s): _____ Note: Additional testing may be required to confirm this information.		<input type="checkbox"/>	<input type="checkbox"/>												
2) Have you or any family member(s) who are applying for coverage used other smokeless tobacco products within the last 12 months? If "yes", list name(s): _____ Note: Additional testing may be required to confirm this information.		<input type="checkbox"/>	<input type="checkbox"/>												
3) Do you or any family member(s) who are applying for coverage use alcohol or illicit/recreational drugs? If yes, complete below::		<input type="checkbox"/>	<input type="checkbox"/>												
<table border="1"> <thead> <tr> <th>Name</th> <th>Which do you/family member drink/use?</th> <th>How often do you/family member drink/use?</th> </tr> </thead> <tbody> <tr> <td>_____</td> <td> <input type="checkbox"/> Alcohol <input type="checkbox"/> Illicit Drugs <input type="checkbox"/> Both alcohol & drugs </td> <td> <input type="checkbox"/> Seldom <input type="checkbox"/> Occasionally <input type="checkbox"/> Daily </td> </tr> <tr> <td>_____</td> <td> <input type="checkbox"/> Alcohol <input type="checkbox"/> Illicit Drugs <input type="checkbox"/> Both alcohol & drugs </td> <td> <input type="checkbox"/> Seldom <input type="checkbox"/> Occasionally <input type="checkbox"/> Daily </td> </tr> <tr> <td>_____</td> <td> <input type="checkbox"/> Alcohol <input type="checkbox"/> Illicit Drugs <input type="checkbox"/> Both alcohol & drugs </td> <td> <input type="checkbox"/> Seldom <input type="checkbox"/> Occasionally <input type="checkbox"/> Daily </td> </tr> </tbody> </table>		Name	Which do you/family member drink/use?	How often do you/family member drink/use?	_____	<input type="checkbox"/> Alcohol <input type="checkbox"/> Illicit Drugs <input type="checkbox"/> Both alcohol & drugs	<input type="checkbox"/> Seldom <input type="checkbox"/> Occasionally <input type="checkbox"/> Daily	_____	<input type="checkbox"/> Alcohol <input type="checkbox"/> Illicit Drugs <input type="checkbox"/> Both alcohol & drugs	<input type="checkbox"/> Seldom <input type="checkbox"/> Occasionally <input type="checkbox"/> Daily	_____	<input type="checkbox"/> Alcohol <input type="checkbox"/> Illicit Drugs <input type="checkbox"/> Both alcohol & drugs	<input type="checkbox"/> Seldom <input type="checkbox"/> Occasionally <input type="checkbox"/> Daily		
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_____	_____/_____(mm/yyyy)														
_____	_____/_____(mm/yyyy)														
_____	_____/_____(mm/yyyy)														

5) List Primary Care Physician, phone number and date of last visit for each person applying:

Name of Applicant:	Primary physician name, phone number, city & state:	Date of last visit:

6) Do you or any family member(s) applying for coverage currently have or have ever been diagnosed or treated for any health conditions or diseases (either Inpatient, Outpatient or Emergency Room) pertaining to the following organ systems or diseases?	Yes	No
	<input type="checkbox"/>	<input type="checkbox"/>

Check "Yes" or "No" for all conditions listed below as they apply for any covered family member.

NOTE: If you answer "Yes" to any of these screening questions, you must also answer the **Secondary Health Questionnaire** related to those conditions. The page numbers listed below refer to related questions in the attached *Secondary Health Questionnaire*.

Yes	No		Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	1. Diabetes/Sugar in Urine/Abnormal Blood Sugar/Pre-Diabetes, [pg *]	<input type="checkbox"/>	<input type="checkbox"/>	10. Nervous System/Brain Disorder/Headache/Epilepsy/Seizure Disorder, [pg*]
<input type="checkbox"/>	<input type="checkbox"/>	2. Endocrine/Thyroid/Pituitary/Adrenal, [pg *]	<input type="checkbox"/>	<input type="checkbox"/>	11. Mental or Psychiatric Condition/Depression/Behavioral (e.g., Attention-Deficit Hyperactivity Disorder)or Eating Disorder, [pg*]
<input type="checkbox"/>	<input type="checkbox"/>	3. High Blood Pressure/Hypertension, [pg *]	<input type="checkbox"/>	<input type="checkbox"/>	12. Back or Neck Disorder/Lumbago/Disc Herniation or Protrusion/Sciatica/Sacroiliac Disorder, [pg *]
<input type="checkbox"/>	<input type="checkbox"/>	4. Heart/Circulatory/Stroke/Aneurysm/Cholesterol, [pgs *]	<input type="checkbox"/>	<input type="checkbox"/>	13. Arthritis/Rheumatoid Arthritis/Bone/Joint Disorder/Inflammatory Joint Disorder/TMJ, [pgs *]
<input type="checkbox"/>	<input type="checkbox"/>	5. Respiratory/Lung/Asthma/Allergies/TB/COPD, [pg *]	<input type="checkbox"/>	<input type="checkbox"/>	14. Muscular Disorder/Lupus/Connective Tissue Disorder/Auto-Immune Disorder, [pg *]
<input type="checkbox"/>	<input type="checkbox"/>	6. Ears/Eyes/Nose/Throat/Skin Disorder, [pg *]	<input type="checkbox"/>	<input type="checkbox"/>	15. Cancers/Tumors/Cysts/Neoplasms, [pgs *]
<input type="checkbox"/>	<input type="checkbox"/>	7. Digestive/Intestinal/Liver Disorder/Acid Reflux/Crohn's/ Polyps/ Hepatitis/Cirrhosis [pgs *]	<input type="checkbox"/>	<input type="checkbox"/>	16. HIV/AIDS/ARC/Chronic or Infectious Disease, [pg *]
<input type="checkbox"/>	<input type="checkbox"/>	8. Prostate/Reproductive Organ Disorder/Infertility/STD, [pg *]	<input type="checkbox"/>	<input type="checkbox"/>	17. Any Other Illness, Disease or Injury, [pg *]
<input type="checkbox"/>	<input type="checkbox"/>	9. Urinary Tract/Kidney or Renal Disease, [pg *]	<input type="checkbox"/>		

Statements of Understanding

Please read all statements below.

