MercyCare HMO, Inc.
Individual HMO Member Policy

ENTIRE POLICY

This Policy document, issued by MercyCare HMO, Inc. (referred to in the Policy as "MercyCare") describes the terms, conditions and limitations of coverage for certain Hospital, medical and other services provided under the Policy. This Policy, the Schedule of Benefits, Your Application, and any addendums or riders, make up Your Policy with MercyCare.

PARTICIPATING PROVIDERS

Participating Providers have agreed to accept discounted payments for Covered Services with no additional billing to the Member other than Copayment, Coinsurance and Deductible amounts. You may obtain further information about the participating status of professional providers and information on out-of-pocket expenses by calling the toll free telephone number on Your Identification Card.

IMPORTANT NOTICE CONCERNING STATEMENTS IN THE APPLICATION FOR YOUR INSURANCE

Please read the copy of the Application accompanying this Policy. OMISSIONS OR MISSTATEMENTS IN THE APPLICATION COULD CAUSE AN OTHERWISE VALID CLAIM TO BE DENIED. Carefully check the Application and write to Us within 10 days if any information shown on the form is not correct and complete. The Application is part of the insurance contract. The insurance coverage was issued on the basis that the answers to all questions and any other material information shown on the Application are correct and complete.

YOUR RIGHT TO RETURN THIS POLICY

Free Look. You have the right to return this policy within 10 days of its delivery. Your premium will be refunded if after examination of the policy You are not satisfied for any reason. Keep in mind, open enrollment and special enrollment last for a limited time. Returning this policy after the annual open enrollment period ends may prevent You from purchasing another policy until the next open enrollment period.

GUARANTEED RENEWABILITY

The Policy is guaranteed renewable except as stated in the "Termination of Coverage/Disenrollment" provision of the "Coverage Information" section of this Policy.

NOTICE REGARDING PEDIATRIC DENTAL SERVICES

This Policy does not include pediatric dental services as required under the federal Patient Protection and Affordable Care Act. This coverage is available in the insurance market and can be purchased as a stand-alone product. Please contact MercyCare's Customer Service Department at: (877) 908-6027, Your agent, or the *American Health Benefits Exchange,* also called the *Health Insurance Marketplace (Marketplace),* if You wish to purchase pediatric dental coverage or a stand-alone dental services product.

MercyCare HMO, Inc.
580 N. Washington St.
P.O. Box 550 Janesville,
Wisconsin 53547-0550

Toll Free: **(877) 908-6027**
TTY/TDD: **(800) 947-3529**

mercycarehealthplans.com

TABLE OF CONTENTS

INTRODUCTION

UNDERSTANDING THIS POLICY

You should read this Policy document, the Schedule of Benefits, and any addendums or riders carefully. These documents, combined, explain the terms and conditions of Your insurance coverage. They contain a great deal of information about the services and supplies covered under this Policy. It is important that You understand all parts of this Policy in order to get the most out of Your coverage.

Once You are enrolled, this is Your Policy for as long as You remain eligible for coverage and make all required premium payments. This Policy replaces any previous policies that You may have been issued by Us.

As a Member, You are responsible for understanding the benefits to which You are entitled under the Policy and the rules You must follow to receive those benefits.

Some of the terms that are used in this Policy have specific meanings and are capitalized throughout the document. These terms and their meanings can be found in the Glossary of this Policy.

INTERPRETING THIS POLICY

We have the authority to interpret this Policy and all questions that arise under it.
In general, We only cover services if they are Medically Necessary. When required, We will review the facts and determine whether a Member's requested service is Medically Necessary, consistent with terms of this Policy.

QUESTIONS?

If, after You read this Policy, You have questions, please call the Customer Service Department at (877) 908-6027. Any quotation of benefits given by MercyCare or its representative is not a guarantee of coverage. Coverage is determined based on the terms and conditions of Your Policy.

OBTAINING SERVICES

PROVIDER DIRECTORY

Providers listed in Our provider directory are Participating Providers. Providers who are not listed in Our provider directory are Non-Participating Providers. You can access Our provider directory online on Our website at mercycarehealthplans.com, or You can request a paper copy by calling Customer Service at (877) 908-6027.

In order to provide You with the most up-to-date provider directory, We reserve the right to modify the list of Participating Providers at any time.

If Our provider directory contains inaccurate Participating Provider information and You relied on the inaccurate information to obtain needed Covered Services, We cannot impose higher cost sharing than would apply for a Participating Provider and the cost sharing amounts must be applied to the Participating Provider Deductible and Out-of-Pocket Maximum amounts.

PRIMARY CARE PROVIDER SELECTION

At the time You enroll in this Policy, You are required to select a Primary Care Provider (PCP). Each family Member may have a different PCP.

A Member's PCP:

- Provides entry into MercyCare's health care system.
- Evaluates a Member's total health care needs.
- Provides personal medical care in one or more medical fields.
- Is in charge of coordinating other health services and referring the Member to other Health Care Providers when appropriate.

You must notify Us of Your PCP selection. You may have indicated Your selection on Your Application. If You did not, or You wish to change that selection, please call Customer Service at (877) 908-6027. You may change Your PCP at any time as long as You notify Customer Service. Your PCP is responsible for Your care and is available to assist You in finding an appropriate provider for any additional care You may need.

We will notify You at least 60 days before a Health Care Provider leaves Our Provider Network. If Your PCP leaves Our Provider Network, You will be asked to select a new PCP.

You have the right to select a Woman's Principal Health Care Provider (WPHCP)
Illinois law allows You to select a WPHCP in addition to Your selection of a PCP. A WPHCP is a Physician specializing in obstetrics and gynecology (OB-GYN) or specializing in family practice.

You may see a WPHCP without a Referral from Your PCP. If You have not already selected a WPHCP, You may do so now or at any other time. You are not required to have or to select a

WPHCP. To designate a WPHCP from the list, call (877) 908-6027 and tell Our staff which You have selected.

Your WPHCP must be a Participating Provider Physician. You may get the list of participating obstetricians, gynecologists, and family practice specialists from Our provider directory, which You can find on Our website at mercycarehealthplans.com or by calling (877) 908-6027. We will send the directory to You within 10 days of Your call.

NON-EMERGENCY CARE

Unless You need Emergency Care, or Urgent Care while outside the Service Area, to receive benefits for services described in this Policy, You must receive such services directly from:

- A Participating Provider; or
- A Non-Participating Provider for whom You have gotten an approved Referral from Us.

Non-Participating Provider Services Received at a Participating Provider Facility

If during a visit at a participating health care facility You receive Covered Services from a Non-Participating Provider, We will calculate cost-sharing for the Non-Participating Provider service based on the lesser of, the median contracted rate for the service received or the amount We negotiate with or are contracted to pay the provider. You will be responsible for any applicable Deductible, Coinsurance or Copayment amounts shown in the Schedule of Benefits applicable to Participating Providers.

- For purposes of this provision, the following definitions apply:
  - "During a visit," with respect to items and services furnished to an individual at a participating health care facility, includes equipment and devices, telemedicine services, imaging services, and laboratory services, even if the provider furnishing such items or services is not at the facility.
  - "Participating health care facility" means a hospital, critical access hospital, an ambulatory surgical center, a laboratory, a radiology facility or imaging center that has a contract with Us.

This provision may not apply if the provider notified You of their Non-Participating Provider status at least 72 hours in advance of receiving certain service and You gave written consent to treatment.

REFERRAL REQUIREMENTS

In order to obtain specialty services or treatment that cannot be obtained from a Participating Provider, the following rules apply:

- Your Primary Care Provider or Woman's Principal Health Care Provider must request and We must approve the Referral.
- The referring provider must complete a Referral form. A verbal request for Referral is not acceptable.
- A Referral that is not submitted for Our review, or one which We do not approve, is not valid.

Note: You do not need a Referral from Your Primary Care Provider or Woman's Principal Health Care Provider to seek services from a licensed behavioral health or Substance Use Disorder provider

within Our Provider Network.

If We approve the Referral:

- We will determine with the referring Participating Provider, the duration of the Referral and/or the number of visits for which coverage is authorized based on Medical Necessity.
- We will reimburse Your Covered Expenses as if You saw a Participating Provider, even if the services were rendered by a Non-Participating Provider. We will base Our payment on the lesser of the provider's charges or the amount We negotiate with or are contracted to pay the provider. You will be responsible for only the Deductible, Coinsurance and/or Copayment amounts that apply to a Participating Provider.

A Referral request is often only approved for an initial consultation or office visit. If the provider determines that You need additional services, he or she must request Our Prior Authorization for the additional services.

If Prior Authorization for the additional services is requested by a Non-Participating Provider and We determine that the Medically Necessary services can be provided by a Participating Provider, We may deny the Prior Authorization request and refer You to a Participating Provider. **If We do not approve the Referral request, We will not cover these services if You choose to obtain them from a Non-Participating Provider.**

The referring Participating Provider and Our Quality Health Management Department will determine the duration of the Referral or the number of visits authorized based on what is medically appropriate. If a Referral is not approved by the Quality Health Management Department, it is not considered valid and the services are not considered authorized.

Standing Referral

If You require ongoing treatment from another Physician or provider, Your Primary Care Provider or Woman's Principal Health Care Provider may apply for a Standing Referral to that Physician or provider from Your Primary Care Provider or Woman's Principal Health Care Provider. If approved by MercyCare, the Standing Referral shall be effective for the period necessary to provide the referred services for up to a period of one year. Notwithstanding anything in Your Policy to the contrary, for the services rendered by Non-Participating Providers, We will reimburse Your Covered Expenses as if You saw a Participating Provider. We will base Our payment on the lesser of, the Non-Participating Provider's charges or the amount We negotiate with the Non-Participating Provider. You will be responsible for only the Deductible, Coinsurance and/or Copayment amounts that apply to a Participating Provider.

Failure to follow the above requirements will result in the non-coverage of Claims associated with those services, except for Emergency Care or Urgent Care when you are outside the Service Area.

PRIOR AUTHORIZATION

To assure proper medical management, certain services require Prior Authorization from MercyCare to be covered under the Plan, except in an Emergency or Urgent Care situation. Failure to get Prior Authorization means the procedure will be denied upon Claim submission, unless the service is for a state mandated benefit or an Essential Health Benefit. We will review state mandated and Essential Health Benefit services or supplies for Medical Necessity prior to processing the Claim. If we deny the Claim, You will be responsible for payment.

See the "Prescription Drug Benefit Provisions" section of this Policy for Prior Authorization Requirements related to Prescription Drugs.

Review Period

Prior Authorization is not required for Emergency Care or Urgent Care. For all other services, We will notify You and Your Health Care Provider of Our decision no later than five calendar days after receiving all information needed to complete Our Prior Authorization review.

Length of Prior Authorization Approval

If We approve a Prior Authorization request, the approval will be valid for the lesser of six months after the date Your Health Care Provider receives Our notice of approval or the length of treatment as determined by Your Health Care Provider.

For recurring services for treatment of Chronic or long-term conditions that require Prior Authorization, a Prior Authorization approval will remain valid for the lesser of 12 months from the date Your Health Care Provider receives Our notice of approval or the length of treatment as determined by Your Health Care Provider.

New Members

If You are a new Member under the Plan, We will honor a Prior Authorization for a Covered Service granted to You by Your previous health insurance issuer for up to 90 days after Your coverage effective date, if You provide Us with a copy of the Prior Authorization approval.

Services and Supplies Requiring Prior Authorization

- Autism Treatment
- Biofeedback services
- Cardiac Rehabilitation
- Cochlear Implants
- Dental surgery
- Durable Medical Equipment including but not limited to Orthotic Devices
- Genetic Testing and counseling
- Habilitative Services
- Home health care
- Hospice care
- Hospital services, inpatient and outpatient
- Insulin pumps
- Magnetic Resonance Imaging (MRI)

- Maternity services received out of the Service Area in the last 30 days of pregnancy
- Medical Supplies
- Mental Illness, Serious Mental Illness
    - Inpatient, partial hospitalization, or treatment in a Residential Treatment Facility
    - ECT Therapy or other mental health procedures
- Non-Participating Provider services and supplies
- Pharmaceuticals administered in provider's office
- Positron emission tomography (PET) imaging
- Prosthesis
- Reproductive/Infertility Services
- Surgical services, inpatient, outpatient, and at a Free-Standing Surgical Facility
- Skilled Nursing Facility services
- Temporomandibular disorders (TMJ)
- Transplants

This is not a complete list. Please visit Our website at mercycarehealthplans.com for a complete up-to-date list of Covered Services that require Prior Authorization. You may also contact Our Customer Service Department at (877) 908-6027 for more information.

If We add a service to the list of services requiring Prior Authorization, We will update the list on Our website in advance of implementing the new requirement. We cannot deny a claim for failure to obtain Prior Authorization if the Prior Authorization requirement was not posted on Our website on the date of service.

CONCURRENT REVIEW

Concurrent review occurs at intervals during the course of the member's inpatient or outpatient treatment. If MercyCare Quality Health Management (QHM) is advised of the need for treatment for a longer period of time than was initially certified, the treating Physician will be asked to provide additional medical information to evaluate the need for additional services.

If the member's inpatient or outpatient treatment for those services continues longer than originally certified by MercyCare and the additional services are not certified through the concurrent review process, benefits may not be payable for the additional services.

AFTER HOURS CARE

MercyCare has systems in place to maintain a twenty-four (24) hour answering service and ensure that each Primary Care Provider or Woman's Principal Health Care Provider provides a twenty-four (24) hour answering arrangement and a twenty-four (24) hour on-call arrangement for all members. In the case of Emergency, You will be instructed to dial 911.

CONTINUITY OF CARE/TRANSITION OF CARE

New Members

If You are a new enrollee and You are receiving care for a condition that requires an Ongoing Course of Treatment or if You are pregnant, and Your Physician is in Our Service Area but does not belong to Our Provider Network, You may be able to continue care with that provider through a transition period.

We will provide continuity of care benefits for Covered Services at the Participating Provider level of benefits during a transition period of 90 days from Your Enrollment Effective date to continue an Ongoing Course of Treatment, or through post-partum care if You had entered the second or third trimester of pregnancy upon Your Enrollment Effective Date. You must submit a written request to the Plan for transition of care benefits within 15 business days of Your eligibility effective date.

This provision does not apply if:

- You have successfully transitioned to a Participating Provider; or
- You have already met or exceeded the benefit limitations of the Plan; or
- The care being provided is not Medically Necessary.

Continued Care Coverage with Terminating Providers

If at the time of Your enrollment Our materials indicated that Your Health Care Provider was or would be a Participating Provider, We will continue to treat Your Primary Care Provider as a Participating Provider throughout Your entire Contract Period. This is true even if Your Primary Care Provider terminates as a Participating Provider during Your Contract Period.

If You are undergoing a course of treatment with a Health Care Provider who terminates as a Participating Provider, We will continue to cover treatment provided by this Health Care Provider as a Participating Provider for You as follows:

- Continuity of care coverage will continue for a period up to 90 days starting on the date you receive notice from MercyCare that Your provider is terminating from Our Provider Network.
- If You are in Your second or third trimester of pregnancy when Your Health Care Provider terminates as a Participating Provider, We will continue to cover services provided by this Health Care Provider as a Participating Provider until the end of Your post-partum care.

This provision does not apply to a Health Care Provider who is no longer practicing in the Service Area, has lost his or her license, or who was terminated from the Provider Network for professional misconduct.

DEDUCTIBLES, COPAYMENTS AND COINSURANCE

Except for listed Preventive Care Services, You must pay a Deductible, Copayment or Coinsurance amount for most Covered Expenses as shown in Your Schedule of Benefits. Definitions of these cost-sharing features are found in the Glossary.

Deductibles

Most Covered Expenses are subject to a Deductible when indicated in the Schedule of Benefits.

The single Deductible amount is the most that any Member must pay per Contract Period before We will pay for Covered Expenses. Once a Member has met the single Deductible amount, We will begin paying Claims for that Member as described in the Schedule of Benefits.

The family Deductible amount is the most that the Subscriber and his or her covered Dependents must pay in a Contract Period before We will pay for Covered Expenses. Once the family Deductible amount has been met, We will begin paying Claims for the entire family as described in the Schedule of Benefits.

You will not receive Deductible credit for any of the following:

- Any Copayments You pay.
- Any amounts You pay for Covered Expenses that are marked in the Schedule of Benefits as not subject to the Deductible.
- Any amounts You pay to Non-Participating Providers, except when You have an approved Referral from Us.
- Any amounts You pay for services or supplies that are not Covered Expenses.

Copayments and Coinsurance

For most Covered Expenses, You will be required to pay a portion of the total cost. The amount of Copayment or Coinsurance that applies to Covered Expenses depends on the Covered Service received.

You must pay any fixed dollar Copayments regardless of whether You have satisfied Your Deductible. Coinsurance payments begin once You meet the Deductible, if a Deductible applies.

OUT-OF-POCKET MAXIMUM

The Out-of-Pocket Maximum is the most You will pay in Deductible, Copayment and Coinsurance amounts for Covered Expenses in a Contract Period. This includes both medical and pharmacy services. You can find the Out-of-Pocket Maximum amount in Your Schedule of Benefits.

The “single” Out-of-Pocket Maximum amount is the most that each Member will pay out-of-pocket each Contract Period. The “family” Out-of-Pocket Maximum amount is the most that the Subscriber and his or her covered Dependents, combined, will pay out-of-pocket each Contract Period.

The following **never** apply to the Out-of-Pocket Maximum amount:

- Amounts You pay for services or supplies that are not Covered Services;
- Amounts You pay for services or supplies that are subject to coverage limitations, and You exceed those limitations;
- Amounts You pay for services or supplies that require Prior Authorization without first getting Prior Authorization from Us;
- Amounts You pay for services or supplies that require a Referral without getting an approved Referral from Us before receiving services.

In these circumstances, You may be responsible for charges even if You have met Your Out-of-Pocket Maximum for the Contract Period.

EMERGENCY AND URGENT CARE

****Please refer to Your Schedule of Benefits for Copayment information on "Emergency Care" and "Urgent Care". ****

EMERGENCY CARE

If You need Emergency Care while You are inside the Service Area, please go to the nearest Participating Provider whenever possible. If You are unable to reach a Participating Provider, You should go to the nearest medical facility for help. Prior authorization is not required for Emergency Care services**.**

If You receive Emergency Care and are admitted as an inpatient after You receive Emergency Care, please contact Our Customer Service Department at (877) 908-6027 as soon as possible, but no later than 48 hours after receiving services.

Examples of situations for which Emergency Care is appropriate include, but are not limited to:

- Heart attack,
- Stroke,
- Loss of consciousness,
- Significant blood loss,
- Suffocation,
- Attempted suicide,
- Convulsions,
- Epileptic seizures,
- Acute allergic reactions,
- Acute asthmatic attacks,
- Acute hemorrhages,
- Acute appendicitis,
- Coma,
- Drug overdose,
- Any condition for which You are admitted to the Hospital as an inpatient from the emergency room.

Other Acute conditions are emergencies when these four elements exist:

- They require immediate medical care for Bodily Injury or Sickness.
- Symptoms are unexpected and severe enough to cause a person to seek medical help right away.
- Immediate care is secured.
- Diagnosis or the symptoms themselves show that immediate care was required.

If you receive covered Emergency Care services from a Non-Participating Provider, You will be responsible for any applicable Deductible, Coinsurance or Copayment amounts shown in the Schedule of Benefits. You will have no greater cost than if you received the Covered Service from a Participating Provider. Services provided for the treatment of criminal sexual assault are provided without Deductible or other cost-sharing.

Cost-sharing for Emergency Care services received from a Non-Participating Provider will count toward the Participating Provider Deductible and Out-of-Pocket Maximum amounts.

Should You be admitted to the Hospital as an inpatient, benefits will be paid as explained in the "Hospital Services" and "Physician Services" provisions in the "Medical Benefit Provisions" section of this Policy. If You are admitted to the Hospital as an inpatient immediately following Emergency Care, the emergency room Copayment, if applicable, will be waived.

URGENT CARE/CONVENIENT CARE/IMMEDIATE CARE

Urgent Care is care for a Bodily Injury or Sickness that You need sooner than a Routine doctor's visit. Examples of Urgent Care situations are broken bones, sprains, non-severe bleeding, minor cuts and burns, and drug reactions. Prior authorization is not required for Urgent Care services

Mercyhealth Urgent Care locations can be found at www.mercyhealthsystem.org. Other Urgent Care Participating Providers can be found at www.mercycarehealthplans.com.

If You are inside the Service Area, please go to the nearest Participating Provider whenever possible. If You are unable to reach a Participating Provider, You should go to the nearest medical facility for help.

If You require Urgent Care and You are outside the Service Area and cannot return home without medical harm, You should seek care from the nearest medical facility.

You will be responsible for any applicable Deductible, Coinsurance or Copayment amounts shown in the Schedule of Benefits. If you receive Covered Services from a Non-Participating Provider, You will have no greater cost than if you received the Covered Service from a Participating Provider.

Cost-sharing for Urgent Care services received from a Non-Participating Provider will count toward the Participating Provider Deductible and Out-of-Pocket Maximum amounts.

MEDICAL BENEFIT PROVISIONS

Members are entitled to these benefit provisions subject to the terms, conditions and exclusions of the Policy. MercyCare's determinations in the administration of the Plan, includes determinations as to whether services or supplies are Covered Services or are Medically Necessary Covered Services. Coverage is subject to any Copayment, Coinsurance, Deductible and/or other limits shown in the Schedule of Benefits.

AMBULATORY SURGICAL FACILITY

Benefits for Covered Services described in this Policy are available if rendered by an ambulatory surgical facility.

AMBULANCE SERVICES

Covered Services:

- Local transportation in a specially equipped certified vehicle from Your home, scene of accident or medical Emergency to a Hospital, between Hospital and Hospital, between Hospital and Skilled Nursing Facility or from a Skilled Nursing Facility or Hospital to Your home. If there are no facilities in the local area equipped to provide the care needed, Ambulance Transportation then means the transportation to the closest facility that can provide the necessary service.
- Air ambulance service is covered in an Emergency as described in the "Emergency and Urgent Care" section of this Policy.

Non-Covered Services:

- Ambulance service for long distance trips or for use of an ambulance because it is more convenient than other transportation.

AUTISM SPECTRUM DISORDER

Covered Services:

- Treatment for Autism Spectrum Disorder(s) shall include the following care when prescribed, provided or ordered for an individual under the age of 21, diagnosed with an Autism Spectrum Disorder by (a) Your Primary Care Provider or Woman's Principal Health Care Provider who has determined that such care is Medically Necessary, or (b) a certified, registered or licensed health care professional with expertise in treating effects of Autism Spectrum Disorder(s) and when the care is determined to be Medically Necessary. Services include:
    - Psychiatric care, including diagnostic services;
    - Psychological assessment and treatment;
    - Habilitative or Rehabilitative Services;
    - Therapeutic care, including behavioral occupational therapy, physical therapy and speech therapy that provide treatment in the following areas: a) self-care and feeding, b) pragmatic, receptive and expressive language, c) cognitive functioning, d) Applied

Behavior Analysis, intervention and modification, e) motor planning and f) sensory processing;
- Dental care and anesthetics provided by a dentist in a dental office, oral surgeon's office, Hospital, or ambulatory surgical treatment center for a Member under age 26 diagnosed with an Autism Spectrum Disorder.

