Health Insurance for Individuals

Comprehensive Individual Health Insurance Coverage Policy

Issued by: Mercy Health Plans

This Policy is guaranteed renewable

Policy for Non-Occupational Injury and Non-Occupational Illness

NOTICE:
Please read the copy of the Application attached to this Policy. Carefully check the Application and write to Mercy Health Plans, 14528 S Outer 40, Suite 300, Chesterfield, Missouri 63017 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. This Application is part of this Policy and the Policy was issued on the basis that answers to all questions and the information shown on the Application are correct and complete.

This Policy is underwritten by Mercy Health Plans. The Benefits and main points of coverage under the Plan are set forth in this Policy and Schedule of Coverage and Benefits and any attached Riders. The Benefits are effective only while You are covered by the Individual PPO Policy.

This Policy describes the Benefits for health care services provided by Mercy Health Plans and the extent to which Benefit Payment may be limited. The Policy may be terminated by Mercy Health Plans or by You as described in this Policy.

You may return this Policy within ten (10) days of its receipt for full refund of any Premiums paid if, after examining it, You are not satisfied for any reason. Written notification is required to return this Policy. If services are utilized during this (10) day period, this policy is assumed to be accepted. Any coverage returned for a refund of Premium will be null and void from its inception.

Mercy Health Plans
14528 S Outer 40, Suite 300
Chesterfield, Missouri 63017
314-214-8100
800-830-1918
www.mercyhealthplans.com

Table of Contents

Comprehensive Individual Health Expense Coverage Policy

This Policy is a legal document between **Mercy Health Plans (“The Plan”, “We”, “Us”, “Our”)**and **the Enrolling Individual (“You”, “Your”)** to provide Benefits to Covered Persons, subject to the terms, conditions, exclusions and limitations of the Policy. We issue the Policy based on the Enrollee’s application and payment of the required Policy Premium.

The Policy includes:

- The Enrollee’s application
- Any Amendments and Riders
- The Schedule of Coverage and Benefits

Changes to the Document

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

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

Information You Should Have

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

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

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

This Policy will renew automatically every 12 months from the date that Your coverage begins. You must notify Us in writing if You want to terminate this policy at any time during each 12-month period. We must receive Your termination notice prior to Your requested date of termination.

We are delivering the Policy in the State of Arkansas. The laws of the State of Arkansas govern this Policy.

The validity of the Policy will not be contested after the Policy has been in force for two (2) years from the date of issue. No statement relating to insurability made by any person covered under the Policy will be used to contest the validity of the Policy after it has been in force for a period of two (2) years. In addition, the statement must be contained in a written instrument signed by the person making the statement. The assertion, at any time, of defenses based upon the person’s ineligibility for coverage under the Policy or upon other provisions in the Policy will not be precluded.

Section 1: Introduction to Your Policy

OTHER INSURANCE REDUCES BENEFITS – READ CAREFULLY

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

Information about Defined Terms

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

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

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

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

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

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

Required Premiums, Premium Changes and Grace Period

The Plan requires automatic withdrawal of premiums on or about the 15th of each month for this Policy. You must pay the required Premium within a 31-day grace period to keep this Policy in force. All premiums must be paid via any one of the following methods:

- ACH Direct Debit Program
- Credit Card payment
- A check for the entire annual Premium

Your Policy will renew automatically every twelve (12) months from the date that Your coverage begins. You must notify Us in writing if You want to terminate this Policy at any time during each 12-month period. We must receive Your termination notice prior to Your requested date of termination.

Upon the payment of a claim under this Policy, any Premium then due and unpaid or covered by any note or written order may be deducted from the claim payment. We may change the amount of Your Premiums on any monthly due date upon giving You sixty (60) days prior written notice.

We may change the terms and conditions of this Policy to conform to the laws of the State of Arkansas, to conform to Federal law or to conform to underwriting policies established by Mercy Health Plans after submission to and approval by the Arkansas Insurance Department. For changes in terms and conditions, We must give written notice thirty (30) days before the change. This notice may be in the form of a new Policy or a Rider or Amendment to this Policy.

Don't Hesitate to Contact Us

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

Section 2: Eligibility

How to Enroll

If Eligible, the Enrolling Individual must complete an enrollment application and submit the properly completed form to Us, along with any required Premium. We will not provide Benefits for health services that You receive before Your effective date of coverage.

If You Are Hospitalized When Your Coverage Begins

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

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

If You Are Eligible for Medicare

If You are eligible for Medicare, You are not eligible to begin or continue coverage under this Policy.

Who is Eligible for Coverage?

Subscriber

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

To be eligible for this coverage, Your primary domicile and residence must be within Arkansas.

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

Children who are ages 6 months – 18 years may qualify as eligible persons under a Child Only Policy.

Except as We have described in Section 3 (When Coverage Begins), You may not enroll without acceptance by the Plan.

Dependents

Dependent generally refers to the Subscriber's spouse and children. When a Dependent actually enrolls, We refer to that person as an Enrolled Dependent. Dependents may include Full-Time Students ages 19 - 23. 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. For a completed definition of Dependent and Enrolled Dependent, or Full-Time Student, see Section 14 (Definitions of Terms).

If both parents of a Dependent child are enrolled as a Subscriber, only one parent may enroll the child as a Dependent.

Except as We have described in Section 3 (When Coverage Begins), Dependents may not enroll without acceptance by the Plan.

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

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

The Subscriber must reimburse Us for any Benefits that We pay for a child at a time when the child did not satisfy these conditions.

Except as We have described in Section 3 (When Coverage Begins), Dependents may not enroll without acceptance by the Plan.

Who is not eligible to enroll?

Persons not eligible for coverage include -

a) Those whose coverage was previously terminated for the following causes:

- Fraud or misrepresentation in the application
- Abuse of services or facilities
- Improper use of ID Card
- Misconduct detrimental to Plan operations and the delivery of services
- Failure to pay Premiums more than twice in the past 12 months, or to pay Premiums in a timely manner in accordance with the terms of the Policy.

Refer to Section 4 (When Coverage Ends) for a detailed description of these causes that lead to termination.

Section 3: When Coverage Begins

Initial Enrollment Period

The Initial Enrollment Period is the first time You enroll yourself and/Your eligible dependents, subject to acceptance by the Plan. Coverage begins on the Effective Date as determined by the Plan and when We approve Your completed application and receive any required Premium.

Adding New Dependents

Subscribers may enroll Dependents who join their family because of any of the following events:

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

Coverage for a new Dependent begins on the date of the event and the following applies:

Birth – For a newborn Dependent, We must be notified within ninety (90) days or Your next Premium due date, whichever is greater.
Legal Adoption or Filing a petition for adoption – We must be notified within sixty (60) days of the date You filed a petition for adoption of a child for which You have physical custody and is under Your charge, care and control. Coverage will begin on the date of the filing of the petition for adoption, or from the moment of birth, if the petition is filed for adoption of a newborn within sixty (60) days after the birth of the child.
Marriage, Legal permanent general guardianship and court or administrative order – We must be notified within thirty-one (31) days of the event.

Upon receiving notification of a new Dependent, We will provide You with an enrollment application and instructions necessary to enroll the new Dependent. You will have ten (10) additional days from the date You received the enrollment application to enroll a new Dependent.

Coverage for a Disabled Child

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

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

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

We will ask You to furnish Us with proof of the disabled child's incapacity and dependency after the date coverage would otherwise have ended because the child reached a certain age. Before We agree to this extension of coverage for the child, We may require that a Physician chosen by Us examine the child. We will pay for that examination.

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

Section 4: When Coverage Ends

General Information about When Coverage Ends:

- We may discontinue this Benefit plan and/or all similar benefit plans at any time for the reasons explained in the Policy, as permitted by law.
- Your entitlement to Benefits automatically ends on the date that coverage ends, unless You are hospitalized and Totally Disabled on that date, in which case Your coverage ends on the date of Your inpatient confinement to the hospital.
- When Your coverage ends, We will still pay claims for Covered Health Services that You received before Your coverage ended. However, once Your coverage ends, We do not provide Benefits for health services that You receive for medical conditions that occurred after Your coverage ended.
- An Enrolled Dependent's coverage ends on the date the Subscriber's coverage ends.

Events Ending Your Coverage

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

Event	Description
The Entire Individual Policy Ends	Your coverage ends on the date the Individual Policy ends. The Plan is responsible for notifying You that Your coverage has ended: If We terminate the Policy because We will no longer issue this particular type of individual health benefit plan within the applicable market, We will provide at least ninety (90) days prior written notice to the Enrolling Individual and all Covered Persons.
You Are No Longer Eligible for Coverage	Your coverage ends on the date You are no longer eligible to be a Subscriber or Enrolled Dependent. Please refer to Section 2 (Eligibility) and Section 14 (Definitions of Terms) for more information. When You turn age 65 or become eligible for Medicare You are no longer eligible for coverage. If Your coverage ends due to Your death and we receive notification within one (1) year of Your death, premiums paid for coverage beyond the date of Your death will be refunded to You or your estate within thirty (30) days after We receive written proof of Your death.
We Receive Notice to End Coverage	Your coverage ends at the end of the month that We receive Your request in writing. We must receive Your termination notice prior to Your requested date of termination. Your Policy will renew automatically every twelve (12) months from the date that Your coverage begins. You must notify Us in writing if You want to terminate this policy at any time during each 12-month period.
Fraud, Misrepresentation or False Information	Your coverage ends on the date We identify in a notice that Your coverage is terminated because of fraud or misrepresentation. We will provide written notice to the Subscriber that coverage has ended. During the first three (3) years the Policy is in effect, if You provided Us with false information or misrepresentation of material facts regarding Your application or coverage, We have the right to demand that You pay back all Benefits We paid to You, or paid in Your name, during the time You were incorrectly covered under the 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.

Event	Description
Abuse of Services or Facilities	In the event of abuse by a Covered Person in the use of services or facilities, that person's coverage may be restricted or canceled by the Plan upon at least thirty-one (31) days' prior written notice to the Individual and the Member.
Improper Use of ID Card	Your coverage ends when You permit an unauthorized person to use Your ID card, or You used another person's card. When Your coverage is terminated because of improper use of Your ID card, We will provide written notice to the Subscriber that coverage has ended on the date We identify in the notice.
Non-Payment of Premiums	This Policy will automatically end on the last day of the period for which Premiums have been paid, if Premiums are not paid within the grace period when due. The grace period is thirty-one (31) days from the Premium due date.
Reinstatement of Coverage	If Premium is not paid by the end of the grace period (thirty-one (31) days from the Premium due date), coverage will end as of the date to which Your last Premium was paid. However, this Policy may be reinstated. After You receive a termination notice from Us, You will have five (5) working days to notify Us in writing of Your desire to reinstate Your Policy. **Reapplication for Coverage** If you fail to request reinstatement within five (5) working days of receipt of a termination notice from Us and want to renew Your coverage, you will have to reapply for a new individual policy. However, You may not reapply for coverage for a period of twelve (12) months from the date Your coverage ended due to nonpayment of Premiums.
Death of Subscriber	Coverage ends for the Subscriber and his/her Dependents as of the date of the Subscriber's death.
Misconduct	In the event Your misconduct is detrimental to the safe Plan operations and the delivery of services, Your coverage may be canceled immediately.
Moving Out of State	Coverage will end within sixty (60) days after We receive notice of Your move out of Arkansas.

Section 5: How You Get Care

Identification cards

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

If You do not receive Your ID card within thirty (30) days after the Effective Date of Your enrollment, or if You need replacement cards, call Us at 866-450-3249. You must show Your ID card every time You request Health Care Services from a Network Provider.

Where You get covered care:

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

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

- Covered Health Services are received while the Individual Policy is in effect.
- Covered Health Services are received prior to the date that any of the individual termination conditions listed in Section 4 (When Coverage Ends) occurs.
- The person who received Covered Health Services is a Covered Person and meets all eligibility requirements specified in the Policy.

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

Network Providers

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

A directory of Network Providers is available on our website at www.mercyhealthplans.com. We update the provider directory periodically, however, before obtaining services You should always verify the Network status of a provider. A provider's status may change. You can verify the provider's status by calling Our Customer Contact Center at 866-450-3249.

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

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

Network Benefits

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

- Provided by a Network Physician or other Network Provider
- Emergency Health Services.

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

Designated Facilities and Other Providers

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

In both cases, Network Benefits will only be paid if Your Covered Health Services for that condition are provided by or arranged by the Designated Facility or other provider chosen by Us.

Non-Network Benefits

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

What You must do to get covered care

You must notify Us before getting certain Covered Health Services from either Network or Non-Network Providers. **You are responsible for ensuring that Your provider obtains any required prior-authorization before You receive Covered Health Services.** The details are shown in the *Must You Notify Us?* column in Section 12 (Covered Benefits).

We urge You to confirm with Us that the services You plan to receive are Covered Health Services, even if not indicated in the *Must You Notify Us?* column. To notify Us, call Our Customer Contact Center at the telephone number listed on Your ID card. Prior authorization does not mean Benefits are payable in all cases. That's because in some instances, certain procedures may not meet the definition of a Covered Health Service and therefore are excluded. In other instances, the same procedure may meet the definition of Covered Health Services. By calling before You receive treatment, You can check to see if the service is subject to limitations or exclusions including, but not limited to:

- The Cosmetic Procedures exclusion. Examples of procedures that may or may not be considered Cosmetic include: breast reduction and reconstruction (except after cancer surgery when it is always considered a Covered Health Service); vein stripping, ligation and sclerotherapy, and upper lid blepharoplasty;
- The Experimental, Investigational or Unproven Services exclusion;
- Any other contract limitation or exclusion.

Care Management

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

Emergency Health Services

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

Network Benefits are paid for Emergency Health Services, even if a Non-Network Provider provides the services.

- If You are confined in a Non-Network Hospital after You receive Emergency Health

Services, We must be notified within two (2) working days or on the same day of admission if reasonably possible. Please note, however, that claims payment is not conditional on notification. We may elect to transfer You to a Network Hospital as soon as it is medically appropriate to do so. If You choose to stay in the Non-Network Hospital after the date We decide a transfer is medically appropriate, Non-Network Benefits may be available if the continued stay is determined to be a Covered Health Service.

- If You are admitted as an inpatient to a Network Hospital within twenty-four (24) hours of receiving treatment for the same condition as an Emergency Health Service, You will not have to pay the Copayment for Emergency Health Services. The Copayment for an Inpatient Stay in a Network Hospital will apply instead.