1. I understand that this is an application only, and I should not cancel any coverage that I currently have until I am notified of acceptance for coverage by Mercy Health Plans (MHP).
2. I understand that I will receive either an acceptance, premium adjustment or denial from MHP, or a letter explaining the reason for the delay, within 60 days of MHP's receipt of this application.].
3. I understand that if the bank returns any payments due to insufficient funds, I will be assessed a fee. Additionally, I understand that if my premiums are not paid within the billing grace period, my coverage will be terminated as to the date when my premiums were paid in full. If my coverage is terminated, I will be unable to reapply for an Individual policy with Mercy Health Plans for one year.
4. I understand that if a Producer (Agent or Broker) is handling my request, the agent is not authorized to waive a complete answer to any question, make a decision as to insurability, make or alter any contract or waive any other rights or requirements of Mercy Health Plans.
5. I understand that if I or any covered family members am/are accepted for medical coverage, any pre-existing medical and/or mental health condition disclosed within this application will not be covered for up to 12 months after my effective date. (Credit may be given for prior creditable coverage upon receipt of certificate of creditable coverage.)
6. I understand that if any pre-existing condition(s) is/are subsequently discovered that were not disclosed during the application process, benefits will be withheld for 12 months for that condition or the coverage may be rescinded in its entirety at MHP's discretion.
7. I understand that I or any of my covered family members may need to obtain a physical examination at my own expense and submit the results as part of my application for coverage, if such an examination has not been performed within the last two years.
8. I understand that I or any of my covered family members have an obligation to notify Mercy Health Plans if we become aware of any medical conditions/injuries/disease states that would cause a reasonably prudent person to seek or require medical attention, from the time this application is signed to before the effective date of coverage. In this situation, MHP has the right to re-underwrite the application using this new information, and the decision to provide coverage may change.
9. I understand and agree that Mercy Health Plans may obtain or request information needed to process this application from me, my physician(s) and medical or pharmaceutical databases. A Mercy Health Plans' employee will then review this information. Any and all additions or corrections will then become part of the application. I understand that Mercy Health Plans will rely on this form and any information received to issue coverage.
10. I understand that if I omit or falsify information in a manner that is considered fraudulent or intentionally misleading, this may result in the cancellation of this coverage based on the terms of the policy. I agree to promptly repay any benefit payment(s) to which my covered family member(s) and/or I were not entitled.
11. I understand and agree that other health insurance coverage that I have might reduce my benefits under this Policy.

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.

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 must sign at the bottom of this form.

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. Federal regulations require that we inform you that under certain limited circumstances (e.g., judicial subpoena, state health department, etc.) the information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by such regulation.

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 to MHP in writing to our 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 must agree to the terms of this authorization by signing below.

By signing, I agree that I have fully read this entire application, including all seven (7) pages of the Secondary Health Questionnaire, and I understand and agree with all statements contained herein. I also certify that I have answered all questions on the application and Secondary Health Questionnaire completely and accurately. I understand and agree to the release of information for the purpose(s) described above in this document.

By checking this box I hereby certify that I have read all seven (7) pages of the Secondary Health Questionnaire and that I have no responses or information to provide to any of the questions presented.

	Signature Required:	Printed Name:	Date:
Applicant	X		
Applicant's Spouse	X		
Dependent 18 yrs. or older	X		
Dependent 18 yrs. or older	X		
Dependent 18 yrs. or older	X		

If your application is dated more than 60 days before the requested effective date for coverage, a new application may need to be completed.

Note: Coverage will not begin until all necessary information is received by MHP. MHP will notify you of the approved effective date.

SECONDARY HEALTH QUESTIONNAIRE

Note: You must answer each question for yourself and for everyone you are applying for. Answer all categories 'YES' or 'NO'. If you answer 'YES' to a category, make sure to complete the detailed section not only for yourself but for everyone you are applying for.

Have you/family member ever been diagnosed with, or sought treatment for any of the following conditions?

	YES	NO
1. Diabetes/Sugar in Urine/Abnormal Blood Sugar/Pre-Diabetes/Hypoglycemia	<input type="checkbox"/>	<input type="checkbox"/>

If YES, list family member(s) affected:

Diabetes/Pre-diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Which type of diabetes has been diagnosed?		
Type I, Insulin Dependent	<input type="checkbox"/>	<input type="checkbox"/>
If Type I, # units of insulin per day?		
<input type="checkbox"/> < 75 units <input type="checkbox"/> > 100 units		
<input type="checkbox"/> 75-100 units <input type="checkbox"/> Don't know		
Type II, Non-Insulin dependent	<input type="checkbox"/>	<input type="checkbox"/>
Gestational	<input type="checkbox"/>	<input type="checkbox"/>
Date of delivery (in MM/YYYY)	____/____/____	
Other type/Don't know	<input type="checkbox"/>	<input type="checkbox"/>
Date initial diabetes diagnosis made: (MM/YYYY)	____/____/____	
Oral meds to control blood sugar?	<input type="checkbox"/>	<input type="checkbox"/>
Provide recent HbA1c or average glucose levels (within last six months).		
If fasting glucose levels		
<input type="checkbox"/> 65-115 <input type="checkbox"/> 116-175 <input type="checkbox"/> >175		
If random glucose levels		
<input type="checkbox"/> <200 <input type="checkbox"/> 201-250 <input type="checkbox"/> >250		
If HbA1c level _____		
In addition, do you/family member have any of these conditions?		
Diabetic eye complications	<input type="checkbox"/>	<input type="checkbox"/>
Peripheral neuropathy	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Coronary Artery Disease	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Problems/Renal Failure	<input type="checkbox"/>	<input type="checkbox"/>
Hypoglycemia	<input type="checkbox"/>	<input type="checkbox"/>