BIOFEEDBACK

Biofeedback is covered only for treatment of headaches, spastic torticollis, urinary incontinence, and for the treatment of post-traumatic stress disorder when rendered by a behavioral health practitioner. Biofeedback services must be Prior Authorized by MercyCare.

BONE MASS MEASUREMENT AND OSTEOPOROSIS

Bone mass measurement and the diagnosis and treatment of osteoporosis are Covered Services under the Policy. Unless otherwise stated, benefits will be provided as described in the "Preventive Care Services" provision of this section of the Policy.

CARDIAC REHABILITATION

Cardiac rehabilitation is covered when Medically Necessary and when Prior Authorized by MercyCare.

Covered Services:
- Phase II cardiac rehabilitation must be provided in an outpatient department of a Hospital, in a medical center or in a clinic program. This benefit applies only to Members with a recent history of:
  - a heart attack;
  - coronary bypass surgery;
  - onset of angina pectoris;
  - heart valve surgery;
  - onset of decubital angina;
  - percutaneous transitional angioplasty;
  - cardiac transplant; or
  - Chronic heart failure defined as patients with left ventricular ejection fraction of 35% or less and New York Heart Association (NYHA) class II to IV symptoms despite being on optimal heart failure therapy for at least 6 weeks.
- Benefits are payable only for Members who begin an exercise program immediately, or as soon as medically indicated, following a Hospital Confinement for one of the conditions above.

Non-Covered Services:
- Maintenance or Long-Term Therapy.
- Behavioral or vocational counseling.
- Phase III cardiac rehabilitation.

CHIROPRACTIC SERVICES

Covered chiropractic services are limited as specified in the Schedule of Benefits.

Covered Services:

- Medically Necessary chiropractic services.

Non-Covered Services:

- Maintenance or Long-Term Therapy, as determined by Us after review of the Member's case history or treatment plan submitted by a provider

CONGENITAL HEART DISEASE SURGERIES

Covered Services:

- Congenital heart Disease (CHD) surgeries to treat conditions including, but not limited to, coarctation of the aorta, aortic stenosis, tetralogy of fallot, transposition of the great vessels and hypoplastic left or right heart syndrome.
    - Coverage under this subsection includes the facility charge and the charge for supplies and equipment.
    - Coverage for professional services is described in the "Physician Services" provision within this section of the Policy.
    - Surgery may be performed as open or closed surgical procedures or may be performed through interventional cardiac catheterization.

COSMETIC AND RECONSTRUCTIVE SURGERY

Covered Services:

- Coverage for the treatment of breast cancer includes:
    - Reconstruction of the breast on which a mastectomy was performed.
    - Inpatient coverage following a mastectomy for a length of time determined by the attending Physician to be Medically Necessary and in accordance with protocols and guidelines based on sound scientific evidence and upon evaluation of the patient and the coverage for and availability of a post-discharge Physician office visit or in- home nurse visit to verify the condition of the patient in the first 48 hours after discharge.
    - Surgery and reconstruction of the other breast to produce a symmetrical appearance.
    - Prosthesis and physical complications of all stages of mastectomy, including lymphedemas.
- Reconstructive surgery which is either:
    - Medically Necessary and incidental to or following surgery necessitated by Bodily Injury or Sickness, or
    - Caused by Congenital Disease or abnormality of a Dependent Child, which results in a functional defect, or
    - Resulting from accidental injuries, scars, tumors, or Diseases.
- Removal of breast implants when such removal is Medically Necessary for treatment of Sickness or Bodily Injury. However, removal of breast implants that were implanted solely for cosmetic reasons is not covered.

Non-Covered Services:

- Plastic or cosmetic surgery which is undertaken solely to improve the Member's appearance and which is not Medically Necessary for the correction of a functional defect caused by a Bodily Injury or Sickness. Psychological reasons do not represent a medical/surgical necessity.
- Excision of excessive skin, subcutaneous tissue, and/or fat, including but not limited to such surgery to the abdomen, thigh, leg, hop, buttock or arm (except when done as part of post-mastectomy reconstruction).
- Removal of breast implants that were implanted solely for cosmetic reasons.

DENTAL / ORAL SURGERY

Covered Services:

Treatment with Prior Authorization from MercyCare includes:

- Bodily Injury to permanent, Sound and Natural Teeth and bone, but only if:
    - The Bodily Injury occurs while You are a Member covered by the Plan; and
    - The Bodily Injury is not caused by chewing or biting; and
    - The treatment begins within 90 days of the Bodily Injury with a maximum of 180 days from the date of Bodily Injury to complete treatment.
- Consultation by an oral surgeon or appropriate specialist. Included with this would be the cost of X-rays or other diagnostic tests performed in conjunction with given evaluation.
- Covered procedures include:
    - Surgical removal of impacted wisdom teeth (third molars).
    - Excision of tumors or cysts from the jaws, cheeks, lips, tongue, roof or floor of the mouth.
    - Excision of exostoses of the jaws and hard palate (provided that this procedure is not done in preparation for dentures or other prostheses).
    - Treatment of fractures of the facial bones.
    - External incision and drainage of abscesses or cellulitis.
    - Incision or excision of accessory sinuses, salivary glands or ducts.
    - Surgical procedures to address Congenital deformities and conditions resulting from medical Disease or previous medical therapeutic processes affecting the jaws, cheeks, lips, tongue, roof or floor of the mouth.
    - Surgical procedures to correct accidental injuries of the jaws, cheeks, lips, tongue, roof or floor of the mouth.
    - Surgical treatment of accidental injuries to any teeth which had an intact root or were part of a permanent bridge, prior to the injury. This particular benefit covers complete restoration of the injured teeth.
    - Implants to support a dental prosthesis when an integral part of treatment for medical conditions as described above.
    - Any abutment or dental prosthesis resting on these implants is not covered, except to replace a tooth that had originally been injured, as described above.
    - Durable Medical Equipment or prosthetic appliances such as obturators or surgical splints are covered, when an integral part of treatment for conditions described above.
    - Anesthesia services administered at the same time as a covered surgical procedure, by oral and maxillofacial surgeons when such services are rendered in the surgeon's office or ambulatory surgical facility.

- Charges incurred for Hospital care and anesthesia that is provided in conjunction with dental care provided in a Hospital, ambulatory surgical treatment center, or by a certified anesthesiologist, if the Member:
  - Is a child age 6 or under;
  - Has a Chronic disability that arises from a mental or physical impairment or combination of mental or physical impairments; and is likely to continue indefinitely; and results in substantial functional limitations in one or more of the following areas of a major life activity: self-care, receptive and expressive language, learning, mobility, capacity of independent living, or economic self-sufficiency; or
  - Has a medical condition that requires Hospital Confinement or general anesthesia for dental care.
- For a Member under age 26 diagnosed with an Autism Spectrum Disorder, dental care and anesthetics provided by a dentist in a dental office, oral surgeon's office, Hospital, or ambulatory surgical treatment center.

Non-Covered Services:

- Oral surgery performed solely for the fitting of dentures or the restoration or correction of teeth.
- All services performed by a dentist or orthodontist, except those specifically listed in this Policy. These exclusions include, but are not limited to:
  - Dental implants.
  - Services (regardless of cause or complexity) provided for the care, treatment, removal, or replacement of teeth or structures directly supporting teeth (e.g., preparation of the mouth for dentures, removal of Diseased teeth in an infected jaw). Structures directly supporting the teeth mean the periodontium, which includes the gingivae, periodontal membrane, cementum of the teeth, and the alveolar bone (i.e. alveolar process and tooth sockets).
  - Shortening of the mandible or maxilla.
  - Correction of malocclusion.
  - Treatment for any jaw joint problems, other than temporomandibular disorders, including cranio-maxillary, craniomandibular disorder, or other conditions of the joint linking the jaw bone and skull.
  - Hospital costs for any of these services except as specifically described in the Policy.
  - Oral surgery except as specifically described in this Policy.
  - All periodontal procedures.
  - Any treatment for bruxism - including splint devices.
  - Braces or oral fixation devices.

DIABETES SERVICES

Covered Services:

- Self-management education programs, including medical nutrition therapy and education programs.
- For Members age 65 or older, diabetes counseling provided in the Member's home by licensed dietitian nutritionists and certified diabetes educators.
- Insulin pump if Prior Authorized and meets the medical criteria established by MercyCare.

- Diabetic equipment and supplies, including blood glucose monitors, blood glucose monitors for the legally blind, cartridges for the legally blind, lancets and lancing devices, syringes and needles, test strips for glucose monitors, and glucagon Emergency kits.
- Insulin and FDA approved oral agents used to control blood sugar from a Participating Pharmacy. **Note:** You will pay no more than $100 for a 30-day supply of covered prescription insulin. This does not include insulin that is administered to You intravenously. On January 1 of each year, this limit will increase by a percentage equal to the percentage change from the preceding year in the medical care component of the Consumer Price Index of the Bureau of Labor Statistics of the United States Department of Labor.
- Regular foot care exams by a Physician.

DURABLE MEDICAL EQUIPMENT AND MEDICAL SUPPLIES

Covered Services:
Durable Medical Equipment is covered only with Prior Authorization by MercyCare and when:

- Determined to be Medically Necessary, and
- Purchased at a participating DME provider or other provider authorized by MercyCare, and
- Ordered or prescribed by a Participating Provider, or a Non-Participating Provider with an active Referral approved by MercyCare, and
- Not generally available over the counter (OTC).

If more than one piece of DME can meet Your functional needs, Benefits are available only for the equipment that meets the minimum specifications for Your needs. If You rent or purchase a piece of DME that exceeds this guideline, You will be responsible for any cost difference between the piece You rent or purchase and the piece We have determined is the most cost-effective.

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).
- Delivery pumps for tube feedings (including tubing and connectors).
- Braces, including necessary adjustments to shoes to accommodate braces. Braces that stabilize an injured body part and braces to treat curvature of the spine are considered DME and are a Covered Health Service. Braces that straighten or change the shape of a body part are Orthotic Devices, and are covered. Dental braces are excluded from coverage.
- Prescription foot orthotics when the Member has a documented diagnosis of diabetes with neuropathy or peripheral vascular Disease.
- Mechanical equipment necessary for the treatment of Chronic or Acute respiratory failure (except that air-conditioners, humidifiers, dehumidifiers, air purifiers and filters, and personal comfort items are excluded from coverage).
- Burn garments.
- Insulin pumps and all related necessary supplies as described under Diabetes Services.
- External cochlear devices and systems. Benefits for cochlear implantation are provided under the applicable medical/surgical benefit categories in this Policy.

Benefits under this provision also include speech aid devices and tracheo-esophageal voice devices required for treatment of severe speech impediment or lack of speech directly attributed to a Sickness or Injury. Benefits for the purchase of speech aid devices and tracheo-esophageal voice devices are available only after completing a required three-month rental period.

Benefits under this provision do not include any device, appliance, pump (excluding an insulin pump), machine, stimulator, or monitor that is surgically implanted into the body.

We will decide if the equipment should be purchased or rented. Benefits are available for repairs and replacement, unless damage is due to misuse, malicious breakage or gross neglect. Benefits are not available to replace lost or stolen items.

Non-Covered Services:

- Durable medical equipment required for athletic performance and/or participation.
- Garments and/or other equipment and supplies that are not Medically Necessary to treat a covered Bodily Injury or Sickness.
- Replacement for lost or stolen items; or items damaged due to misuse, malicious breakage, or gross neglect.
- Physician equipment, home testing and monitoring equipment, including but not limited to blood pressure equipment, stethoscopes, otoscopes, equipment that tests for blood levels other than glucose, oxygen level monitoring equipment and equipment that may monitor other types of measures or values.
- Exercise or physical fitness equipment (examples: treadmills, exercise bikes, bicycles, foam roller, etc.).
- Any food, liquid or nutritional supplements including those prescribed by a Physician.
- Motorized vehicles or power operated vehicles, including but not limited to motorized scooters, except for motorized wheel chair when medically necessary.
- DME for comfort, personal hygiene or convenience, including but not limited to:

• Air conditioners • Air cleaners • Air purifiers • Air humidifiers • Air dehumidifiers • Alcohol wipes • Alternative communication devices (except as otherwise described as covered in this Policy) • Automobile modifications or lifts • Band-Aids • Baskets (for wheelchairs or walkers) • Bath benches • Bath chairs • Car seats	• Feeding aids • Grab bars • Grooming aids • Heating pads • Home bathtub spas • Home massage equipment • Home remodeling or modifications • Lamb's wool sheepskin padding • Lap trays not used for trunk support • Lumbar rolls or cushions • Massagers or Thera Cane • Non-medical self-help devices • Occipital release boards • Orthotic socks	• Pillows • Portable care or travel nebulizers • Raised toilet seats • Reaching aid • Safety equipment (e.g. gait belts, knee and elbow pads or safety glasses) • Shower chairs • Strollers • Stroller or wheelchair canopies • Toileting systems or lifts • Tongue depressors • Vaporizers • Vehicle transfer or safety tie down restraints • Wheelchair attendant

• Cervical pillows • Dressing sticks or aids • Diapers • Disposable gloves • Disposable undergarments • Eating utensils • Egg crate mattress pads • Electric patient lifts • Ergonomic chairs	• Oral hygiene products • Oral nutritional supplements or infant formula available OTC • OTC antibiotic ointments • OTC dressing supplies (e.g. 4X4 gauze, tape, betadine, etc.)	controls • Wheelchair backpacks or clips • Wheelchair swingaway, retractable or removable hardware when not needed for slide transfer • Wheelchair work or cut-out trays • Wigs

- Prescribed or non-prescribed Medical Supplies and disposable supplies. Examples include: elastic stockings, ace bandages, gauze and dressings, and urinary catheters. This exclusion does not apply to:
    - Disposable supplies necessary for the effective use of DME for which Benefits are provided in this Section.
    - Diabetic supplies for which Benefits are provided as described under Diabetes Services
    - Ostomy supplies for which Benefits are provided as described under Ostomy Supplies.
- Tubings and masks except when used with DME as described under this section.

EMERGENCY CARE

Please refer to the “Emergency and Urgent Care” section of this Policy.

GENETIC TESTING AND COUNSELING

Covered Services:
With Prior Authorization from Us, Genetic Testing is covered when:

- The test is not considered Experimental or Investigational, and
- The test is Medically Necessary, and
- The results will affect the course of Medically Necessary treatment.

With Prior Authorization from Us, Genetic Counseling is covered when:

- It is associated with a covered and approved test, or
- It is for the purpose of determining if a specific Genetic test is appropriate.

Non-Covered Services:

- Direct-to-consumer Genetic Testing.
- Paternity testing.
- Fetal sex determination.
- Genetic Testing of a non-Plan Member.
- Genetic Counseling that is associated with non-covered genetic tests.
- Genetic Testing when the results do not provide direct medical benefit to the Member.

HEARING EXAMS AND HEARING AIDS

Covered Services:

- Members under age 18
  - Hearing aids and hearing exams are covered when prescribed by a Participating Provider Physician or licensed audiologist;
  - New hearing aids are covered one per ear in a 24-month period.
  - Hearing aids must be obtained from a Participating Provider.
  - Reconditioning and repair of existing aids is covered when Medically Necessary.
  - Related services such as selection, fitting, and adjustment of ear molds to maintain optimal fit is covered when Medically Necessary.
- Members age 18 and older:
  - Hearing aids, including necessary parts, attachments, or accessories, and an ear mold obtained from a Participating Provider Physician, licensed audiologist, or licensed hearing aid dispenser.
  - Related services necessary to assess, select, and adjust or fit the hearing aid, including the audiological exam, replacement ear molds, and repairs.
  - Benefit is limited to $2,500 per aid every 24 months, for the aid and all related services.
- Bone anchored hearing aids (osseointegrated auditory implants).
- External cochlear devices and systems. Benefits for cochlear implantation are provided under the applicable medical/surgical benefit categories in this Policy.

Non-Covered Services:

- Expenses for hearing aids and related services for Members 18 years of age or older that exceed $2,500 per aid every 24 months.
- Hearing aids for Members under age 18 if more than one per ear in any 24-month period.

HOME HEALTH CARE

Home health care is covered with Prior Authorization, when the attending Physician certifies that:

- Confinement in a Hospital or Skilled Nursing Facility would be necessary if home care were not provided.
- Necessary care and treatment are not available from the Member's immediate family, or others living with the Member without causing undue hardship.
- The home health care services are provided and coordinated by a state licensed or Medicare certified home health agency or certified rehabilitation agency.

The attending Physician must establish a home health care plan, approve it in writing and review this plan at least every two months, unless the attending Physician determines that less frequent reviews are sufficient. If You were hospitalized immediately before the home health care services began, the Physician who was the primary provider of care during the Hospital Confinement must approve an initial home care plan.

Covered Services:

- The evaluation of the need for home care when approved or requested by the attending Physician.

- Home nursing care that is provided from time to time or on a part-time basis. It must be provided or supervised by a registered nurse.
- Physical, respiratory, occupational and speech therapy.
- Medical Supplies, drugs and medicines prescribed by a Physician and lab services by or from a Hospital. These services are covered to the same extent such items would be covered in the Policy if You were Confined to a Hospital.
- Nutritional counseling under the supervision of a registered or certified dietitian if considered Medically Necessary as part of the home care plan.

Non-Covered Services:
- Custodial Care

HOSPICE CARE

Covered Services:
- Hospice care services are covered with Prior Authorization and approval from Us if a Member's life expectancy is 1 year or less.
- The care is available on an intermittent basis with on-call services available on a 24-hour basis. It includes services provided in order to ease pain and make the Member as comfortable as possible.
- Hospice care must be provided through a licensed Hospice care provider approved by Us and cover:
    - Home health care
    - Medical Supplies and dressings
    - Medication
    - Nursing Services − Skilled and non-Skilled
    - Occupational therapy
    - Pain management services
    - Physical therapy
    - Physician visits
    - Social and spiritual services
    - Respite Care Service.

HOSPITAL SERVICES

Covered Services:
- Inpatient and outpatient Hospital services are covered when rendered by a Hospital or Free-Standing Surgical Facility and are Prior Authorized by MercyCare.
- Inpatient Hospital services include the following:
    - Daily room and board in a semi-private, ward, intensive care or coronary care room, including general nursing care if Medically Necessary. A private room will be covered if determined by MercyCare to be Medically Necessary.
    - Hospital services and supplies determined to be Medically Necessary furnished for Your treatment during Confinement, including drugs administered to You as an inpatient.
    - Inpatient Confinement days are covered when care is being directed by a provider and with authorization from MercyCare.

    - Rehabilitation Services
- Partial hospitalization benefits are available if treatment is a MercyCare approved program
- Preadmission Testing
    - Benefits are provided for preoperative tests given to You as an Outpatient to prepare You for Surgery which You are scheduled to have as an inpatient, provided that benefits would have been available to You had You received these tests as an inpatient in a Hospital. Benefits will not be provided if You cancel or postpone the Surgery.
    - These tests are considered part of Your inpatient Hospital surgical stay.
- Outpatient Hospital services include services and supplies, including drugs, when incurred for the following:
    - Emergency room treatment provided in accordance with the "Emergency Care" provision of this section of the Policy.
    - Surgical day care.
    - Regularly scheduled treatment such as chemotherapy, inhalation therapy, and radiation therapy.
    - Diagnostic testing which includes laboratory, x-ray and other diagnostic testing.

Non-Covered Services:

- Inpatient Hospital services for days that are NOT authorized by MercyCare as being Medically Necessary.
- Continued Hospital stay(s), if a Participating Provider has documented that care could effectively be provided in a less acute care setting.
- Take-home drugs dispensed prior to Your release from Confinement, whether billed directly or separately by the Hospital.
- Inpatient and outpatient Hospital services for non-covered treatment.
- Durable medical equipment. Please see the "Durable Medical Equipment" provision in this section of the Policy.

KIDNEY DISEASE TREATMENT

Kidney Disease treatment is limited to all inpatient and outpatient services provided. This benefit is limited to all services and supplies directly related to kidney Disease, including but not limited to, dialysis, transplantation, donor-related services, and related Physician charges.

MASSAGE THERAPY

Massage Therapy to treat muscle pain or dysfunction is covered when provided by licensed Health Care Provider or under the direct supervision of a licensed Health Care Provider, limited to 2 massages per year.

MENTAL HEALTH AND SUBSTANCE USE DISORDER TREATMENT

Covered Services are the same as those provided for any other condition, as specified in the other benefit sections of this Policy. Services are covered if rendered by a provider licensed or certified under the statutes of Illinois and in accordance with accepted principles of their profession.

Outpatient Treatment
Treatment received while not Confined to a Hospital or Qualified Treatment Facility.

Inpatient Treatment
Treatment received while Confined as a registered bed patient in a Hospital or Qualified Treatment Facility.

Residential Treatment
Treatment received while Confined in a licensed Residential Treatment Facility.

Partial Hospitalization Treatment Program
Therapeutic treatment program in a Hospital for patients with Mental Illness and Substance Use Disorder.

Intensive Outpatient Treatment Program
A Hospital-based program that provides services for at least three hours per day, two or more days per week, to treat Mental Illness or Substance Use Disorders or specializes in the treatment of co-occurring Mental Illness and Substance Use Disorders. Dual diagnosis programs offer integrated and aligned assessment, treatment and discharge planning services for treatment of severe or complex co-occurring conditions which make it unlikely that You will benefit from programs that focus solely on Mental Illness conditions. Dual diagnosis programs are delivered by behavioral health practitioners who are cross-trained.

Intensive Outpatient Program services may be available with less intensity if You are recovering from severe and/or Mental Illness and/or Substance Use Disorder conditions. If You are recovering from severe and/or Chronic Mental Illness and/or Substance Use Disorder conditions, services may include psychotherapy, pharmacotherapy, and other interventions aimed at supporting recovery such as the development of recovery plans and advance directives, strategies for identifying and managing early warning signs of relapse, development of self-management skills, and the provision of peer support services.

Psychiatric Collaborative Care Model Services
An evidence-based, integrated behavior health service delivery method that includes a formal collaborative arrangement among the primary care team consisting of a PCP, a care manager, and a psychiatric consultant including, but not limited to the following elements:

- Care directed by the primary care team;
- Structured care management;
- Regular assessments of clinical status using validated tools; and
- Modification of treatment as appropriate.

Detoxification
Benefits for Covered Services received for detoxification will be provided under the “Hospital Services” and “Physician Services” provisions in this section of this Policy, as for any other condition. Covered Services received for detoxification are not subject to the Substance Use Disorder treatment provisions specified above.

Prescription Drugs
Prescription Drug charges used for the outpatient treatment of Mental Illness, Serious Mental Illness, and Substance Use Disorder will be covered based on Your Prescription Drug benefit.

Substance Use Disorder Treatment
Acute Treatment Services: 24-hour medically supervised addiction treatment that provides evaluation and withdrawal management and may include biopsychosocial assessment, individual & group counseling, psychoeducational groups, and discharge planning.

Clinical Stabilization Services: 24-hour treatment, usually following Acute treatment services for substance abuse, which may include intensive education and counseling regarding the nature of addiction and its consequences, relapse prevention, outreach to families & significant others, and aftercare planning for individuals beginning to engage in recovery from addiction.