Section 6: Your Cost for Covered Services

This is what You will pay for covered care:

Copayments

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

Coinsurance

Coinsurance is the percentage of Our Eligible Expenses that You must pay for Your care. Coinsurance doesn't begin until after You meet Your deductible. **Only Coinsurances count toward Your Out-of-Pocket Maximum.**

Deductible

A Deductible is a fixed expense You must incur within a Calendar Year for certain covered services and supplies before We start paying Benefits for them. For a complete definition of Annual Deductible, see Section 14 (Definitions of Terms).

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

Deductibles do not apply to Your Out-of-Pocket Maximum.

For Your Annual Deductible see Your Schedule of Coverage and Benefits.

Eligible Expenses

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

Charges in Excess of the UCR

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

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

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

Out-of-Pocket Maximum

The maximum You pay out of Your pocket in a Calendar Year for Coinsurances. For a complete definition of Out-of-Pocket Maximum, see Section 14 (Definitions of Terms).

If You use both Network Benefits and Non-Network Benefits, two separate Out-of-Pocket Maximums apply. Once You reach the Out-of-Pocket Maximum for Network Benefits, those Benefits are payable at 100% of Eligible Expenses during the rest of that Calendar Year. Once You reach the Out-of-Pocket Maximum for Non-Network Benefits, those Benefits are payable at 100% of Eligible Expenses during the rest of that Calendar Year.

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

- Any charges for Non-Covered Health Services;
- Copayments for Covered Health Services available by an optional Rider (other than an optional Rider required by state law);

- The amount of any reduced Benefits if You don't notify Us as described in (Section 12: Covered Benefits) under the *Must You Notify Us?* Column;
- Charges that exceed Eligible Expenses;
- Any Copayments for Covered Health Services in Section 12 (Covered Benefits);
- The Annual Deductible.

For Your Annual Out-of-Pocket Maximum see Your Schedule of Coverage and Benefits.

Maximum Policy Benefit

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

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

Section 7: How to File a Claim

Network Provider

We pay Network Providers directly for Your Covered Health Services, so Network Providers file claims on Your behalf to Us. If a Network Provider bills You for any Covered Health Service, contact Us. However, You are responsible for meeting any Annual Deductible and for paying Copayments or Coinsurance to a Network Provider at the time of service, or when You receive a bill from the provider.

Non-Network Provider

When You receive Covered Health Services from a Non-Network Provider, You may be responsible for filing Your claim directly with Us.

How to File a Claim

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

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

Required Information for Claims

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

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

Claim Forms

Upon receipt of a notice of claim submitted within the time fixed in the Policy for filing proofs of loss below, We will furnish You claim forms for filing proofs of loss. If We do not furnished You a form within fifteen (15) days after receiving Your notice, You will be deemed to have complied with the requirements of this Policy. Your notice of claim should contain written proof covering the occurrence, the character and extent of the loss for which claim is made.

Proof of Loss

Written proof of such loss and notice of claim must be provided to Us within ninety (90) days after the date of such loss. Failure to furnish such proof within such time will not invalidate nor reduce any claim if it was not reasonably possible to furnish such proof within such time. In no event, except in the absence of legal capacity of the claimant, will a claim be valid later than one year from the time proof is otherwise required. All Benefits payable under the policy will be paid within thirty (30) days after receipt of proof. Written proof of claim must be furnished to the Plan at P. O. Box 4568, Springfield, MO 65808.

Time of Payment of Claims

Eligible reimbursements payable under this Policy will be paid upon receipt of due written proof of such claim. All eligible reimbursement will be payable to Network Providers. Reimbursement for services received from Non-Network Providers will be paid to the insured unless You provide Us with a written assignment of Benefits form signed by You, allowing payment directly to the Non-Network Provider. (Note: The claim may be submitted by the Provider of service indicating an "Assignment of Benefits on File". In this case, reimbursement will be made to the Provider.) We will send You an Explanation of Benefits form or letter. This will show You what services were paid, how much was paid, who was paid, when payment was made or why payment for some services was not made or was made in part.

There may be some circumstances for which We must seek additional information from You to process the claim. If this occurs, We will send You written notice within thirty (30) days after receipt of the claim. The notice will contain an explanation of the additional information that is required. We will suspend (pend) the claim until We receive the requested information from You. Within thirty (30) days of receipt of the requested information, the claim will be reprocessed in accordance to the terms and Benefits of Your coverage. If We deny all or any part of Your claim, We will send You an Explanation of Benefits form or a letter telling You why it was denied. The form or letter may also tell You what other information, if any, We would need to reconsider Our decision. If You do not agree with Our decision, You have the right to appeal Your claim. See Section 9 (Complaints, Grievances and Appeals). You may also call or write Us, or You may contact the Arkansas Insurance Department.

Action on Claims

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

Release of Records

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

Direct Payment to Public Hospitals

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

Section 8: Coordinating Benefits with Other Coverage

When You have coverage under more than one plan

This section describes how Benefits under the Policy will be coordinated with those of any other plan that provides Benefits to You.

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

Definitions

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

Other (Another) Plan — A Plan, or "other plan" is any of those which provides Benefits or services for, or because of, medical or dental care or treatment:

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

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

This Plan — This Policy provides Benefits for individual health care expenses under Mercy Health Plans.

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

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

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

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

General Information:

When You have other health coverage

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

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

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

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

When other Government agencies are responsible for Your care

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

Order of Benefit Determination Rules

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

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

General

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

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

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

Rules:

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

1. Nondependent / Dependent

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

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

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

2. Dependent child whose parents are not separated or divorced

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

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

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

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

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

4. Joint Custody

If the specific terms of the court decree state that the parents will share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the Plans covering the child will follow the "Birthday Rule" described above.

5. Active or inactive employee

The Plan that covers You as an employee is Primary, if You are neither laid off nor retired. The same would hold true if You are a Dependent of a person covered as a retiree and an employee. If the other Plan does not have this rule and if, as a result, the plans do not agree on the order of Benefits, this rule (#5) is ignored.

6. Continuation coverage

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

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

7. Longer/Shorter length of coverage

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

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

Effect on the Benefits of this Plan

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

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

   i. The Benefits that would be payable for the allowable expense under this Plan in the absence of this COB provision; and
   ii. The Benefits that would be payable for the allowable expenses under the other Plans, in the absence of provisions with a purpose like that of this COB provision (whether or not claim is made) exceeds those allowable expenses in a claim determination period. In that case, the Benefits of this plan will be reduced so that they and the Benefits payable under the other plans do not total more than those allowable expenses. When the Benefits of this plan are reduced as described previously, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of this Plan.

Right to Receive and Release Needed Information

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

By accepting Coverage under this Policy, You agree to:

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

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

Coordinating Benefit Payments

The Plan will make every effort to expedite the exchange of COB information required to process Your claim (s) under these COB provisions. Eligible reimbursements payable under this Policy will be paid upon receipt of due written proof of such claim and any additional information requested including COB information. Payment will be made within ninety (90) days after receipt of a completed claim form. See "Time Payment of Claims" in Section 6 for more information.

Reconciliation of Payments

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

Right of Recovery

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

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

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

Right of Reimbursement

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

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

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

- That You will cooperate with Us in protecting Our legal and equitable rights to subrogation and reimbursement, including, but not limited to:
  - Providing any relevant information requested by Us,

- Signing and/or delivering such documents as We or Our agents reasonably request to secure the subrogation and reimbursement claim,
- Responding to requests for information about any accident or injuries,
- Making court appearances, and
- Obtaining Our consent or Our agents' consent before releasing any party from liability or payment of medical expenses.

- That we have the sole authority and discretion to resolve all disputes regarding the interpretation of the language stated herein;
- In the event You recover funds from a third party that are subject to this Right of Reimbursement section, reasonable costs of collection and/or attorney's fees may be assessed against You and Us in the proportion each benefits from the recovery.
- That regardless of whether You have been fully compensated or made whole, We may collect from You the proceeds of any full or partial recovery that You or Your legal representative obtain, whether in the form of a settlement (either before of after any determination of liability) or an non-economic damage settlement or judgment;
- That Benefits paid by Us may also be considered to be Benefits advanced;
- That You will not accept any settlement that does not fully compensate or reimburse Us without Our written approval, nor will You do anything to prejudice Our rights under this provision;
- That, upon Our request, You will assign to Us all rights of recovery against Third Parties, to the extent of the tortfeasors for whom You are seeking recovery, to be paid before any other of Your claims are paid;
- That We may, at Our option, take necessary and appropriate action to preserve Our right under these subrogation provisions, including filing suit in Your name, which does not obligate Us in any way to pay Your part of any recovery We might obtain;
- That We shall not be obligated in any way to pursue this right independently or on Your behalf.

Section 9: Complaints, Grievances & Appeals

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

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

Arkansas Insurance Department
Consumer Services Division
Third and Cross Streets
Little Rock, AR 72201
1-800-852-5494
www.mercyhealthplans.com

Step	Description

1 **What to do first. Contact Our Customer Contact Center. The telephone number is shown on Your ID card.**

Customer Contact Center Representatives are available to take Your call during regular working hours, Monday through Friday. At other times, You may leave a message on voicemail. A Customer Contact Center Representative will return Your call. If You would rather send Your Complaint to Us in writing at this point, You may write to Us at the address listed below.

The Plan agrees to investigate and endeavor to resolve any and all Complaints received from Members with regard to the nature of professional services rendered or Benefits provided under this Policy. Any inquiries, Complaints or the like, will be made to the Plan by telephone or arranged appointment to the Customer Contact Center Representative at:

Mercy Health Plans
ATTN: Customer Contact Center
14528 S. Outer 40, Suite 300
Chesterfield, Missouri 63017-5743
866-450-3249

The Customer Contact Center Representative will make every effort to resolve the concern to Your satisfaction during the initial telephone call or interview with the Plan. Resolution of Complaints through this process will not preclude Your rightful access to review through the Grievance Process.

2 **Ask Us in writing to reconsider Our initial decision.**

Minimum Time to File a Grievance: You must file a Grievance no later than one hundred eighty (180) days from the date that written notice was sent from the Plan informing You of the event that gave rise to the Grievance.

First Level Grievance Procedure: Ask Us in writing to reconsider Our initial decision. You, Your authorized representative, or Your Provider can submit a Grievance described below.

a) Write to Us no later than one hundred eighty (180) days from the date that written notice was sent from the Plan to You, informing You of the event that gave rise to the Grievance; and

b) Send Your request to Us at: Mercy Health Plans, Attn: Corporate Appeals, 14528 S. Outer 40, Suite 300, Chesterfield, Missouri 63017-5743.

c) Include a statement about why You believe Our initial decision was wrong, based on specific benefit provisions in this brochure; and

d) Include copies of documents that support Your claim, such as physician letters, operative reports, bills, medical

records, and Explanation of Benefits (EOB) forms.

The Plan will acknowledge receipt of Your Grievance in writing within ten (10) working days. A complete investigation of the Grievance will follow. Someone who is neither the individual who made the initial determination, nor the subordinate of such individual will conduct the review.

In the case of a Grievance involving a medical judgment, the Plan will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, and who is neither the individual who was consulted on the initial claim determination, nor the subordinate of such individual.

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

Within fifteen (15) calendar days for a service You have not yet received; or

Within thirty (30) calendar days for a service You have already received.

This written determination will include information about Your right to file an appeal, if We maintain Our denial.

3 **Ask Us in writing to reconsider Our Grievance decision. This is called an Appeal.**

Minimum Time to File a Grievance: A second level Grievance (called an "appeal") may be filed no later than one hundred eighty (180) days from the date the Plan sent You a resolution of Your first level Grievance.

Second Level Grievance/Appeal Procedure: To appeal a denial regarding Your first level Grievance, You, Your authorized representative, or Your Provider must -

a) Write to Us no later than one hundred eighty (180) days from the date We sent You written resolution of Your first level Grievance; and

b) Send Your request to Us at: Mercy Health Plans, Attn: Corporate Appeals, 14528 S. Outer 40, Suite 300, Chesterfield, Missouri 63017-5743.

c) Include a statement about why You believe Our decision was wrong based on specific benefit provisions in this brochure.

When We receive Your appeal, it will be submitted to a Grievance Advisory Panel consisting of other enrollees and representatives of the Plan that were not involved in the circumstances giving rise to the Grievance or in any subsequent investigation or determination of the Grievance; and, when the Grievance involves an Adverse Determination, a majority of persons that are appropriate clinical peers in the same or similar specialty as would typically manage the case being reviewed that were not involved in the circumstances giving rise to the Grievance or in any subsequent investigation or determination of the Grievance. Review by the Grievance Advisory Panel will follow the same time frames as the first level Grievance review.

We will write to You with Our decision.

Expedited Grievance/Appeal Procedure: When the standard time frames in the complaint, Grievance 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 seventy-two (72) hours after receiving a request for an expedited review. This will be followed by written notification of that decision within three (3) working days of the notification of the determination.

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

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

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

(a) The requested health care service does not meet the health benefit plan's requirements for medical necessity, or

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

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

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

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

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

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

Section 10: Utilization Review

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

Initial Determinations

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

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

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

Concurrent Review Determinations

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

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

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

Retrospective Review Determinations

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

Adverse Determination

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

Reconsideration of an Adverse Determination

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

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

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

Lack of Information

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

Complaint and Grievance Procedures

These procedures address all Complaints, Grievances, and appeals concerning operation of Mercy Health Plans except any Complaints that allege or indicate possible professional liability. These procedures are designed to provide timely, thorough and fair review of determinations in utilization management and claims payment. The complaint procedure is more fully described in Section 9 (Complaints, Grievances and Appeals).

Section 11: General Provisions

Your Relationship with Us

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

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

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

Our Relationship with You

The relationship between You and the Plan is solely a contractual relationship between independent contractors. You are not Our agent or employee. Neither We nor any of Our employees are Your agents.

We do not provide health care services or supplies, nor do We practice medicine. We are **not** liable for any act or omission of any provider.

We are not considered to be an employer for any purpose with respect to the administration or provision of Benefits under Your benefit plan.

You are solely responsible for all of the following:
- Enrollment and classification changes (including classification changes resulting in Your enrollment or the termination of Your coverage);
- The timely payment of the required Premium to Us.

Your Relationship with Providers

The relationship between You and any provider is that of provider and patient;
- You are responsible for choosing Your own provider;
- You must decide if any provider treating You is right for You;
- This includes providers You choose and providers to whom You have been referred;
- You must decide with Your provider what care You should receive;
- Your provider is solely responsible for the quality of the services provided to You.