	YES	NO
2. Endocrine System/Thyroid/Pituitary/Adrenal	<input type="checkbox"/>	<input type="checkbox"/>

If YES, list family member(s) affected:

Hyperthyroidism/Hashimoto's Thyroiditis/Graves Disease/Excess thyroid hormone	<input type="checkbox"/>	<input type="checkbox"/>
What kind of treatments have you/family member had for this?		
<input type="checkbox"/> Surgery <input type="checkbox"/> Radioactive Iodine <input type="checkbox"/> Other		
If surgery, date of surgery: (MM/YYYY)	____/____/____	
If surgery not done, does RX control disease?	<input type="checkbox"/>	<input type="checkbox"/>
Hypothyroidism-low thyroid hormone	<input type="checkbox"/>	<input type="checkbox"/>
Toxic Thyroid Goiter-Plummer's Disease	<input type="checkbox"/>	<input type="checkbox"/>
When was diagnosis made (in MM/YYYY)?	____/____/____	
Hyperparathyroidism	<input type="checkbox"/>	<input type="checkbox"/>
Did you/family member have surgery for?	<input type="checkbox"/>	<input type="checkbox"/>
If NO, does medication control disease?	<input type="checkbox"/>	<input type="checkbox"/>
If YES, date of surgery: (MM/YYYY)	____/____/____	
Hyperaldosteronism (Cushing's disease)	<input type="checkbox"/>	<input type="checkbox"/>
Is the cause of disease known?	<input type="checkbox"/>	<input type="checkbox"/>
If cause is known, describe condition:		

Date condition diagnosed: (in MM/YYYY)	____/____/____	
Is the condition stable with treatment?	<input type="checkbox"/>	<input type="checkbox"/>
Addison's Disease (Chronic Adrenal Insufficiency)	<input type="checkbox"/>	<input type="checkbox"/>

Growth Hormone Deficiency	<input type="checkbox"/>	<input type="checkbox"/>
Other Thyroid/Endocrine system disorder	<input type="checkbox"/>	<input type="checkbox"/>
Please describe: _____		

	YES	NO
3. High Blood Pressure/Hypertension	<input type="checkbox"/>	<input type="checkbox"/>

If YES, list family member(s) affected:

THREE recent blood pressure readings in systolic/diastolic format

Systolic	Diastolic	Date Taken

Readings taken while on meds for hypertension?	<input type="checkbox"/>	<input type="checkbox"/>
Diagnosed with malignant hypertension?	<input type="checkbox"/>	<input type="checkbox"/>
Has the diagnosis of hypertension required:		
An ER visit?	<input type="checkbox"/>	<input type="checkbox"/>
A hospital stay?	<input type="checkbox"/>	<input type="checkbox"/>

	YES	NO
4. Heart/Circulatory/Stroke/Aneurysm/Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>

If YES, list family member(s) affected:

Aneurysm	<input type="checkbox"/>	<input type="checkbox"/>
Which type of aneurysm?		
<input type="checkbox"/> Abdominal/Descending Thoracic Aortic <input type="checkbox"/> Brain		
<input type="checkbox"/> Femoral/Peripheral <input type="checkbox"/> Other type		
Has aneurysm been operated on?	<input type="checkbox"/>	<input type="checkbox"/>
If YES, date of surgery: (MM/YYYY)	____/____/____	
If NO, any further problems?	<input type="checkbox"/>	<input type="checkbox"/>
Hypercholesterolemia/Hyperlipidemia/High blood lipids/High blood cholesterol	<input type="checkbox"/>	<input type="checkbox"/>
What are cholesterol levels (in mg/dl)?		
<input type="checkbox"/> <=220 <input type="checkbox"/> >220<=250		
<input type="checkbox"/> >250<=300 <input type="checkbox"/> >300		
Are above levels while on cholesterol meds?	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>
What type of anemia do you/family member have?		
<input type="checkbox"/> Unknown/Other <input type="checkbox"/> Thalassemia Major		
<input type="checkbox"/> Pernicious <input type="checkbox"/> Iron Deficiency		
<input type="checkbox"/> Sickle Cell <input type="checkbox"/> Hemolytic Anemia		
If hemolytic, have you/family member had a splenectomy?	<input type="checkbox"/>	<input type="checkbox"/>
If YES, date of surgery: (MM/YYYY)	____/____/____	
Bleeding disorders/Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>
Coronary Artery Disease/Heart Attack/Myocardial Infarction	<input type="checkbox"/>	<input type="checkbox"/>
Have you/family member had?		
<input type="checkbox"/> Angioplasty/Balloon/Stent Procedure - How many? _____		
<input type="checkbox"/> Cardiac Bypass Surgery		
<input type="checkbox"/> Neither Angioplasty nor Bypass Surgery		
If performed, date procedure done: (MM/YYYY)	____/____/____	

If history of heart attacks, give date: (MM/YYYY) _____/_____/_____

Congestive Heart Failure

Is the only treatment drug therapy?

Have you/family member had any hospitalizations for?

Cardiomegaly/Enlarged heart

Are you/family member a heart transplant candidate?

Is the reason for the enlargement known?