Covered Services:
- Medically Necessary treatment as described above, including psychological testing and neuropsychological testing, of Mental Illness and/or Substance Use Disorder.
- Court ordered mental health and/or Substance Use Disorders services are covered, if provided by a provider to whom the Plan has issued a Referral.
- Services rendered pursuant to an emergency detention situation are covered, when rendered by any provider as long as the Plan has been notified within 72-hours so that continuing care may be arranged.
- Medically Necessary services provided though a Psychiatry Collaborative Care Model for services billed in accordance with 215 ILCS 356z.33.
- Family therapy is covered only if the diagnosed Member is present at the family therapy session.
- Services are covered if rendered by a Physician licensed to practice medicine in all its branches, licensed clinical Psychologist, licensed clinical social worker, or licensed clinical professional counselor if the condition or disorder is covered by the Policy, and the providers are authorized to provide said services under the statutes of Illinois and in accordance with accepted principles of their professions.

Non-Covered Services:
- Maintenance or Long-Term Therapy.
- Biofeedback, except that provided by a licensed healthcare provider for treatment of headaches, spastic torticollis and urinary incontinence, or by a behavioral health practitioner for the treatment of post-traumatic stress disorder.
- Hypnotherapy, marriage counseling.
- In-home treatment services, except those for treatment of autism with Prior Authorization.
- Halfway houses, supervised living, group homes, boarding houses or other facilities that provide primarily a supportive environment and that address long term social needs.
- Custodial or Respite Care.
- Travel time for Qualified Providers, supervising providers, professionals, therapists or paraprofessionals.
- Chelation therapy.
- Child care fees.
- Hyperbaric oxygen therapy.

- Special diets or supplements.
- Treatment provided by parents or legal guardians.
- Wilderness treatment programs or any related or similar program, school, and/or education service.

NEWBORN CARE

Covered Services:

- Newborn benefits include the following services when received or authorized by the newborn's Primary Care Physician:
    - Nursery room, board, and care.
    - Routine or Preventive exam and other Routine or Preventive professional services when received by the newborn child before release from the Hospital.
    - Circumcisions when rendered prior to discharge from the Hospital.
    - Plastic surgery performed to reconstruct or restore function to a body part with a functional defect present at birth.
    - Well-child care rendered after release from the Hospital.

A Primary Care Provider should be chosen for the newborn before delivery so that the chosen Physician can be notified upon delivery.

PHYSICAL, SPEECH, OCCUPATIONAL AND PULMONARY THERAPY

Covered Services:

- Outpatient Habilitative and Rehabilitative Services, including physical therapy, speech therapy, occupational therapy and pulmonary Rehabilitation, are covered when rendered by a Participating Provider. See Your Schedule of Benefits for the limits that apply separately to Habilitative and Rehabilitative Services.
- Therapy must be necessitated by a medical condition and not be primarily educational in nature.
- Covered Services are limited to therapy which is expected to result in significant improvement within two months in the condition for which it is rendered, except as specifically provided for (a) under the Autism Spectrum Disorder(s) provision and the plan must be established before treatment is begun and must relate to the type, amount, frequency and duration of the therapy and indicate the diagnosis and anticipated goals, or (b) prescribed as preventive or maintenance physical therapy for Members affected by multiple sclerosis, or (c) a child under 19 years of age diagnosed by a Physician with a Congenital, Genetic or Early Acquired Disorder for Medically Necessary and therapeutic and not Experimental or Investigational.
- Provider must be a licensed physical, occupational, pulmonary or speech therapist and must not live in the patient's home or be a family member.
- Providers for Habilitative Services for children with a Congenital, genetic, or Early Acquired Disorder must be a licensed physical, occupational, pulmonary or speech therapist and licensed nurse, licensed audiologist, licensed optometrist, licensed nutritionist, licensed social worker and licensed Psychologist and must not live in the patient's home or be a family member.
- Medically Necessary Preventive Physical Therapy for insureds diagnosed with multiple sclerosis. For the purposes of this provision. "Preventive Physical Therapy" means physical

therapy that is prescribed by a Physician licensed to practice medicine in all of its branches for the purpose of treating parts of the body affected by multiple sclerosis, but only where the physical therapy includes reasonably defined goals, including, but not limited to, sustaining the level of function the person has achieved, with periodic evaluation of the efficacy of the physical therapy against those goals. The coverage required under this provision shall be subject to the same Deductible, Coinsurance, cost- sharing limitation, treatment limitation, Contract Period maximum, or other limitations as provided for other physical or Rehabilitative Therapy benefits covered by the Policy.

Non-Covered Services:

- Any form of therapy or treatment for learning or developmental disabilities, including: hearing therapy for a learning disability and communication delay; therapy for perceptual disorders, mental retardation and related conditions; evaluation and therapy for behavior disorders; special evaluation and treatment of multiple disabilities, hyperactivity, or sensory deficit and motor dysfunction; developmental and neuro-educational testing or treatment; and other special therapy except as specifically listed in this Policy.
- Vocational testing and counseling, including evaluation and treatment and work hardening programs.
- Special education therapy such as music therapy, animal therapy including hippotherapy, or recreational therapy, except as specifically provided for in this Policy.
- Speech and hearing screening examinations are limited to the Routine or Preventive screening tests performed by a provider for determining the need for correction.
- Maintenance or Long-Term Therapy and any maintenance or therapy program that consists of activities that preserve the patient's present level of function and prevent regression of that function, except as specifically provided for in this Policy.

PHYSICIAN SERVICES

Covered Services:
Physician services include in office services; Routine or Preventive physicals; inpatient and outpatient visits; and home visits.

Non-Covered Services:
Any services and/or supplies given primarily at the request of, for the protection of, or to meet the requirements of a party other than the Member, when such services and/or supplies are not otherwise Medically Necessary or appropriate, unless the services and/or supplies are state-mandated.

Excluded services and supplies include physical exams, immunizations, and other services and supplies required for employment (including travel for employment), licensing, marriage, adoption, insurance, camp, school, and sports.

PODIATRY SERVICES

Covered Services:

- Medically Necessary examinations.

Non-Covered Services:
The following services are not covered except when prescribed by a provider who is treating a Member for diabetes or peripheral vascular Disease:

- Services rendered in the examination, treatment or removal of all or part of corns, calluses, hypertrophy or hyperplasia of the skin or subcutaneous tissues of the feet.
- Services related to the cutting, trimming or other non-operative partial removal of toenails.
- Treatment of flexible flat feet.

PREGNANCY CARE

Pregnancy care is covered for a Subscriber, a Subscriber's covered Dependent spouse, or a Subscriber's covered Dependent child.

Covered Services:

- Pre- and post-natal care, including pre-natal HIV testing ordered by an attending Physician, physician assistant, or advance practice registered nurse.
- Inpatient Hospital care as follows:
    - A minimum of 48 hours of inpatient care following a vaginal delivery for the mother and the newborn,
    - A minimum of 96 hours of inpatient care following a delivery by caesarian section for the mother and newborn.

  Important Note: A shorter length of Hospital inpatient stay for services related to maternity and newborn care may be provided if the attending Physician determines, in accordance with the protocols and guidelines developed by the American College of Obstetricians and Gynecologists or the American Academy of Pediatrics, that the mother and the newborn meet the appropriate guidelines for that length of stay based upon evaluation of the mother and newborn and the coverage and availability of a post-discharge Physician office visit or in-home nurse visit to verify the condition of the infant in the first 48 hours after discharge.
- Abortion services for non-elective and elective abortions.

Non-Covered Services:

- Surrogate mother services, except, medical expenses incurred by a surrogate for Infertility related services will be covered.
- Maternity services received out of the Service Area in the last 30 days of pregnancy without Prior Authorization from the Us except in an emergency. Prior Authorization is based on Medical Necessity.
- Amniocentesis or chorionic villi sampling (CVS) solely for sex determination.

PREVENTIVE CARE SERVICES

In addition to the benefits otherwise provided in this Policy, (and notwithstanding anything in Your Policy to the contrary), the following preventive care services will be considered Covered Services to the extent required by law when ordered by Your Participating Primary Care Provider or Woman's Principal Health Care Provider and will not be subject to any Deductible, Coinsurance, Copayment or benefit dollar maximum:

- Evidence-based items or services that have in effect a rating of “A” or “B” in the current recommendations of the United States Preventive Services Task Force (USPSTF);
- Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (CDC) with respect to the individual involved;
- For infants, children and adolescents, evidenced-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA); and
- For women, additional preventive care and screenings recommended in comprehensive guidelines supported by the HRSA.

The preventive care services described in this provision may change as USPSTF, CDC and HRSA guidelines are modified.

More information about the preventive services coverage required under the Patient Protection and Affordable Care Act can be found at https://www.healthcare.gov/coverage/preventive-care-benefits/.

If a recommendation or guideline for a particular preventive health service does not specify the frequency, method, treatment or setting in which it must be provided, We may use reasonable medical management techniques to determine coverage.

If a covered preventive health service is provided during an office visit and is billed separately from the office visit, You may be responsible for cost-sharing for the office visit only. If an office visit and the preventive health service are billed together and the primary purpose of the visit was not the preventive health service, You may be responsible for cost-sharing for the office visit including the preventive health service.

Some laboratory or diagnostic studies may be subject to a Deductible and/or Coinsurance if We determine they are not part of a Preventive examination. When a Member has symptoms or a history of a Sickness or Bodily Injury, laboratory or diagnostic studies relating to that Sickness or Bodily Injury are no longer considered part of a Preventive visit.

Preventive Care Services for Adults:

- Abdominal aortic aneurysm screening for men who have ever smoked;
- Alcohol misuse screening and counseling;
- Aspirin use for men and women of certain ages;
- Blood pressure screening;
- Cholesterol screening for adults of certain ages or at higher risk;
- Colorectal cancer screening for adults over age 50;
- Depression screening;
- Diabetes (Type 2) screening for adults with high blood pressure;
- Diet and physical activity counseling for adults at higher risk for Chronic Disease (e.g. cardiovascular Disease);
- Falls prevention exercise or physical therapy and vitamin D supplementation to prevent falls in community-dwelling adults age 65 years and older who are at increased risk for falls;
- Hepatitis B screening for all adults with high risk for infection;
- HIV screening for everyone ages 15 to 65 and other ages at increased risk;

- Pre-exposure Prophylaxis (PrEP) antiviral therapy for the prevention of HIV infection for individuals at high risk of infection, as well as HIV baseline and monitoring services essential to the efficacy of PrEP, as specified by the USPSTF.
- The following immunization vaccines for adults (doses, recommended ages, and recommended populations vary):
    - Hepatitis A
    - Hepatitis B
    - Herpes Zoster
    - Human papillomavirus
    - Influenza (Flu shot)
    - Haemophilus influenzae type b (HIB)
    - Measles, Mumps, Rubella
    - Meningococcal
    - Pneumococcal
    - Tetanus, Diphtheria, Pertussis
    - Varicella
- Annual lung cancer screening for adults 50 to 80 years who have a 20 pack-year smoking history and currently smoke or have quit within the past 15 years;
- Obesity screening and counseling;
- Sexually transmitted infections (STI) prevention counseling for adults at high risk;
- Skin cancer behavioral counseling for fair skin adults under age 25;
- Tobacco Use Cessation Program for Tobacco Users 18 years and older;
- Syphilis screening for adults at higher risk;
- Tuberculin screening for adults at higher risk;
- Hepatitis C virus (HCV) screening for persons at high risk for infection;
- One-time HCV screening for adults born between 1945 and 1965; and
- Statin preventive medication for adults 40 to 75 years with no history of cardiovascular Diseases (CVD), 1 or more CVD risk factors, and a calculated 10-year CVD event risk of 10% or greater determined by a universal lipids screening.

Preventive Care Services for Men

- One-time screening for abdominal aortic aneurysm by ultrasonography in men ages 65 to 75 years who have ever smoked.

Preventive Care Services for Women (including pregnant women):

- Anemia screening on a routine basis for pregnant women;
- Aspirin use for women after 12 weeks gestation with high risk for preeclampsia;
- Bacteriuria urinary tract screening or other infection screening for pregnant women;
- BRCA counseling about Genetic Testing and counseling for women at higher risk;
- Breast cancer mammography screenings as follows:
    - Age 35-39: 1 baseline mammogram;
    - Age 40 and over, annually.
    - Mammography examinations including breast tomosynthesis and screening MRI for women of any age if such exams are deemed Medically Necessary by a Health Care Provider.

    - Includes a comprehensive ultrasound screening of an entire breast or breasts if a mammogram demonstrates heterogeneous or dense breast tissue, when Medically Necessary as determined by a Physician.
    - These services are covered at no cost to the You, except the Deductible apples if Your Schedule of Benefits indicates that Your Plan is a high deductible health plan (HDHP).
- Breast cancer medication prevention counseling for women at higher risk;
- Breast feeding comprehensive support and counseling from trained providers, as well as access to breastfeeding supplies and equipment including breast pumps, for pregnant and nursing women;
- Cervical cancer screening;
- Chlamydia infection screening for younger women and women at higher risk;
- Contraception: FDA-approved contraceptive; methods, sterilization procedures, and patient education and counseling;
- Domestic and interpersonal violence screening and counseling for all women;
- Folic acid supplements for women who may become pregnant;
- Gestational diabetes screening for women after 24 weeks pregnant and those at high risk of developing gestational diabetes;
- Gonorrhea screening for all women at higher risk;
- Hepatitis B screening for pregnant women at their first prenatal visit;
- HIV screening and counseling for sexually active women and prenatal HIV testing;
- Human papillomavirus (HPV) DNA test: high risk HPV DNA testing every 3 years for women with normal cytology results who are age 30 or older;
- Low-dose aspirin as preventive medication after 12 weeks of gestation in women who are at high risk for preeclampsia;
- Osteoporosis screening for women over age 60, depending on risk factors;
- Preeclampsia screening;
- Rh incompatibility screening for all pregnant women and follow-up testing for women at higher risk;
- Tobacco Use Cessation Program for all women, and expanded counseling for pregnant Tobacco Users;
- Sexually transmitted infections (STI) counseling for sexually active women;
- Syphilis screening for all pregnant women or other women at increased risk;
- Well-woman visits to obtain recommended preventive services; and
- Intrauterine device (IUD) services related to follow-up and management of side effects, counseling for continued adherence and device removal.

Preventive Care Services for Children:

- Alcohol and drug use assessment for adolescents;
- Autism screening for children at 18 and 24 months;
- Behavioral assessments for children of all ages;
- Blood pressure screenings for children of all ages;
- Cervical dysplasia screening for sexually active females;
- Congenital hypothyroidism screening for newborns;
- Dental caries prevention with fluoride treatments for children under age 6;
- Depression screening for adolescents;
- Development screening for children under age 3, and surveillance throughout childhood;
- Dyslipidemia screening for children of all ages;

- Ocular topical medication for all newborns for gonococcal ophthalmia neonatorum;
- Hearing loss screening for all newborns;
- Height, weight, and body mass measurements children of all ages;
- Hemoglobin screening for all children;
- Hemoglobinopathies or sickle cell screening for all newborns;
- Hepatitis B screening for adolescents at high risk;
- HIV screening for adolescents at higher risk;
- The following immunization vaccines for children from birth to age 18 (doses, recommended ages, and recommended populations vary):
    - Hepatitis A
    - Hepatitis B
    - Hepatitis C virus (HCV)
    - Human papillomavirus
    - Influenza (Flu shot)
    - Measles, Mumps, Rubella
    - Meningococcal
    - Pneumococcal
    - Tetanus, Diphtheria, Pertussis
    - Varicella
    - Haemophilus influenza type b
    - Rotavirus
    - Inactivated Poliovirus Vaccine
    - Any other immunization that is required by law for a child. Allergy injections are not considered immunizations under this benefit provision.
- Iron supplements for children ages 6 to 12 months at risk for anemia;
- Lead screening for children at risk for exposure;
- Medical history for all children throughout development;
- Obesity screening and counseling;
- Oral health risk assessment for younger children up to ten years old;
- Phenylketonuria (PKU) screening for newborns;
- Sexually transmitted infections (STI) prevention and counseling for adolescents at higher risk;
- Skin cancer behavioral counseling for fair skin children birth to age 18;
- Tuberculin testing for children at higher risk of tuberculosis;
- Tobacco use education and counseling;
- Vision screening for all children; and
- Any other immunization that is required by law for a child. Allergy injections are not considered immunizations under this benefit provision.

PRIVATE DUTY NURSING SERVICES—OUTPATIENT

Outpatient Private Duty Nursing services are covered when provided to You in Your home only when the services are of such a nature that they cannot be provided by non-professional personnel and can only be provided by a licensed Health Care Provider. No benefits will be provided when a nurse ordinarily resides in Your home or is a member of Your immediate family.

Outpatient Private Duty Nursing includes teaching and monitoring of complex care skills such as tracheotomy suctioning, medical equipment use and monitoring to home caregivers and is not intended to provide for long term supportive care. Benefits for outpatient Private Duty Nursing services will not be provided when the need for such services is due to the lack of willing or available non-professional individuals.

PROSTHETIC AND ORTHOTIC DEVICES

Prosthetic and Covered Orthotic Devices require Prior Authorization.

Covered Services:

- Replacement of natural or artificial limbs and eyes no longer functional due to physiological change or malfunction beyond repair, if Medically Necessary.
- Adjustments, repairs and replacements of covered devices, appliances and implants needed due to wear or a change in Your condition.
- Medically Necessary Orthotic Devices when obtained by a Participating Provider.
- Prescription custom molded foot orthotics are covered only when the Member has a documented diagnosis of diabetes with neuropathy or peripheral vascular Disease. Benefits are limited to a maximum of two orthotics or one pair of orthotics per Contract Period.

Non-Covered Services:

- Equipment, models, or devices which have features over and above those which are Medically Necessary for the Member. Coverage is limited to the standard model as determined by Us.
- Dental appliances.
- The replacement of covered cataract lenses unless a prescription change is required.

REPRODUCTIVE/INFERTILITY SERVICES

Covered Services:

- The diagnosis and treatment of Infertility including, but not limited to:
    - Uterine embryo lavage.
    - Embryo transfer.
    - Artificial insemination.
    - Low tubal ovum transfer.
    - In vitro fertilization, gamete intra-fallopian tube transfer, zygote intra-fallopian tube transfer, and intracytoplasmic sperm injection if:
        - The Member has been unable to attain or sustain a successful pregnancy through reasonable, less costly medically appropriate Infertility treatments for which coverage is available under the Plan;
        - The procedures are performed at medical facilities that conform to the American College of Obstetrics and Gynecology guidelines for in vitro fertilization clinics or to the American Fertility Society minimal standards for programs of in vitro fertilization.
    - For treatment that involves oocyte retrievals, up to four completed oocyte retrievals, except that if a live birth follows a completed oocyte retrieval, then two more completed oocyte retrievals shall be covered per Contract Period.

- Standard Fertility Preservation Services when Medically Necessary treatment is planned that may directly or indirectly cause iatrogenic Infertility to a Member, such as cancer treatment or other gonadotoxic therapies. Fertility preservation involves the creation of embryos or the retrieval of eggs and sperm that are frozen for future use.

Non-Covered Services:

- Reversal of tubal ligation or vasectomy.
- Medical services rendered to a surrogate for purposes of childbirth; however, medical expenses incurred by a surrogate for Infertility related services will be covered.
- Costs of preserving and storing sperm, eggs and embryos, except Standard Fertility Preservation Services when Medically Necessary treatment is planned that may directly or indirectly cause iatrogenic Infertility to a Member.
- Costs for an egg or sperm donor which are not Medically Necessary, including any fees paid to the donor for non-medical services.
- Oocyte retrievals which are in excess of six retrievals per Contract Period.
- Experimental treatments.

SKILLED NURSING FACILITY

Your Primary Care Provider must certify that Your Skilled Nursing Facility Confinement is Medically Necessary for care or treatment of the Bodily Injury or Sickness that caused the Hospital Confinement. Skilled Nursing Facility services require Prior Authorization from Us and We must consider the services to be at a skilled level of care and Medically Necessary.

Covered Services:

- Charges for daily room and board and general nursing services provided during a Skilled Nursing Facility Confinement if You entered the facility within 24 hours after discharge from a covered Hospital Confinement for continued treatment of the same condition. Confinement in a swing bed in a Hospital is considered the same as a Skilled Nursing Facility.
- Habilitative and rehabilitative physical therapy, occupational therapy, speech therapy; and Durable Medical Equipment if Medically Necessary.

Non-Covered Services:

- Custodial Care.

SURGICAL SERVICES

Covered Services:

- Surgical procedures required to treat a Bodily Injury or Disease when performed by a Physician, dentist or podiatrist or other Health Care Provider acting within the scope of his/her license. Includes:
    - Surgery for morbid obesity including, but not limited to, bariatric surgery; and
    - Elective sterilization procedures. Coverage for such procedures is provided at no cost to You, except that Deductible does apply for vasectomies if Your Schedule of Benefits indicates that Your Plan is a high deductible health plan (HDHP).

- Anesthesia administered by a Physician, dentist or podiatrist other than the operating surgeon, or by a certified registered nurse anesthetist, in connection with a covered surgical procedure.
- Services provided by an assistant surgeon that is a Physician, dentist or podiatrist who actively assists the operating surgeon in the performance of a covered surgical procedure.
- Additional surgical opinion following a recommendation for elective surgery. Benefits are limited to one consultation by a Physician and any related diagnostic service.

See the "Dental / Oral Surgery" provision in this section for information regarding covered oral surgery and anesthesia services related to dental care.

TELEHEALTH SERVICES

Your Plan provides coverage for Telehealth Services, including Virtual Visits and Virtual Check-Ins, rendered by a Health Care Provider when clinically appropriate and Medically Necessary for the Member.

Telehealth Services are covered in the same manner as any other benefits covered under the Policy. We will pay benefits as if the service was delivered via an in-person encounter based on the service provided and the type of provider that renders the service.

Not all conditions can be addressed via a Virtual Visit. If the Health Care Provider cannot provide the care that You need through a Virtual Visit, he or she may refer You to a more appropriate setting for diagnosis or treatment. Cost-sharing will apply to the Virtual Visit, even if the provider refers You to another care setting.

TEMPOROMANDIBULAR DISORDERS

Covered Services:
Diagnostic procedures and Medically Necessary surgical and non-surgical treatment for the correction of temporomandibular disorders (TMJ), including prescribed intraoral splint therapy devices, are covered if all of the following apply:

- All Temporomandibular related services, including evaluation, must be authorized prior to the Member's receipt of any such services.
- The condition must have been caused by Congenital, developmental or acquired deformity, Sickness or Bodily Injury.
- Under the accepted standards of the profession of the Health Care Provider rendering the service, the procedure or device is reasonable and appropriate for the diagnosis or treatment of this condition.
- The purpose of the procedure or device is to control or eliminate infection, pain, Disease or dysfunction.

Non-Covered Services:

- Cosmetic or elective orthodontic care, periodontal care, or general dental care.

TRANSPLANTS

All transplant-related services, including evaluation, must be Prior Authorized prior to Your receipt of any such services. Services must be performed at a facility approved by Us.

Benefits will be provided for both the recipient of the organ or tissue and the donor subject to the following rules:

- If both the donor and recipient have coverage with MercyCare, each will have his/her expenses paid by his or her own insurance coverage.
- If You are the recipient and Your donor does not have coverage from any other source, this Policy will provide benefits for both You and Your donor. The benefits provided for Your donor will be charged against Your coverage under this Policy.
- If You are the donor and coverage is not available to You from any other source, this Policy will provide benefits for Your Covered Expenses. However, benefits will not be provided for the recipient.

See also the “Kidney Disease Treatment” provision in this section of the Policy.