Administrative Services

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

Amendments to the Policy

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

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

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

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

Assignment

This Policy and all the rights, responsibilities and benefit payments under it are personal to You. You may assign them to any Provider of Covered Service.

Case Management

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

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

Clerical Error

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

Conformity with State Laws

If any provision (s) of this Policy conflicts with the Arkansas law, then those provision (s) are automatically changed to conform to at least the minimum requirements of the law.

Commission or Omission

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

Entire Policy/Changes

The Policy issued to You, Your application, Amendments and Riders constitute the entire Policy. No change in this Policy will be valid until approved by one of Our executive officers and unless such approval be endorsed hereon or attached hereto. No agent has authority to change this Policy or waive any of its provisions.

Examination of Covered Persons

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

Incentives to You

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

Incorporation by Reference

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

Information and Records

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

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

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

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

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

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

You will give Us information reasonably necessary to maintain Your records on a current basis. Failure to provide such information may terminate this Policy. Our clerical errors or delays in keeping or reporting data relative to coverage will not terminate coverage which would otherwise be in force, nor continue coverage which would otherwise be terminated. Upon discovery of errors or delays, We will make whatever change is needed to assure that You have the coverage to which You are entitled to. No retroactive coverage or Premium changes will be made unless prior written approval is received from Us. Retroactive changes beyond sixty (60) days will not be approved unless We are at fault.

Interpretation of Eligibility and Benefits

We have sole discretion to do all of the following:

- Determine eligibility;
- Interpret Benefits under the Policy;

- Interpret the other terms, conditions, limitations and exclusions set out in the Policy, including this Policy and any Riders and Amendments;
- Make factual determinations related to the Policy and its Benefits.

We may delegate this discretionary authority to other persons or entities who provide services in regard to the administration of the Policy.

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

Legal Actions

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

Medicare Eligibility

Benefits under the Policy are not intended to supplement any coverage provided by Medicare. Covered Persons who are eligible for or enrolled in Medicare may NOT be covered under the Policy.

Misstatement of age

If the age of the insured has been misstated, all amounts payable under this Policy shall be equal to the amount that the Premium paid would have been purchased at the actual age when the policy was issued.

Notice

When We provide written notice regarding administration of the Policy to Your authorized representative, that notice is deemed notice to You and Your Enrolled Dependents.

Any notice required under this Policy will be sufficient if it is in writing and mailed or delivered:

a) To You, when addressed to You at the address currently appearing on Our records;
b) To Mercy Health Plans, when addressed to 14528 S Outer 40, Suite 300, Chesterfield, Missouri 63017-5743.

Policies, Identification Cards and Applications

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

Reimbursement to Us

a) As a Covered Person, You agree to refund Us any benefit payment We made to You or on Your behalf for a claim paid or payable under Workers' Compensation or employers' liability law. Even if You fail to claim through a Workers' Compensation or employers' liability law and You could have received payment through such a law if You had filed, reimbursement must still be made to Us. We have the right to credit payments of such claims against future claims in all cases.

b) We have the right to correct benefit payments paid in error. Hospitals, Physicians, other Providers and/or You have the responsibility to return any overpayment including claims made involving fraud to Us. We have the responsibility to make additional payment if an underpayment is made.

Statements by Enrolling Individual or Subscriber

All statements made by You shall be deemed representations and not warranties. Except for fraudulent statements, We will not use any statement made by You to void the Policy after it has been in force for a period of three (3) years.

No statement made by a Covered Person in the application for coverage shall void coverage or be used in any legal proceedings against the Covered Person unless the application (or an exact copy) is included with this Policy.

Time Limit on Certain Defenses

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

Workers' Compensation not Affected

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

Section 12: Covered Benefits

Benefit Description **See Schedule of Coverage and Benefits for Copayment/Coinsurance Amount** **Note: Copayments and Deductibles do not count towards Your Out-of-Pocket (OOP) Maximum; only Coinsurances apply to Your OOP Maximum.**	**Must You Notify Us?** *Note: You are responsible for ensuring that Your provider obtains any required prior-authorization before You receive Covered Health Services.*
1. Allergy ● Office visits ● Injections and serum, treatment, or testing (when no charge is made for physician services)	**Network** No No **Non-Network** No
2. Ambulance Services- Emergency only Medically Necessary ambulance service (either by a licensed ambulance service - ground or air ambulance) to the most appropriate Hospital where Emergency Care can be provided in the case of a Medical Condition and Medically Necessary transportation, when recommended by a Participating Physician; however, use of air ambulance must be authorized in advance by the Plan. Ambulance services do not include safety evacuation or medical transportation from foreign countries, even in emergency situations. See Section 13, S., for related exclusions.	**Network** No **Non-Network** No
3. Chiropractic Care Benefits for Chiropractic Care in the chiropractor's office when provided by a Network Provider licensed to practice chiropractic care. Benefits include diagnosis and related services and are limited to one (1) visit and treatment per day. Any combination of Network and Non-Network Benefits for Chiropractic Care is limited to twenty-six (26) visits per Calendar Year. Services rendered by a Non-Network chiropractor will not be reimbursed. Limitations and exclusions are described in Section 13, C.	**Network** No **Non-Network** No
4. Dental-Anesthesia and Facility Charges Administration of general anesthesia and Hospital charges for dental care if: ● The Covered Person is a child under the age of seven who is determined by two (2) licensed dentists to require, without delay, necessary dental treatment in a hospital or ambulatory surgical center for a significantly complex dental condition; or ● The Covered Person is diagnosed with a serious mental or physical condition; or ● The Covered Person has a significant behavioral problem as determined by the covered person's physician. Limitations and Exclusions are described in Section 13, D. **Prior Authorization Required** Unless We pre-approved these services, Network and Non-Network Benefits for dental anesthesia and related facility charges will be reduced by 50% of Eligible Expenses.	**Network** Yes **Non-Network** Yes
5. Dental Services - Accident only Dental services when all of the following are true: ● Treatment is necessary because of accidental damage ● Dental services are received from a Doctor of Dental Surgery, "D.D.S." or Doctor of Medical Dentistry, "D.M.D."	**Network** Yes

Benefit Description **See Schedule of Coverage and Benefits for Copayment/Coinsurance Amount** **Note: Copayments and Deductibles do not count towards Your Out-of-Pocket (OOP) Maximum; only Coinsurances apply to Your OOP Maximum.**	**Must You Notify Us?** *Note: You are responsible for ensuring that Your provider obtains any required prior-authorization before You receive Covered Health Services.*
● The dental damage is severe enough that initial contact with a Physician or dentist occurred within seventy-two (72) hours of the accident Benefits are available only for treatment of a sound, natural tooth. The Physician or dentist must certify that the injured tooth was: ● A virgin or unrestored tooth ● A tooth that has no decay, no filling on more than two surfaces, no gum disease associated with bone loss, no root canal therapy, is not a dental implant and functions normally in chewing and speech. Dental services for final treatment to repair the damage must be both of the following: ● Started within three (3) months of the accident. ● Completed within twelve (12) months of the accident. Dental x-rays and narrative report for independent dental consultant review may be required. Please note that dental damage that occurs as a result of normal activities of daily living or extraordinary use of the teeth other than for normal biting or chewing is not considered an "accident". Benefits are not available for repairs to teeth that are injured as a result of such activities, or specifically excluded in Section 13, D. **Prior Authorization Required** Please remember that for Benefits You must notify Us as soon as possible before follow-up (post-Emergency treatment begins. You do not have to notify Us before initial Emergency treatment. Unless We pre-approve post-emergency treatment, coverage for accidental dental services will be reduced by 50% of Eligible Expenses.	**Non-Network** Yes
6. Diabetes Services Medically appropriate and necessary equipment, supplies and self-management training for the management and treatment of diabetes. Services are provided for persons with gestational, type I or type II diabetes. Coverage is provided for insulin infusion devices, insulin pumps, and associated supplies. Services for **diabetes self-management training**: Covered Health Services are limited to a program that is in compliance with the National Standards for Diabetes Self-Management Education Program as developed by the American Diabetes Association. Diabetes self-management training shall be provided only upon prescription by a licensed physician and a licensed health care professional must certify that the Covered Person successfully completed the training program. Coverage is limited to one (1) program during the entire time a Covered Person is Covered under this Certificate. However, a Physician may prescribe additional training, due to a significant change in the Covered Person's symptoms or condition. A provider licensed, registered, and/or certified in the state to provide appropriate Health Care Services must provide diabetes self-management training program. Training is to be provided upon the initial diagnosis of diabetes, where there is a significant change in the Member's symptoms and when the Food and Drug Administration for the treatment of diabetes approve new techniques and treatments.	**Network** Yes, but only for those services listed **Non-Network** Yes, but only for those services listed

Benefit Description **See Schedule of Coverage and Benefits for Copayment/Coinsurance Amount** **Note: Copayments and Deductibles do not count towards Your Out-of-Pocket (OOP) Maximum; only Coinsurances apply to Your OOP Maximum.**	**Must You Notify Us?** *Note: You are responsible for ensuring that Your provider obtains any required prior-authorization before You receive Covered Health Services.*
Prior Authorization Required You must obtain Prior Authorization before receiving services for the following: ● Insulin pumps ● Drugs listed on the prior-authorization list on Our website at: **www.mercyhealthplans.com**, or You may call Our Customer Contact Center at the number listed on Your ID card. Unless We pre-approve these services, Network and Non-Network Benefits will be reduced by 50% of Eligible Expenses.	
7. Durable Medical Equipment Durable Medical Equipment (DME) that meets each of the following criteria: ● Ordered or provided by a Physician for outpatient use. ● Used for medical purposes. ● Not consumable or disposable. ● Not of use to a person in the absence of a disease or disability. If more than one piece of standard and basic hospital-type equipment can meet Your functional needs, Benefits are available only for the most cost effective piece of equipment. Examples of DME include: ● Equipment to assist mobility, such as a standard wheelchair. ● A standard Hospital-type bed. ● Oxygen and the rental of equipment to administer oxygen (including tubing, connectors and masks.) We provide Benefits only for a single purchase (including repair/replacement) of a type of DME once every Calendar Year. Any combination of Network and Non-Network Benefits for DME is limited to $5,000 per Calendar Year. This limitation is not applicable to any equipment, supplies or self-management training for the treatment of gestational, type I or type II diabetes. We will decide if the equipment should be purchased or rented. **Prior Authorization Required** We must approve any single item of DME that costs more than $1000 (either purchase price or cumulative rental of a single item.) Unless We pre-approve DME services over $1,000, You will be responsible for paying 100% of the charges and no Benefits will be paid. See Section 13, B. and H., for information on medical supplies and equipment that We do not cover.	**Network** Yes, for items more than $1,000 **Non-Network** Yes, for items more than $1,000
8. Emergency Health Services Emergency Health Services that are required to stabilize or initiate treatment in an Emergency. Emergency Health Services must be received on an outpatient basis at a Hospital or Alternate Facility. You will find more information about Benefits for Emergency Health Services in Section 5 (How You Get Care). Please remember that if You are admitted to a Hospital as a result of an Emergency, You must notify Us within two (2) working days or the same day of admission, or as soon as reasonably possible to receive authorization for continued services related to post-stabilization as needed. If You don't notify Us, Benefits for the Hospital Inpatient Stay will be reduced to by 50% of Eligible Expenses. Benefits will not be reduced for the outpatient Emergency Health Services. Please refer to Hospital – Inpatient Stay below.	**Network** Yes, but only for an Inpatient Stay **Non-Network** Yes, but only for an Inpatient Stay

Benefit Description **See Schedule of Coverage and Benefits for Copayment/Coinsurance Amount** **Note: Copayments and Deductibles do not count towards Your Out-of-Pocket (OOP) Maximum; only Coinsurances apply to Your OOP Maximum.**	**Must You Notify Us?** *Note: You are responsible for ensuring that Your provider obtains any required prior-authorization before You receive Covered Health Services.*
9. Eye Examinations Eye examinations received per Calendar Year by an Ophthalmologist or Optometrist in the provider's office. Benefits include one routine vision exam, including refraction, to detect vision impairment each Calendar Year. Please note that Benefits are not available for charges connected to the purchase or fitting of eyeglasses or contact lenses. See Section 13, T., for more information on limitations and exclusions related to vision care.	**Network** No **Non-Network** No
10. Hearing Screenings for Newborns Newborn hearing screenings, necessary rescreening, audiological assessment and follow-up, and initial amplification.	**Network** No **Non-Network** No
11. Home Health Care Services received from a Home Health Agency that are: ● Ordered by a physician; ● Provided by or supervised by a registered nurse in Your home; and ● You are Homebound or Your physical or mental condition pose a serious and significant impediment to receiving medically necessary services outside the home. Benefits are available only when the Home Health Agency services are provided on a part-time, intermittent schedule and when skilled care is required. Skilled care is skilled nursing, skilled teaching and skilled rehabilitation services when all of the following are true: ● It must be delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome, and provide for the safety of the patient. ● It is ordered by a Physician. ● It is not delivered for the purpose of assisting with activities of daily living, including but not limited to dressing, feeding, bathing, or transferring from a bed to a chair. ● It requires clinical training in order to be delivered safely and effectively. ● It is not Custodial Care. We will decide if skilled care is required by reviewing both the skilled nature of the service and the need for Physician-directed Medical management. A service will not be determined to be "skilled" simply because there is not an available caregiver. Certain extended home infusion services may be more appropriately performed in the home even if You are not Homebound. Any combination of Network and Non-Network Benefits is limited to 60 visits per Calendar Year. See Section 13, K., for related exclusions. **Prior Authorization Required** Unless We pre-approve home health services, Network and Non-Network Benefits will be reduced by 50% of Eligible Expenses.	**Network** Yes **Non-Network** Yes
12. Hospice/Palliative Care Hospice/Palliative care that is recommended by a Physician. Hospice/Palliative care is an integrated program that provides comfort and support services for the terminally ill.	**Network** Yes