If known, describe: _____

Do you/family member have any impairment from condition?

Peripheral Vascular Disease/Claudication

Is diagnosis?

Reynaud's Disease

Buerger's Disease

Neither Reynaud's or Buerger's

Cerebral Vascular Accident (CVA)/Stroke/Transient Ischemic Attack (TIA)/Small Stroke

Was diagnosis CVA or TIA? CVA TIA

Date symptoms began: (MM/YYYY) _____/_____/_____

Any residual impairment?

Arrhythmias/Atrial Fibrillation/Rhythm Problem

Episodes are: Single Multiple Chronic

If multiple, are they controlled?

If YES, are they controlled by?

Drugs Surgical device

Conduction disturbances/Bundle Branch Blocks

Cause known for conduction disturbances?

If cause known, describe: _____

Cardiac implantable device/pacemaker installed?

If YES, date of surgery: (MM/YYYY) _____/_____/_____

Chest pain/Angina/Ischemic Heart Disease

Is clinical work up suggestive of coronary artery disease/blocked cardiac arteries?

If NO, date of symptoms onset: (in MM/YYYY) _____/_____/_____

Deep Vein Thrombosis/Blood Clots in Legs/Phlebitis

Do you/family member currently have one of these conditions?

Have you/family member had?

Single episode Multiple episodes

If single episode, date of onset of symptoms: (MM/YYYY) _____/_____/_____

If multiple, date recovered from last episode: (MM/YYYY) _____/_____/_____

Are you/family member on anti-clotting RX?

Edema/Swelling of the extremities

Do you/family member know what is causing swelling?

If YES, describe: _____

Cardiac Valve disorders/Heart Murmur/Valve Prolapse/Regurgitation/Stenosis of Valve

Have you/family member had surgery for condition?

If YES, was the valve: Repaired Replaced

If YES, date of surgery: (MM/YYYY) _____/_____/_____

If NO, are you/family member symptomatic?

Carotid Artery Occlusion

Is disease symptomatic and documented?

Have you/family member had surgery to correct?

If YES, date of surgery: (MM/YYYY) _____/_____/_____

Cardiomyopathy

Are you/family member on the waiting list for heart transplant?

Do you/family member know what is causing cardiomyopathy?

If YES, describe: _____

Pericarditis

Did you/family member have surgery?

If surgery, date of surgery: (MM/YYYY) _____/_____/_____

Other disease of the heart or circulatory system

Please describe: _____

	YES	NO
5. Respiratory/Lung Disorder/Asthma/TB/COPD	<input type="checkbox"/>	<input type="checkbox"/>

If YES, list family member(s) affected: _____

Allergies/Asthma

Do you/family member have?

Asthma & Allergies

Allergies Only Asthma Only

If allergies, are you/family member on desensitization shots?

If asthma, are attacks occasional or frequent?

Occasional Frequent

If asthma, any hospitalizations for?

If asthma, nebulizer used for acute episodes?

If asthma, are you/family member taking corticosteroids?

Is asthma under control with medications?

Chronic Obstructive Lung Disease (COPD) or Emphysema

Sleep Apnea

If YES, do you/family member have a C-Pap machine?

If NO, has it been recommended by a health care provider that you/family member get a C-Pap machine?

Have you/family member had surgery for?

If YES, date of surgery: (MM/YYYY) _____/_____/_____

Bronchitis

In last two years number of hospitalizations for bronchitis?

Not at all One time > Than once

Pulmonary Embolism/Pulmonary Infarction

Is it known what caused embolism/infarction?

Please describe: _____

Single episode of symptoms?

Are you/family member continuing anticoagulant drug treatment?

Have you/family member fully recovered?

Dyspnea/Shortness of Breath

Known underlying condition causing this?

Please describe underlying condition: _____

Is the shortness of breath exercise induced?

How would you/family member characterize symptoms? Mild Moderate Severe

Pulmonary Hypertension

Are you/family member a recipient/candidate for a lung transplant?

Other respiratory condition

Please describe: _____

	YES	NO
6. Ear/Eye/Nose/Throat/Skin Disorder	<input type="checkbox"/>	<input type="checkbox"/>

If YES, list family member(s) affected: _____

Middle ear infections/tubes in ears/Otitis Media

Are infections chronic?

Has there been more than one infection?

Are tubes present in ear canals?

Date of most recent episode: (MM/YYYY) _____/_____/_____

Any hearing impairment?

If YES, does it require a hearing aid?

If YES, do you/family member need a cochlear implant?

Cataracts

Both eyes?

Have you/family member had surgery on?

If YES, date of surgery: (MM/YYYY) _____/_____/_____

Glaucoma

If YES, provide current ocular pressure: _____

Tonsillitis

Have you/family member had surgery for?

If YES, date of surgery: (MM/YYYY) _____/_____/_____

Single episode of symptoms?

Date of last episode of symptoms: (MM/YYYY) _____/_____/_____

Psoriasis/Chronic Skin Condition/Eczema

Episodes are: Mild Moderate Severe

Taking Enbrel/Other Biologic RX injections for?

Acne

Cellulitis-skin infection

More than one episode?

Are the episodes severe?

When was since last episode? (MM/YYYY) _____/_____/_____

Sinusitis/Sinus Infection

Is condition chronic?

How many infections do you/family member have a year? _____

Other Ear/Eye/Nose/Throat or Skin condition

Please describe: _____

	YES	NO
7. Digestive/Intestinal/Liver Disorder/Acid Reflux/Crohn's/Polyps/Hepatitis/Cirrhosis	<input type="checkbox"/>	<input type="checkbox"/>

If YES, list family member(s) affected: _____

GERD/Gastroesophageal Reflux Disease/Acid Reflux

Did symptoms abate/improve with drug therapy?