Covered Services:

- Organ and tissue transplant surgery, limited to those procedures that are considered by Us to be Medically Necessary and effective. Coverage may be denied for procedures that are determined to be Experimental or Investigational if such determination is supported by the Office of Health Care Technology Assessment within the Agency for Health Care Policy and Research within the federal Department of Health and Human Services, or if the Office of Health Care Technology determines that there is insufficient data or experience to determine whether an organ transplantation procedure is clinically acceptable.
- All of the benefits described in the other benefit sections of this Policy are available for organ or tissue transplant surgery.
- Services related to the procurement of transplant organs, including surgical removal procedures, storage and transportation of the procured organ to the location of the transplant surgery, limited to transportation in the United States or Canada.
- Donor screening and identification costs under approved matched unrelated donor programs. Benefits for Covered Services received will be the same as that specified in those benefit sections.
- Immunosuppressive drugs
    - When a prescribing Participating Provider has indicated on a prescription "may not substitute" for immunosuppressant drugs, We will not require the interchange of another immunosuppressant drug or formulation without notification and the documented consent of the prescribing Participating Provider and the Member, or the parent or guardian if the Member is a child, or the spouse of a patient who is authorized to consent to the treatment of the person.
    - Should We make a Formulary change that would alter coverage for a Member receiving immunosuppressant drugs, We will notify the prescribing Participating Provider and the Member, or the parent or guardian if the patient is a child, or the spouse of the Member who is authorized to consent to the treatment of the patient at least 60 days prior to such change. The notification shall be in writing and shall disclose the Formulary

change, indicate that the prescribing Participating Provider may initiate an appeal, and include information regarding the procedure for the prescribing Physician to initiate the Policy appeal process.

- Transportation and lodging for You and a companion whenever a heart, lung, heart/lung, liver, pancreas or pancreas/kidney transplant is recommended by the transplant recipient's Physician and approved by MercyCare. If the recipient of the transplant is a Dependent Child under the limiting age of this Policy, benefits for transportation and lodging will be provided for the transplant recipient and two companions. All of the following apply:
    - For benefits to be available, the transplant recipient must reside more than 50 miles from the Hospital where the transplant will be performed.
    - Benefits for transportation and lodging are limited to a combined maximum of $10,000 per transplant.
    - The maximum amount that will be provided for lodging is $50 per person per day.

Non-Covered Services:

- Procedures involving non-human and artificial organs.
- Organ transplants, and/or services or supplies rendered in connection with an organ transplant, which are Investigational as determined by the appropriate technological body.
- Transplant services from providers and/or facilities not approved by Us.
- Transplants and all related expenses that have not been Prior Authorized by MercyCare.
- Drugs which are investigational.
- Retransplantation (except for kidney transplants).
- Purchase price of bone marrow, organ, or tissue that is sold rather than donated.
- Storage fees.
- Services provided to any Member who is not the recipient or actual donor, unless otherwise specified in this provision.
- Travel time or related expenses incurred by a Provider.
- Meals.
- Storage and collection fees for cord blood and stem cells for possible and/or indefinite or undetermined need for transplant.

URGENT CARE

Please refer to the "Emergency and Urgent Care" section of this Policy.

VISION CARE

Covered Services:

For all Members:

- Medical eye examinations provided as part of the treatment for pathological conditions when rendered by or at the direction of a Participating Provider.
- Initial eyeglasses or contact lenses are covered only after cataract surgery if purchased from a Participating Provider.

For Children under the age of 19, the following services as limited by the Schedule of Benefits:

- Routine or Preventive eye exams, including refraction to detect vision impairment, when performed by a participating ophthalmologist or licensed optometrist.
- Prescription glasses (including lenses and frames) or contact lenses.

Non-Covered Services:

- Eyeglass frames, lenses, or contact lenses for Members age 19 or older, except for initial eyeglasses or contact lenses after cataract surgery.
- Tints, polishing or other lens treatments done for cosmetic purposes only.
- Vision therapy or orthoptics treatment.
- Keratorefractive eye surgery, including tangential or radial keratotomy.

X-RAY, LABORATORY AND DIAGNOSTIC SERVICES

Covered Services:

- Inpatient and outpatient diagnostic x-ray, laboratory and diagnostic tests.
- Clinical breast examinations:
  - At least every 3 years for women ages 20-39; and
  - Annually for women age 40 or older.
- Breast cancer mammography screenings as follows:
  - Age 35-39: 1 baseline mammogram;
  - Age 40 and over, annually;
  - Mammography examinations including breast tomosynthesis and screening MRI for women of any age if such exams are deemed Medically Necessary by a Health Care Provider; and
  - Comprehensive ultrasound screening of an entire breast or breasts if a mammogram demonstrates heterogeneous or dense breast tissue, when Medically Necessary as determined by a Physician.
- Annual cervical smear or Pap smear test for female Members.
- Surveillance tests for ovarian cancer for women at risk for ovarian cancer.
- An annual digital rectal examination and a prostate-specific antigen test, for asymptomatic men age 50 and over when recommended by a provider; African-American men age 40 and over; and men age 40 and over with a family history of prostate cancer.
- Colorectal cancer screening with sigmoidoscopy or fecal occult blood testing once every 3 years for persons age 50 and over, and once every 3 years for persons age 30 and over and who may be classified as high risk for colorectal cancer because the person or a first-degree family Member of the person has a history of colorectal cancer.

OTHER MEDICAL SERVICES

Covered Services:

- The administration of blood and blood products including blood extracts or derivatives and autologous donations (self to self).
- Cancer therapy except when Experimental or Investigational. The exception for Experimental or Investigational cancer therapy does not apply to Routine Patient Care that is administered to a Member in a Qualified Clinical Trial and that is otherwise a Covered Service.

- Prescription Drugs for the treatment of cancer, that are approved by the federal Food and Drug Administration and must be recognized for the treatment of the specific type of cancer for which the drug has been prescribed in any one of the following established reference compendia:
    - The American Hospital Formulary Service Drug Information;
    - National Comprehensive Cancer Network's Drugs & Biologics Compendium;
    - Thomson Micromedex's Drug Dex; or
    - Elsevier Gold Standard's Clinical Pharmacology.
- Routine Patient Care provided to You in connection with a Qualified Clinical Trial if such services are also Covered Services under this Policy.
- Annual whole body skin examination for lesions suspicious for skin cancer, with no Deductible, Copayment, or Coinsurance, unless Your Plan is a high deductible health plan (HDHP). Deductible applies if Your Schedule of Benefits indicates that Your Plan is a HDHP.
- Medically Necessary office visits and ongoing testing prescribed by a Physician for a Member with tick-borne disease.
- Medically Necessary pain medication and Pain Therapy related to the treatment of breast cancer.
- Treatment of pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections (PANDAS) and pediatric Acute onset neuropsychiatric syndrome (PANS), including, but not limited to, the use of intravenous immunoglobulin therapy.
- Injected Medicines that cannot be self-administered and which must be administered by injection. Benefits will be provided for the drugs and the administration of the injection. This includes routine immunizations and injections that You may need for traveling. Unless otherwise stated, benefits will be provided as described in the “Preventive Care Services” provision of this section of Your Policy.
- Treatment for a fibrocystic breast condition in the absence of a breast biopsy demonstrating an increased disposition to the development of breast cancer unless the enrollee’s medical history is able to confirm a Chronic, relapsing, symptomatic breast condition.
- Pasteurized donated human breast milk for infant consumption which may include human milk fortifiers if indicated by a prescribing licensed practitioner and all of the following conditions are met:
    - The infant’s mother is medically or physically unable to produce breast milk sufficient to the infant’s needs;
    - The breakst milk is obtained from a human milk bank that meets appropriate quality guidelines or is licensed by the Department of Public Health;
    - The milk is Medically Necessary for the child as indicated by a prescribing licensed medical provider.
- Human papillomavirus (HPV) vaccine approved by the FDA.
- Shingles vaccine approved by the FDA for Members 60 years of age.
- Allergy testing and treatment.
- Amino acid-based elemental formulas for the diagnosis and treatment of eosinophilic disorders or short-bowel syndrome.
- Infusion therapy.
- A second opinion from a provider regarding Covered Services.
- Oxygen and its administration.

- Electroconvulsive therapy including benefits for anesthesia administered with the electroconvulsive therapy if the anesthesia is administered by a Physician other than the one administering the therapy.
- Cardiopulmonary monitors determined to be Medically Necessary for a Member 18 years old or younger who has had a cardiopulmonary event.

PRESCRIPTION DRUG BENEFIT PROVISIONS

BENEFIT LEVELS AND FORMULARY

Benefit Levels

This Policy covers Prescription Drugs with six benefit levels or tiers. The Formulary specifies the tier in which each drug is placed.

- Tier 1 is for Preferred Generic drugs, and Select brand name drugs.
- Tier 2 covers Preferred brand name drugs and Select Generic drugs.
- Tier 3 includes all non-Preferred Drugs and clinically-appropriate non-Formulary drugs that have been Prior Authorized by Us.
- Tier 4 covers only Select Generic drugs, Select brand name drugs, specialty drugs, and clinically-appropriate non-Formulary specialty drugs with Prior Authorization from Us.
- Tier $0 includes drugs that are included in the USPSTF list of recommended preventive services, category A or B. These drugs are covered at no cost to You as required by the Patient Protection and Affordable Care Act.
- Tier M is for drugs that are not covered under this "Prescription Drug Benefit Provisions" section. They are instead covered under the "Medical Benefit Provisions" section of this Policy.

Formulary

This drug plan has a closed Formulary, which means that only those drugs listed in the Formulary are covered. See the "Non-Covered Drugs" provision of this section for information on drugs that are not covered under the drug plan.

MercyCare determines the placement of drugs within each tier of this Formulary. Other changes may occur to this Formulary as determined by MercyCare, published monthly. The MercyCare Drug Formulary is available to all Members on the MercyCare website at www.mercycarehealthplans.com. You may obtain a copy of the Formulary by calling the Customer Service Department at (877) 908-6027.

GENERAL GUIDELINES

To ensure that You take full advantage of this Prescription Drug plan, You should follow these guidelines:

- Tell Your Physician about this drug program. Doing so can help him or her in making decisions about the prescriptions being prescribed.
- Use the same pharmacy for all Your prescriptions as much as possible. This allows Your pharmacist an opportunity to know and learn about Your medical conditions, allergies, and drug benefits.
- Ask Your pharmacist to talk with Your doctor to help make sure You receive the most appropriate drugs for Your medical condition.

You have the right to appeal an Adverse Determination for a Formulary or non- Formulary drug. In addition, You have the right to appeal any Adverse Determination. Please refer to the "Complaint Procedures" section to find the procedures related to appeals.

COVERED PRESCRIPTION DRUGS

Eligible Drugs

Drugs that are eligible for coverage include:

- Any Prescription Drug or insulin listed on the Formulary.
- Over the counter (OTC) contraceptive methods, such as spermicides and sponges, but only if the method is Federal Food and Drug Administration (FDA)-approved and prescribed for a woman by her Health Care Provider.
- Biological drugs.
- Fertility drugs prescribed for Infertility.
- Growth hormone therapy.
- Prescription inhalants.
- Naloxone (an Opioid Antagonist).
- At least one intranasal opioid reversal agent prescription for initial prescriptions of opioids with dosages of 50MME or higher.
- Topical anti-inflammatory medication including Ketoprofen, Diclofenac, or other brand equivalent approved by the FDA for Acute and Chronic pain management.
- Epinephrine injectors for Members under age 19.

Please also review the "Special Information for Certain Prescription Drug Types" provision below, for more specific guidelines regarding coverage of certain types of drugs and related expenses.

Coverage Requirements

To be covered, the drug must be all of the following:

- Prescribed by:
  - A Participating Provider;
  - A Non-Participating Provider for treatment of an Emergency Medical Condition; or
  - A Non-Participating Provider that a Member has an approved Referral from Us to see.
- Medically Necessary for Your medical condition and appropriate given Your medical history; and
- Prescribed in a manner consistent with its FDA approval and manufacturer recommendations; and
- Prescribed in its most cost-effective dosing regimen; and
- Used in a manner consistent with any and all guidelines and criteria developed, adopted, or researched by MercyCare.

In general, the Plan only covers Prescription Drugs if they are Medically Necessary. When dictated by the Policy, We will review the provided factual information and determine whether a Member's requested Prescription Drug is Medically Necessary.

You have the right to appeal a denial or other Adverse Determination for a Formulary or non-Formulary drug. Please refer to the "Complaint Procedures" section to find out how to file an appeal.

PRIOR AUTHORIZATION

You must obtain Our Prior Authorization for certain drugs before We will cover them. This Prior Authorization review ensures that Prescription Drugs are used in a manner consistent with all of the criteria cited in the "Covered Drugs" provision above. The Formulary indicates which Formulary drugs require Prior Authorization. You must also obtain Prior Authorization if You are requesting coverage of a drug that is not listed on the Formulary. **It is Your responsibility to make sure Your Health Care Provider has received Our Prior Authorization when required.**

If We impose a new Prior Authorization requirement on a drug listed on Our Formulary, the new requirement will not be implemented until after the Formulary posted on Our website has been updated to reflect the change. We cannot deny a claim for failure to obtain Prior Authorization if the Prior Authorization requirement was not posted on Our website on the date of service.

Depending on how urgently you need access to the Prescription Drug, You may submit either a Standard or Expedited review request. If We deny Your request, You may also request an Independent External Review of Our decision.

Standard Review Request

Your Health Care Provider will need to send a Prior Authorization form and documentation to MercyCare for Our review. We will notify You (and Your designee or prescriber) of Our decision no later than 72 hours after We receive Your request for Prior Authorization.

Expedited Review Request

In exigent circumstances, You (or Your designee or prescriber) may request an expedited review of Your request for Prior Authorization. An exigent circumstance exists if:

- You are suffering from a health condition that may seriously jeopardize Your life, health or ability to gain maximum function;
- You could be subjected to severe pain that cannot be adequately managed without the treatment under review; or
- You are undergoing a current course of treatment using a non-Formulary Prescription Drug.

Your Physician must send the appropriate Prior Authorization form and all necessary documentation to Us for review. We will notify You (and Your designee or prescriber) of Our decision no later than 24 hours after We receive Your request for Prior Authorization.

Length of Prior Authorization Approval

If a request for Prior Authorization is granted, either through the standard or expedited review process, the approval will be valid for the length of the prescription as determined by Your Health Care Provider regardless of any changes, including refills. This includes dosage changes for Prescription Drugs covered under Your Plan when the change is based on evidentiary standards, except for prescriptions for benzodiazepines or Schedule II narcotic drugs, such as opioids. In addition, the approved drug coverage will be treated as an Essential Health Benefit.

New Members
If You are a new Member under the Plan, We will honor a Prior Authorization for a covered Prescription Drug granted to You by Your previous health insurance issuer for up to 90 days after Your coverage effective date, if You provide Us with a copy of the Prior Authorization approval.

EXCEPTION REQUESTS

You may request a coverage exception for non-covered Prescription Drugs under the following circumstances:

- The drug is not on the Formulary and thus not covered.
- We are discontinuing coverage of the drug.
- The Prescription Drug alternatives required to be used in accordance with a step therapy requirement has been ineffective in the treatment or has caused an adverse reaction or harm to the Member.
- The number of doses available under a dose restriction for the Prescription Drug has been ineffective in the treatment of the Member's disease.
- The number of doses available under a dose restriction for the Prescription Drug has been or is likely to be ineffective or may adversely affect the drug's effectiveness or patient compliance, based on both the known relevant physical and mental characteristics of the Member, and the known characteristics of the drug regimen.

The processes for requesting standard and expedited reviews of exceptions are the same as the Prior Authorization processes described above.

INDEPENDENT REVIEW

If We deny Your request for Prior Authorization, of a clinically-appropriate Formulary or non-Formulary drug, or an exception to Step Therapy Requirements or Drug Quantity Limits, You may request an Independent External Review (IER) of Our decision.

If Your IER request is approved, We will cover the Prescription Drug for the length of the prescription, including refills. In addition, coverage of the approved drug will be treated as an Essential Health Benefit.

Please refer to the Complaint Procedures section of this Policy to find more information related to requesting an independent external review.

OBTAINING PRESCRIPTION DRUGS

Filling a Prescription
To fill a prescription, Your pharmacist will need:

- Your prescription; and
- Your member Identification Card.

Once the information from Your Identification Card is entered into the pharmacist's computer, the pharmacist will be able to:

- Verify that You are eligible to receive drugs under the Prescription Drug plan.
- Check to see if the Prescription Drug You have requested is a covered drug.
- See the listing price of the prescription and the amount You will be expected to pay.

Paying for a Prescription

Refer to the Schedule of Benefits to determine how much, if any, You will have to pay out of pocket for Your Prescription Drugs. This may include a Copayment, Deductible and/or Coinsurance amount. If the price of Your Prescription Drug is less than the Copayment stated in the Schedule of Benefits, You will only be required to pay the cost of the Prescription Drug.

If You purchase covered drugs from a Non-Participating Pharmacy, You will be required to pay the full cost of the drug and submit a Claim form to Us. You may obtain this form by visiting Our website at www.mercycarehealthplans.com or calling Our Customer Service Department at (877) 908-6027. If the drug You purchased is covered under this drug plan, We will reimburse up to the amount We would have paid a Participating Pharmacy, less the applicable Copayment, Deductible, and/or Coinsurance amounts. Your out-of-pocket costs will usually be significantly higher when You use Non-Participating Pharmacies.

Payments by Third-Parties

We will apply any third-party payments, financial assistance, discounts, product vouchers, or any other reduction in out-of-pocket expenses made by or on Your behalf for covered Prescription Drugs, to the Deductible, Copayment, Coinsurance, and Out-of-Pocket Maximum amounts that apply to Your plan.

Step Therapy

Certain Prescription Drugs are subject to step therapy requirements. When clinically appropriate, the step therapy program requires Members to try a similar, more cost-effective Prescription Drug before We will approve coverage of a more expensive Prescription Drug. The Formulary indicates which Prescription Drugs are subject to step therapy requirements.

We will approve a step therapy exception for a particular Prescription Drug for 12 months, or until the Policy is renewed, if:

- The required Prescription Drug is contraindicated for the Member; or
- The Member has tried the required Prescription Drug while under the current or previous health insurance and the prescribing Health Care Provider submits evidence of failure or intolerance of the required Prescription Drug; or
- The Member's Health Care Provider selected the requested Prescription Drug for the same medical condition while the Member was covered under this or previous health insurance coverage, and the Member is currently stable on the requested Prescription Drug.

Drug Quantity

For some Prescription Drugs we limit the amount that We will cover over a specific time period. Quantity limits help Your Health Care Provider and Your pharmacist check that You are using the Prescription Drug appropriately and safely. The Formulary indicates which Prescription Drugs are subject to quantity limits.

For most Prescription Drugs the maximum quantity We will cover and You can get at one time is a 30-day supply. We may cover and You may be able to get up to a 90-day supply of a covered non-specialty Prescription Drug if that Prescription Drug is not subject to a specific quantity limit. You will however have to pay three Copay amounts at the time of purchase for a 90-day supply, unless the Prescription Drug is subject to other quantity limits as stated in the Formulary. For high deductible health plans, the maximum quantity of medication you may receive in a single prescription is a supply sufficient for 30 days

We will cover a 12-month supply of FDA-approved contraceptive drugs, devices and other products, including all over-the-counter items except male condoms.

Synchronization of Prescription Drug Refills

On at least one occasion per year per Member, We will allow You to refill certain designated medications with a prorated daily cost-sharing rate so You can synchronize that medication's refill schedule with other medications You may be taking, provided all of the following conditions are met:

- The Prescription Drugs are included on the Formulary or have been approved through the Formulary exceptions process;
- The Prescription Drugs are maintenance medications and You have available refill quantities at the time of synchronization;
- The medications are not Schedule II, III, or IV controlled substances;
- All utilization management criteria specific to the Prescription Drugs must be met at the time of synchronization;
- The Prescription Drugs are of a formulation that can be safely split into short-fill periods to achieve synchronization; and
- The Prescription Drugs do not have special handling or sourcing needs or require a single, designated pharmacy to fill or refill the prescription.

SPECIAL INFORMATION FOR CERTAIN PRESCRIPITON DRUG TYPES

Pain Management and Narcotics

If You are prescribed narcotics for Chronic pain, You are at risk of becoming addicted. One of the important ways for Us to help You avoid this complication is to encourage You to obtain prescriptions for narcotics only from the Physician who is managing Your pain.

For Chronic pain, We will only cover prescriptions for long-acting narcotics or for large quantities of short-acting narcotics if the prescriptions are written by Participating Providers who are pain specialists or Prior Authorized Non-Participating Providers who are pain specialists.

If We become aware of a Member who has Chronic pain and is on narcotics, We have the right to limit the Member's coverage of prescription narcotics to the one Health Care Provider who has the primary responsibility for managing the Member's condition**.**

Specialty Drugs

The treatment of many health conditions involves drugs that require special delivery and instructions. These specialty drugs are designated as such in the MercyCare Drug Formulary. Specialty drugs are

covered only when You obtain them from the specialty pharmacy. You can find a list of designated specialty pharmacies at mercycarehealthplans.com. If Prior Authorization is required, these medications will be limited to the quantity or day supply that was approved in the Prior Authorization.

Immunosuppressant Drugs

When a prescribing Participating Provider has indicated on a prescription "MAY NOT SUBSTITUTE" for immunosuppressant drugs, We will not require the interchange of another immunosuppressant drug or formulation without notification and the documented consent of the prescribing Participating Provider and the Member, or the parent or guardian if the Member is a child, or the spouse of a patient who is authorized to consent to the treatment of the person.

Should We make a Formulary change that would alter coverage for a Member receiving immunosuppressant drugs, We shall notify the prescribing Participating Provider and the Member, or the parent or guardian if the patient is a child, or the spouse of the Member who is authorized to consent to the treatment of the patient at least 60 days prior to such change. The notification will be in writing and will disclose the Formulary change, indicate that the prescribing Participating Provider may initiate an appeal, and include information regarding the procedure for the prescribing Physician to initiate the Policy appeal process.

Off-Label Cancer Drugs

If MercyCare provides coverage for Prescribed Drugs approved by the FDA for the treatment of certain types of cancer, We will not deny coverage of a Prescription Drug solely on the basis that the drug has been prescribed to treat a type of cancer for which the drug has not been approved by the FDA to treat. The drug, however, must be approved by the FDA, and must be recognized for the treatment of the specific type of cancer for which the drug has been prescribed in any one of the following established reference compendia:

- The American Hospital Formulary Service Drug Information;
- National Comprehensive Cancer Network's Drugs & Biologics Compendium;
- Thomson Micromedex's Drug Dex;
- Elsevier Gold Standard's Clinical Pharmacology;
- Authoritative compendia as identified from time to time by the Federal Secretary of Health and Human Services;
- If not in the compendia, recommended for that particular type of cancer in formal clinical studies, the results of which have been published in at least two peer reviewed professional medical journals published in the United States or Great Britain.

In addition to covering any Prescription Drug described within this “Off-Label Cancer Drugs” provision, will also cover any Medically Necessary services associated with the administration of such a drug.

Despite the provisions of this provision, coverage shall not be required for any Experimental or Investigational drugs or any drug that the FDA has determined to be contraindicated for treatment of the specific type of cancer for which the drug has been prescribed.

This provision shall apply only to cancer drugs. Nothing in this provision shall be construed, expressly or by implication, to create, impair, alter, limit, notify, enlarge, abrogate or prohibit reimbursement for Prescription Drugs used in the treatment of any other Disease or condition.