Benefit Description **See Schedule of Coverage and Benefits for Copayment/Coinsurance Amount** **Note: Copayments and Deductibles do not count towards Your Out-of-Pocket (OOP) Maximum; only Coinsurances apply to Your OOP Maximum.**	**Must You Notify Us?** *Note: You are responsible for ensuring that Your provider obtains any required prior-authorization before You receive Covered Health Services.*
Hospice/Palliative care includes physical, psychological, social and spiritual care for the terminally ill person, and short-term grief counseling for immediate family members. Benefits are available when hospice/palliative care is received from a licensed hospice agency. Please contact Us for more information regarding Our guidelines for hospice care. You can contact Us at the telephone number on Your ID card. Any combination of Network and Non-Network Benefits is limited to one hundred and eighty (180) days during the entire period of time You are covered under the Policy. **Prior Authorization Required** Unless We pre-approve hospice/palliative care services, Network and Non-Network Benefits will be reduced by 50% of Eligible Expenses.	**Non-Network** Yes
13. Hospital - Inpatient Stay Inpatient Stay in a Hospital. Benefits are available for: ● Services and supplies received during the Inpatient Stay. ● Room and board in a Semi-private Room (a room with two or more beds), or ● A private room only when medically necessary and approved in advance by the Plan. **Prior Authorization Required** Please remember that You must notify Us as follows: ● For elective admissions; and ● For Emergency admissions: within two (2) working days or the same day of admission, or as soon as is reasonably possible. Unless We pre-approve inpatient Hospital services, Network and Non-Network Benefits will be reduced by 50% of Eligible Expenses.	**Network** Yes **Non-Network** Yes
14. Immunizations Routine immunizations as recommended by the Mercy Health Plans' preventive health guidelines. This excludes immunizations required for international travel. Routine immunizations include poliomyelitis, rubella, rubleola, mumps, tetanus, pertussis, diptheria, hepatitis B haemophilus type b (Hib), and varicella for children from birth to age 18. There is no Copayment, Coinsurance or Deductible for immunizations for children birth to age 18. All other children's preventive health care services, however, will be subject to Copayment, Coinsurance, deductible, or dollar limit provisions.	**Network** No **Non-Network** No
15. Injectables/Infusions Benefits are available for injections/infusions received in a Physician's office, infusion center or through home health, when no other health service is received. Some injectables/infusions received in the locations listed above may incur a Copayment/Coinsurance for the injectable/infusion, in addition to any Copayment for the Physician's office visit, infusion center or home health service, regardless of whether other health services are received. A list of injectables/infusions requiring prior authorization can be obtained at www.mercyhealthplans.com or by calling our Customer Contact Center at the number listed on Your ID card. **Prior Authorization Required** Unless We pre-approve these services, Network and Non-Network Benefits will be reduced by 100 % of Eligible Expenses.	**Network** Yes, but only for those listed **Non-Network** Yes, but only for those listed

Benefit Description **See Schedule of Coverage and Benefits for Copayment/Coinsurance Amount** **Note: Copayments and Deductibles do not count towards Your Out-of-Pocket (OOP) Maximum; only Coinsurances apply to Your OOP Maximum.**	**Must You Notify Us?** *Note: You are responsible for ensuring that Your provider obtains any required prior-authorization before You receive Covered Health Services.*
16. Medical Foods/PKU Benefits are provided for Medical Foods and Low Protein Modified Food Products if the following are met: ● The Medical Food or Low Protein Modified Food Products are prescribed as medically necessary for the therapeutic treatment of phenylketonuria, galactosemia, organic acidemias, and disorders of amino acid metabolism; ● The products are administered under the direction of a physician licensed; and ● The cost of the medical food or low protein modified food products for an individual or a family with a Dependent person or persons exceeds the two thousand four hundred dollars ($2,400) per year per person. See Section 13, J. for limitations and exclusions related to this benefit.	**Network** No **Non-Network** No
17. Mental Health and Substance Abuse Services - Outpatient Mental health, substance abuse and a Chemical Dependency evaluations and assessment prescribed by a licensed professional. ● Diagnosis ● Treatment planning ● Referral services ● Medication management ● Short-term individual, family and group therapeutic services (including Intensive Outpatient Program) ● Crisis intervention For Network Benefits, referrals to a mental health/substance abuse provider are at the sole discretion of the Mental Health/Substance Abuse Designee, who is responsible for coordinating all of Your care. Contact the Mental Health/Substance Abuse Designee regarding Network Benefits for outpatient Mental Health and Substance Abuse Services. Any combination of Network and Non-Network Benefits for these outpatient Mental Health Services and/or Substance Abuse Services is limited to twenty (20) visits per Calendar Year. **Prior Authorization Required** Please remember that You must call and get authorization to receive these Benefits in advance of any treatment through the Mental Health/Substance Abuse Designee. The Mental Health/Substance Abuse Designee phone number appears on Your ID card. Unless We pre-approve these services, Network and Non-Network Benefits will be reduced by 100% of Eligible Expenses. See Section 13, K., Q. for exclusions related to this benefit.	**Network** Yes, You must call the Mental Health/Substance Abuse Designee to receive Benefits. **Non-Network** Yes, You must call the Mental Health/Substance Abuse Designee to receive Benefits.
18. Mental Health and Substance Abuse Services – Inpatient and Intermediate Mental health and substance abuse services received on an inpatient or intermediate care basis in a Hospital or an Alternate Facility. Benefits include detoxification from abusive chemical or substances that is limited to physical detoxification when necessary to protect Your physical health and well-being. The Mental Health/Substance Abuse Designee, who will arrange for the service, will determine	**Network** Yes, You must call the Mental Health/Substance Abuse Designee to receive Benefits.

Benefit Description **See Schedule of Coverage and Benefits for Copayment/Coinsurance Amount** **Note: Copayments and Deductibles do not count towards Your Out-of-Pocket (OOP) Maximum; only Coinsurances apply to Your OOP Maximum.**	**Must You Notify Us?** *Note: You are responsible for ensuring that Your provider obtains any required prior-authorization before You receive Covered Health Services.*
the appropriate setting for the treatment. If an Inpatient Stay is required, it is covered on a Semi-private Room basis. At the discretion of the Mental Health/Substance Abuse Designee, two sessions of intermediate care (such as Partial Hospital Treatment Program) may be substituted for one inpatient day. Network Benefits for Mental Health Services and Substance Abuse Services must be provided by or under the direction of the Mental Health/Substance Abuse Designee. For Network Benefits, referrals to a mental health/substance abuse provider are at the sole discretion of the Mental Health/Substance Abuse Designee, who is responsible for coordination all of Your care. Contact the Mental Health/Substance Abuse Designee regarding Benefits for inpatient/intermediate Mental Health Services and Substance Abuse Services. Any combination of Network and Non-Network Benefits for these inpatient and intermediate Mental Health Services and Substance Abuse is limited to thirty (30) days per Calendar Year. **Prior Authorization Required** Please remember that You must call and get authorization to receive these Benefits in advance of any treatment through the Mental Health/Substance Abuse Designee. The Mental Health/Substance Abuse Designee phone number appears on Your ID card. Unless We pre-approve these services, Network and Non-Network Benefits will be reduced by 100% of Eligible Expenses.	**Non-Network** Yes, You must call the Mental Health/Substance Abuse Designee to receive Benefits.
19. Newborn Child Coverage Coverage for newborn children begins from the moment of birth. Benefits include coverage for illness, injury, congenital defects, premature birth, tests for hypothyroidism, phenylketonuria, galactosemia, sickle-cell anemia, all other disorders of metabolism, and routine nursery care and pediatric charges for a well newborn child for up to 5 full days in a hospital nursery or until the mother is discharged from the hospital following the birth of the child, whichever is the lesser period. **Prior Authorization Required** We must be notified within ninety (90) days or Your next Premium due date, whichever is greater. Unless We pre-approve these services, Network and Non-Network Benefits will be reduced by100% of Eligible Expenses.	**Network** Yes **Non-Network** Yes
20. Nutritional Counseling Nutritional counseling that is appropriately included as part of the course of treatment based on the efficacy of the diet and lifestyle and treatment of the disease states, in accordance with Plan policies and procedures, which are subject to change. Expenses for nutritional counseling for up to three (3) visits in a Calendar Year are covered. Coverage is provided for only certain conditions such as diabetic education, congestive heart failure, malnutrition and nutritional deficiencies. See Section 13, K. and J., for related limitations or exclusions to this benefit.	**Network** No **Non-Network** No
21. Observation	**Network**

Benefit Description **See Schedule of Coverage and Benefits for Copayment/Coinsurance Amount** **Note: Copayments and Deductibles do not count towards Your Out-of-Pocket (OOP) Maximum; only Coinsurances apply to Your OOP Maximum.**	**Must You Notify Us?** *Note: You are responsible for ensuring that Your provider obtains any required prior-authorization before You receive Covered Health Services.*
Observation Services are those services furnished by a hospital on the hospital's premises, including use of a bed and periodic monitoring by a hospital's nursing or other staff, that are reasonable and necessary to evaluate an outpatient's condition or determine the need for a possible admission to the hospital as an inpatient. Most observation services do not exceed one (1) day. Members may be admitted as Observation status to beds in the emergency room, an observation unit, the intensive care unit, or a regular floor. If an Observation admission results in a conversion to an Inpatient Admission, the Observation Co-payment will be waived. The alternate Copayment/Coinsurance will apply. **Prior Authorization Required** Unless We pre-approve these services, Network and Non-Network Benefits will be reduced by 50% of Eligible Expenses.	Yes, if exceeds one day **Non-Network** Yes, if exceeds one day
22. Orthotics Covered orthotic device/equipment is the standard, basic equipment necessary to continue average daily activities. The following items are covered when ordered and provided by a Physician and obtained from an orthotic Provider: ● Braces/support including necessary adjustments to shoes to accommodate braces. Braces that stabilize an Injured body part are considered Durable Medical Equipment and are a Covered Health Service. ● Trusses ● Splints ● Collars ● Foot orthotics are a covered treatment for neuropathy or severe vascular insufficiency due to diabetes, or vascular disease. Braces that straighten or change the shape of a body part are orthotic devices, and are covered only for Instrumental Activities of Daily Living. Orthotics for sports-related activities are not covered. Dental braces are excluded from coverage. See Section 13, D., G. and H. for mechanical equipment, medical supplies and other related services that are not covered. Any combination of Network and Non-Network Benefits for prosthetic devices is limited to $5,000 per Calendar Year. Please note that this limitation does not apply to breast prostheses. **Prior Authorization Required** We must pre-approve any orthotic device/equipment that costs more than $1,000. Unless We approve orthotic services over $1,000,Network and Non-Network Benefits will be reduced by 100% of Eligible Expenses.	**Network** Yes, for items more than $1,000 **Non-Network** Yes, for items more than $1,000

Benefit Description **See Schedule of Coverage and Benefits for Copayment/Coinsurance Amount** **Note: Copayments and Deductibles do not count towards Your Out-of-Pocket (OOP) Maximum; only Coinsurances apply to Your OOP Maximum.**	**Must You Notify Us?** *Note: You are responsible for ensuring that Your provider obtains any required prior-authorization before You receive Covered Health Services.*
23. Osteoporosis Services/Bone Density Testing Diagnosis, treatment, and appropriate management of osteoporosis for Covered Persons with a condition or medical history for which bone mass measurement is medically indicated.	**Network** Physician Office services: No Outpatient facility/diagnostic services: No **Non-Network** Physician Office services: No Outpatient facility/diagnostic services: No
24. Outpatient Diagnostic Services Covered Health Services received on an outpatient basis at a Hospital or alternate facility for laboratory and medical diagnostic services. ● Lab ● Radiology/x-ray; ● Other diagnostic tests and therapeutic treatments (including cancer Chemotherapy or intravenous infusion therapy); Benefits under this Section include only the facility charge and the charge for required services, supplies and equipment. When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services* below.	**Network** Lab: No Radiology: No Other: No **Non-Network** Lab: No Radiology: No Other: No
25. Outpatient Surgery/Hospital Procedures Covered surgical services and other medical care received on an outpatient basis at a Hospital or alternate facility. Benefits under this Section include only the facility charge and the charge for required services, supplies and equipment. Benefits for related professional fees are described under *Professional Fees for Surgical and Medical Services* below and may incur separate Copayment/Coinsurance in addition to the outpatient facility Copayment. Surgical Implants, whether inserted in the inpatient, outpatient, or office setting, including pacemakers, stents, and other implantable devices or treatments. Copayment is consistent with type of service required. Implants for cosmetic or psychological reasons are excluded, see Section 13, L. **Prior Authorization Required** Unless We pre-approve these services, Network and Non-Network Benefits will be reduced by 50% of Eligible Expenses.	**Network** Yes **Non-Network** Yes
26. Physician's Office Services Covered Health Services received in a Physician's office including: ● Treatment of a Sickness or Injury; ● Preventive medical care; ● Well-baby and well-child care including children's preventive health care services for children from birth through 18 years of age; ● Routine physical examinations; ● Vision and hearing screenings. (Vision screenings do not include refractive examinations to detect vision impairment. See *Eye Examination* earlier in this Section.) ● Testing for lead poisoning;	**Network** No **Non-Network** No

Benefit Description **See Schedule of Coverage and Benefits for Copayment/Coinsurance Amount** **Note: Copayments and Deductibles do not count towards Your Out-of-Pocket (OOP) Maximum; only Coinsurances apply to Your OOP Maximum.**	**Must You Notify Us?** *Note: You are responsible for ensuring that Your provider obtains any required prior-authorization before You receive Covered Health Services.*
● Second opinion rendered by a specialist in that specific diagnosis area, including but not limited to when a patient with a newly diagnosed cancer is referred to such specialist by his or her attending physician. Coverage for this second opinion is subject to the same conditions as any other benefit when the specialist is not a Participating Physician.	
27. Preventive Health & Wellness Care Preventive Health Screenings are for non-symptomatic persons in accordance with the American Cancer Society guidelines and Mercy Health Plans' preventive health guidelines. Preventive Health Screenings include one (1) routine test of each of the following every Calendar Year, unless otherwise indicated : ● Cholesterol Tests ● Colon Screening: o Colonoscopy – one (1) routine screening every ten (10) years o Double-contrast Barium Enema – one (1) routine screening every five (5) years o Flexible Sigmoidoscopy – one (1) routine screening every five (5) years o Fecal Occult Blood Test ● Mammography ● Pap Test ● Pelvic Exam ● Prostate Exam ● PSA test Preventive Health Screenings are covered In-Network with no Deductible. Deductible and Coinsurances will apply to services received from a Non-Network Provider.	**Network** Physician Office services for: Pap/Pelvic Exam: No Prostate Exam: No Outpatient facility/diagnostic services for: Cholesterol Tests: No Colon Screening: No Mammography: No PSA test: No Copayment will be consistent with type of service required. **Non-Network** No Coinsurance will be consistent with type of service required.
28. Professional Fees for Surgical and Medical Services Professional fees for surgical procedures and other medical care provided in an outpatient facility. You may incur a separate Copayment/Coinsurance in addition to the outpatient facility charge. When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services* above.	**Network** No **Non-Network** No
29. Prosthetic Devices The purchase, fitting, necessary adjustment of prosthetic devices which replace or repair all or part of a limb including tissue, or replace all or part of the function of a permanently inoperative or malfunctioning body organ is a covered benefit. This includes limbs, eyes, and prosthetic lenses when the organic lens is missing, breast prostheses (including a post mastectomy brassiere). Supplies, adjustments, and repair or replacement of these devices, necessary to maintain their effective use, is provided when needed due to loss, irreparable damage, normal wear or a change in the patient's condition, and deemed necessary by the Plan. Even when the device has been in use prior to the users enrollment, so long as the device remains Medically Necessary, it will be covered. Covered prosthetic equipment is the standard, basic equipment necessary to continue average daily activities. The following devices and related services are not covered as Prosthetic Equipment: a. All mechanical organs b. Computer assisted devices	**Network** Yes, for items more than $1,000 **Non-Network** Yes, for items more than $1,000