Are drugs you/family member taking prescribed by physician?

Ulcers/Peptic Ulcers/Duodenal Ulcers/Gastric Ulcers

Have you/family member had surgery for condition?

If YES, date of surgery: (MM/YYYY) _____/_____/_____

Crohn's Disease/Inflammatory Bowel Disease

Have you/family member had surgery for condition?

If YES, what kind of surgery was done? Partial bowel resection Total bowel resection

If YES, date of surgery: (MM/YYYY) _____/_____/_____

Colitis/Irritable Bowel Syndrome (IBS)/Spastic Colitis

Currently under treatment Single Attack in the past Multiple Attacks in the past

If multiple date of last episode of symptoms: (MM/YYYY) _____/_____/_____

Gastrointestinal Bleeding

When was last bleeding episode? (MM/YYYY) _____/_____/_____

Are you/family member currently under treatment?

Cirrhosis of the Liver/Hepatitis/Liver Disease

Which type of liver disease has been diagnosed? Cirrhosis Hepatitis C Hepatitis A Alcoholic Hepatitis Hepatitis B Chronic Hepatitis

If Hepatitis A, B or C - Normal liver function tests?

If Hepatitis C - Taking Interferon by injection?

Gall Bladder Disease/Cholelithiasis/Cholecystitis

Was it a single attack of symptoms?

Has the gall bladder been removed?

If YES, date of surgery: (MM/YYYY) _____/_____/_____

If NO, date of last attack of symptoms? (MM/YYYY) _____/_____/_____

Fatty Liver (NASH)

Ulcerative Colitis/Chronic Inflammation of Colon

Single or multiple episodes?

Have you/family member had surgery for condition?

If YES, date of surgery: (MM/YYYY) _____/_____/_____

If YES, are you/family member on prescription medications?

If NO, is condition under control?

If NO, are you/family member taking steroid medication?

If NO, date last episode of symptoms: (MM/YYYY) _____/_____/_____

Diverticulitis/Diverticulosis

Do you/family member currently have symptoms from this?

Have you/family member had surgery for?

If YES, date of surgery: (MM/YYYY) _____/_____/_____

Colon Polyps/Rectal Polyps

Benign?

Have you/family member had surgery on?

If YES, date of surgery: (MM/YYYY) _____/_____/_____

Hernia

If YES, what kind of hernia? Inguinal Femoral Scrotal Ventral

Has it been operated on?

If no, any symptoms from?

If no operation and symptomatic, are symptoms managed by medicine?

Pancreatitis

	YES	NO
Is condition chronic or acute?	<input type="checkbox"/>	<input type="checkbox"/>
Any history of alcohol use?	<input type="checkbox"/>	<input type="checkbox"/>
Any subsequent liver disease?	<input type="checkbox"/>	<input type="checkbox"/>
Single episode of pancreatitis?	<input type="checkbox"/>	<input type="checkbox"/>
Do you/family member currently have this condition?	<input type="checkbox"/>	<input type="checkbox"/>
If NO, date of last episode of symptoms: (MM/YYYY) _____/_____/_____		

Other digestive/intestinal disorder
 Please describe: _____

	YES	NO
8. Prostate/Reproductive Organ Disorder/ Infertility/ STD	<input type="checkbox"/>	<input type="checkbox"/>

If YES, list family member(s) affected: _____

Uterine fibroids/Dysfunctional Uterine Bleeding
 Have you/family member had a hysterectomy?
 If YES, date of surgery: (MM/YYYY) _____/_____
 Was there a malignancy?
 Benign Prostatic Hypertrophy/Prostatic Enlargement
 Is there a malignancy?
 Have you/family member had prostate surgery?
 If YES, date of surgery: (MM/YYYY) _____/_____
 Any symptoms or voiding difficulties related to prostatic enlargement?
 Sexually transmitted diseases
 Which type?
 Genital Herpes-Date of last episode: (MM/YYYY) _____/_____
 Chlamydia - Is it present at this time?
 Gonorrhea - Is it present at this time?
 Syphilis - Is it present at this time?
 Venereal Warts - Is it present at this time?
 Infertility
 If YES, are you/family member on infertility treatments?
 Ovarian cysts
 Are the cysts benign?
 Any symptoms from condition?
 Cervical Dysplasia/Abnormal Pap Smears
 More than one abnormal Pap in the last 2 years?
 Prolapsed Uterus
 Have you/family member had surgery to correct?
 If YES, date of surgery: (MM/YYYY) _____/_____
 Do you/family member have a history of complications of pregnancies or deliveries?
 Have you/family member had an infant that was premature?
 With congenital abnormalities/anomalies/defects?
 Please describe: _____

 Other disorder/abnormality of the reproductive system
 Please describe: _____

	YES	NO
9. Urinary Tract/Kidney or Renal Disease	<input type="checkbox"/>	<input type="checkbox"/>

If YES, list family member(s) affected: _____

Cystitis/Urinary Tract Infection (UTI)/Pyuria/Urethritis
 Single episode?
 When was last episode (in MM/YYYY)? _____/_____
 Was there any protein/discharge/blood in urine?
 Cystic disease of kidneys
 Solitary Cyst Polycystic
 Have you/family member had surgery?
 If YES, date of surgery: (MM/YYYY) _____/_____

Have you or any family member applying for coverage had a kidney transplant
 If YES, date of surgery: (MM/YYYY) _____/_____
 Any post-surgical complications?
 Renal calculi/Kidney stones
 Currently have?
 If NO, date of last episode: (MM/YYYY) _____/_____
 More than two episodes of symptoms?
 Were stones in one or both kidneys?
 Unilateral/One kidney only
 Bilateral/Both kidneys
 Interstitial cystitis
 Currently have?
 If NO, date of last episode: (MM/YYYY) _____/_____
 Acute Renal failure/Chronic Renal failure
 Currently have?
 If NO, date of recovery: (MM/YYYY) _____/_____
 Urinary Incontinence
 Other Kidney/Urinary tract disorder
 Please describe: _____