Topical Eye Medication
We will cover the refill of a prescription for topical eye medication when:

- The medication is to treat a Chronic eye condition;
- The Member requests refill before the last day of the prescribed dosage period, and after at least 75% of the predicted days of use; and
- The prescribing Physician or optometrist indicates on the original prescription that refills are permitted and that any refills the Member requests do not exceed the total number of refills prescribed.

Opioid Use Disorder Treatment
The Plan provides benefits for buprenorphine products or brand equivalent products for medically assisted treatment of opioid use disorder. Prior Authorization, dispensing limits, and first fail requirements do not apply.

We will cover at least one Opioid Antagonist, including:

- The medication product;
- Administration devices; and
- Any related pharmacy administration fees.

Coverage includes refills for expired or utilized Opioid Antagonists.

Prescription Inhalants
We will not deny or limit coverage for prescription inhalants, which enable Members suffering from asthma or other life-threatening bronchial ailments to breathe, based upon a restriction on the number of days before a Member can get an inhaler refill if, contrary to the restriction, the inhalant is Medically Necessary and has been ordered or prescribed by the Member's treating Physician.

Cancer Medications
Our coverage of oral cancer medications will not be any more restrictive than Our coverage of intravenous or injected cancer medications.

Long-Term Antibiotic Therapy
Your Plan covers Medically Necessary long-term antibiotic therapy prescribed by a Physician for a Member with a tick-borne disease. A drug, including an Experimental drug, is covered for off-label use in the treatment of a tick-borne disease if the drug has been approved by the FDA.

NON-COVERED DRUGS

Prescription Drug benefits are not available for any of the following:

- Replacement of any lost, stolen, or destroyed drugs.
- Therapeutic devices or appliances, including hypodermic needles or syringes (except for diabetic supplies listed in the Formulary).
- Any drug or medicine that is administered or delivered by the Health Care Provider to You. Such drugs if Medically Necessary may however be covered under the “Medical Benefit Provisions” of the Policy.
- A brand name Prescription Drug when it is available as a Generic.

- A Generic or brand name Prescription Drug that is over-the counter and the over-the counter version is listed in the Formulary.
- Any non-Formulary Prescription Drug that is available over-the-counter, even if You have a prescription.
- A specialty drug that is not obtained from the designated specialty pharmacy.
- Any drug or medicine which is taken by or administered to You while You are a patient in a licensed hospital, rest home or sanitarium, extended care facility, convalescent Hospital, Skilled Nursing Facility or similar institution. Such drugs if Medically Necessary may however be covered under the "Medical Benefit Provisions" of the Policy.
- Any drug labeled "Caution: limited by Federal Law to Investigational Use" or other wording having similar intent.
- Experimental drugs, FDA approved drugs used for non-FDA approved uses, or FDA approved drugs used in non-FDA approved regimens, even though a charge is made to You, except that coverage shall be provided for any Prescription Drug which meets the following criteria:
    - Is prescribed for the treatment of HIV infection or an Illness or medical condition arising from or related to HIV infection; and
    - Is approved by the FDA, including phase-3 Investigational drugs; and
    - If the drug is an Investigational new drug, is prescribed and administered in accordance with the treatment protocol approved by the FDA for Investigational new drugs.
- Anabolic steroids.
- Brand name anti-obesity and anorexients (weight loss drugs).
- Any Prescription Drug which is not Medically Necessary.
- Any Prescription Drug for a non-covered procedure or the treatment of a complication from a non-covered procedure/service.
- Any Prescription Drug for a Sickness or Bodily Injury not covered by the Plan.
- Medication other than Prescription Drugs or preferred OTC drugs with or without a prescription order.
- Prescription Drugs, which the Member is entitled to receive without charge under any Worker's Compensation laws or any municipal state or federal program.
- Nutritional supplements.
- Any Prescription Drugs dispensed to a Member prior to the Member's Effective Date of coverage under the Plan or after the Member's termination date.
- Any drug when used for cosmetic treatment.
- Any drug when used for treatment of hair loss or hair growth.
- Any medication used to obtain, treat, or enhance sexual performance and/or function, even if the problem is caused by organic Diseases or mental health condition, unless the medication is listed as covered in the Formulary.
- Any Prescription Drugs administered by injection except for insulin injections and injections approved by Our Pharmacy and Therapeutics Committee to be covered under the Prescription Drug Benefit.
- Homeopathic Medications.
- Special formulations of covered drugs such as sustained release intended primarily for Member convenience.
- Special packaging of covered drugs intended primarily for Member convenience. This includes drugs that are not prescribed in their most cost-effective dosing regimen.
- Any drug used to treat hyperhidrosis.

GENERAL EXCLUSIONS AND LIMITATIONS

The following are not covered under the Plan:

- Treatment of a Bodily Injury or Sickness arising from or sustained in the course of any occupation or employment (for compensation, profit or gain) if:
    - Benefits are provided or payable, or would have been provided or payable if You had applied for coverage, under any Worker's Compensation or Occupational Disease Act or Law. Benefits are considered payable under any Worker's Compensation or Occupational Disease Act or Law, in spite of any denial of coverage, until such denial has been upheld by any available independent review; or
    - You fail to file a Claim for benefits for which You are eligible under any Worker's Compensation or any Occupational Disease Act or Law.
- Services or supplies that are furnished to You by the local, state or federal government and services or supplies to the extent payments or benefits for such services or supplies are provided by or available from the local, state or federal government (for example, Medicare) whether or not those payments or benefits are received. This exclusion however shall not be applicable to medical assistance benefits under Article V, VI, or VII of the Illinois Public Aid Code (Ill. Rev. Stat. ch. 23 § 1-1 et seq.) or similar Legislation of any state; benefits provided in compliance with the Tax Equity and Fiscal Responsibility Act; or as otherwise provided by law.
- Any loss caused by:
    - War or any act of war declared or not; or
    - Any act of international armed conflict or any conflict involving armed forces of any international authority.
- Services or supplies that do not meet accepted standards of medical or dental practice including, but not limited to, services which are Experimental/Investigational in nature. This exclusion however does not apply to a) the cost of Routine Patient Care associated with Experimental/ Investigational treatment if You are a Member participating in a Qualified Clinical Trial, if those services or supplies would otherwise be covered under this Policy if not provided in connection with an Qualified Clinical Trial program; or b) Applied Behavior Analysis used for the treatment of Autism Spectrum Disorder(s) granted at the time the services and supplies are provided.
- Services or supplies that a Member received prior to his or her Effective Date of coverage, after the date his or her coverage under the Policy terminated, or after he or she has been disenrolled from the Plan, unless otherwise stated in this Policy.
- Medical expenses resulting from Your commission or attempted commission of a civil or criminal battery or felony.
- Charges for any treatment related to a non-Covered Service.
- Cosmetic Surgery and related services and supplies, except as specifically stated in this Policy.
- Repair or replacement of appliances and/or devices due to misuse or loss, except as specifically mentioned in this Policy.
- Any treatment or services provided by, or at the direction of:
    - A person residing in Your household; or
    - A family Member (such as Your lawful spouse, child, parent, grandparent, brother, sister, or any person related in the same way to Your covered Dependent).

- Services or supplies for which no charge is made or for which You would not have to pay without this coverage.
- Services and supplies not Medically Necessary for diagnosis and/or treatment of a covered Bodily Injury or Sickness.
- Long term care services.
- Respite care services, except as specifically mentioned in the “Hospice Care” provision of the “Medical Benefit Provisions” section.
- Inpatient Private Duty Nursing services.
- Occupational, physical and speech therapy which are considered Maintenance Therapy, except as specifically described in this Policy.
- Maintenance care.
- Any Copayment, Coinsurance, and/or Deductible amounts that You must pay, as shown in the Schedule of Benefits and/or in any rider attached to this Policy.
- All services or supplies not specifically covered in the “Medical Benefit Provisions” or the “Prescription Drug Benefit Provisions” sections of this Policy, or by any rider attached to the Policy.
- Any service not provided or received in accordance with the terms and conditions of this Policy.
- Ancillary medical services (including Hospital facility charges, anesthesia charges, and lab and x-ray charges) provided during the course of a non-covered Bodily Injury or Sickness. This exclusion does not apply to benefits for dental surgery as described in the “Medical Benefit Provisions” section.
- Expenses for medical reports, including preparation and presentation.
- Services or supplies for holistic medicine, including homeopathic medicine, or other programs with an objective to provide complete personal fulfillment.
- Charges for missed appointments.
- Coma stimulation/recovery programs.
- Treatment, services or supplies provided while the Member is held, detained or imprisoned in a local, state or federal penal or correctional institution, or while in the custody of law enforcement officials. Persons on work release are exempt from this exclusion.
- Sexual counseling services are limited to those techniques commonly used by providers for conditions producing significant physical and mental symptoms.
- Any treatment or devices used to obtain, treat, or enhance sexual performance and/or function. This includes dysfunction caused by organic Diseases.
- Acupuncture.
- Reversal of vasectomies.
- Services, supplies and drugs rendered or provided to You outside of the United States, if the purpose of the travel to the location was for receiving medical services, supplies or drugs.
- Dental care, except as directly required for the treatment of a medical condition or as otherwise provided for in this Policy.
- Services and/or supplies provided to You outside the United States, unless they are received for treatment of an Emergency Medical Condition, notwithstanding any provision in the Policy to the contrary.
- Any drug or treatment used to treat hyperhidrosis.
- Animal-based therapy, including hippotherapy.
- Auditory integration training.
- The removal by any method of common warts and plane flat warts.

- Skin tag removal.
- Charges related to childbirth in the home setting (home delivery).
- Excision of excessive skin, subcutaneous tissue, and/or fat, including but not limited to such surgery to the abdomen, thigh, leg, hip, buttock or arm (except when done as part of post-mastectomy reconstruction.)
- Non-medical diagnostic evaluation and treatment of Learning Disabilities for developmental delays.

COVERAGE INFORMATION

ELIGIBILITY FOR COVERAGE

Eligibility Overview

Generally, to qualify for enrollment, an individual must be a citizen of the United States or a resident legal alien; not be eligible for or enrolled in Medicare at the time of Application; and reside within Our Service Area. Except for Dependent children, We consider a Member's residence to be the location in which he or she spends at least nine months out of a 12-month Contract Period. Individuals incarcerated, other than incarcerated individual pending disposition of charges, are not eligible for enrollment.

To be enrolled as a Member and be eligible for benefits, an individual must also qualify as either a Subscriber or Dependent as stated below.

No one can be denied coverage because of a pre-existing medical condition.

Subscriber

A Subscriber is the individual who carries the Policy. The Subscriber is typically a parent or the oldest enrolled Member in a family.

Dependent

Dependent means all of the following:

- The Subscriber's lawful spouse. A "spouse" includes a Subscriber's partner in a Civil Union; therefore, all of the provisions that pertain to a lawful spouse also apply to a party of a Civil Union.
- A Subscriber's Child under the age of 26 (the limiting age), regardless of financial dependence, residency, student status, employment status, marital status, eligibility for other coverage, or any combination of those factors. "Child" when used in this Policy means:
    - Natural blood-related child(ren);
    - Stepchild(ren);
    - Child(ren) through Civil Union;
    - Adopted child(ren);
    - Child(ren) who is in the Subscriber's custody under an interim court order prior to finalization of adoption or placement of adoption vesting temporary care;
    - Foster child(ren);
    - Child of the Subscriber's child; or
    - Child(ren) for whom the Subscriber has been appointed as legal guardian;
- An unmarried Dependent Child under age 30 who:
    - Lives within the Service Area of the Plan network for this Policy; and
    - Has served as an active or reserve member of any branch of the Armed Forces of the United States; and
    - Has received a release or discharge other than a dishonorable discharge.

If You wish to add or delete Dependents or change the information contained on Your Application, You must complete a Change of Status Form. If You applied for coverage through the Marketplace,

You may complete the form through the Marketplace. If You applied for coverage directly from MercyCare, You may obtain a Change of Status Form from MercyCare.

Continued Coverage for Disabled Dependent

A Dependent Child who reaches the limiting age while covered under this Policy will remain eligible for coverage if and as long as the Dependent Child is:

- Incapable of self-sustaining employment because of intellectual disability or physical disability which existed before the Dependent reached the limiting age; and
- Is dependent on his or her parents or other care providers for lifetime care and supervision.

Within two months prior to a Dependent Child reaching the limiting age, or at any reasonable time after attainment of the limiting age, MercyCare may inquire whether the Dependent Child is in fact a disabled and dependent person. Written proof of disability and dependency must be provided to MercyCare in a form satisfactory to MercyCare within 31 days after such inquiry. If written proof is not provided within 31 days, MercyCare may terminate the coverage of the Dependent.

MercyCare, at Our sole discretion, may require the Dependent Child to be examined from time to time by a provider for the purpose of determining the existence of the incapacity prior to granting continued coverage. Such examinations may occur at reasonable intervals during the first two years after continuation under this section is granted and annually thereafter.

Eligibility Questions

If You enrolled directly through Mercycare and have further questions about Your eligibility, please call the Customer Service Department at (877) 908-6027.

If You enrolled through the Marketplace, please contact the Marketplace at www.healthcare.gov.

ENROLLMENT PERIODS AND EFFECTIVE DATES

You may apply for enrollment in the Plan by submitting a completed Application. MercyCare will notify You of the Effective Date of Your coverage. If You complete an Application for coverage through the Marketplace, the Marketplace will determine Your Effective Date.

Enrollment Periods

Eligible individuals and their Dependents can either enroll in coverage:

- During the annual open enrollment period; or
- During a special enrollment period if they experience a qualifying event.
    - Examples of qualifying events include:
        - The eligible individual or his or her Dependents lose coverage (except when the loss of coverage is due to a failure to pay premiums or due to any situations that would give MercyCare the right to rescind or cancel coverage).
        - The eligible individual gains a Dependent or becomes a Dependent through marriage, establishment of a Civil Union, birth, adoption or placement for adoption, placement in foster care, or legal guardianship.
        - The eligible individual gains access to new qualified health plans as a result of a permanent move.

        - The Marketplace determines that the eligible individual (or his or her Dependent) is eligible to enroll or change health plans.
        - The eligible individual or his or her Dependents are covered under a plan for which employer contributions or government subsidies cease.
    - The eligible individual has 60 days from the date of the qualifying event to enroll. If the eligible individual knows that he or she will be losing coverage under another health plan in advance, he or she can notify Us up to 60 days prior to the date he or she loses coverage.
    - Members who purchased coverage through the Marketplace must notify the Marketplace of any changes within 60 days before or after the qualifying event.

Effective Dates

- If You enroll during the annual open enrollment period, Your coverage effective date will be January 1.
- If You enroll during a special enrollment period, Your coverage effective date will be as follows:
    - In the following circumstances, coverage is effective on the first day of the month after the individual notifies Us or the Marketplace that the qualifying event has occurred (where applicable):
        - Marriage or establishment of a Civil Union partnership.
        - The eligible individual or his or her Dependent loses coverage under another health plan. However, if the eligible individual or his or her Dependent notifies Us in advance that he or she will lose coverage under another health plan, then his or her coverage will be effective on the first day of the month following the date he or she loses coverage
    - In the following circumstances, coverage is effective on the date of the qualifying event, unless the eligible individual elects a coverage Effective Date of the first day of the month following the qualifying event.
        - Birth;
        - Adoption;
        - Placement for adoption
        - Placement in foster care; or
        - Placement in legal guardianship.
- A newborn child is covered from the moment of birth and for the next 31 days.
    - In order to continue coverage beyond 31 days:
        - If You enrolled directly through MercyCare, You must notify Us of the child's birth, pay the required premium, and submit a Change of Status form to add the newborn child. You must do this before the end of the first 31 days of coverage. **Note**: The Change of Status form will not be used to disclaim, waiver or otherwise limit eligibility or coverage.
        - If You enrolled through the Marketplace, You must notify the Marketplace of the child's birth and pay the required premium. You must do this before end of the first 31 days of coverage.
    - If You fail to notify MercyCare or the Marketplace (where applicable), then the newborn's coverage will terminate at the end of the 31-day period, unless, within one year of the child's birth, You pay all past due premiums plus interest on those premiums at the rate of 5.5% per year.
- You must pay all required premium amounts for Your coverage to become effective.

BENEFIT CHANGES

MercyCare will notify You of any benefit changes, in writing, at least 60 calendar days before the Policy renews. Benefit changes become effective when the Policy renews.

GRACE PERIOD

Non-APTC Grace Period
If You do not receive an Advanced Premium Tax Credit (APTC), You have a 31-day grace period to make a premium payment. If You do not make a premium payment by the end of the grace period, Your coverage under this Policy will terminate as of the last day of the month Your premium was paid in full.

APTC Grace Period
If You receive an APTC, You have a three consecutive month grace period to make a premium payment. If You do not make a premium payment by the end of the grace period, Your coverage under this Policy will terminate as of the last day of the first month of Your grace period. If Your coverage is terminated, You are responsible for any Claims costs We incur on Your behalf after Your coverage ends.

TERMINATION OF COVERAGE / DISENROLLMENT

You must provide notification of any event triggering termination promptly. Either MercyCare or the Marketplace may terminate benefits or cancel the Policy. Generally, if You obtained coverage through the Marketplace, Your coverage will end on the date determined by the Marketplace. If MercyCare terminates Your coverage, We will send the termination effective date to the Marketplace with the reason for termination.

Disenrollment
We may disenroll You as follows when any of the following occurs:

- If You fail to pay the required premiums by the end of Your grace period, Your coverage will end as described under the "Grace Period" provision, above.
- If You have performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact in connection with Your coverage, Your coverage will end on the earliest date permitted by state law.
    - Examples of fraud or misrepresentation of material fact include providing false information to obtain coverage or allowing someone else to use Your ID card to make a Claim.
    - If You use fraud or a misrepresentation of material fact to obtain coverage and/or make a Claim, We can require You to pay back the amount that We have paid on Your behalf.
- If You have moved outside the Service Area, Your coverage will end on the last day of the month following the date You establish residence outside the Service Area.

Dependent Loss of Eligibility

- Coverage that terminates due to a Dependent Child reaching the limiting age of 26 will terminate at the end of the month in which the Dependent Child reaches the limiting age.

- Coverage for a Dependent who loses eligibility for any other reason will generally terminate on the date of the event, but no later than the last day of the month following the date of the event.

Voluntary Disenrollment

- If You enrolled directly through Us, You must submit a request for voluntary discontinuation of coverage. Your coverage will end either on the date You requested, or on the last day of the month prior to Our receipt if the requested disenrollment date was greater than 30 days prior to Our receipt.
- If You obtained coverage through the Marketplace, You must request disenrollment through the Marketplace. Your coverage will end on the date determined by the Marketplace.

Product Discontinuation

If We discontinue offering a particular type of health insurance coverage, the Policy will terminate upon the Renewal Date and We will provide 90 days' written notification to You. In the event of termination, You may purchase any other product We offer in Your market.

EXTENSION OF BENEFITS

Termination of Policy

If You are covered under this Policy and are Totally Disabled as a result of a covered Bodily Injury or Sickness existing on the date the Policy terminates, We will continue to provide coverage until the earliest of the following:

- The date Your Primary Care Provider certifies that You are no longer Totally Disabled; or
- The date any applicable maximum benefit is paid; or
- The end of 12 consecutive months immediately following the date of termination of coverage; or
- The date You obtain similar coverage under another policy, other than temporary coverage, for the condition or conditions causing the Total Disability.

Termination of Member's Coverage

If You are Confined in the Hospital on the date Your coverage terminates under this Policy, We will continue to cover the inpatient Hospital services You receive during the Hospital Confinement. Benefits for these Hospital services will continue until the earliest of the following:

- The date on which Your Hospital Confinement ends; or
- The date on which 90 consecutive days pass since Your coverage ended under this Policy.

This "Extension of Benefits" provision applies only to Covered Services relating to the condition(s) which existed on the date Your coverage terminated.

GENERAL PROVISIONS

ADVANCE DIRECTIVES

If You are over the age of 18 and of sound mind, You may execute a living will or durable power of attorney for health care. The documents tell others what Your wishes are if You are physically and mentally unable to express Your wishes in the future.

If You do have an advance directive, You should give a copy to Your Primary Care Provider. Also, please notify Us in writing, as We are required, by law, to advise Your Primary Care Provider and the clinic, that You have an advance directive. You are not required to send the forms to Us.

CASE MANAGEMENT/ALTERNATIVE TREATMENT

Case management is a program We offer to Members. We employ professional staff to provide case management services. As part of this case management, We reserve the right to direct treatment to the most effective option available.

CLERICAL ERRORS

No clerical errors made by Us will invalidate coverage that is otherwise validly in force or continue coverage otherwise validly terminated, provided that the error is corrected promptly and in no event more than 60 days after the error is made.

CONFIDENTIALITY OF INFORMATION

MercyCare is required by law to maintain the privacy of Your personal health and financial information. We limit the collection of this information to that which is necessary to administer Our business and provide quality services.

We administer electronic, physical, and procedural safeguards that comply with federal regulations to safeguard Your information and review these safeguards to protect Your privacy. We limit the use of oral, written, and electronic personal information about You and ensure that only an authorized workforce with the need to know have access to it.

A Notice of Privacy Practices is available to You describing how MercyCare may use and disclose this information and how You can access this information. The Notice is available at www.mercycarehealthplans.com.

CONFORMITY WITH STATE AND FEDERAL LAWS

We comply with all state and federal laws. Any provision of this Policy which, on its Effective Date, is in conflict with federal law and the laws of the state in which the Policy is issued, is automatically amended to conform to the minimum requirements of such laws.

TIME LIMIT ON CERTAIN DEFENSES

After two years from the date of issue of this Policy no misstatements, except fraudulent misstatements, made by You in the Application for the Policy shall be used to void the Policy or to deny a Claim for loss incurred or disability commencing after the expiration of such two year period.

All statements made by You shall (in the absence of fraud) be deemed representations and not warranties. No such statement shall be used in defense to a Claim under the Policy unless it is contained in a written Application. No Claim for loss incurred or disability commencing after two years from the date of issue of the Policy shall be reduced or denied on the ground that a Disease or physical condition not excluded from coverage by name or specific description effective on the date of loss had existed prior to the Effective Date of coverage of this Policy.

LEGAL ACTIONS

No civil action shall be brought to recover on this Policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of this Policy. No such action shall be brought after the expiration of three years after the time written proof of loss is required to be furnished.

PHYSICAL EXAMINATION

We have the right to request a Member to receive a physical examination to determine eligibility for claimed services or benefits. We will pay for the expense of the physical examination. By completing the Application for coverage, You have consented to such an examination.

PROOF OF COVERAGE

As a Member, it is Your responsibility to show Your MercyCare Identification Card each time You receive services.

QUALITY ASSURANCE

Our Medical Management Program is designed to ensure that quality medical care is accessible and appropriate to Your needs, and to identify problems with care and correct those problems.

There are many elements to this Program, including a process for choosing and deciding whether to retain Participating Providers; guidelines and education for Providers regarding medical management and quality of care; review of medical data to monitor provision of care and treatment results; and consideration of Member complaints and Grievances to detect problems in provision of care.

If You have any questions about this Program, please contact Our Customer Service Department.