Benefit Description **See Schedule of Coverage and Benefits for Copayment/Coinsurance Amount** **Note: Copayments and Deductibles do not count towards Your Out-of-Pocket (OOP) Maximum; only Coinsurances apply to Your OOP Maximum.**	**Must You Notify Us?** *Note: You are responsible for ensuring that Your provider obtains any required prior-authorization before You receive Covered Health Services.*
c. Dental and TMJ appliances d. Devices employing robotics e. Electrical continence aids, anal or urethral f. Investigational or obsolete devices and supplies g. Remote control devices See Section 13, L., R., C. and D., for more details on related exclusions. Breast prosthesis as required by the Women's Health and Cancer Rights Act of 1998. Breast prosthesis may follow a mastectomy at any time. If more than one prosthetic device can meet Your functional needs, Benefits are available only for the most cost-effective prosthetic device. Benefits for prosthetic devices are limited to a single purchase of each type of prosthetic device each Calendar Year. Please note that this limitation does not apply to breast prostheses. Any combination of Network and Non-Network Benefits for prosthetic devices is limited to $5,000 per Calendar Year. Please note that this limitation does not apply to breast prostheses. **Prior Authorization Required** We must pre-approve any single prosthesis that costs more than $1,000. Unless We Pre-approve prosthetic devices over $1,000, Network and Non-Network Benefits will be reduced by 100% of Eligible Expenses.	
30. Reconstructive Procedures Services for reconstructive procedures, when a physical impairment exists and the primary purpose of the procedure is to improve or restore physiologic function. Reconstructive procedures include surgery or other procedures which are associated with an Injury, Sickness or Congenital Anomaly. The fact that physical appearance may change or improve as a result of a reconstructive procedure does not classify such surgery as a Cosmetic Procedure when a physical impairment exists, and the surgery restores or improves function. Cosmetic Procedures are excluded from coverage. Procedures that correct an anatomical Congenital Anomaly without improving or restoring physiologic function are considered Cosmetic Procedures. The fact that a Covered Person may suffer psychological consequences or socially avoidant behavior as a result of an Injury, Sickness or Congenital Anomaly does not classify surgery or other procedures done to relieve such consequences or behavior as a reconstructive procedure. See Section 13, L. for related limitations and exclusions. Please note that Benefits for reconstructive procedures include breast reconstruction following a mastectomy and reconstruction of the non-affected breast to achieve symmetry. Reconstructive surgery for breast reconstruction may follow a mastectomy at any time. Other services required by the Women's Health and Cancer Rights Act of 1998, including breast prostheses and treatment of complications, are provided in the same manner and at the same level as those for any other Covered Health Service. You can contact Us at the telephone number on Your ID card for more information about Benefits for mastectomy-related services. **Prior Authorization Required** Please remember that You must notify Us before receiving services. When You notify Us, We can verify that the service is a reconstructive procedure rather than a Cosmetic Procedure. Cosmetic Procedures are always excluded from coverage. Unless We pre-approve a Covered reconstructive	**Network** Yes **Non-Network** Yes

Benefit Description **See Schedule of Coverage and Benefits for Copayment/Coinsurance Amount** **Note: Copayments and Deductibles do not count towards Your Out-of-Pocket (OOP) Maximum; only Coinsurances apply to Your OOP Maximum.**	**Must You Notify Us?** *Note: You are responsible for ensuring that Your provider obtains any required prior-authorization before You receive Covered Health Services.*
Service, Network and Non-Network Benefits will be reduced by 50% of Eligible Expenses.	
31. Rehabilitation Services - Outpatient Therapy Short-term outpatient rehabilitation services for: ● Physical Therapy; ● Occupational Therapy; ● Speech Therapy; ● Pulmonary Rehabilitation therapy; ● Cardiac Rehabilitation therapy. Also includes Covered Health Services received on an outpatient basis at a Hospital or alternate facility for treatment for loss or impairment of speech or hearing. "Short-term" means rehabilitation services that are expected to result in significant physical improvement in Your condition within two months of the start of treatment. Rehabilitation services must be performed by a licensed therapy provider, under the direction of a Physician. Please note that We will pay Benefits for Speech Therapy only when the speech impediment or speech dysfunction results from Injury, stroke or a Congenital Anomaly. Exclusions are described in Section 13, Q. Any combination of Network and Non-Network Benefits is limited as follows: ● 20 visits of Physical Therapy per Calendar Year. ● 20 visits of Occupational Therapy per Calendar Year. ● 20 visits of Speech Therapy per Calendar Year. ● 36 visits of Pulmonary Rehabilitation therapy within a 12-week period per Calendar Year. ● 36 visits of Cardiac Rehabilitation therapy within a 12-week period per Calendar Year.	**Network** Speech Therapy: No Occupational Therapy: No Physical Therapy: No Pulmonary Rehabilitation: No Cardiac Rehabilitation: No **Non-Network** Speech Therapy: No Occupational Therapy: No Physical Therapy: No Pulmonary Rehabilitation: No Cardiac Rehabilitation: No
32. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services Medically Necessary services for an Inpatient Stay in a Skilled Nursing Facility or Inpatient Rehabilitation Facility. Benefits are available for: ● Services and supplies received during the Inpatient Stay; ● Room and board in a Semi-private Room (a room with two or more beds). Any combination of Network and Non-Network Benefits is limited to 60 days per Calendar Year. Please note that Benefits are available only for the care and treatment of an Injury or Sickness that would have otherwise required an Inpatient Stay in a Hospital. **Prior Authorization Required** You must notify Us before receiving services for an elective or Non-elective admission. For emergency admission, You must notify Us within two (2) working days or as soon as reasonably possible. If You don't notify Us, Benefits will be reduced by 50% of Eligible Expenses.	**Network** Yes **Non-Network** Yes
33. Transplantation Services Covered Health Services for the following organ and tissue transplants when ordered by a Physician. For Network Benefits, transplantation services must be received at an approved facility in the designated transplant network. Benefits are available for the transplants listed below when the	**Network** Yes

Benefit Description **See Schedule of Coverage and Benefits for Copayment/Coinsurance Amount** **Note: Copayments and Deductibles do not count towards Your Out-of-Pocket (OOP) Maximum; only Coinsurances apply to Your OOP Maximum.**	**Must You Notify Us?** *Note: You are responsible for ensuring that Your provider obtains any required prior-authorization before You receive Covered Health Services.*
transplant is Medically Necessary and is not an Experimental, Investigational or Unproven Service: ● Bone marrow transplants (either from You or from a compatible donor) and peripheral stem cell transplants, with or without high dose Chemotherapy. Not all bone marrow transplants meet the definition of a Covered Health Service. Benefits include the treatment of breast cancer by dose-intensive Chemotherapy bone marrow transplants or stem cell transplants, when performed pursuant to nationally accepted peer review protocols. ● Heart transplants ● Heart/lung transplants ● Lung transplants ● Kidney transplants ● Kidney / Pancreas transplants ● Liver transplants ● Liver/small bowel transplants ● Pancreas transplants ● Small bowel transplants ● Intestinal and autologous transplants for testicular and other germ cell tumors Benefits are also available for cornea transplants that are provided by a Physician at a Hospital. We do not require that cornea transplants be performed at a Designated Facility in order for You to receive Network or Non-Network Benefits. Non-Network Benefits are limited to $30,000 per transplant. Please note that this limitation does not apply to dose intensive chemotherapy or bone marrow transplants. Organ or tissue transplants or multiple organ transplants other than those listed above are excluded from coverage as described in Section 13, R. We have specific guidelines regarding Benefits for transplant services. Contact Us at the telephone number on Your ID card for information about these guidelines. **Prior Authorization Required** You must notify Us as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). Unless We pre-approve these services (and before a pre-transplantation evaluation is performed at a transplant center), Benefits will be reduced by 100% of Eligible Expenses.	**Non-Network** Benefit not available out of network with the exception of corneal transplant, which does not require prior authorization
34. Urgent Care Center Services Covered Health Services received at an Urgent Care Center. If radiology and other diagnostics services are provided and billed separately from the Urgent Care Center, additional copayments/coinsurances may apply. When services to treat urgent health care needs are provided in a Physician's office, Benefits are available as described under *Physician's Office Services* earlier in this Section.	**Network** No **Non-Network** No
35. Tobacco Cessation Education Program Education Benefits are available for up to one smoking cessation Individual support program per Calendar Year at a Plan-approved Participating Provider. Participating Providers generally offer up to five American Lung Association certified sessions per program. One Copayment applies to each program. Tobacco cessation products are available only through a prescription drug Rider.	**Network** No **Non-Network** No

Section 13: Exclusions – Things We Don't Cover

This Section contains information about Medical services that are not covered. We call these Exclusions. It's important for You to know what services and supplies are not covered under the Policy.

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

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

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

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

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

Category	Description

9. Devices that are primarily non-medical in nature or used primarily for comfort, including but not limited to:

- Bed boards
- Elevators
- Foam pads
- Heating pads
- Beds other than standard single hospital beds
- Overbed tables
- Carafes
- Emesis basins
- Maternity belts
- Bathtub seats
- Standing tables

10. Chair lifts, bathtub lifts, bed lifter, and other similar devices.
11. Exercise equipment including but not limited to parallel bars, weights, bicycles, rowing machines, and treadmills.

C. Chiropractic

Under no circumstances will coverage be provided for:

1. Services beyond the scope of the participating chiropractor's license to practice Chiropractic Care.
2. Services rendered by a Non-Network chiropractor.
3. Services in excess of the chiropractic visit limitations indicated in Your Schedule of Coverage and Benefits.
4. Preventive care services.
5. Services for examination and/or treatment of strictly non-neuromusculoskeletal disorders.
6. Rental or purchase of air conditioners, air purifiers, therapeutic mattresses, orthotics, prosthetics, herbal and dietary services, Durable Medical Equipment, supplies, or any other similar devices, appliances, or equipment whether or not their use or installation is for the purpose of providing therapy or easy access.
7. Services that are not considered Medically Necessary and/or clinically appropriate.

D. Dental

1. Dental care except as described in Section 12 (Covered Benefits) under the heading, "Dental Services Accident Only and Dental – Anesthesia and Facility Charges".
2. Preventive care, diagnosis, treatment of or related to the teeth, jawbones or gums, whether the services are considered to be medical or dental in nature. Examples include all of the following:
   - Extraction, restoration and replacement of teeth;
   - Medical or surgical treatments of dental conditions;
   - Services to improve dental clinical outcomes;
   - Services for overbite or underbite;
   - Services related to surgery for cutting through the lower or upper jaw bone;
   - Maxillary and mandibulary osteotomies
3. Dental implants and associated oral surgery and supplies, even if associated with Accidental Dental Services. This includes but is not limited to any enabling procedures for implants, as well as placement, maintenance, restoration, and removal of dental implants. Any prosthetic superstructure fabricated upon a dental implant is also excluded.
4. Dental braces and occlusal splints, even if associated with Accidental Dental Services.
5. Dental X-rays, supplies and appliances and all associated expenses, including hospitalizations and anesthesia. The only exceptions to this are for any of the following:
   - Transplant preparation;
   - Initiation of immunosuppressives;
   - The direct treatment of acute traumatic Injury;
   - The direct treatment of cancer (i.e., injury to teeth as a direct effect of cancer treatment);
   - Cleft palate;
   - Covered Persons with conditions outlined in Section 12 (Covered Benefits) under Dental – Anesthesia and Facility Charges;

Category	Description
	6. Treatment of congenitally missing, malpositioned, or super numerary teeth, even if part of a Congenital Anomaly,. This does not include coverage for any related 7. Orthodontic services. 8. Services for the evaluation and treatment of temporomandibular joint syndrome (TMJ), whether the services are considered to be medical or dental in nature. 9. Upper and lower jawbone surgery except as required for direct treatment of acute traumatic injury or cancer. 10. Orthognathic surgery, jaw alignment and treatment for the temporomandibular joint, except as a treatment of obstructive sleep apnea.
E. Drugs	1. Prescription drug products for outpatient use (including self-injectables) that are filled by a prescription order or refill. 2. Non-injectable medications given in a Physician's office except as required in an Emergency. 3. Over the counter drugs and treatments. 4. Charges for supplies for use beyond the first twenty-four (24) hours following discharge from the Hospital as an Inpatient or following the provision of Emergency Care, including any prescription drugs intended primarily for home use.
F. Experimental, Investigational or Unproven Services	1. Experimental, Investigational or Unproven Services are excluded. The fact that an Experimental, Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Benefits if the procedure is considered to be Experimental, Investigational or Unproven in the treatment of that particular condition.
G. Foot Care	1. Routine foot care (including the cutting or removal of corns and calluses). 2. Nail trimming, cutting, or debriding, unless the charges are for the removal of a nail or root in connection with the treatment of a metabolic or peripheral-vascular disease or infection. 3. Hygienic and preventive maintenance foot care. Examples include the following: – Cleaning and soaking the feet; – Applying skin creams in order to maintain skin tone; – Other services that are performed when there is not a localized illness, Injury or symptom involving the foot. 4. Treatment of flat feet, painful feet, fallen arches, metatarsalgia, plantar fasciitis, neuromas, tendonitis, bursitis, varus or valgus deformities, and other conditions of the feet unless otherwise noted in this document. 5. Treatment of subluxation of the foot. 6. Shoe orthotics, orthopedic shoes and other supportive appliances for feet except as otherwise noted in this document.
H. Medical Supplies and Appliances	1. Devices used specifically as safety items or to affect performance in sports-related activities. 2. Prescribed or Non-prescribed medical supplies and disposable supplies. Examples include: – Elastic stockings – Ace bandages – Gauze and dressings – Disposable sheets and bags – Fabric supports – Surgical face masks – Incontinent pads, including diapers – Irrigating kits – Pressure leotards – Surgical leggings and support hose Exceptions include diabetic supplies covered under the medical benefit, ostomy supplies and supplies associated with equipment and home care services that have