	YES	NO
10. Nervous System/Brain Disorder/Headache/ Epilepsy/Seizure Disorder	<input type="checkbox"/>	<input type="checkbox"/>

If YES, list family member(s) affected: _____

Headaches/Migraines/Cluster Headaches
 Situational Headaches (menstrual, stress, other)?
 Characterization of severity & frequency of headaches (Pick one):
 Mild and/or less than 5/year Severe and/or > 10/year
 Moderate and/or 5 - 10/year Onset less than 6 months
 Head Injury/Concussion
 Was there a loss of consciousness?
 If YES, how long was loss of consciousness?
 < 1 hour < 1 day More than 1 day
 If < 1 hour, any residual problems post recovery?
 If < 1 day, give date of recovery: (MM/YYYY) _____/_____
 If < 1 day, any residual problems post recovery?
 Encephalitis/Encephalomyelitis
 Currently have?
 If NO, any residual complications post recovery?
 If NO, how long since recovery (in MM/YYYY)? _____/_____
 Neuroma/Abnormal Nerve Growth
 Is growth benign?
 Have you/family member been operated on?
 If YES, when was surgery (MM/YYYY)? _____/_____
 If NO, when was recovery (MM/YYYY)? _____/_____
 Is the diagnosis Morton's Neuroma?
 Amyotrophic Lateral Sclerosis (ALS)/Lou Gehrig's Disease
 Reflex Sympathetic Dystrophy
 If YES, have currently or recovered from?
 Current Recovered from
 If recovered, date of recovery: (MM/YYYY) _____/_____
 Chronic Fatigue Syndrome
 If YES, have currently or recovered from?
 Currently have Recovered from
 If recovered, date of recovery: (MM/YYYY) _____/_____

Peripheral Neuropathy
 Is another disease condition causing neuropathy?
 If YES, please describe: _____

Epilepsy/Seizure Disorder
 Do you/family member know what type of seizure has been diagnosed?
 If YES, what is seizure type?
 Febrile Petit Mal Jacksonian
 Grand Mal Focal
 Is another disease condition causing seizures?
 If YES, please describe: _____

Heat Exhaustion/Heat Stroke
 Which diagnosis? Heat Exhaustion Heat Stroke
 Single episode?
 If NO, date of last episode: (MM/YYYY) _____/_____/_____

Autism
 Cerebral Palsy
 Paralysis/Hemiplegia/Paraplegia
 Parkinson's Disease
 Spina Bifida
 Viral Meningitis
 Bacterial Meningitis
 Muscular Dystrophy
 Multiple Sclerosis
 Motor Neuron Disease
 Neuralgia/Neuritis
 Dementia
 Other disorder of the nervous system
 Please describe: _____

	YES	NO
11. Mental or Psychiatric Condition/Depression/ Behavioral (e.g., Attention-Deficit Hyperactivity Disorder) or Eating Disorder	<input type="checkbox"/>	<input type="checkbox"/>

If YES, list family member(s) affected: _____

Affective Disorders
 What is diagnosis (pick one below)?
 Obsessive Compulsive Disorder (OCD)
 Panic Disorder Agoraphobia
 Anxiety Disorder Neuroses
 Is treatment effective?
 If YES, date treatment became effective? (MM/YYYY) _____/_____/_____

What is characterization of severity of symptoms?
 Mild Moderate Severe

Schizophrenia/Paranoia
 Eating Disorder/Bulimia/Anorexia
 Do you/family member currently have an eating disorder?
 When was recovery? (MM/YYYY) _____/_____/_____

Attention Deficit Disorder/ADD/ADHD

	YES	NO
What is characterization of severity of symptoms?		
<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe		
Are symptoms controlled by medication?	<input type="checkbox"/>	<input type="checkbox"/>

Situational Depression/Mild Depression/Anxiety
 Is only current treatment prescription medication?

Major Depression/Bipolar Disorder
 When was diagnosis made? (MM/YYYY) _____/_____/_____

Have you/family member ever sought, or are you seeking professional counseling/therapy for a mental health issue?

Date of last treatment? (MM/YYYY) _____/_____/_____

Other mental health/psychiatric disorder

Please describe: _____

	YES	NO
12. Back or Neck Disorder/Lumbago/Disc Herniation or Protrusion/Sciatica/Sacroiliac Disorder	<input type="checkbox"/>	<input type="checkbox"/>

If YES, list family member(s) affected: _____

Cervical (Neck) or Thoracic (Mid Back) or Lumbar (Low Back) Disc Herniation or Protrusion

Are you/family member under current treatment for?

Have you/family member had surgery for condition?

If YES, any subsequent problems post-op?

If YES, date of surgery: (MM/YYYY) _____/_____/_____

If no surgery was done, have you/family member recovered?

If you/family member have recovered, date of Recovery: (MM/YYYY) _____/_____/_____

Low Back Pain/Lumbago/SI Joint/Sciatica

Are you/family member under current treatment for?

If not in current treatment, date of last episode: (MM/YYYY) _____/_____/_____

Spinal Fractures

Any lingering neurological defects?

Was fracture a compression fracture?

When was last treatment (in MM/YYYY)? _____/_____/_____

Spinal Stenosis

Have you/family member had surgery for condition?

If YES, date of surgery: (MM/YYYY) _____/_____/_____

Low Back Strain/Whiplash/Muscle Spasm

Are you/family member under current treatment for?