REINSTATEMENT

In the event the premium is not paid within the time granted, including any grace period, and coverage is terminated, reinstatement of coverage under this Policy is subject to the approval from the Health Insurance Marketplace and is subject to the Enrollment Periods described in this Policy. MercyCare requires all past due premium amounts to be paid in full prior to reinstatement of coverage.

MEMBER RIGHTS AND RESPONSIBILITIES

MercyCare offers Members a three-way partnership between You, Your doctors and Your health plan. Our goal is to assure You receive appropriate, quality health care and develop a relationship with a Primary Care Provider who coordinates and manages Your medical care. As a health plan Member and a patient, You have rights and responsibilities as part of the MercyCare partnership. Please visit Our website at www.mercycarehealthplans.com or call Us at (877) 908-6027 for more information about Your Member rights and responsibilities.

RIGHTS OF RECOVERY

SUBROGATION AND REIMBURSEMENT

Except as otherwise provided in the "Coordination of Benefits" section of this Policy, in the event We make payment on Your behalf for Covered Expenses, We shall be subrogated to all of Your rights of recovery against any person or organization for such payments. Our subrogation and reimbursement rights apply to full and partial settlements, judgments, or other recoveries paid or payable to Your or Your representative, no matter how those proceeds are captioned or characterized.

When You receive benefits under this Policy, We are subrogated to Your right to recover for Bodily Injury or Sickness allegedly caused by or for which another party may be liable, to the extent of the reasonable value of the benefits provided to You. In providing benefits to You, We may compensate providers on a capitated basis. Regardless of any such capitation arrangement, when You receive a benefit under this Policy for a Sickness or Bodily Injury, We are subrogated to Your right to recover the reasonable value of the benefit provided on account of such Bodily Injury or Sickness, which reasonable value shall be deemed to be the amount that We would have paid the provider on a fee for service basis.

Our rights of subrogation and reimbursement apply to any recoveries that You make, including benefits or payments for underinsured or uninsured motorist protection, no-fault or traditional auto insurance, medical payment coverage (auto, homeowners or otherwise), worker's compensation coverage or third party administrators.

By making payment for Covered Expenses, We are granted a lien on the proceeds of any settlement, judgment, or other payment, which You receive, and You consent to said lien. We are not required to help You pursue Your Claim for damages or personal injuries and no amount of associated costs, including attorney's fees, shall be deducted from Our recovery without the Our express written consent. No so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall defeat this right unless applicable state law provides otherwise. You agree to take whatever

steps are necessary to help Us secure said lien and to execute and deliver all instruments and papers and do whatever else is necessary to secure the Our rights of subrogation and reimbursement. You agree to cooperate with Our representatives in completing such forms and in giving such information surrounding any Sickness or Bodily Injury as Our representatives deem necessary.

You agree to do nothing to prejudice Our rights under this provision. You agree not to make any settlement that specifically excludes or attempts to exclude the benefits paid by Us. You may not accept any settlement that does not fully reimburse Us without Our written approval. You agree to notify Us of any Claim made on Your behalf in connection with a Bodily Injury or Sickness and shall include the amount of the benefits paid by Us on Your behalf in any Claim made against any other persons. If You receive any payment from any party as a result of Sickness or Injury, and We allege some or all of those funds are due to Us, You shall hold those funds in trust, either in a separate bank account in Your name or in Your attorney's trust account. You agree that You will serve as a trustee over those funds to the extent of the benefits We have paid.

Under applicable state law, We may have no right to recover from You if You have not been made whole. However, if You have been made whole, We have a first priority right to recover up to 100% of the benefits paid by Us out of the proceeds of any settlement, judgment, or other payment before You receive any proceeds. You agree You are made whole if a claim results in payment to You, by way of settlement, compromise, judgment or other payment, of an amount less than the combined total of any available third party payments. If there is a dispute as to whether You have been made whole, We may obtain a judicial determination of the issue.

In the case of Your wrongful death or survival claims, the provisions of this section apply to Your estate, the personal representative of Your estate, and Your heirs or beneficiaries. Neither You, Your personal representative, any representative of Your estate, Your heirs or Your beneficiaries, may allocate recovery among wrongful death and survivorship claims, whether by settlement or otherwise, in a manner that does not reimburse Us 100% of Our interest without written consent from Us or Our representative.

WORKERS COMPENSATION

The Policy is not issued in lieu of nor does it affect any requirement for coverage by Workers' Compensation. If You are eligible for Workers' Compensation coverage for a Bodily Injury or Sickness arising from or sustained in the course of any occupation or employment for compensation, profit or gain that Bodily Injury or Sickness is not covered under this Policy, except when such occupation or employment is as a domestic servant; employee of a farmer or other employer that is not required to have Worker's Compensation coverage; volunteer; or sole proprietor, partner, or LLC member of a business on a substantially full-time basis.

This exclusion applies whether or not You actually have Worker's Compensation coverage, or file a Claim or receive benefits under any coverage You have. If We paid for the treatment of any such Bodily Injury or Sickness, We have the right to recover such payments as described under the "Right to Recovery" provision of the "Coordination of Benefits" section of this Policy, unless the Bodily Injury or Sickness arose from or was sustained in the course of one of the exceptions described in the above paragraph. You must reimburse Us, and We will exercise the right to recover against You.

The recovery rights will be applied even if:

- Any Workers' Compensation benefits are in dispute or are made by means of settlement or compromise; or
- No final determination is made that the Bodily Injury or Sickness arose from or was sustained in the course of any occupation or for compensation, profit or gain; or
- The amount of any Workers' Compensation due for medical or health care is not agreed upon or defined by You or Workers' Compensation carrier; or
- The medical or health care benefits are specifically excluded from any Workers' Compensation settlement or compromise.

This provision will also apply to coverage that You may receive under any Occupational Disease Act or Law.

COORDINATION OF BENEFITS

DEFINITIONS

The following definitions apply to this section.

Allowable Expense
Any necessary, reasonable, and customary health care item or expense that is covered, even partially, under one or more plans. The difference between the cost of a private Hospital room and a semi-private Hospital room is not considered an allowable expense unless it is determined that the patient's stay in a private Hospital room is Medically Necessary.

When a plan provides benefits in the form of services, the reasonable cash value of each service rendered shall be considered both an allowable expense and benefit paid.

Allowable expenses under any other plan include the benefits that would have been payable if (a) a Claim had been duly made; or (b) the Member had complied with all plan provisions, such as Prior Authorization of admissions and Referrals. MercyCare will not reduce benefits because the Member has elected a level of benefits under another plan that is lower than he or she could have elected.

Claim Determination Period
A calendar year. However, it does not include any part of a year that a person is not covered under this Plan, or any part of a year before this or a similar Coordination of Benefit provision became effective.

Plan
Means any of the following that provides benefits or services for medical or dental care:

- Individual or Group insurance or Group-type coverage, whether insured or uninsured, that includes continuous 24-hour coverage. This includes pre-payment, Group practice or individual practice coverage. It also includes coverage other than school accident-type coverage.
- Coverage under a governmental plan or coverage that is required or provided by law. This does not include a state plan under Medicaid. It also does not include any plan whose benefits, by law, are in excess to those of any private insurance program or other non-governmental program.

Primary Plan/Secondary Plan
Primary Plan/Secondary Plan is determined by the Order of Benefit Determination rules. When the Plan is considered Primary, benefits will be paid for Covered Expenses as if no other coverage were involved. When the Plan is considered Secondary, benefits will be paid based on what was already paid by the primary Plan.

This Plan
The health plan offered by MercyCare and described in this Policy.

ORDER OF BENEFIT DETERMINATION

The rules outlined below establish the order of benefit determination as to which plan is primary and which plan is secondary.

1. ***No coordination of benefits provision***: If the other plan does not have a coordination of benefits provision, that plan will be considered primary.

2. ***Non-Dependent/Dependent:*** The plan that covers a person as an Employee, Member or Subscriber, other than a Dependent, is considered primary. The plan that covers a person as a Dependent of an Employee, Member or Subscriber is considered secondary.

3. ***Dependent Children:*** When a Dependent child has coverage under both parents' plans, the Birthday Rule is used to determine which plan will be considered primary.

   Birthday Rule: The plan of the parent whose birth date occurs first in a calendar year is considered primary. If both parents have the same birth date, the plan that has covered the parent for a longer period of time will be considered primary. If the other plan does not use the Birthday Rule to determine the coordination of benefits, the other plan's rule will determine the order of benefits.

4. ***Dependent Children with Divorced or Separated Parents****:* When a Dependent child has coverage under both parents' plans and a court order awards custody of the child to one parent, benefits for the child are determined in this order:

   - First, the plan of the parent with custody of the child;
   - Then, the plan of the spouse of the parent who has custody of the child; and
   - Finally, the plan of the parent who does not have custody of the child.

   If the specific terms of a court decree state that both parents share joint custody and do not specify which parent is responsible for health care expenses, the order of benefits will be determined by the Birthday Rule.

   If a court decree orders that one parent be responsible for health care expenses, the plan of that parent will be considered primary.

   NOTE: The rules and the coordination of benefits for Dependent children of divorced or separated parents will only apply when We have been informed of the court ordered terms. Retroactive coordination will not be allowed.

5. ***Dependent Child if Parents Share Joint Custody:*** If the specific terms of a court decree state that the parents shall 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 shall follow the order of benefit determination rules outlined in #4 above.

6. ***Young Adults as a Dependent:*** For a Dependent child who has coverage under either or both parents' plans and also has his or her own coverage as a Dependent under a spouse's plan, rule 9, “Longer/Shorter Length of Coverage” applies. In the event the Dependent child's coverage under the spouse's plan began on the same date as the Dependent child's coverage under either or both parents' plans, the order of benefits shall be determined by applying the birthday rule of rule #3 to the Dependent child's parent or parents and the Dependent's spouse.

7. ***Active/Inactive Employee:*** The benefits of either a plan that covers a person as an Employee who is neither laid off nor retired (or as that Employee's Dependent) are determined before those of a plan that covers that person as a laid-off or retired Employee (or as that Employee's Dependent). 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 shall not apply.

8. ***Continuation of Coverage:*** If a person whose coverage is provided under a right of continuation pursuant to federal or state law also is covered under another plan, the following shall be the order of benefit determination:
   - First, the benefits of a plan covering the person as an Employee, Member or Subscriber (or as that person's Dependent);
   - Second, the benefits under the continuation coverage. If the other plan does not contain the order of benefits determination described within this section, and if, as a result, the programs do not agree on the order of benefits, this requirement shall be ignored.

9. ***Longer/Shorter Length of Coverage:*** If none of the above rules apply to the covered Member, the plan that has covered the Member for a longer period of time will be considered primary.

EFFECT ON BENEFITS WHEN THIS PLAN IS SECONDARY

We will apply these provisions when it is determined that this Plan be considered secondary under the Order of Benefit Determination rules. The benefits of this Plan will be reduced when the sum of the following exceeds the allowable expenses in a Claim determination period:

- The benefits that would be payable for the allowable expenses under this Plan in the absence of this Coordination of Benefits provision; and
- 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 Coordination of Benefits provision, whether or not a Claim is made.

Under this provision, 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.

MERCYCARE’S RIGHTS UNDER THE COORDINATION OF BENEFITS PROVISION

Right to Necessary Information

In order to apply and coordinate benefits appropriately, We may require certain information. We have the right to decide what information We need in order to determine Our payment, and to obtain that information from any organization or person. We may obtain the information without Your consent, but will do so only as it is needed to apply the coordination of benefits rules. We also have the right to

give necessary information to another organization or person in order to coordinate benefits. Medical records remain confidential as required by state law.

Facility of Payment
We will adjust payments made under any other plan that should have been made by Us. If We make such a payment on behalf of a Member, it will be considered a benefit payment for that Member's Policy, and We will not be responsible to pay that amount again.

Right to Recovery
Payments made by Us that exceed the amount that We should have paid may be recovered by Us. We may recover the excess from any person or organization to whom, or on whose behalf, the payment was made.

COORDINATION OF BENEFITS WITH MEDICARE

In all cases, coordination of benefits with Medicare will conform to federal statutes and regulations. If You are eligible for Medicare benefits, but not necessarily enrolled, Your benefits under this Plan will be coordinated to the extent benefits otherwise would have been paid under Medicare as allowed by federal statutes and regulations. Except as required by federal statutes and regulations, this Plan will be considered secondary to Medicare.

Please note: You may be entitled to receive additional benefits
The amount by which Your benefits under this Plan have been reduced when this Plan is secondary and another plan first pays its benefits on a primary basis, is called Your "savings." Savings can be used to pay for services that are not covered under this Plan, provided that the services are covered in whole or in part under another plan. Savings can only be used to pay for services rendered in the same calendar year in which the Claim that earned the savings is actually processed. Please notify Us, by calling customer service, if there are expenses incurred during this calendar year which may entitle You to these additional benefits.

CLAIMS PROVISIONS

We Will Pay Claims Directly

We will pay Participating Providers directly for Covered Expenses You incur, and You will not have to submit a Claim. However, if You use a Non-Participating Provider or receive a bill for some other reason, a Claim must be submitted to Us within 20 days after the services are received, or as soon as possible. If We do not receive the Claim as soon as reasonably possible and within 12 months after the date it was otherwise required, We may deny coverage of the Claim.

If circumstances beyond Your control prevent You from submitting such proof to Us within this time period, We will accept a proof of Claim, if provided as soon as possible and within one year following the 20-day period. If We do not receive the written proof of Claim required by Us within that one-year and 20-day period, no benefits are payable for that service.

Types of Claims

How You file a Claim for benefits depends on the type of Claim it is. You or Your authorized representative may file a Claim. There are several categories of Claims for benefits:

- **Pre-service Claim**: a Claim for a benefit under the Policy with respect to which the terms of the Policy require approval of the benefit in advance of obtaining medical services.
- **Urgent Care Claim**: any Claim for medical care or treatment with respect to which, in the opinion of the treating Physician, lack of immediate processing of the Claim could seriously jeopardize the life or health of You or Your covered Dependent or subject You or Your covered Dependent to severe pain that cannot be adequately managed without the care or treatment that is the subject of the Claim. This type of Claim generally includes those situations commonly treated as emergencies.
- **Concurrent Care Claim**: a Claim for an extension of the duration or number of treatments provided through a previously approved Claim. Where possible, this type of Claim should be filed at least 24 hours in before the expiration of any course of treatment for which an extension is being sought.
- **Post-service Care Claim**: a Claim for payment or reimbursement after services have been provided.
- **Disability Claim**: a Claim reviewed under the Policy's definition of Total Disability, e.g., extended benefits.

Pre-service, Urgent Care and Concurrent Care Claims may also be described as requests for coverage or authorization of benefits. These terms may be used interchangeably in Your Member materials and in the administration of Your coverage.

How to Submit a Claim

To submit a Claim, send an itemized bill from the Physician, Hospital, or other provider to the following address:

MercyCare HMO, Inc.
Claims Department
P.O. Box 550
Janesville, WI 53547-0550

Written proof of Your Claim includes:

- The completed Claim forms if required by Us;
- The actual itemized bill for each service; and
- All other information that We need to determine Our liability to pay benefits under the Policy, including, but not limited to, medical records and reports.

Be sure to include Your name and Identification Card number with Your claim. Also, If the services were received outside the United States, please be sure to indicate the appropriate exchange rate at the time the services were received.

All Claims will be paid within 30 days following receipt by MercyCare of due written proof of loss. MercyCare will notify You within 30 days after receipt of Your Claim if You have failed to provide sufficient documentation for Your Claim. If MercyCare does not pay a Claim within such period, You will be entitled to interest at the rate of nine per cent per annum from the 30th day after receipt of such proof of loss to the date of MercyCare pays the Claim, provided that interest amounting to less than one dollar need not be paid. Any required interest payments shall be made within 30 days after the payment.

Incomplete and Incorrectly Filed Claims

An incomplete Claim is a correctly filed Claim that requires additional information, including but not limited to, medical information, coordination of benefits questionnaire, or a subrogation questionnaire.

An incorrectly filed Claim is one that lacks information which enables Us to determine what, if any, benefits are payable under the terms and conditions of the Policy. Examples include, but are not limited to, Claims filed that are missing procedure codes, diagnosis information or dates of service.

Procedures for Appointing an Authorized Representative

You or Your Dependent may have someone act on Your behalf for purposes of filing Claims, making inquiries and filing appeals. Please contact the Customer Service Department at 1-800-908-6027 for more information about appointing someone to represent You.

Timing of Claims Determinations

Urgent Care Claims

If Your Claim involves Urgent Care, We will notify You or Your authorized representative of Our initial decision on the Claim as soon as feasible, but in no event more than 72 hours after receiving the Claim.

If the Claim does not include sufficient information for Us to make a decision, You or Your representative will be notified within 24 hours after We receive the Claim of the need to provide additional information.

If You do not respond within 48 hours to Our request, Your Claim may be denied.

Concurrent Care Claims

If Your Claim involves concurrent care, We will notify You of this decision within 72 hours after receiving the Claim, if the Claim was for Urgent Care and was received by Us at least 24 hours before

the expiration of the previously approved time period for treatment or number of treatments. We will give You time to provide any additional information required to reach a decision.
If Your concurrent care Claim does not involve Urgent Care or is filed less than 24 hours before the expiration of the previously approved time period for treatment or number of treatments, We will respond according to the type of Claim involved (i.e., urgent, pre-service or post-service.)

Pre-Service Claims
A Pre-service Claim is any Claim for a benefit under the Policy, which requires Prior Authorization or precertification before obtaining medical care.

If Your Claim is for pre-service authorization, We will notify You of Our initial determination as soon as possible, but not more than 15 days from the date We receive the Claim. This 15-day period may be extended by MercyCare for an additional 15 days if the extension is required due to matters beyond Our control. You will have at least 45 days to provide any additional information We request from You.

If You fail to follow Our procedures for filing a Pre-service Claim, You or Your authorized representative shall be notified orally or in writing not more than 5 days (24 hours in the case of Urgent Care) following the failure. This notice, however, applies only when You submit a Claim to the appropriate Claims unit with the requested identifying Claim information.

Post-Service Claim
If Your Claim is for a post-service reimbursement or payment of benefits, We will notify You within 30 days of receiving Your Claim if the Claim has been denied or if further information is required. The 30 days can be extended to 45 days if We notify You within the initial 30 days of the circumstances beyond Our control that require an extension of the time period, and the date by which We expect to make a decision.

If We need more information to decide a post-service Claim, We will notify You of the specific information We need to complete the Claim. You will be given at least 45 days from the receipt of the notice to provide the necessary information.

Disability Claims
If Your Claim requires Us to decide whether You have a disability as defined by Us, We will notify You of Our decision no later than 30 days after We receive the Claim.

If We determine that an extension of time is needed to process Your Claim due to matters beyond Our control, We will notify You before the end of the 30-day period after filing of the Claim. The extended period may not exceed 45 days after the filing of the Claim. Any notice of extension will explain the standard on which the entitlement to a disability benefit under the Policy is based, the unresolved issues that prevent a decision in the Claim, and any additional information needed to resolve the Claim. You will have at least 45 days from the receipt of the notice to submit the requested information. We will make a decision after the requested information has been received within the required time period.

Notice of Claims Denial
If, for any reason, Your Claim is denied, in whole or in part, We will send You a written notice containing the basis for the decision, including information You need to identify the Claim such as the date of service, the health care provider, the Claim amount, the diagnosis code and its meaning, and the treatment code and its meaning; the denial code and its meaning and a description of the standard that was used to deny the Claim; a description of available internal appeals and external review processes, information on how to initiate an appeal; information You need to perfect the Claim; and information about the appeal process and about filing an action in federal court under section 502 of ERISA if You disagree with Our decision on the Claim.

Claims Payment
We may pay all or a portion of any benefits provided for health care services to the provider or to the Subscriber, if so directed in writing at the time the Claim is filed.

Benefit Payment Upon Death
Benefits accrued on Your behalf upon death shall be paid, at MercyCare's option, to any one of more of the following:

- Your spouse; or
- Your Dependent children, including legally adopted children; or
- Your parents; or
- Your brothers and sisters; or
- Your estate.

Any payment made by MercyCare in good faith will fully discharge Us to the extent of such payment.

Question or Dispute About Services or Payment
In the event of a question or dispute concerning the provision of health care services or payment for such services under the Policy, We may require that You be examined, at the expense of Us, by a Participating Provider designated by MercyCare.

If You have any questions about a Claim, please contact Customer Service at (877) 908-6027.

CONSENT TO RELEASE INFORMATION

CONSENT AND AUTHORIZATION

A Member consents to the release of medical and/or legal information to Us for himself or herself and for his/her covered Dependents when he/she signs the Application and when his/her Identification Card is used to receive health care services. We have the right to deny coverage for the health services of any Member who will not consent to release information to Us.

Each Member authorizes and directs any person or institution that has examined or treated the Member to furnish to Us at any reasonable time, upon Our request, any and all information and records or copies of records relating to the examination or treatment rendered to the Member. We agree that such information and records will be considered confidential to the extent required by law. We shall have the right to submit any and all records concerning health care services rendered to Members to appropriate medical review personnel. Expenses incurred to obtain such records for Us will be the responsibility of the Member.

PHYSICIAN AND HOSPITAL REPORTS

Physicians and Hospitals must give Us reports to help Us determine contract benefits due to You. You agree to cooperate with Us to execute releases that authorize Physicians, Hospitals, and other health care providers to release all records to Us regarding services You receive. It is also a condition for MercyCare to pay benefits. All information must be furnished to the extent We deem it necessary in a particular situation and as allowed by pertinent statutes.

RIGHT TO COLLECT NEEDED INFORMATION

You must cooperate with MercyCare and when asked will assist Us by:

- Authorizing the release of medical information including the names of all providers from whom You received medical attention;
- Providing information regarding the circumstances of Your Bodily Injury or Sickness; and
- Providing information to Us about other health care and insurance coverage and benefits.

COMPLAINT PROCEDURES

**** MercyCare is committed to ensuring that all Member concerns are handled in an appropriate and timely manner. We ensure that every Member has the opportunity to express dissatisfaction with any aspect of the Plan. ****

VERBAL COMPLAINT

If You have a complaint regarding a decision made by Us or with any other aspect of the Plan, You may contact Our Customer Service Department at (877) 908-6027 (TDD/TTY 800-947-3529).

If the Customer Service Department is unable to resolve Your complaint initially, they will contact You by phone with the outcome within 10 working days of the receipt of the complaint.

If You are not satisfied with the resolution of the complaint, You may submit a written request for a Grievance hearing.

CLAIM APPEAL PROCEDURES

Definitions

Adverse Benefit Determination

- A denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination; or
- Failure to provide in response to a Claim or make payment for, a benefit resulting from the application of utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be Experimental or Investigational or not Medically Necessary or appropriate; or,
- If an Ongoing Course of Treatment had been approved by Us and We reduce or terminate such treatment (other than by amendment or termination of the Group's benefit plan) before the end of the approved treatment period, that is also an Adverse Benefit Determination; or

In addition, an Adverse Benefit Determination also includes an “Adverse Determination.” For purposes of this benefit program, We will refer to both an Adverse Determination and an Adverse Benefit Determination as an Adverse Benefit Determination, unless indicated otherwise.

Adverse Determination

- A determination by Us or Our designated utilization review organization that, based upon the information provided, a request for a benefit under the Plan's health benefit plan upon application of any utilization review technique does not meet the Plan's requirements for Medical Necessity, appropriateness, health care setting, level of care, or effectiveness or it is determined to be Experimental or Investigational and the requested benefit is therefore denied, reduced, or terminated or payment is not provided or made, in whole or in part, for the benefit; or

- A rescission of coverage determination, which does not include a cancellation of discontinuance of coverage that is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage.