Category	Description
	been provided in accordance with Plan policies and procedures. 3. Orthotic and prosthetic appliancesfor sports-related activities. 4. Tubings and masks are not covered except when used with Durable Medical Equipment as described in Section 12 (Covered Benefits). 5. Devices and equipment that are not normally appropriate outside of a hospital (or other provider) setting, including but not limited to: o Esophageal dilators o Home monitoring devices and supplies, except Medically Necessary cardiac monitoring devices (such as holter monitors and event recorders) o Home prenatal monitoring and associated nursing support 6. The following are not covered under the medical benefit: o Insulin syringes with needles o Lancets and lancet devices o Glucometers, test strips and related supplies. 7. Lift Seats.
I. Mental Health/Substance Abuse	1. Services performed in connection with conditions not classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. 2. Services utilizing methadone treatment as maintenance, L.A.A.M (1-Alpha-Acetyl-Methadol), Cyclazocine, or their equivalents. 3. Treatment provided in connection with or to comply with involuntary commitments, police detentions and other similar arrangements unless medically necessary and authorized by the Mental Health/Substance Abuse Designee. Medically Necessary care may include any of the following: a. Not consistent with prevailing national standards of clinical practice for the treatment of such conditions including but not limited to Mental Health Services and Substance Abuse Services that extend beyond the period necessary for short term evaluation, diagnosis, treatment or crisis intervention. b. Not consistent with prevailing professional research demonstrating that the services or supplies will have a measurable and beneficial health outcome. c. Typically do not result in outcomes demonstrably better than other available treatment alternatives that are less intensive or more cost effective. d. Not consistent with the Mental Health/Substance Abuse Designee's level of care guidelines or best practices as modified from time to time. 4. Services or supplies for the diagnosis or treatment of Mental Illness, alcoholism or substance abuse disorders that, in the reasonable judgment of the Mental Health/Substance Abuse Designee, are any of the following: a. Not consistent with prevailing national standards of clinical practice for the treatment of such conditions including but not limited to Mental Health Services and Substance Abuse Services that extend beyond the period necessary for short term evaluation, diagnosis, treatment or crisis intervention. b. Not consistent with prevailing professional research demonstrating that the services or supplies will have a measurable and beneficial health outcome. c. Typically do not result in outcomes demonstrably better than other available treatment alternatives that are less intensive or more cost effective. d. Not consistent with the Mental Health/Substance Abuse Designee's level of care guidelines or best practices as modified from time to time. 5. Mental Health Services and Substance Abuse Services that extend beyond the period necessary for short-term evaluation, diagnosis, treatment or crisis. Intervention. 6. Mental Health Services as treatment for insomnia and other sleep disorders, neurological disorders and other disorders with a known physical basis. 7. Treatment or services, except for the initial diagnosis, for a primary diagnosis of Mental Retardation, Learning, Motor Skills, and Communication Disorders, Pervasive Developmental Disorder, Conduct Disorder, Dementia, Sexual, Paraphilia, and Gender Identity Disorders, and Personality Disorders, as well as other Mental Illnesses that will not substantially improve beyond the current level of functioning, or that are not

Category	Description
	subject to modification or management according to prevailing national standards of clinical practice, as reasonably determined by the Mental Health/Substance Abuse Designee. 8. Residential treatment services. The Mental Health/Substance Abuse Designee may consult with professional clinical consultants, peer review committees or other appropriate sources for recommendations and information regarding whether a service or supply meets any of these criteria.
J. Nutrition	1. Megavitamin and nutrition based therapy (for any purpose). 2. Vitamins (other than those prenatal vitamins prescribed for a Member who is then pregnant). 3. Nutritional counseling and other hospital-based educational programs for either individuals or groups, except for treatment of Diabetes or certain illnesses and conditions. 4. Medical foods and other nutritional and electrolyte supplements taken orally, parenterally or enterally regardless of the disease state, including infant formula and donor breast milk. This exclusion does not apply to the treatment of Phenylketonuria or any inherited disease of amino or organic acids, or nutritional supplements ordered by a Physician in connection with home care, which requires the Member to have a feeding tube as a sole source of nutrition.
K. Personal/Career	1. Physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments that are otherwise covered under the Policy when: a. Required solely for purposes of career, education, sports or camp, travel, recreation, employment, insurance, marriage or adoption. b. Related to judicial or administrative proceedings or orders. c. Conducted for purposes of medical research. d. Required to obtain or maintain a license of any type. 2. Custodial Care. See Section 14 (Definitions of Terms). *3.* Domiciliary care or any nursing care on full-time basis in Your home. 4. Private Duty Nursing. See Section 14 (Definitions of Terms). 5. Respite care. 6. Rest cures. 7. Psychosurgery including vagus nerve stimulation. 8. Medical and surgical treatment of excessive sweating (hyperhidrosis). 9. Medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea. 10. Oral appliances for snoring. 11. Care for an Injury or Illness resulting from participation in, or in consequence of having participated in an illegal occupation or the commission of an assault or felony. 12. Work place evaluations and work hardening treatment.
L. Physical Appearance	1. Cosmetic Procedures. See the definition in Section 14 (Definitions of Terms). Examples include: – Pharmacological regimens, nutritional procedures or treatments. – Scar, keloid or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures). – Skin abrasion procedures performed as a treatment for acne. – Liposuction. – Correction of asymmetric breasts or abnormal nipple-areolar complexes and protruding ears. – All other cosmetic services **except** if medically necessary to: i. Repair a functional disorder caused by a disease or an accidental injury suffered while insured by the Plan; ii. Restore or improve function for a structurally abnormal congenital or developmental defect or anomaly in a Member under age nineteen (19). Anomaly is defined as a marked deviation beyond the range of

Category	Description
	normal human variation; or iii. Reconstructive breast surgery performed post-mastectomy; 2. Replacement of an existing breast implant if the earlier breast implant was performed as a Cosmetic Procedure. Note: Replacement of an existing breast implant is considered reconstructive if the initial breast implant followed mastectomy. See *Reconstructive Procedures* in Section 12 (Covered Benefits). 3. Physical conditioning programs such as athletic training, bodybuilding, exercise, fitness, flexibility, and diversion or general motivation. 4. Weight loss programs whether or not they are under medical supervision. Weight loss programs for medical reasons are also excluded. 5. Wigs, regardless of the reason for the hair loss. 6. Treatment of benign gynecomastia (abnormal breast enlargement in males). 7. Surgical and Non-surgical treatment of obesity, including morbid obesity. Treatment includes but is not limited to, stomach stapling, jaw wiring, gastric banding, gastric balloon or bypass surgery, dietary/nutritional supplements, behavioral/community support programs, exercise programs, and medical testing, medications, and office visits associated with any weight loss program. 8. Growth hormone therapy except for growth hormone deficiencies. 9. Sex transformation operations. 10. Breast Reduction Surgery (Reduction Mammoplasty).
M. Preexisting Conditions	Benefits for the treatment of a Preexisting Condition are excluded until the date You have been covered under this Policy for a period of twelve (12) months, except this waiting period will not apply to: a. a child who is placed in a Member's physical custody for purposes of adoption if the petition for adoption is filed within sixty (60) days of placement of such child; or b. a newborn if an application for coverage is filed within ninety (90) days of the birth of the child. c. a person who has had creditable coverage for eighteen (18) months without a break of sixty-three (63) days or more.
N. Providers	1. Services performed by a provider who is a family member by birth or marriage, including Spouse, brother, sister, parent or child. This includes any service the provider may perform on himself or herself. 2. Services performed by a provider with Your same legal residence. 3. Services provided at a freestanding or Hospital-based diagnostic facility without an order written by a Physician or other provider. Services that are self-directed to a free-standing or Hospital based diagnostic facility. Services ordered by a Physician or other provider who *is* an employee or representative of a free-standing or Hospital-based diagnostic facility, when that Physician or other provider: a. Has not been actively involved in Your medical care prior to ordering the service, or b. Is not actively involved in Your medical care after the service is received. This exclusion does not apply to mammography testing. 4. Charges Incurred for broken appointments with a Participating Physician.

Category	Description
O. Reproduction	1. Health services and associated expenses for Infertility treatments including, but not limited to, medical care or prescription drugs used to stimulate ovulation, or assisted reproductive technology (ART). ART includes any combination of chemical and/or mechanical means of obtaining a mature male or female reproductive cell and placing it into a medium (whether internal or external to the human body) to enhance the chance reproduction will occur. Examples of ART include, but are not limited to, artificial insemination, in vitro fertilization, gametic intra fallopian transfer, zygote intra fallopian transfer, pronuclear state tubal transfer and surrogate Pregnancy. In-vitro fertilization unless superceded by maternity plan option. 2. Surrogate parenting. 3. Voluntary sterilization or the reversal of voluntary sterilization. 4. Health services and associated expenses for elective abortion. Elective abortion means an abortion for any reason other than a spontaneous abortion or loss of the fetus as a result of the only treatment available to save the life of the mother. 5. Fetal reduction surgery. 6. Health services associated with the use of Non-surgical or drug induced Pregnancy termination. 7. Services (including pharmaceuticals) provided in connection with treatment or surgery to change gender or restore sexual function, unless otherwise covered in this Policy. 8. Maternity Services, unless superseded by an Addendum/Rider. Complications of Pregnancy, however, are covered.
P. Services Provided under Another Plan	1. Health service for which other coverage is required by Federal, state or local law to be purchased or provided through other arrangements. 2. Health services for treatment of Injury, Sickness or Mental Illness arising out of or in the course of, any employment, whether or not covered by Workers' Compensation or similar law. If coverage under Workers' Compensation or similar legislation is optional for You because You could elect it, or could have it elected for You, Benefits will not be paid for any Injury, Sickness or Mental Illness that would have been covered under Workers' Compensation or similar legislation if that coverage had been elected. 3. Health services for treatment of military service-related disabilities, when You are legally entitled to other coverage and facilities are reasonably available to You. 4. Health services while on active military duty. Upon notifying Mercy Health Plans of entry into military service, any pro-rata unearned premiums shall be refunded. 5. Injury or Illness incurred while incarcerated in any local, municipal, state or Federal facility.
Q. Therapies/Psychological Testing	1. Speech, physical, occupational, and other rehabilitative services solely for speech/language delay or articulation disorders or other developmental delay, regardless of origin. Speech Therapy for central processing disorders, dyslexia, attention deficit disorder or other learning disabilities, stammering, stuttering, conceptual handicap, psychosocial speech delay, and voice therapy for vocational or avocational singers, and procedures that may be carried out effectively by the patient, family, or caregivers are not covered Benefits. Speech, physical, occupational, and other rehabilitative services are not covered except as required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke, or a Congenital Anomaly. 2. Cognitive therapy as a medical treatment (non-mental health) unless provided for acute brain injury. 3. Psychological testing except when medically necessary and authorized in advanced by the Mental Health/Substance Abuse designee. Medically Necessary care may include any of the following: a. Not consistent with prevailing national standards of clinical practice for the treatment of such conditions including but not limited to Mental Health Services and Substance Abuse Services that extend beyond the period necessary for short term evaluation, diagnosis, treatment or crisis

Category	Description
	intervention. b. Not consistent with prevailing professional research demonstrating that the services or supplies will have a measurable and beneficial health outcome. c. Typically do not result in outcomes demonstrably better than other available treatment alternatives that are less intensive or more cost effective. d. Not consistent with the Mental Health/Substance Abuse Designee's level of care guidelines or best practices as modified from time to time. 4. Neuropsychological testing to assist in planning educational and vocational programs, for the purpose of disability determinations, and/or for forensic determinations is not a covered benefit. Neuropsychological testing, for an individual who has suffered a brain injury (including cognitive degeneration as seen in individual's with Alzheimers), is covered when: – Results of the assessment will significantly alter the treatment plan; – This type of assessment is the least intrusive, as well as most time and resource efficient method of meeting treatment goals for; and – Testing is not used to confirm previous testing/diagnostic results. 5. Neuropsychological testing when used for the diagnosis of attention deficit disorder. 6. All Educational Services, including treatment of learning disorders and acquired cognitive deficits. 7. Water exercise and other exercises not under the supervision of a physical therapist. 8. Services or supplies that cannot reasonably be expected to lessen a Member's disability, and enable him/her to live outside an institution. 9. Long-term therapy for conditions such as developmental delay, ADHD, and autism.
R. Transplants	1. Health services for organ and tissue transplants, except those described in Section 12 (Covered Benefits). 2. Health services connected with the removal of an organ or tissue from You for purposes of a transplant to another person. (Donor costs for removal are payable for a transplant through the organ recipient's Benefits under the Policy). 3. Health services for transplants involving mechanical or animal organs. 4. Any solid organ transplant that is performed as a treatment for cancer. 5. Any multiple organ transplant not listed as a Covered Health Service under the heading *Transplantation Health Services* in Section 12 (Covered Benefits).
S. Travel	1. Health services provided in a foreign country, unless required as Emergency Health Services. 2. Travel or transportation expenses, even though prescribed by a Physician, except for medically necessary ambulance services. Some travel expenses related to covered transplantation services may be reimbursed at Our direction. 3. Air Ambulance Services outside the Continental United States for any reason.
T. Vision and Hearing	1. Purchase cost of eye glasses, contact lenses (except for eyeglasses or contact lenses prescribed following cataract surgery, up to a maximum of a $300.00 dollar benefit per lifetime), or hearing aids. 2. Fitting charge for hearing aids, eye glasses or contact lenses. 3. Eye exercise therapy (orthoptics or pleoptic training). 4. Surgery that is intended to allow You to see better without glasses or other vision correction including radial keratotomy, laser, and other refractive eye surgery.
U. General/ Administrative	1. Health services and supplies that do not meet the definition of a Covered Health Service - see the definition in Section 14 (Definitions of Terms). 2. Health services received as a result of any catastrophic act or incident of war, whether declared or undeclared or caused during service in the armed forces of any country. 3. Health services received after the date Your coverage under the Policy ends, including health services for medical conditions arising before the date Your coverage under the Policy ends. 4. Health services for which You have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under the Policy.