Ankylosing Spondylitis/Spondylolisthesis

Have you/family member had surgery for condition?

If YES, date of surgery: (MM/YYYY) _____/_____/_____

If NO, is condition symptomatic/requiring treatment?

Sciatica/Radiculitis/Radiating pain to legs or arms

Do you/family member have any neurological defects?

Are you/family member currently under treatment for?

Are episodes recurrent?

When was last episode (in MM/YYYY)? _____/_____/_____

Spinal deformities/Scoliosis/Lordosis

Have you/family member had surgery for condition?

If surgery, any continuing problems post-op?

If surgery was done, date of surgery: (MM/YYYY) _____/_____/_____

If no surgery, are you/family member currently under treatment?

If you/family member are currently under treatment, is condition?

Mild Moderate Severe

If no current treatment, date of last treatment? (MM/YYYY) _____/_____/_____

Spina Bifida/Myelocele
 Have you/family member had surgery for condition?
 If YES, date of surgery: (MM/YYYY) _____/_____
 If YES, any residual neurological defects?
 Other back/neck disorder
 Please describe: _____

	YES	NO
13. Arthritis/Rheumatoid Arthritis/Bone/Joint Disorder/Inflammatory Joint Disease/TMJ	<input type="checkbox"/>	<input type="checkbox"/>

If YES, list family member(s) affected: _____

Arthritis
 Kinds of arthritis do you/family member have?
 Degenerative Chronic proliferative
 Hypertrophic Arthritis deformans
 Senile Psoriatic
 Juvenile Rheumatoid Chondrocalcinosis
 Adult Rheumatoid Septic
 Atrophic Acute Infectious
 Osteoarthritis
 Is condition asymptomatic?
 If symptomatic, date of first onset of symptoms: (MM/YYYY) _____/_____
 Is more than one joint affected?
 If no, is the joint a hip or knee?
 Have you/family member had a hip/knee replacement?
 If you/family member had surgery, date of surgery: (MM/YYYY) _____/_____
 Characterization of disease progression/degree of disability:
 Mild, Minimal Moderate to Severe
 Is there a joint infection?
 Osteomyelitis/Bone Infection/Bone Abscess
 Was there only a single episode?
 Involved joint/bone was:
 Major joint/bone Minor joint/bone
 TMJ Disorder/Disease
 TMJ Syndrome/Jaw Pain
 Under current treatment for?
 If NO, date treatment completed: (MM/YYYY) _____/_____
 Bursitis/Tennis Elbow/Tendonitis/Synovitis
 Was there only a single episode of symptoms?
 Under current treatment for?
 Osteoporosis
 Is underlying cause known for condition?
 If YES, please describe cause for condition below:

 Any symptoms from?
 Any subsequent fractures?
 Do you/family member take steroids for condition?
 Carpal Tunnel Syndrome
 Have you/family member had surgery for?
 If YES, date of surgery: (MM/YYYY) _____/_____
 Ligament tears/Torn Meniscus/Osteochondritis/Dessicans/Chondromalacia
 Have you/family member had surgery for?
 If surgery, date of surgery: (MM/YYYY) _____/_____

Bone dislocation
 Was the dislocation (choose one, below)?
 Congenital hip Patella (kneecap)
 Shoulder Knee (not kneecap)
 Hip-traumatic Other joint-traumatic
 Was there a single episode of symptoms?
 Do you/family member currently have?
 Have you/family member had surgery on?
 If YES, date of surgery: (MM/YYYY) _____/_____
 Dislocation was:
 Unilateral/one sided Bilateral/both sides
 Bone fracture
 Has treatment been completed?
 Have you/family member had surgery on?
 If YES, date of surgery: (MM/YYYY) _____/_____
 Was the fracture? Union Non-Union
 Was the fracture of?
 Leg/hip/foot
 Arm/hand/shoulder
 Other bone
 Foot pain
 Bunions
 If YES, have you/family member had surgery for?
 If YES, date of surgery: (MM/YYYY) _____/_____
 Plantar fasciitis
 Rotator cuff tear
 Have you/family member had surgery on?
 If YES, date of surgery: (MM/YYYY) _____/_____
 Date of original injury: (MM/YYYY) _____/_____
 Gout/Gouty Arthritis/Hyperuricemia
 Characterization of number of attacks:
 Few Frequent
 Are attacks well controlled by medication/diet?
 Other bone/joint disorder
 Please describe: _____

	YES	NO
14. Muscular Disorder/Lupus/Connective Tissue/Autoimmune Disorder	<input type="checkbox"/>	<input type="checkbox"/>

If YES, list family member(s) affected: _____

Collagen diseases:Scleroderma/Ehlers-Danlos Syndrome/Mixed Connective Tissue disease/Necrotizing Angiitis
 Lupus Erythematosus
 Fibromyalgia/Myitis/Myositis
 Currently being treated?
 If no current treatment, date of recovery: (MM/YYYY) _____/_____
 Recurrent episodes?
 Polymyositis/Neuromyositis/Dermatomyositis
 Autoimmune Disorder/Disease
 Please describe: _____

Ligament tears/Meniscus tears/Osteochondritis/Dessicans/Chondromalacia
 Have you/family member had surgery for condition?
 If surgery, date of surgery: (MM/YYYY) _____/_____

Other Muscle/Connective Tissue/Autoimmune disorder
 Please describe: _____

	YES	NO
15. Cancer/Tumors/Cysts/Neoplasm	<input type="checkbox"/>	<input type="checkbox"/>

If YES, list family member(s) affected: _____

	YES	NO
Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Breast Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Basal Cell/Squamous Cell Skin Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Prostate Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Lipoma/Adipose Tumor	<input type="checkbox"/>	<input type="checkbox"/>
Colon/Rectal Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Melanoma	<input type="checkbox"/>	<input type="checkbox"/>
Other kind of cancer	<input type="checkbox"/>	<input type="checkbox"/>

