MercyCare HMO, Inc.
Small Group HMO
Member Certificate of Coverage

ENTIRE POLICY

This Certificate of Coverage (Certificate) describes the health insurance benefits provided by MercyCare HMO, Inc. (MercyCare) to covered Employees and their covered Dependents, through the Group. The Certificate of Coverage (Certificate), the Schedule of Benefits, the Group Contract, any riders, addenda or endorsements thereto, and the applications of the Group and the Employee, constitute the entire Policy. No change in the Policy shall be valid until approved by an executive officer of MercyCare and unless such approval be endorsed hereon or attached hereto. No agent has authority to change the Policy or to waive any of its provisions.

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.

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 Our Customer Service Department at (877) 908-6027, Your agent, or the *American Health Benefits Exchange*, also called the *Health Insurance 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	

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INTRODUCTION

UNDERSTANDING THIS CERTIFICATE

You should read this Certificate, the Schedule of Benefits, the Group Contract, and any riders, addenda or endorsements, 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 the coverage that You have.

Once You are enrolled, this is Your Certificate for as long as You remain eligible for and continue to elect coverage. This Certificate replaces any previous Certificates that You may have been issued. However, if the terms of this Certificate differ from the terms of the Policy, the Policy will govern.

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 Certificate have specific meanings and are capitalized throughout the document. These terms and their meanings can be found in the Glossary section of this Certificate.

INTERPRETING THIS CERTIFICATE

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

QUESTIONS?

If after You read this Certificate and/or other Policy documents, You have questions, please contact Your Group's Insurance Administrator or call Our Customer Service Department at (877) 908-6027. Any quotation of benefits given by a MercyCare representative is not a guarantee of coverage. Coverage is determined based on the terms and conditions of Your Policy.

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.

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 Enrollment Form. 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 Your Group's Employee benefits coordinator. You can also get this information in 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, or Urgent Care while outside the Service Area, to receive benefits for services described in this Certificate, 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.

REFERRAL REQUIREMENTS

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

- You, Your Primary Care Provider or Woman's Principal Health Care Provider must request and We must approve the Referral before You receive care.
- 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 charge 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 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, You 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. State mandated and Essential Health Benefit services will be reviewed for Medical Necessity prior to Claim payment.

Services and supplies requiring Prior Authorization include:

- 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 of the Covered Services that require Prior Authorization. Please contact Our Customer Service Department at (877) 908-6027 for more information.

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

The Plan must be contacted to arrange for continuity of care as stated in this section. If, at the time of Your enrollment or most recent renewal, MercyCare made materials available to You indicating that Your Health Care Provider was or would be a Participating Provider, that provider will be treated as a Participating Provider for You during Your entire plan year, even if the provider terminates as a Participating Provider. If You are undergoing a course of treatment with a Health Care Provider who terminates as a Participating Provider, that provider will continue to be treated as a Participating Provider for You until the earliest of (a) the end of the course of treatment, (b) 90 days from the provider's termination, or (c) the end of Your Plan year (if the course of treatment involves Your pregnancy, and You are in the second or third trimester at the time the provider terminates, the provider will continue to be treated as a Participating Provider for You through post-partum care). This paragraph does not apply to a provider who is no longer practicing in the Service Area, has lost his or her license, or is terminated from the Plan's provider network for professional misconduct.

Transition of Care Benefits
If You are a new HMO enrollee and You are receiving care for a condition that requires an Ongoing Course of Treatment or if You have entered into the second or third trimester of pregnancy, and Your Physician does not belong to the Plan's network, but is within the Plan's Service Area, You may request the option of transition of care benefits. You must submit a written request to the Plan for transition of care benefits within 15 business days of Your eligibility effective date.

If You are a current HMO enrollee and You are receiving care for a condition that requires an Ongoing Course of Treatment or if You have entered into the second or third trimester of pregnancy and Your Primary Care Provider or Woman's Principal Health Care Provider leaves the Plan's network, You may request the option of transition of care benefits. Seeing a Physician once or twice a year for a Chronic Condition does not qualify as "Ongoing Course of Treatment". You must submit a written request to the Plan for transition of care benefits within 30 business days after receiving notification of Your Primary Care Provider or Woman's Principal Health Care Provider's termination.