Appeals

Standard Appeal

You have the right to seek and obtain a full and fair review of any Adverse Benefit Determination or any other determination made by Us in accordance with the benefits and procedures detailed in this Policy.

An appeal of an Adverse Benefit Determination may be filed by You or a person authorized to act on Your behalf. In some circumstances, a Health Care Provider may appeal on his/her own behalf. Your appeal maybe filed concurrently with the Health Care Provider appeal. Deadlines for filing appeals or external review requests are not delayed by appeals made by a Health Care Provider.

Your designation of a representative must be in writing as it is necessary to protect against disclosure of information about You except to Your authorized representative. To obtain an Authorized Representative Form, You or Your representative may call Us at the number on the back of Your Identification Card.

You must submit an appeal request in writing within 180 days after You receive notice of an Adverse Benefit Determination. You may give a written explanation of why you think We should change Our decision and You or Your authorized representative or provider may give any additional information or documents You want to add to make Your point. You and Your authorized representative may ask to review Your file and any relevant documents.

MercyCare HMO, Inc.
Attn: Complaint Coordinator
P.O. Box 550
Janesville, WI 53547-0550
(877) 908-6027
Fax: 608-741-5238
mercycarecomplaints@mhemail.org

We will provide You or Your authorized representative with any new or additional evidence or rationale and any other information and documents used in the denial or the review of Your Claim without regard to whether such information was considered in the initial Adverse Benefit Determination. Such new or additional evidence or rationale and information will be provided to You or Your authorized representative sufficiently in advance of the date a final decision on appeal is made in order to give You a chance to respond.

If the initial benefit determination regarding the Claim is based in whole or in part on a medical judgment, the appeal will be conducted by individuals associated with MercyCare and/or by external advisors, but who were not involved in making the initial determination. Before You or Your authorized representative may bring any action to recover benefits the claimant must exhaust the appeal process and must raise all issues with respect to a Claim and must file an appeal or appeals and the appeals must be finally decided by Us.

MercyCare HMO, Inc.

Timing of Standard Appeal Determinations
Upon receipt of a concurrent, pre-service or post-service appeal, We will notify the party filing the appeal within three business days of all the information needed to review the appeal.

For concurrent or pre-service appeal, We will render a decision as soon as practical, but in no event more than 15 business days after receipt of all required information (if the appeal is related to health care services and not related to administrative matters or complaints) or 30 days after the appeal has been received by Us, whichever is sooner. For a concurrent appeal, Your coverage will continue while Your appeal is being processed.

For post-service appeal, We will render a decision as soon as practical, but in no event more than 15 business days after receipt of all required information (if the appeal is related to health care services and not related to administrative matters or complaints) or 60 days after the appeal has been received by Us, whichever is sooner.

Notice of Appeal Determination
We will notify the party filing the appeal, (You and/or Your provider), orally of its determination, followed-up by a written notice of the determination. The written notice to You or Your authorized representative and/or provider will include:

- The reasons for the determination;
- A reference to the benefit plan provisions on which the determination is based, and the contractual, administrative or protocol for the determination;
- Subject to privacy laws and other restrictions, if any, the identification of the Claim, date of service, Health Care Provider, Claim amount (if applicable), and a statement describing denial codes with their meanings and the standards used. Upon request, diagnosis/treatment codes with their meanings and the standards used are also available;
- An explanation of the Plan's external review processes (and how to initiate an external review) and a statement of Your right, if any, to bring a civil action under Section 502(a) of ERISA following a final denial on internal appeal;
- In certain situations, a statement in non-English language(s) that written notice of Claim denials and certain other benefit information may be available (upon request) in such non-English language(s);
- In certain situations, a statement in non-English language(s) that indicates how to access the language services provided by MercyCare;
- The right to request, free of charge, reasonable access to and copies of all documents, records and other information relevant to the Claim for benefits;
- Any internal rule, guideline, protocol or other similar criterion relied on in the determination, or a statement that a copy of such rule, guideline, protocol or other similar criterion will be provided free of charge on request;
- An explanation of the scientific or clinical judgment relied on in the determination, or a statement that such explanation will be provided free of charge upon request;
- A description of the standard that was used in denying the Claim and a discussion of the decision;
- Contact information for the Department of Insurance complaint division as stated in the “Department of Insurance” provision within the “Complaint Procedures” section of this Policy;

- The right to file an external review if the internal appeal has been delayed by Us, 30 days for concurrent or prospective, and 60 days for retrospective;
- The right to file for external review if an expedited internal appeal has been delayed by Us 48 hours;
- Notice that the provider and Member each have the right to appeal one time each for the Adverse Benefit Determination.

If Our decision is to continue to deny or partially deny Your provision of or payment for a health care service or course of treatment or You do not receive timely decision or We waive the exhaustion requirement of its internal appeals process, You may be able to request an external review of Your Claim by an independent review organization not associated with MercyCare, who will review the denial and issue a final decision. You can file an external review You can request an external review regardless of the status of a provider appeal. Your external review rights are described in the "Independent External Review" section below.

Expedited Appeal
If Your situation meets the definition of an expedited clinical appeal, You may be entitled to an appeal on an expedited basis. An expedited clinical appeal is an appeal of a clinically urgent nature related to health care services, including but not limited to, procedures or treatments ordered by a Health Care Provider, as well as continued hospitalization. Before authorization of benefits for an Ongoing Course of Treatment is terminated or reduced, MercyCare will provide You with notice at least 24 hours before the previous benefits authorization ends and an opportunity to appeal. For the Ongoing Course of Treatment, coverage will continue during the appeal process.

Upon receipt of an expedited pre-service or concurrent clinical appeal, We will notify the party filing the appeal, as soon as possible, but in no event more than 24 hours after submission of the appeal, of all the information needed to review the appeal. We will render a decision on the appeal within 24 hours after it receives the requested information, but in no event more than 48 hours after the appeal has been received by MercyCare.

INDEPENDENT EXTERNAL REVIEW

You or Your authorized representative may make a request for a standard external review or expedited external review of an Adverse Determination or Final Adverse Determination by an independent review organization (IRO).

You may also have a right to an independent external review if MercyCare fails to comply with state and federal laws governing internal Claims and appeals procedures.

A "Final Adverse Determination" means an Adverse Determination involving a Covered Service that has been upheld by MercyCare or its designated utilization review organization, at the completion of the Plan's internal appeal process procedures.

Standard External Review
You or Your authorized representative must submit within 4 months (120 days) of receiving an Adverse Determination or Final Adverse Determination a written request for a standard external independent review to the Director of the Illinois Department of Insurance ("Director") at:

MercyCare HMO, Inc.

Illinois Department of Insurance
Office of Consumer Health Insurance
External Review Unit
320 W. Washington Street
Springfield, IL 62767-0001
(877) 850-4740 (toll free)
FAX (217)557-8495
Email: Doi.externalreview@illinois.gov
https://mc.insurance.illinois.gov/messagecenter.nsf

You may submit additional information or documentation to support Your request for the health care services. Within one business day after the date of receipt of the request, the Director will send a copy of the request to Us.

Preliminary Review
Within five business days of receipt of the request from the Director, We will complete a preliminary review of Your request to determine whether:

- You were a covered person at the time health care service was requested or provided;
- The service that is the subject of the Adverse Determination or the Final Adverse Determination is a Covered Service under this benefit program, but We have determined that the health care service is not covered;
- You have exhausted the Plan's internal appeal process, unless You are not required to exhaust the Plan's internal appeal process pursuant to the Illinois Health Carrier External Review Act; and
- You have provided all the information and forms required to process an external review.

For appeals relating to a determination based on treatment being Experimental or Investigational, We will complete a preliminary review to determine whether the requested service or treatment that is the subject of the Adverse Determination or Final Adverse Determination is a Covered Service, except for Our determination that the service or treatment is Experimental or Investigational for a particular medical condition and is not explicitly listed as an excluded benefit. In addition, Your Health Care Provider has certified that one of the following situations is applicable:

- Standard health care services or treatments have not been effective in improving Your condition;
- Standard health care services or treatments are not medically appropriate for You; or
- There are no available standard health care services or treatment covered by the Plan that is more beneficial than the recommended or requested service or treatment.

In addition, during the preliminary review, We will determine whether:

- Your Health Care Provider has certified in writing that the health care service or treatment is likely to be more beneficial to You, in the opinion of Your Health Care Provider, than any available standard health care services or treatments; or
- Your Health Care Provider, who is a licensed, board certified or board eligible Physician qualified to practice in the area of medicine appropriate to treat Your condition has certified in writing that scientifically valid studies using accepted protocols demonstrate that the health

care service or treatment requested is likely to be more beneficial to You than any available standard health care services or treatments.

Notification
Within one business day after completion of the preliminary review We shall notify the Director, You and Your authorized representative, if applicable, in writing whether the request is complete and eligible for an external review. If the request is not complete or not eligible for an external review, the Director, You and Your authorized representative shall be notified by Us in writing of what materials are required to make the request complete or the reason for its ineligibility.

Our determination that the external review request is ineligible for review may be addressed with the Director by filing a complaint with the Director. The Director may determine that a request is eligible for external review and require that it be referred for external review. In making such determination, the Director's decision shall be in accordance with the terms of Your benefit program (unless such terms are inconsistent with applicable laws) and shall be subject to all applicable laws.

Assignment of IRO
When the Director receives notice that Your request is eligible for external review following the preliminary review, the Director will, within one business day after the receipt of the notice, (a) assign an IRO on a random basis from those IROs approved by the Director; and (b) notify MercyCare, You and Your authorized representative, if applicable, of the request's eligibility and acceptance for external review and the name of the IRO.

Provide Documentation to the IRO
Within five business days after the date of receipt of the notice provided by the Director of assignment of an IRO, We shall provide to the assigned IRO the documents and any information considered in making the Adverse Determination or Final Adverse Determination. In addition, You or Your authorized representative may, within five business days following the date of receipt of the notice of assignment of an IRO, submit in writing to the assigned IRO additional information that the IRO shall consider when conducting the external review.

The IRO is not required to, but may, accept and consider additional information submitted after five business days. If MercyCare or its designated utilization review organization does not provide the documents and information within five business days, the IRO may end the external review and make a decision to reverse the Adverse Determination or Final Adverse Determination. A failure by MercyCare or designated utilization review organization to provide the documents and information to the IRO within five business days shall not delay the conduct of the external review. Within one business day after making the decision to end the external review, the IRO shall notify MercyCare, You and, if applicable, Your authorized representative, of its decision to reverse the determination.

If You or Your authorized representative submitted additional information to the IRO, the IRO shall forward the additional information to MercyCare within one business day of receipt from You or Your authorized representative. Upon receipt of such information, MercyCare may reconsider the Adverse Determination or Final Adverse Determination. Such reconsideration shall not delay the external review. We may end the external review and make a decision to reverse the Adverse Determination or Final Adverse Determination. Within one business day after making the decision to end the

external review, We shall notify the Director, the IRO, You, and if applicable, Your authorized representative of its decision to reverse the determination.

IRO's Decision
In addition to the documents and information provided by MercyCare and You, or if applicable, Your authorized representative, the IRO shall also consider the following information if available and appropriate:

- Your pertinent medical records;
- Your Health Care Provider's recommendation;
- Consulting reports from appropriate Health Care Providers and other documents submitted to MercyCare or its designated utilization review organization, You, Your authorized representative or Your treating Provider;
- The terms of coverage under the benefit program;
- The most appropriate practice guidelines, which shall include applicable evidence–based standards and may include any other practice guidelines developed by the federal government, national or professional medical societies, boards and associations;
- Any applicable clinical review criteria developed and used by MercyCare or its designated utilization review organization; and
- The opinion of the IRO's clinical reviewer or reviewers after consideration of the items described above.

Within one business day after the receipt of notice of assignment to conduct an external review with respect to a denial of coverage based on a determination that the health care service or treatment recommended or requested is Experimental or Investigational, the IRO will select one or more clinical reviewers, as it determines is appropriate, to conduct the external review. The clinical reviewers must meet the minimum qualifications set forth in the Illinois Health Carrier External Review Act, and neither You, Your authorized representative, if applicable, nor MercyCare will choose or control the choice of the Physicians or other health care professionals to be selected to conduct the external review.

Each clinical reviewer will provide a written opinion to the IRO within 20 days after being selected by the IRO to conduct the external review on whether the recommended or requested health care service or treatment should be covered. The IRO will make a decision within 20 days after the date it receives the opinion of each clinical reviewer, which will be determined by the recommendation of a majority of the clinical reviewers.

Within five days after the date of receipt of the necessary information, but in no event more than 45 days after the date of receipt of request for an external review, the IRO will render its decision to uphold or reverse the Adverse Determination or Final Adverse Determination and will notify the Director, MercyCare, You and Your authorized representative, if applicable, of its decision.

The written notice will include all of the following:

- A general description of the reason for the request for external review;
- The date the IRO received the assignment from the Director;
- The time period during which the external review was conducted;
- References to the evidence or documentation including the evidence–based standards, considered in reaching its decision or, in the case of external reviews of Experimental or

Investigational services or treatments, the written opinion of each clinical reviewer as to whether the recommended or requested health care service or treatment should be covered and the rationale for the reviewer's recommendation;
- The date of its decisions;
- The principal reason or reasons for its decision, including what applicable, if any, evidence–based standards that were a basis for its decision; and
- The rationale for its decision.

Upon receipt of a notice of a decision reversing the Adverse Determination or Final Adverse Determination, MercyCare shall immediately approve the coverage that was the subject of the determination.

The IRO is not bound by any Claim determinations reached prior to the submission of information to the IRO. The Director, You, Your authorized representative, if applicable, and MercyCare will receive written notice from the IRO.

Expedited External Review

If You have a medical condition where the timeframe for completion of an expedited internal review of an appeal involving an Adverse Determination; a Final Adverse Determination; or, a standard external review as described above, would seriously jeopardize your life or health or your ability to regain maximum function, then You or Your authorized representative may file a request for an expedited external review by an IRO not associated with MercyCare.

In addition, if a Final Adverse Determination concerns an admission, availability of care, continued stay or health care service for which You received Emergency Care services, but have not been discharged from a facility, then You or Your authorized representative may request an expedited external review. You or Your authorized representative may file the request immediately after a receipt of notice of a Final Adverse Determination if MercyCare fails to provide a decision on a request for an expedited internal appeal within 48 hours.

You may also request an expedited external review if a Final Adverse Determination concerns a denial of coverage based on the determination that the treatment or service in question is considered Experimental or Investigational and Your Health Care Provider certifies in writing that the treatment or service would be significantly less effective if not started promptly.

Expedited external review will not be provided for retrospective adverse or final Adverse Determinations.

Your request for an expedited independent external review may be submitted to the Director either orally (by calling (877) 850-4740) or in writing as set forth above for requests for standard external review.

Notification

Upon receipt of a request for an expedited external review, the Director shall immediately send a copy of the request to MercyCare. MercyCare shall immediately notify the Director, You and Your authorized representative, if applicable, whether the expedited request is complete and eligible for an expedited external review.

MercyCare's determination that the external review request is ineligible for review may be addressed with the Director by filing a complaint with the Director. The Director may determine that a request is eligible for expedited external review and require that it be referred for an expedited external review. In making such determination, the Director's decision shall be in accordance with the terms of the benefit program (unless such terms are inconsistent with applicable law) and shall be subject to all applicable laws.

Assignment of IRO
If Your request is eligible for expedited external review, the Director shall immediately assign an IRO on a random basis from the list of IROs approved by the Director; and immediately notify MercyCare of the name of the IRO.

Provide Documentation to the IRO
Upon receipt from the Director of the name of the IRO assigned to conduct the external review, MercyCare or its designated utilization review organization shall immediately, (but in no case more than 24 hours after receiving such notice) provide to the assigned IRO the documents and any information considered in making the Adverse Determination or Final Adverse Determination. In addition, You or Your authorized representative may submit additional information in writing to the assigned IRO.

If MercyCare or its designated utilization review organization does not provide the documents and information within 24 hours, the IRO may end the external review and make a decision to reverse the Adverse Determination or Final Adverse Determination.

Within one business day after making the decision to end the external review, the IRO shall notify the Director, MercyCare, You and, if applicable, Your authorized representative, of its decision to reverse the determination.

IRO's Decision
As expeditiously as Your medical condition or circumstances requires (but in no event more than 72 hours after the date of receipt of the request for an expedited external review), the assigned IRO will render a decision whether or not to uphold or reverse the Adverse Determination or Final Adverse Determination and will notify the Director, MercyCare, You and, if applicable, Your authorized representative.

If the initial notice regarding its determination was not in writing, within 48 hours after the date of providing such notice, the assigned IRO shall provide written confirmation of the decision to You, the Director, MercyCare and, if applicable, Your authorized representative, including all the information outlined under the standard process above.

If the external review was a review of Experimental or Investigational treatments, each clinical reviewer shall provide an opinion orally or in writing to the assigned IRO as expeditiously as Your medical condition or circumstances requires, but in no event less than five calendar days after being selected. Within 48 hours after the date it receives the opinion of each clinical reviewer, the IRO will make a decision and provide notice of the decision either orally or in writing to the Director, MercyCare, You and Your authorized representative, if applicable. The assigned IRO is not bound by

any decisions or conclusions reached during MercyCare's utilization review process or the Plan's internal appeal process.

Upon receipt of a notice of a decision reversing the Adverse Determination or Final Adverse Determination, MercyCare shall immediately approve the coverage that was the subject of the determination.

An external review decision is binding on MercyCare. An external review decision is binding on You, except to the extent You have other remedies available under applicable federal or state law. You and Your authorized representative may not file a subsequent request for external review involving the same Adverse Determination or Final Adverse Determination for which You have already received an external review decision.

DEPARTMENT OF INSURANCE

You may resolve Your problem by taking the steps outlined above. You may also contact the Illinois Department of Insurance by filing a complaint with the Department. The Illinois Department of Insurance will notify Us of the complaint. We will have 21 days to respond to the Illinois Department of Insurance.

The operations of the Plan are regulated by the Illinois Department of Insurance. Filing an appeal does not prevent You from filing a Complaint with the Illinois Department of Insurance or keep the Illinois Department of Insurance from investigating a complaint.

You can contact the Illinois Department of Insurance at:

Illinois Department of Insurance
Office of Consumer Health Insurance
320 W. Washington Street
Springfield, IL 62767-0001
(877) 527-9431 (toll free)
FAX (217) 558-2083
Email: Consumer_complaints@ins.state.il.us
https://mc.insurance.illinois.gov/messagecenter.nsf

GLOSSARY

Throughout this Policy, many words are used which have a specific meaning when applied to Your health care coverage. The definitions of these words are listed below in alphabetical order. These defined words will be capitalized when used in this Policy.

ACUTE (ILLNESS/INJURY)
An Illness or Injury that is of rapid onset with an expected short-term duration.

AMBULANCE TRANSPORTATION
Local transportation in a specially equipped certified vehicle:

- From Your home, the scene of an accident or a medical emergency to a Hospital;
- Between Hospital and Hospital;
- Between Hospital and Skilled Nursing Facility; or
- From a Hospital or Skilled Nursing Facility to Your home.

If there are no facilities in the local area equipped to provide the care needed, Ambulance Transportation then means the transportation to the closest facility that can provide the necessary service.

APPLICATION
The form completed by a potential Member requesting coverage from MercyCare and listing all Dependents to be covered on the Effective Date of coverage. Applications may be submitted either to the Marketplace or to MercyCare.

APPLIED BEHAVIOR ANALYSIS
The design, implementation, and evaluation of environmental modifications using behavioral stimuli and consequences to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relations between environment and behavior.

AUTISM SPECTRUM DISORDER
Pervasive developmental disorders as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, including autism, Asperger's disorder, and pervasive developmental disorder not otherwise specified. Diagnosis must be made by a licensed Physician to practice medicine or a licensed clinical Psychologist with expertise in diagnosing Autism Spectrum Disorders.

BODILY INJURY (or INJURY)
An injury resulting from an accident, independent of all other causes.

CHANGE OF STATUS FORM
The form You must complete if You wish to add or delete Dependents or change the information contained on Your Application. If You applied for coverage through a Marketplace, You may complete the form through the Marketplace. If You applied for coverage directly from MercyCare, You may obtain a Change of Status Form from MercyCare.

CHIROPRACTOR
A duly licensed chiropractor.

CHRONIC (ILLNESS/CONDITION)
Illness or condition that is of long duration and shows little change, or a slow progression, of the symptoms or condition. Treatment is supportive in nature and not curative.

CIVIL UNION
A legal relationship between two persons, of either the same or opposite sex, established pursuant to 750 ILCS 75.

CLAIM
A demand for payment due in exchange for health care services rendered.

COINSURANCE
The Member's portion, expressed as a percentage of the fee for Covered Expenses that You are required to pay for certain Covered Services under the Policy.

CONFINEMENT/CONFINED
- The period of time between admission as an inpatient or outpatient to a Hospital, alcohol and other drug abuse (AODA) Residential Treatment Facility, Qualified Treatment Facility, Skilled Nursing Facility or licensed ambulatory surgical center, and discharge therefrom; or
- The time spent receiving Emergency Care for Sickness or Bodily Injury in a Hospital. Hospital swing bed Confinement is considered the same as Confinement in a Skilled Nursing Facility. If You are transferred to another facility for continued treatment of the same or related condition, it is considered one Confinement.

CONGENITAL
A condition that exists at birth but is not hereditary.

CONGENITAL OR GENETIC DISORDER
A disorder that includes, but is not limited to, hereditary disorders. Congenital or Genetic Disorders may also include, but are not limited to, Autism or an Autism Spectrum Disorder, cerebral palsy, and other disorders resulting from early childhood Illness, trauma or Injury.

CONTRACT PERIOD
The period beginning with the Effective Date or the Renewal Date of the Policy and ending on December 31 of the year in which this Policy became effective. All eligible expenses and all payment amounts listed in this Policy are per Contract Period, unless otherwise stated in the specific benefit subsection within this Policy.

COPAYMENT
A fixed dollar amount that You are required to pay for certain Covered Services provided under this Policy. You are responsible for paying the Copayment directly to the provider, usually when You receive the service.

COVERED EXPENSE
A charge for a Covered Service.

COVERED SERVICE
A Medically Necessary treatment, service or supply that is eligible for payment under this Policy.

CUSTODIAL CARE
The provision of room and board, nursing care, personal care or other care designed to assist You in the activities of daily living. Custodial care occurs when, in the opinion of a Participating Provider, You have reached the maximum level of recovery. If You are institutionalized, Custodial Care also includes room and board, nursing care, or other care when, in the opinion of a Participating Provider, medical or surgical treatment cannot reasonably be expected to enable You to live outside an institution. Custodial care also includes rest cures, respite care, and home care provided by family members.

DEDUCTIBLE
A pre-determined amount of money that an individual Member may have to pay before benefits are payable by MercyCare. The single Deductible applies to each Member each Contract Period, and the family Deductible amount is the most that the Subscriber and his or her dependents must pay each Contract Period.

DEPENDENT
See the "Eligibility for Coverage" provision in the "Coverage Information" section of this Policy.

DISEASE
A definite pathological process having a characteristic set of signs and symptoms. It may affect the whole body or any of its parts, and its etiology, pathology, and prognosis may be known or unknown.