Please describe: _____

Are you/family member under current treatment?
 If NO, date treatment completed: (MM/YYYY) ____/____/____
 What was stage of the tumor?
 Stage I Stage II Stage III Stage IV
 When diagnosed? (in MM/YYYY) ____/____/____
 Was the treatment surgery alone?
 If YES, date of surgery: (MM/YYYY) ____/____/____
 If not, what were the other treatments?
 Please describe: _____

Is cancer in remission?
 Is the cancer metastatic?
 Is the cancer recurrent?
 Have you/family member been told you have an abnormal, suspicious lesion/possible pre-malignant condition?
 Has the lesion been removed?
 Cyst
 Please describe: _____
 Has the cyst been removed?

	YES	NO
16. HIV/AIDS/ARC Chronic or Infectious Disease	<input type="checkbox"/>	<input type="checkbox"/>

Have you or any family member applying for coverage been positively diagnosed or treated for HIV/AIDS/ARC Chronic or infectious Disease?
 If YES, list family member(s) affected: _____

HIV (human immunovirus)	<input type="checkbox"/>	<input type="checkbox"/>
AIDS (Acquired Immune Deficiency Syndrome)	<input type="checkbox"/>	<input type="checkbox"/>
ARC (AIDS related complex)	<input type="checkbox"/>	<input type="checkbox"/>
Other chronic or Infectious disease	<input type="checkbox"/>	<input type="checkbox"/>

Please describe: _____

	YES	NO
17. Any other Illness, Disease, Condition or Injury	<input type="checkbox"/>	<input type="checkbox"/>

If YES, list family member(s) affected: _____

As a result of an injury or illness have you/family member had any of the treatments listed below?

Bone or skin graft(s)	<input type="checkbox"/>	<input type="checkbox"/>
Joint replacement	<input type="checkbox"/>	<input type="checkbox"/>
Loss of limb	<input type="checkbox"/>	<input type="checkbox"/>
Loss or surgical removal of organ	<input type="checkbox"/>	<input type="checkbox"/>

If YES, please describe: _____

Other Disease/Disease Condition/Disorder/Injury not previously described
 Please describe: _____

 Date of last treatment (in MM/YYYY): ____/____/____
 Treating Physician: _____

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	XXXXXXXXXX <i>See Cover Letter</i>	See Cover Letter	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No

PPACA Uniform Compliance Summary

Reset Form

SECTION A – Individual Health Benefit Plans

TOI	Category	Statute Section	Grandfathered	Non-Grandfathered
H161 Individual Health - Major Medical	<p>Eliminate Pre-existing Condition Exclusions for Enrollees Under Age 19</p> <p>Explanation:</p> <p>Page Number: COC Amend, p. 4</p>	[Sections 2704 and 1255 of the PHSA/Section 1201 of the PPACA]	N/A	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If no, please explain.
H161 Individual Health - Major Medical	<p>Eliminate Annual Dollar Limits on Essential Benefits</p> <p>Except allows for "restricted" annual dollar limits for essential benefits for plan years prior to January 1, 2014.</p> <p>Explanation: DME, Prosthetics, Orthotics, Mental Health, limits filed as variables until essential benefits are confirmed by federal regulation.</p> <p>Page Number: Schedule Amendment</p>	[Section 2711 of the PHSA/Section 1001 of the PPACA]	N/A	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If no, please explain.
H161 Individual Health - Major Medical	<p>Eliminate Lifetime Dollar Limits on Essential Benefits</p> <p>Explanation: We have "No Lifetime Benefit Maximum" already filed; no change needed.</p> <p>Page Number: N/A</p>	[Section 2711 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.
H161 Individual Health - Major Medical	<p>Prohibit Rescissions – Except for fraud or intentional misrepresentation of material fact.</p> <p>Explanation:</p> <p>Page Number: COC Amend, pg. 2</p>	[Section 2712 of the PHSA/Section 1001 of 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.

PPACA Uniform Compliance Summary

SECTION A – Individual Health Benefit Plans

TOI	Category	Statute Section	Grandfathered	Non-Grandfathered
H161 Individual Health - Major Medical H161	Preventive Services – Requires coverage and prohibits the imposition of cost-sharing for specified preventative services. Explanation: Preventive already a standard benefit for Grandfathered plans. Page Number: Schedule Amend, pg. 2-3	[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.
H161 Individual Health - Major Medical	Extends Dependent Coverage for Children Until age 26 – If a policy offers dependent coverage, it must include dependent coverage until age 26. Explanation: Page Number: CPC Amend, pg 1	[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.
H161 Individual Health - Major Medical	Appeals Process – Requires establishment of an internal claims appeal process and external review process. Explanation: Page Number: COC Amend, pg 2-3	[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.
H161 Individual Health - Major Medical	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. Explanation: MHP is already in compliance as this has always been standard practice for MHP. Page Number: N/A	[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.

PPACA Uniform Compliance Summary

SECTION A – Individual Health Benefit Plans

TOI	Category	Statute Section	Grandfathered	Non-Grandfathered
H161 Individual Health - Major Medical	<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: In compliance, not a PCP plan. Members can see any doctor.</p> <p>Page Number: N/A</p>	<p>[Section 2719A of the PHSA/Section 10101 of the PPACA]</p>	N/A	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If no, please explain.
H161 Individual 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: In compliance as this is PPO product, no referrals required; no authorization to see OB/GYN</p> <p>Page Number: N/A</p>	<p>[Section 2719A of the PHSA/Section 10101 of the PPACA]</p>	N/A	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If no, please explain.