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 covered Employee 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. This 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 applicable Deductible amounts, 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 Employee 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 or Coinsurance 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:

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

We have the right to transfer You (at no expense to You) to the facility of Our choice upon receiving confirmation from Your attending Physician that You are able to travel.

We will reimburse Your Covered Expenses as if You had utilized 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 only for the Deductible, Coinsurance and/or Copayment amounts that apply to a Participating Provider.

Treatment of an Emergency

If You obtain Emergency treatment in the Hospital emergency room, Your Primary Care Provider or Woman's Principal Health Care Provider must be notified of Your condition as soon as possible and benefits will be limited to the initial treatment of Your Emergency Medical Condition unless further treatment is ordered by Your Primary Care Provider or Woman's Principal Health Care Provider. If inpatient Hospital care is required, it is especially important for You or Your family to contact Your Primary Care Provider or Woman's Principal Health Care Provider as soon as possible.

When You receive Emergency treatment in a Hospital emergency room, You will be responsible for the Deductible, Copayment and/or Coinsurance amounts as shown in the Schedule of Benefits. Services provided for the treatment of criminal sexual assault are provided without Deductible or other cost sharing.

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 Certificate. If You are admitted to the Hospital as an inpatient immediately following emergency treatment, the emergency room Copayment, if one was applied, will be waived.

Post-stabilization Services Following an Emergency:
If post-stabilization services, are provided at a facility that is not a Participating Provider and are determined to be Medically Necessary by Us, such services will be considered Covered Services if a treating Physician licensed to practice medicine in all its branches documents in Your medical record Your presenting symptoms; Emergency Medical Condition; and time, phone number dialed, and result of the communication for request for authorization of post-stabilization medical services and 1) We authorize such care or 2) after two documented good faith efforts, the treating Physician has attempted to contact MercyCare for Prior Authorization of post-stabilization medical services and We were not accessible or the authorization was not denied within 60 minutes of the request.

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.

In the Service Area
To be covered, Urgent Care must be received from a Participating Provider or at a participating Urgent Care center. Urgent Care locations can be found at www.mercyhealthsystem.org.

Outside the Service Area
If You require Urgent Care and You are outside the Service Area and cannot return home without medical harm, You should seek care by the nearest Physician, hospital or clinic.

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 Certificate 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:

- Your benefits for the diagnosis and treatment of Autism Spectrum Disorder(s) are the same as your benefits for any other condition. Treatment for Autism Spectrum Disorder(s) shall include the following care when prescribed, provided or ordered for an individual 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, and
- Urinary incontinence.

Biofeedback services must have Prior Authorization from 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 Certificate.

CARDIAC REHABILITATION

Cardiac rehabilitation is covered when Medically Necessary and with Prior Authorization from 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 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 Certificate.

- 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 completely-bony-impacted teeth.
  - 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 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 periodontic 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.
- Regular foot care exams by a Physician.

DURABLE MEDICAL EQUIPMENT AND MEDICAL SUPPLIES

Covered Services:
Durable Medical Equipment (DME) 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 Ongoing Course of Treatment devices, and are covered. Dental braces are excluded from coverage.
- Prescription foot Ongoing Course of Treatment 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:

A – E	F – O	P – Z
• Air conditioners • Air cleaners • Air purifiers • Air humidifiers • Air dehumidifiers • Alcohol wipes • Alternative communication devices (except as otherwise described as covered in this Certificate) • Automobile modifications or lifts • Band-Aids • Baskets (for wheelchairs or walkers) • Bath benches • Bath chairs • Car seats • Cervical pillows • Dressing sticks or aids • Diapers • Disposable gloves • Disposable undergarments • Eating utensils • Egg crate mattress pads • Electric patient lifts • Ergonomic chairs	• 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 • Oral hygiene products • Oral nutritional supplements or infant formula available OTC • OTC antibiotic ointments • OTC dressing supplies (e.g. 4X4 gauze, tape, betadine, etc.)	• 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 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 Certificate.