Category	Description
	5. Charges in excess of the Usual and Customary Rate (UCR), or in excess of any specified limitation. 6. Complications of Health Care Services that are not Covered Health Services, except for Complications of Pregnancy. 7. Charges made for completion of forms and/or filing of claims in connection with the Benefits provided under this Plan. 8. Autopsies (post-mortem exams)

Section 14: Definitions of Terms

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

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

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

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

Annual Deductible/Deductible — If applicable, the amount You must pay for Covered Health Services in a Calendar Year before We will begin paying for Benefits in that Calendar Year. Deductible amounts are separate from and not reduced by copayments. Deductible and copayments are in addition to any Coinsurance You pay.

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

Calendar Year — January 1 through December 31 of the same year.

Cardiac Rehabilitation — A comprehensive program to rehabilitate the heart.

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

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

Certificate of Coverage — This document including all Riders, Amendments and Schedule of Coverage.

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

Chemotherapy — Treatment of disease by FDA-approved antineoplastic agents.

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

Coinsurance — The percentage of Our allowance that You must pay for Your care. You may also be responsible for additional amounts. See Section 6 (Your Cost for Covered Services).

Complaint

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

Complications of Pregnancy

Means:

a) Conditions requiring hospital confinement (when pregnancy is not terminated), whose diagnoses are distinct from pregnancy but are affected by pregnancy, including but not limited to acute nephritis, nephrosis, cardiac decompensation, missed abortion, and similar medical and surgical conditions of comparable severity, but shall not included false labor, occasional spotting, physician prescribed rest period during the period of pregnancy, morning sickness, hyperemesis gravidarum, pre-eclampsia and similar conditions associated with the management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy; and

b) Non-elective cesarean section, termination of ectopic pregnancy, and spontaneous termination of pregnancy occurring during a period of gestation in which a viable birth is not possible.

Congenital

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

Congenital Anomaly

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

Copayment

A Copayment is a fixed amount of money You pay when You receive covered services. See Section 6 (Your Cost for Covered Services).

Cosmetic Procedures

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

Covered Health Service(s)/Covered Services

Covered Health Service is a Health Care Service or supply which is not excluded under Section 13 (Exclusions) and meets the following conditions:

1) Prescribed by a Physician for the therapeutic treatment of Injury, Illness or Complications of Pregnancy;
2) Deemed Medically Necessary and appropriate in type, level, setting, and length of service; and if required by the Plan, is authorized on a prospective and timely basis by the Plan's Medical Director.
3) Rendered in accordance with generally accepted medical practice and professionally recognized standards;

Provided on or after the Effective Date and before Your coverage terminates in accordance with Section 4 (When Coverage Ends) and at a time when You met all applicable requirements for eligibility set forth in Section 3 (When Coverage Begins).

Covered Person

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

Custodial Care

Services that:

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

Dependent

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

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

To be eligible for coverage under the Policy, a Dependent's domicile and his/her primary residence must be in Arkansas. The definition of Dependent is subject to the conditions and limitations:

- A Dependent includes any unmarried Dependent child under 19 years of age;
- A Dependent includes an unmarried Dependent child who is 19 years of age or older to 23 years of age only if You furnish evidence upon Our request, satisfactory to Us, of all the following conditions:
    - The child must not be regularly employed on a full-time basis;.
    - The child must be a Full-Time Student;
    - The child must be primarily Dependent upon the Subscriber for support and maintenance.

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

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

Designated Facility

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

Durable Medical Equipment

Medical equipment that is all of the following:

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

Educational Service

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

Effective Date

The date coverage begins for You and any applicable Dependent(s) under this Policy, as determined by Us.

Eligible Expenses

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

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

- As indicated in the most recent edition of the Current Procedural Terminology (CPT),

a publication of the American Medical Association;
- As reported by generally recognized professionals or publications;
- As used for Medicare;
- As determined by medical staff and outside medical consultants pursuant to other appropriate source or determination that We accept.

Eligible Person The Enrolling Individual specified in both the application and the Policy. An Eligible Person's domicile and his/her primary residence must be located within Arkansas.

Emergency The sudden and, at the time, unexpected onset of a health condition that manifests itself by symptoms of sufficient severity that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that immediate medical care is required, which may include, but will not be limited to any of the following:
- Placing the person's health in significant jeopardy;
- Serious impairment to a bodily function;
- Serious dysfunction of any bodily organ or part;
- Inadequately controlled pain;
- With respect to a pregnant woman who is having contractions, either of the following:
- Inadequate time to affect a safe transfer of a pregnant woman to another hospital before delivery;
- The transfer to another hospital may pose a threat to the health or safety of the woman or unborn child.

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

Enrolled Dependent A Dependent who is properly enrolled under the Policy.

Enrolling Individual The individual to whom the Policy is issued.

Experimental or Investigational Services Medical, surgical, diagnostic, psychiatric, substance abuse or other Health Care Services, technologies, supplies, treatments, procedures, drug therapies or devices that, at the time We make a determination regarding coverage in a particular case, are determined to be any of the following:
- Not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service or the United States Pharmacopoeia Dispensing Information as appropriate for the proposed use.
- Subject to review and approval by any institutional review board for the proposed use.
- The subject of an ongoing clinical trial that meets the definition of a Phase 1 clinical trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight.

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

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

Full-Time Student An unmarried Dependent child who is between the ages of 19 – 23 that meets all the following conditions:
- The child must not be regularly employed on a full-time basis;
- The child must be primarily dependent upon the Subscriber for support and maintenance;
- The child must be attending, fulltime, a recognized course of study or training at one of the following:
    - An accredited high school;
    - An accredited college or university;
    - A licensed vocational school, technical school, beautician school, automotive school or similar training school.

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

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

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

Health Care Service(s) Those health services provided for cosmetic or other non-medical purposes, or for the purpose of preventing, diagnosing or treating a Sickness, Injury, Mental Illness, substance abuse, or their symptoms.

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

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

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

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

Infertility The inability to conceive after one year of unprotected sexual intercourse or the inability to sustain a successful Pregnancy. (Sexual intercourse means the sexual union between a male and female.)

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

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

Inpatient Rehabilitation Facility A Hospital (or a special unit of a Hospital that is designated as an Inpatient Rehabilitation Facility) that provides rehabilitation health services (Physical Therapy, Occupational Therapy and/or Speech Therapy) on an inpatient basis, as authorized by law.

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

Inpatient Stay	An uninterrupted confinement, following formal admission to a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility.
Instrumental Activities of Daily Living (IADL)	Activities related to independent living and include preparing meals, managing money, shopping for groceries or personal items, performing light or heavy housework, and using the telephone.
Intensive Outpatient Program	Active therapeutic programming 3 ½ hours or less per session. Therapy sessions are usually two to three times per week and are a combination of group and individual work.
Low Protein Modified Food Products	Food products specifically formulated to have less than one gram of protein per serving and intended for the dietary treatment of an inherited metabolic disease under the direction of a Physician.
Maximum Policy Benefit	The maximum amount that We will pay for Benefits during the entire period of time that You are enrolled under the Policy issued to the Enrolling Individual. The Maximum Policy Benefit includes any amount that We have paid for Benefits under a former Policy issued to the Enrolling Individual that is replaced by the current Policy, as well as any amount that We may pay under a later Policy that replaces the Enrolling Individual's current Policy. When the Maximum Policy Benefit applies, it is described in Section 6 (Your Cost for Covered Services).
Medically Necessary	Health Care Services that are ordered by a Health Provider, without which there would be significant risk of a serious deterioration and/or a significant impairment that, if not treated, could seriously affect one's ability to function within his or her normal environment. Although some Health Care Services are medically acceptable, they may not be medically necessary. Health Care Services need to be (1) medically appropriate and necessary to meet the basic health needs of the Member; (2) rendered in the most cost-efficient manner and type of setting appropriate for the delivery of the Covered Service; (3) consistent in type, frequency and duration of treatment with scientifically-based guidelines of national medical, research, or health care coverage organizations or governmental agencies that are accepted by the Plan; (4) consistent with the diagnosis of the conditions; and (5) of demonstrated medical value. Medically Necessary does not include care that is provided primarily for the convenience of the Member or a Health Provider, or care that is rendered more frequently than that accepted as medically appropriate by the medical profession.
Medicare	Parts A, B, C and D of the insurance program established by Title XVIII, United States Social Security Act, as amended by 42 U.S.C. Sections 1394, et seq. and as later amended.
Medical Foods	Products that are intended to meet the distinctive nutritional requirements of a person with a particular disease or condition for which nutritional requirements are established by recognized scientific principles and formulated to be consumed or administered enterally under the direction of a physician.
Member	A Member means any Subscriber or Dependent.
Mental Health Services	Covered Health Services for the diagnosis and treatment of Mental Illnesses. The fact that a condition is listed in the current Diagnostic and Statistical Manual of the American Psychiatric Association does not mean that treatment for the condition is a Covered Health Service.
Mental Health/Substance Abuse Designee	Refers to St. John's Mercy Managed Behavioral Health or other applicable designated agent that provides and manages Mental Health Services for the Plan.
Mental Illness	Those Conditions classified as mental disorders in the American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders, except mental retardation
Network/Network Provider	When used to describe a provider of Health Care Services, this means a provider that has a participation agreement in effect with Us or with Our affiliate (directly or through one or more other organizations) to provide Covered Health Services to Covered Persons.

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

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

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

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

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

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

Out-of-Pocket Maximum If applicable, the maximum amount of Coinsurance You pay every Calendar Year. If You use both Network Benefits and Non-Network Benefits, two separate Out-of-Pocket Maximums apply. Once You reach the Out-of-Pocket Maximum for Network Benefits, those Benefits are payable at 100% of Eligible Expenses during the rest of that Calendar Year. Once You reach the Out-of-Pocket Maximum for Non-Network Benefits, those Benefits are payable at 100% of Eligible Expenses during the rest of that Calendar Year. See Section 6 (Your Cost for Covered Services).

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

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

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

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

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

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

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

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

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

Preventive Health Screening(s) Routine tests performed on a healthy individual who has no signs or symptoms of disease. Preventive Health Screenings are for the purpose of detecting abnormalities or malfunctions of bodily systems and parts according to accepted medical practice. Tests performed on a symptomatic patient are classified as diagnostic tests. Diagnostic tests will incur deductibles and/or Copayments/Coinsurances consistent with the services received.

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

Preexisting Condition An Injury or Sickness that was diagnosed or treated, or for which prescription medications or drugs were prescribed or taken within the twelve (12) month period ending on the person's Effective Date. A Preexisting Condition does not include Pregnancy. Genetic information is not an indicator of a Preexisting Condition, if there is not a diagnosis of a condition related to the genetic information.

Pregnancy Includes all of the following:

- Prenatal care;
- Postnatal care;
- Childbirth;
- Any complications associated with Pregnancy.

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

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

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

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

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

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

Skilled Nursing Facility A Hospital or nursing facility that is licensed and operated as required by law. A Skilled Nursing Facility is not, other than incidentally, a place that provides minimal Care, Custodial

Care, ambulatory Care, part-time Care, or Care for Mental Illness and Substance Abuse, pulmonary tuberculosis or venereal disease.

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

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

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

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

Termination Date Means:

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

b. For the Member and Dependent(s), the last date on which this Policy is in force.

Total Disability or Totally Disabled Means:

a. The Member or Dependent is inpatient in a Hospital or other similar health care facility; or

b. The Member is unable to perform the material and substantial duties of his or her occupation; or

c. If a Dependent, s/he cannot participate in a material or substantial manner in activities normally associated with a person of like age and gender who is not Totally Disabled.

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

Well-conducted randomized controlled trials. (Two or more treatments are compared to each other, and the patient is not allowed to choose which treatment is received.)

Well-conducted cohort studies. (Patients who receive study treatment are compared to a Individual of patients who receive standard therapy. The comparison Individual must be nearly identical to the study treatment Individual.)

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

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

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

Usual and Customary Rate (UCR)

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

a) The rate allowed by Medicare for the particular service or supply;
b) The usual fee which the individual health professional most frequently charges for a service or supply;
c) The prevailing rate of fees charged for identical or similar services in the same geographical area by health professionals of similar training and experience;
d) Unusual circumstances or complications that require additional time, skill and experience in connection with the provided service or supply;
e) The frequency of the determination of the usual and customary fee;
f) A general description of the methodology used to determine usual and customary fees;
g) The percentile that determines the maximum benefit the Plan will pay for any Accidental Injury dental procedure, if the usual and customary fee is determined by taking a sample of fees submitted on actual claims from licensed dentists and then making the benefit by selecting a percentile of those fees.

Utilization Review

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

You/Your

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

NOTICE OF PRIVACY PRACTICES

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

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

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

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

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

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

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

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

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

Member Authorization

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

YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION

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

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

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

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

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

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

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

Changes

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

Complaints

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

Contact The Plan

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

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

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

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

DISCLAIMER
The Arkansas Life and Health Insurance Guaranty Association ("Guaranty Association") may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions and require continued residency in this state. You should not rely on coverage by the Guaranty Association in purchasing an insurance policy or contract.
Coverage is NOT provided for Your policy or contract or any portion of it that is not guaranteed by the insurer or for which You have assumed the risk, such as non-guaranteed amounts held in a separate account under a variable life or variable annuity contract.
Insurance companies or their agents are required by law to provide You with this notice. However, insurance companies and their agents are prohibited by law from using the existence of the Guaranty Association to induce You to purchase any kind of insurance policy.

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

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

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

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

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

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

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

LIMITS ON AMOUNT OF COVERAGE

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

OUTPATIENT PRESCRIPTION DRUG ADDENDUM

This addendum amends the Comprehensive Individual Health Insurance Coverage Policy and the Schedule of Coverage and Benefits attached thereto (collectively, the "Policy"), and unless otherwise expressly stated in this addendum, is subject to all provisions, exclusions, and limitations set forth in the Policy. Any applicable Deductible, Coinsurance and/or Copayment will not count towards any applicable Out-of-Pocket Maximum.

This addendum is issued to the enrolling individual and provides Benefits for Outpatient Prescription Drugs. Benefits are greater if received at a Participating Pharmacy. The Copayments described in this addendum shall not be counted against the Out-of-Pocket Maximum as set forth in the Schedule of Coverage and Benefits.

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

I. GLOSSARY OF TERMS

This section:

- Defines the terms used throughout this addendum.
- Is not intended to describe Benefits.

Annual Drug Deductible - the amount You are required to pay for covered Prescription Drugs in a Calendar Year before We begin paying for Prescription Drugs.