DURABLE MEDICAL EQUIPMENT (DME)
Medical equipment that is:

- Able to withstand repeated use, and
- Is not disposable, and
- Primarily and customarily used to serve a medical purpose, and
- Not generally useful except for the treatment of a Bodily Injury or Sickness, and
- Is appropriate for use in the home, and
- Is not implantable in the body, and
- Provides therapeutic benefits or enables the patient to perform certain tasks that he or she would be unable to perform or otherwise undertake due to certain covered medical conditions or Illnesses

EARLY ACQUIRED DISORDER
A disorder resulting from Illness, trauma, Injury, or some other event or condition suffered by a child developing functional life skills such as, but not limited to, walking, talking, or self-help skills. Early Acquired Disorder may include, but is not limited to, Autism or an Autism Spectrum Disorder, cerebral palsy, and other disorders resulting from early childhood Illness, trauma, or Injury.

EFFECTIVE DATE
The date that a Subscriber or Dependent becomes enrolled and entitled to the benefits specified in this Policy.

EMERGENCY CARE
Care that includes:

- Transportation services, including but not limited to ambulance services;
- A medical screening examination that is within the capability of the emergency department of a Hospital or a freestanding emergency department, including ancillary services routinely available to the emergency department, to evaluate such Emergency Medical Condition; and
- To the extent they are within the capabilities of the staff and facilities at the emergency facility
    - Such further medical examination and treatment, including covered inpatient and outpatient hospital services furnished by a Health Care Provider qualified to furnish those services, as are required to Stabilize the patient; and
    - Services furnished after the patient is Stabilized while undergoing outpatient observation or an inpatient or outpatient stay, including items and services from any department within the Hospital,
        - Post-stabilization services are no longer considered Emergency Care services once the patient is able to travel using nonmedical or nonemergency medical transportation and is in a condition to receive notice of, or consent to, treatment rendered by a Non-Participating Provider.

EMERGENCY MEDICAL CONDITION
A medical condition that manifests itself by Acute symptoms of sufficient severity, including severe pain, to lead a prudent layperson with an average knowledge of health and medicine reasonably to conclude that a lack of immediate medical attention will likely result in any of the following:

- Serious jeopardy to the person's health or, with respect to a pregnant woman, to the health of the woman or her unborn child.
- Serious impairment to the person's bodily functions.
- Serious dysfunction of one or more of the person's body organs or parts.

ESSENTIAL HEALTH BENEFIT(S)
Health care service under section 1302(b) of the Patient Protection and Affordable Care Act and applicable regulations. Such benefits generally include the following categories:

- Ambulatory patient services
- Emergency Care services
- Hospitalization
- Maternity and newborn care
- Mental health and Substance Use Disorder services, including behavioral health treatment
- Prescription Drugs
- Rehabilitative and Habilitative Services and devices
- Laboratory services
- Preventive and wellness services and Chronic Disease management
- Pediatric services, including oral and vision care.

EXPERIMENTAL/INVESTIGATIONAL
The use of any service, treatment, procedure, facility, equipment, drug, devices or supply for a Member's Bodily Injury or Sickness that:

- Requires the approval by the appropriate federal or other governmental agency that has not been granted at the time it is used; or
- Is not yet recognized as acceptable medical practice to treat that Bodily Injury or Sickness, as determined by MercyCare for a Member's Bodily Injury or Sickness.

The criteria that MercyCare's Quality Health Management Department uses for determining whether a service, treatment, procedure, facility, equipment, drug, device or supply is considered to be Experimental or Investigative include whether:

- It is commonly performed or used on a widespread geographic basis.
- It is generally accepted to treat that Bodily Injury or Sickness by the medical profession in the United States.
- Its failure rate or side effects are unacceptable.
- The Member has exhausted more conventional methods of treating the Bodily Injury or Sickness.
- It is recognized for reimbursement by Medicare, Medicaid and other insurers and self-funded plans.

MercyCare's Quality Health Management Department shall determine whether any treatment, procedure, facility, equipment, drug, device, or supply is Experimental/Investigational, and will consider the guidelines and practices of Medicare, Medicaid, or other government-financed programs in making its determination.

Although a Health Care Provider may have prescribed treatment, and the services or supplies may have been provided as the treatment of last resort, MercyCare still may determine such services or supplies to be Experimental/Investigational within this definition. Treatment provided as part of a Qualified Clinical Trial or a research study is Experimental/Investigational.

FORMULARY
The comprehensive listing of Prescription Drugs available to You as a Member.

FREE-STANDING SURGICAL FACILITY
Any accredited public or private establishment that has permanent facilities equipped and operated primarily for performing surgery with continuous Physician services and registered professional nursing services whenever a patient is in the facility. It does not provide services or accommodations for patients to stay overnight.

GENERIC
A Prescription Drug available from more than one drug manufacturer that has the same active therapeutic ingredient as the brand or trade name Prescription Drug prescribed to You.

GENETIC COUNSELING
The process in which a genetic counselor educates families or individuals about their risk of passing on a genetic predisposition for certain disorders to future generations or of having an inherited disorder themselves. This process integrates the following:

- Helping people understand and adapt to the medical, psychological and familial implications of genetic contributions.
- Interpretation of family and medical histories to assess the chance of Disease occurrence or recurrence.
- Education about inheritance, testing, management, prevention, resources and research.
- Counseling to promote informed choices and adaptation to the risk or condition.

GENETIC TESTING
A test using deoxyribonucleic acid (DNA) extracted from an individual's cells in order to determine the presence of a Genetic Disease or disorder or the individual's predisposition for a particular Genetic Disease or Disorder.

GRIEVANCE
Any dissatisfaction that You have with Us or with a provider of service that has been expressed in writing by You or on Your behalf. See the "Complaint Procedures" section in this Policy for more information.

HABILITATIVE SERVICES
Health care services prescribed by a treating Physician pursuant to a treatment plan to help a person maintain, learn, or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

HEALTH CARE PROVIDER
Any health care facility or person duly licensed to render Covered Services to You. Includes:
- Medical or osteopathic Physicians, Hospitals, and clinics.
- Podiatrists, physical therapists, Physician's assistants, Psychologists, Chiropractors, nurse practitioners, dentists, or other health care professional licensed by the State of Illinois, or other applicable jurisdiction to provide Covered Services.
- Nurses licensed by the State of Illinois and certified as a nurse anesthetist to provide Covered Services.
- Nurse midwives licensed by the state in which they practice to provide Covered Services.

HOSPICE
A centrally administered program designed to provide for the physical, psychological and spiritual care for dying persons and their families. The goal of Hospice care is to allow the dying process to proceed with a minimum of patient discomfort while maintaining dignity and a quality of life. Hospice Care Program Service is available in the home, Skilled Nursing Facility or special Hospice care unit.

HOSPITAL
A facility which is a duly licensed institution for the care of the sick which provides services under the care of a Physician including the regular provision of bedside nursing by registered nurses and which is either accredited by the Joint Commission on Accreditation of Hospitals or certified by the Social Security Administration as eligible for participation under Title XVIII, Health Insurance for the Aged and Disabled.

Hospital does not mean an institution that is chiefly:

- A place for treatment of Substance Use Disorder
- A nursing home; or
- A federal hospital.

Hospital includes those Hospitals providing surgery on a formal arrangement basis with another institution.

IDENTIFICATION CARD
The card issued to Members that indicates eligibility for coverage under this Policy.

INFERTILITY
The inability to conceive a child after one year of Unprotected Sexual Intercourse or the inability to sustain a successful pregnancy. The one year requirement will be waived if Your Physician determines that a medical condition exists that renders conception impossible through Unprotected Sexual Intercourse, including but not limited to, Congenital absence of the uterus or ovaries, absence of the uterus or ovaries due to surgical removal due to a medical condition, Involuntary sterilization due to Chemotherapy or radiation treatments; or, efforts to conceive as a result of one year of medically-based and supervised methods of conception, including artificial insemination, have failed and are not likely to lead to a successful pregnancy.

LEARNING DISABILITY
An inability or defect in the ability to learn. It occurs in children and is manifested by difficulty in learning basic skills such as writing, reading and mathematics.

LIFE-THREATENING DISEASE OR CONDITION
Any Disease or condition from which the likelihood of death is probable unless the course of the Disease or condition is interrupted.

MAINTENANCE OR LONG-TERM THERAPY
Ongoing therapy delivered after the Acute phase of a Sickness has passed. It begins when a patient's recovery has reached a plateau or non-measurable improvement if his/her condition has slowed or ceased entirely and only minimal rehabilitative gains can be demonstrated. The determination of what constitutes Maintenance or Long-Term Therapy is made by MercyCare after reviewing an individual's case history or treatment plan submitted by a provider.

MEDICAID
A program instituted pursuant to Title XIX (Grants to States for Medical Assistance Programs) of the United States Social Security Act, as added by the Social Security Amendments of 1965 as now or hereafter amended.

MEDICALLY NECESSARY or MEDICAL NECESSITY
Health care services or supplies needed to prevent, diagnose or treat a Sickness, Bodily Injury, condition, Disease or its symptoms and that meet accepted standards of medicine.

MEDICAL SUPPLY(IES)
A disposable, consumable, Medically Necessary item which usually has a one time or limited time use and is then discarded.

MEDICARE
Title XVIII (Health Insurance Act for the Aged) of the United States Social Security Act, as added by the Social Security Amendments of 1965 as now or hereafter amended.

MEMBER
The Subscriber and his/her Dependents who have been enrolled and are entitled to benefits under the Policy.

MENTAL ILLNESS
Those Illnesses classified as mental health disorders in the edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association which is current as of the date services are rendered to a patient. See also the definition for Serious Mental Illness.

MERCYCARE
MercyCare HMO, Inc.

NON-PARTICIPATING PHARMACY
Any pharmacy that does not have a contractual relationship with Us for the provision of pharmacy services or supplies to Members.

NON-PARTICIPATING PROVIDER
A provider not listed in the most current provider directory.

ONGOING COURSE OF TREATMENT
The treatment of a condition or Disease that requires repeated health care services pursuant to a plan of treatment by a Physician because of the potential for changes in the therapeutic regimen.

ORTHOTIC DEVICE
A supportive device for the body or a part of the body, head, neck or extremities including, but not limited to leg, back, arm and neck braces.

OPIOID ANTAGONIST
A drug that binds to opioid receptors and blocks or inhibits the effect of opioids acting on those receptors. This includes, but is not limited to, naloxone hydrochloride or any other similarly acting drug approved by the U.S. Food and Drug Administration.

OTC (Over the Counter)
Drug purchased over-the-counter (OTC). OTC drugs on the Preferred Drug list are covered only with a prescription.

OUT-OF-POCKET MAXIMUM
The most You will pay in Deductible, Copayment and Coinsurance Amounts for Your Covered Expenses in a Contract Period. The amount of the Out-of-Pocket Maximum is shown in the Schedule of Benefits.

PAIN THERAPY
Therapy that is medically-based and includes reasonably defined goals, including, but not limited to stabilizing or reducing pain, with periodic evaluations of the efficacy of the Pain Therapy against these goals.

PARTICIPATING PHARMACY
Any pharmacy that has contracted with Us to provide pharmacy services or supplies to Members.

PARTICIPATING PROVIDER
A Health Care Provider under contract with Us to provide health care services, items or supplies to Members. Participating Providers are listed in the most current provider directory.

PHYSICIAN
A physician duly licensed to practice medicine in all of its branches.

PLAN
The health insurance coverage offered by MercyCare HMO, Inc. as described in this Policy.

POLICY
This document, a Member's Schedule of Benefits, the Application which You completed, and any addendums or riders included in Your Member materials which has been issued to You and which summarizes the terms, conditions, and limitations of Your health care coverage.

PREFERRED DRUG
Name brand, Generic or OTC drugs in Our Preferred Drug list, as determined by Us.

PRESCRIPTION DRUG
Any medicinal substance, the label of which, under the Federal Food, Drug and Cosmetic Act, is required to bear the legend: “Caution: Federal Law prohibits dispensing without prescription.”

PRIMARY CARE PROVIDER (PCP)
A Physician or nurse practitioner who spends a majority of clinical time engaged in general practice or in the practice of internal medicine, pediatrics, gynecology, obstetrics, psychiatry or family practice, or a Chiropractor, and who You have selected to be primarily responsible for assessing, treating or coordinating Your health care needs.

PRIOR AUTHORIZATION
A decision made by Us prior to You obtaining a Covered Service, that a health care service, treatment plan, Prescription Drug or Durable Medical Equipment is Medically Necessary. This Policy outlines the types of Covered Services which require Prior Authorization.

PRIVATE DUTY NURSING
Skilled nursing services provided on a one-to-one basis by an actively practicing registered nurse (R.N.) or licensed practical nurse (L.P.N.). Private Duty Nursing is shift nursing of eight hours or greater per day and does not include nursing care of less than eight hours per day.

PROVIDER NETWORK
A group of Health Care Providers contracted with MercyCare to provide services for Members within a specific geographic location.

PSYCHOLOGIST
- A Clinical Psychologist who is registered with the Illinois Department of Professional Regulation pursuant to the Illinois "Psychologist Registration Act" (111 Ill. Rev. Stat. § 5301 et seq., as amended or substituted); or
- In a state where statutory licensure exists, a Clinical Psychologist who holds a valid credential for such practice; or
- If practicing in a state where statutory licensure does not exist, a psychologist who specializes in the evaluation and treatment of Mental Illness and Substance Use Disorder and who meets the following qualifications:
    - Has a doctoral degree from a regionally accredited University, College or Professional School and has two years of supervised experience in health services of which at least one year is postdoctoral and one year in an organized health services program; or
    - Is a Registered Clinical Psychologist with a graduate degree from a regionally accredited University or College and has not less than six years' experience as a psychologist with at least two years of supervised experience in health services.

QUALIFIED CLINICAL TRIAL
A Phase I, Phase II, Phase III, or Phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other Life-Threatening Disease or Condition, and is a type of trial that meets one or more of the following criteria:
- The study or investigation is approved by the FDA, or approved and funded by one or more of the following:
    - National Institutes of Health (NIH). (Includes National Cancer Institute).
    - Centers for Disease Control and Prevention.
    - Agency for Healthcare Research and Quality.
    - Centers for Medicare and Medicaid Services.
    - A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
    - Department of Defense.
    - Department of Veterans Affairs.
    - Department of Energy.
- The study or investigation is conducted under an investigational new drug application reviewed by the FDA; or
- The study or investigation is a drug trial that is exempt from having such an investigational new drug application.

The study or investigation must have been reviewed and approved through a system of peer review that the Secretary determines: a) to be comparable to the system of peer review of studies and

investigations used by the National Institutes of Health; and b) assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.

QUALIFIED TREATMENT FACILITY
A facility, institution, or clinic duly licensed to provide mental health or Substance Use Disorder treatment; primarily established for that purpose; and operating within the scope of its license.

REFERRAL
A written request submitted to Us by Your Primary Care Provider or Woman's Principal Health Care Provider, for You to obtain a specialty services or treatment from a Non-Participating Provider.

REHABILITATION or REHABILITATIVE SERVICES
Health care services that help a person get back or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt or disabled. These services may include physical and occupational therapy, speech-language pathology and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

RESIDENTIAL TREATMENT FACILITY
A facility setting offering a defined course of therapeutic intervention and special programming in a controlled environment, which also offers a degree of security, supervision, structure, and is licensed by the appropriate state and local authority to provide such service.

It does not include half-way houses, supervised living, group homes, boarding houses or other facilities that provide primarily a supportive environment and address long-term social needs, even if counseling is provided in such facilities.

Patients are medically monitored with 24-hour medical availability and 24-hour onsite nursing service for patients with Mental Illness and/or Substance Use Disorders. The Plan requires that any Mental Illness and/or Substance Use Disorder Residential Treatment Facility must be licensed in the state where it is located, or accredited by a national organization that is recognized by MercyCare as set forth in its current credentialing policy, and otherwise meets all other credentialing requirements set forth in such policy.

RENEWAL DATE
The date on which this Policy renews coverage.

ROUTINE OR PREVENTIVE
Any physical exam or evaluation done in accordance with medically appropriate guidelines for age and sex, in consideration of a Member's personal and/or family medical history, when an exam is otherwise not indicated for the treatment of an existing or known Bodily Injury or Sickness.

ROUTINE PATIENT CARE
Includes items, services, and drugs provided to You in connection with a Qualified Clinical Trial that would be covered under this Plan if You were not enrolled in such Qualified Clinical Trial, provided that You were eligible to participate in the Qualified Clinical Trial according to the trial protocol with respect to treatment of cancer or other Life-Threatening Disease or Condition and either (a) the referring Participating Provider has concluded that Your participation in the Qualified Clinical Trial is

appropriate according to the trial protocol or (b) You provide medical and scientific information establishing that Your participation in the Qualified Clinical Trial is appropriate according to the trial protocol.

Routine Patient Care does not include the Investigational item, device, or service, itself; items and services provided solely to satisfy data collection and analysis needs and that are not used in Your direct clinical management; and a service that is clearly inconsistent with widely accepted and established standards of care for Your diagnosis.

SCHEDULE OF BENEFITS
A summary of coverage and limitations provided under the Policy.

SELECT DRUG (SELECT)
Brand, generic, or OTC drugs chosen based on the efficacy, safety and cost of the drug, as determined by us.

SERIOUS MENTAL ILLNESS
The following psychiatric Illnesses as defined in the most current edition of the Diagnostic and Statistical Manual (DSM) published by the American Psychiatric Association:

- Schizophrenia;
- Paranoid and other psychotic disorders;
- Bipolar disorders (hypomanic, manic, depressive, and mixed);
- Major depressive disorders (single episode or recurrent);
- Schizoaffective disorders (bipolar or depressive);
- Pervasive developmental disorders;
- Obsessive-compulsive disorders;
- Depression in childhood and adolescence; and
- Panic disorder;
- Post-traumatic stress disorders (Acute, Chronic, or with delayed onset); and
- Anorexia nervosa and bulimia nervosa.

SERVICE AREA
The geographical area in which We are authorized to offer a health Plan.

SICKNESS (or ILLNESS)
Any condition or Disease that affects or causes loss of normal body function, other than those resulting from Bodily Injury.

SKILLED NURSING FACILITY
An institution or a distinct part of an institution which is primarily engaged in providing comprehensive skilled services and rehabilitative inpatient care and is duly licensed by the appropriate governmental authority to provide such services.

SOUND AND NATURAL TEETH
Teeth that would not have required restoration in the absence of a Member's traumatic Bodily Injury, or teeth with restoration limited to composite or amalgam fillings. It does not mean teeth with a crown or root canal therapy.

STABILIZE
To provide such medical treatment of an Emergency Medical Condition as may be necessary to assure, within reasonable medical probability that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility, or transfer of the individual between floors or departments in a single facility. For a pregnant woman having contractions, it means to deliver (including the placenta).

STANDARD FERTILITY PRESERVATION SERVICES
Procedures based upon current evidence-based standards of care established by the American Society for Reproductive Medicine, the American Society of Clinical Oncology, or other national medical associations that follow current evidence-based standards of care.

STANDING REFERRAL
A written Referral from Your Primary Care Provider or Woman's Principal Health Care Provider for an Ongoing Course of Treatment pursuant to a treatment plan specifying needed services and time frames as determined by Your Primary Care Provider or Woman's Principal Health Care Provider, the consulting Physician or Provider and the Plan.

SUBSTANCE USE DISORDER
The following mental disorders as defined in the most current edition of the Diagnostic and Statistical Manual (DSM) published by the American Psychiatric Association: 1) substance abuse disorders; 2) substance dependence disorders; and 3) substance induced disorders. All Medical Necessity determinations for Substance Use Disorders will be made in accordance with the most current edition of the American Society of Addiction Medicine Patient Placement Criteria

SUBSCRIBER
An eligible individual whose completed Application and premium have been accepted by Us.

TELEHEALTH SERVICES
The evaluation, diagnosis, or interpretation of electronically transmitted patient-specific data between a remote location and a licensed health care professional that generates interaction or treatment recommendations. Includes telemedicine and the delivery of health care services, including treatment of Mental Illness and Substance Use Disorders and diabetes counseling provided by licensed dietician nutritionists and certified diabetes educators, provided through an interactive telecommunications system, asynchronous store and forward system, remote patient monitoring technologies, Virtual Visits, and Virtual Check-Ins.

TOBACCO USE CESSATION PROGRAM
A program recommended by a Physician that follows evidence-based treatment, such as outlined in the United States Public Health Service guidelines to tobacco use cessation. "Tobacco Use Cessation Program" includes education and medical treatment components designed to assist a person in ceasing the use of tobacco products. "Tobacco Use Cessation Program" also includes education and counseling by Physicians or associated medical personnel and all FDA-approved medications for the treatment of tobacco dependence irrespective of whether they are available only over the counter, only by prescription, or both over the counter and by prescription. In addition, the Plan will communicate with You on an annual basis the importance and value of early detection and

proactive management of cardiovascular Disease. We provide free of charge, online and telephone tobacco cessation services. Please visit Our website at mercycarehealthplans.com or call Us at (877) 908-6027 for more information about how to obtain these services. We also cover with no Copayment or other cost-sharing, Prescription Drugs approved by the FDA for tobacco cessation.

TOBACCO USER
A person who is permitted under state and federal law to legally use tobacco, with tobacco use (other than religious or ceremonial use of tobacco), occurring on average four or more times per week that last occurred within the past six months (or such other meaning required or permitted by applicable law). Tobacco includes, but is not limited to, cigarettes, cigars, pipe tobacco, smokeless tobacco, snuff, etc.

For additional information, please call the number on the back of Your Identification Card or visit Our website at mercycarehealthplans.com.

TOTAL DISABILITY OR TOTALLY DISABLED
For a Subscriber or his or her employed covered spouse, that the person is at all times prevented from engaging in any job or occupation for wage or profit for which he or she is reasonably qualified by education, training, or experience.

For a covered spouse who is not employed and a covered Dependent child, Total Disability means a disability preventing the person from engaging in substantially all of the usual and customary activities of a person in good health and of the same age and sex.

Total Disability will be determined based upon the medical opinion of Our Medical Director and other appropriate sources.

UNPROTECTED SEXUAL INTERCOURSE
Sexual union between a male and a female, without the use of any process, device or method that prevents conception, including but not limited to, oral contraceptives, chemicals, physical or barrier contraceptives, natural abstinence or voluntary permanent surgical procedures, and includes appropriate measures to ensure the health and safety of sexual partners.

URGENT CARE
Care for an accident or Illness that You need sooner than a Routine doctor's visit. Examples include, but are not limited to, broken bones, sprains, non-severe bleeding, minor cuts and burns, and drug reactions.

VIRTUAL CHECK-IN
A brief patient-initiated communication using a technology-based service (excluding facsimile) between an established patient and a health care professional. "Virtual check-in" does not include communications from a related office visit provided within the previous seven days, or communications that lead to an office visit or procedure within the next 24 hours or soonest available appointment.

VIRTUAL VISIT
A patient-initiated, real-time audio or visual interaction via the use of technology, between a patient and a Health Care Provider at different locations for assessment, diagnosis, consultation, treatment, education, care management, and self-management.

WE/US/OUR
MercyCare HMO, Inc. (MercyCare)

WOMAN'S PRINCIPAL HEALTH CARE PROVIDER (WPHCP)
A Physician specializing in obstetrics or gynecology or specializing in family practice.

YOU/YOUR
Any Member enrolled in the Plan.