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

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

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

Covered Services – the medical care, services, and supplies:

a. provided, directed or authorized by the Covered Person's Prescriber;
b. prescribed by a duly licensed health care provider for the therapeutic treatment of Injury, Illness or pregnancy;
c. deemed Medically Necessary and appropriate in type, level, setting, and length of service by Us;
d. rendered in accordance with generally accepted medical practice and professionally recognized standards;
e. not considered to be experimental, investigational, or which are performed for research purposes;
f. provided on or after the Effective Date and before a Covered Person's coverage terminates and at a time the Covered Person met all applicable requirements for eligibility; and services that are specifically included and not excluded or limited in the Policy.

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

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

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

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

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

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

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

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

Plan Deductible – The amount You pay in a Calendar Year for covered health services, not to include outpatient prescription drugs, before You are eligible to receive benefits.

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

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

Prescription Drug – a medication, product, or device that has been approved by the Food and Drug Administration (FDA) and that can, under federal or state law, be dispensed only pursuant to a Prescription Order or Refill. Prescription Drugs are given a status of Tier One (or "First Tier"), Tier Two (or "Second Tier"), Tier Three (or "Third Tier"), Tier Four (or "Fourth Tier"), or Not Covered by the Plan's Formulary Committee. A Prescription Drug includes a medication that, due to its characteristics, is appropriate for self-administration or administration by a non-skilled caregiver. For the purpose of this benefit, this definition also includes:
- Inhalers (with spacers)
- Insulin
- The following diabetic supplies:
    - insulin syringes with needles
    - blood testing strips – glucose
    - urine testing strips – glucose

- ketone testing strips and tablets
- lancets and lancet devices
- glucose monitors

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

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

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

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

Specialty Pharmaceutical – any drug used to treat a complex, often chronic disease that requires complex care management. Specialty Pharmaceuticals may be self-administered or administered by a trained health-care professional. Specialty Pharmaceuticals include those drugs used to treat rheumatoid arthritis (e.g., Enbrel, Humira, Kineret, Remicade) multiple sclerosis (e.g., Avonex, Betaseron, Copaxone, Rebif), hepatitis C (e.g., Intron-A, PEG-Intron), and other chronic diseases. They are typically high-cost (greater than $500 a month) and often require special handling, and close monitoring of the patient's condition. Most Specialty Pharmaceuticals will incur a Tier Four Copayment, and are subject to coverage limitations. See Section IV. Benefit Information for more details.

Tier Four – Tier Four drugs incur Your highest Copayment and are typically Specialty Pharmaceuticals. They may be classified as either Brand or Generic by First Databank or Medi-Span. Coverage limitations for Tier Four drugs may exist; please refer to Section IV. Benefit Information.

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

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

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

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

II. INTRODUCTION

Coverage Policies and Guidelines

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

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

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

If the pharmacy is unable to verify Your coverage, You will be required to pay 100% of the cost of the Prescription Drug at the pharmacy. Our contracted pharmacy reimbursement rates (Our Prescription Drug Cost) will not be available to You.

You may seek reimbursement from Us by submitting the paid pharmacy receipt(s) to Us at the address shown on the cover page of Your Policy within sixty (60) days after the Prescription Drug is actually dispensed. The receipt(s) must show the name of the Prescription Drug, the National Drug Code (NDC) number, the units dispensed, the amount You paid, and the date of purchase. Failure to furnish receipts within the time required will not invalidate any claim, if it was not reasonably possible to give notice within the time required. When You submit a claim on this basis, You may pay more because You failed to verify Your eligibility when the Prescription Drug was dispensed. If the Prescription Drug is dispensed by a Non-Participating Pharmacy, You must pay for the Prescription Drug at the time it is dispensed and then file a claim for reimbursement with Us (less any required Copayment/Coinsurance and any deductible), as described in Your Policy. We will not reimburse You for the difference between what We pay a Participating Pharmacy and a Non-Participating Pharmacy's usual and customary charge (which may include a dispensing fee and sales tax) for that Prescription Drug. We will not reimburse You for any Non-Covered Drug.

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

Rebates and Other Payments to Us
We may receive rebates for certain Brand-name drugs included on Our Formulary. We do not consider these rebates in calculating any percentage Copayments. We are not required to pass on to You, and We do not pass on to You, amounts payable to Us under rebate programs or other such discounts.

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

Section 1: What's Covered - Prescription Drug Benefits
We provide benefits under this addendum for Outpatient Prescription Drugs designated as covered at the time the Prescription Order or Refill is dispensed by a Participating Pharmacy. Refer to exclusions in Your Policy and in Section V of this addendum.

Benefits for Outpatient Prescription Drugs
Benefits for Outpatient Prescription Drugs are available when the Outpatient Prescription Drug meets the definition of a Covered Service.

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

Quantity Limits

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

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

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

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

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

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

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

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

Medical Emergencies
When You obtain a Prescription Drug from a Non-Participating Pharmacy, as part of Emergency Care, You will be required to pay 100% of the cost for the Prescription Drug at the pharmacy. You may seek reimbursement from Us by submitting the paid pharmacy receipt(s) to Us at the address shown on the cover page of Your Policy within sixty (60) days after the Prescription Drug is actually dispensed. Failure to furnish receipts within the time required will not invalidate any claim, if it was not reasonably possible to give notice within the time required. The receipt(s) must show the name of the Prescription Drug, the National Drug Code (NDC) number, units dispensed, the amount paid, and the date purchased. Upon review of the relevant medical records and any other relevant information reasonably requested by Us, Our Chief Medical Officer or designee will determine whether the Prescribed Drugs were in fact part of, or related to Emergency Care. If it is determined that the Prescription Drug was dispensed as part of Emergency Care, You will be reimbursed the cost incurred by You, less the appropriate Copayment and any applicable Service Charge. If it is determined that the Prescription Drug was NOT dispensed as part of Emergency Care, You will pay the appropriate Non-Network Coinsurance and any applicable Service Charge.

What You Must Pay
If applicable, You may be responsible for paying an Annual Drug Deductible in addition to Your Annual Deductible for the Policy as described in the Schedule of Coverage and Benefits.

You are responsible for paying the applicable Copayment/Coinsurance and any applicable Service Charge as described in the Schedule of Coverage and Benefits when Prescription Drugs are obtained from a retail, mail

service, or specialty pharmacy. The Prescription Drug Copayment/Coinsurance is in addition to any other place-of-service Copayments/Coinsurance (i.e., medical office, home care, etc.).

Mercy Health Plans negotiates with Network Pharmacies on your behalf for a discounted rate for prescription drugs. This discount is passed on to You when You use Your Mercy Health Plans drug coverage. If for some reason, Your claim at a Network Pharmacy does not get paid under Your prescription drug coverage and You pay full retail price for it (rather than the discounted price). You may be eligible for reimbursement. You may submit Your receipts to Our Pharmacy Department for processing at:

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

Prescriptions that are eligible for reimbursement will be reimbursed at Our discounted rate, minus Your Copayment/Coinsurance. This means that You may not be refunded the full retail price that You originally paid.

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

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

III. PAYMENT INFORMATION

Payment Term	Description	Amounts
Annual Drug Deductible	If applicable, the amount You pay for covered Prescription Drugs at a retail, mail service, or specialty pharmacy in a Calendar Year before We begin paying for Prescription Drugs.	***If applicable, see the Annual Drug Deductible in the Schedule of Coverage and Benefits for amount.***
Copayment/Coinsurance	The amount You pay for covered Prescription Drugs. It can be either a specific dollar amount or a percentage of the Prescription Drug Cost. ***See Glossary of Terms for definition of Prescription Drug***.	For Prescription Drugs at a retail Participating Pharmacy, You are responsible for paying the lower of: ● The applicable Copayment / Coinsurance and any Service Charge or ● The Participating Pharmacy's Usual and Customary Charge (which includes a dispensing fee and possible sales tax) for the Prescription Drug. For Prescription Drugs at a Participating mail service or Specialty pharmacy, You are responsible for paying the lower of: ● The applicable Copayment/ Coinsurance and any Service Charge or ● The Prescription Drug Cost for that Prescription Drug. For Prescription Drugs at a Non-Participating Pharmacy, You are responsible for paying the Non-Network Coinsurance. (See Section IV. Benefit Information for more on obtaining Prescription Drugs from a Non-Participating Pharmacy)

IV. BENEFIT INFORMATION

Description of Pharmacy Type and Supply Limits	Your Copayment Amount
Up to a 30 day supply of Prescription Drugs from a Participating Retail or Specialty Participating Pharmacy As written by the Prescriber, *up to* a consecutive 30- day supply of a Prescription Drug, unless limited by the drug manufacturer's packaging size, or based on quantity limits, or to the extent a Prescription Drug: ● Is normally prescribed in limited supplies in accordance with generally accepted medical practice. ● As written by the Prescriber, one (1) unit (vial, pen, or other form) of glucagon, Epipen, or successor products. ● *Up to* three (3) consecutive 30-day supplies of certain smoking cessation products (nicotine replacement gum or patches, nicotine inhaler, or Zyban) per year. All products require a Prescription Order. Copayment will be consistent with Your Prescription drug benefit. No reimbursement will be made for products not purchased through the prescription counter. ● If a Prescription Drug is prescribed in a single dosage amount for which the particular Prescription Drug is not manufactured in such single dosage amount and requires dispensing the particular Prescription Drug in a combination of different manufactured dosage amounts, We will only impose one co-payment for the dispensing of the combination of manufactured dosages that equal the prescribed dosage for such Prescription Drug. If You were charged more than one co-payment in this situation, You may request a reimbursement form from Us by calling Our Customer Contact Center at the telephone number on Your ID card. **NOTE:** Specialty Pharmaceuticals are limited to a *maximum* of a thirty (30)-day supply per Prescription Order or Refill. ***See Glossary of Terms for definition of Prescription Drug.***	**Network:** See Your applicable Copayments stated in the Schedule of Coverage and Benefits. **Non-Network:** See Your applicable Copayments stated in the Schedule of Coverage and Benefits.
Prescription Drugs from a Mail Service Participating Pharmacy The following supply limits apply: ● As written by the provider, *up to* a consecutive 90-day supply of a Prescription Drug, unless limited by the drug manufacturer's packaging size, or based on quantity limits, or to the extent a Prescription Drug is normally prescribed in limited supplies in accordance with generally accepted medical practice. ● **NOTE:** Specialty Pharmaceuticals are limited to *a maximum* of a thirty (30)-day supply per Prescription Order or Refill. It is not recommended, therefore, that You	**Network:** See Your applicable Copayments stated in the Schedule of Coverage and Benefits. **Non-Network:** See Your applicable Copayments stated in the Schedule of Coverage and Benefits.

use a mail-order pharmacy to obtain Your Specialty Pharmaceutical. To receive the maximum Benefit, Your provider must write Your Prescription Order or Refill for the full 90-day supply. If You receive less than a 90-day supply from a Mail Service Pharmacy, You will still be required to pay the Mail Services Copayments/Coinsurances. ***See Glossary of Terms for definition of Prescription Drug.***	
Prescription Drugs from a Non-Participating Pharmacy If the Prescription Drug is dispensed by a Non-Participating Pharmacy, You must pay for the Prescription Drug at the time it is dispensed and then file a claim for reimbursement with Us, as described in Your Policy. We will not reimburse You for the difference between what We pay a Participating Pharmacy and a Non-Participating Pharmacy's usual and customary charge (which can include a dispensing fee and sales tax) for that Prescription Drug. We will not reimburse You for any non-covered drug. In most cases, You will pay more if You obtain Prescription Drug from a Non-Network Pharmacy. The following supply limits apply: As written by the provider, up to a consecutive 30-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits.	See Your applicable Copayments stated in the Schedule of Coverage and Benefits.

V. WHAT'S NOT COVERED - EXCLUSIONS

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

1. Coverage for Prescription Drugs for any amount dispensed in excess of the supply limits addressed above and/or any additional quantity limits as discussed in section II.
2. Drugs that are prescribed, dispensed, or intended for use while You are an inpatient in a Hospital, Skilled Nursing Facility, or Alternate Facility.
3. Experimental, Investigational, or Unproven services and medications; medications not approved by the FDA; medications used for experimental or unproven indications ("off-label" uses) and/or dosage regimens determined by Us to be experimental.
4. Prescription Drugs furnished by the local, state, or federal government. Any Prescription Drug to the extent payment or benefits are provided or available from the local, state, or federal government (for example, Medicare) whether or not payment or benefits are received, except as otherwise provided by law.
5. Prescription Drugs for any condition, injury, sickness or mental illness arising out of, or in the course of, employment for which benefits are available under any Workers' Compensation law or other similar laws, whether or not a claim for such benefits is made or payment or benefits are received.
6. Any product dispensed for the purpose of appetite suppression or weight loss.
7. Compounded drugs that do not contain at least one ingredient that requires a Prescription Order.
8. Drugs available over-the-counter that do not require a Prescription Order by federal or state law before being dispensed.
9. Any drug that is therapeutically equivalent to an over-the-counter drug.

10. Durable Medical Equipment. Prescribed and non-prescribed outpatient supplies, other than the diabetic supplies and inhaler spacers specifically stated as covered.
11. Replacement Prescription Drugs resulting from lost, stolen, damaged, or destroyed medications.
12. General and injectable vitamins, except prenatal vitamins that require a Prescription Order and are prescribed for a Covered Person who is then pregnant or attempting to conceive.
13. Unit dose packaging of Prescription Drugs.
14. Medications used for cosmetic purposes only.
15. New Prescription Drugs and/or new dosage forms until they are reviewed and approved by Our Formulary Management Committee.
16. Prescription Drugs or dosage forms that are determined to not be a Covered Service.
17. Prescription Drugs or devices to treat erectile dysfunction including, but not limited to, impotency.
18. Drugs that are determined to be Non-Covered by Our Formulary Management Committee for any reason, including but not limited to, safety, efficacy, cost, narrow therapeutic index, etc.
19. Medical foods or other products that are intended to meet the distinctive nutritional requirements of a person with a particular disease or condition for which nutritional requirements are established by recognized scientific principles and formulated to be consumed or administered enterally under the direction of a physician. Exceptions include nutritional supplement or formulas for the treatment of phenylketonuria (PKU) or any inherited disease of amino and organic acids, or services ordered by a Physician in connection with home care that require the Member to have a feeding tube, or services that are expressly authorized in advance by the Plan's Chief Medical Officer.
20. Immunizations received through a Network or Non-Network pharmacy. See Your Comprehensive Individual Health Insurance Coverage Policy for immunization services covered under Your medical Benefit.
21. Prescription Drugs whose primary purpose or direct effect is the removal, destruction, or interference with the implantation of a fertilized ovum, embryo, or fetus.
22. Prescription Drugs when prescribed to treat infertility.

Charles S. Gilham, Vice President
Mercy Health Plans