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 non-Plan Member.
- Genetic Counseling that is associated with a non-covered genetic test.
- Genetic Testing when the results will not provide a 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 obtained through a Participating Provider Physician or audiologist.
    - The reconditioning and repair of existing aids is covered when considered Medically Necessary.
    - New hearing aids are covered one per ear in a 24-month period.
    - 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 hearing aid per ear during any 24-month period.

HOME HEALTH CARE

Covered Services:

- Home health care benefits are 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 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.
- It is necessary that the attending Physician establish a home health care plan, approve it in writing and review this plan at least every 2 months, unless the attending Physician determines that less frequent reviews are sufficient
- Home health care means one or more of the following:
  - 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; and
  - Nutritional counseling under the supervision of a registered or certified dietitian if considered Medically Necessary as part of the home care plan.
- 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.

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 Certificate.
    - 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 Certificate.

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. This Plan provides coverage for the following:

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 3 hours per day, 2 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
A psychiatric collaborative care model is 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
Covered Services received for detoxification are not subject to the Substance Use Disorder treatment provisions specified above. Benefits for Covered Services received for detoxification will be provided under the “Hospital Services” and “Physician Services” provisions in this section of the Certificate, as for any other condition.

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:

- Outpatient and inpatient treatment, including psychological testing and neuropsychological testing, of Mental Illness and/or Substance Use Disorder. Services must be provided by a provider whose services have been Prior Authorized by MercyCare. The services must be considered Medically Necessary.
- 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 performed 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 provided 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, someone 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 the Employee, the Employee's covered Dependent spouse, or the Employee's covered Dependent child.

Covered Services:
- Pre-natal 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 caesarean 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 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 Certificate (and notwithstanding anything in the 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 above 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 people at high risk;
- Hepatitis C virus (HCV) screening for adults at high risk for infection;
- One time Hepatitis C virus screening for adults born between 1945 and 1965.

- Human Immunodeficiency Virus (HIV) screening for everyone ages 15 to 65, and other ages at increased risk;
- 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 (Chickenpox)
- Lung cancer screening for adults 55 to 80 years at high risk for lung cancer because they are heavy smokers or have quit in 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;
- Statin preventive medication for adults aged 40 to 75 years with no history of cardiovascular Disease (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.
- Syphilis screening for adults at higher risk;
- Tuberculin screening for adults at higher risk;
- Tobacco Use Cessation Program for tobacco users.

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;
- Breast cancer genetic test counseling (BRCA) about Genetic Testing and counseling for women at higher risk for breast cancer;
- 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 applies if Your Schedule of Benefits indicates that Your Plan is a high deductible health plan (HDHP).
- Breast cancer chemoprevention 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. This does not apply to health plans sponsored by certain exempt “religions employers.”

- Domestic and interpersonal violence screening and counseling for all women;
- Folic acid supplements for women who may become pregnant;
- Gestational diabetes screening for women 24 through 28 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 30 or older;
- Intrauterine device (IUD) services related to follow-up and management of side effects, counseling for continued adherence and device removal;
- 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;
- Sexually transmitted infections (STI) counseling for sexually active women;
- Syphilis screening for all pregnant women or other women at increased risk;
- Tobacco use screening and cessation interventions for all women with expanded counseling for pregnant Tobacco Users; and
- Well-woman visits to obtain recommended Preventive services for women

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 screening for children of all ages;
- Cervical dysplasia screening for sexually active females;
- Depression screening for adolescents;
- Development screening for children under age three, and surveillance throughout childhood;
- Dyslipidemia screening for children of all ages;
- Fluoride varnish application to the primary teeth of all infants and children starting at the age of primary tooth eruption;
- Fluoride chemoprevention supplements for children ages 6 months through 5 years without fluoride in their water source;
- Gonorrhea preventive medication for the eyes of all newborns;
- Hearing loss screening for all newborns;
- Height, weight, and body mass measurements for children of all ages;
- Hematocrit or hemoglobin screening for all children;
- Hemoglobinopathies or sickle cell screening for all newborns;
- Hepatitis B screening for adolescents at high risk for infection;
- HIV screening for adolescents at higher risk;
- Hypothyroidism screening for newborns;
- The following immunization vaccines for children from birth through age 18 (doses, recommended ages, and recommended populations vary):
    - Diphtheria, Tetanus, Pertussis (Whooping Cough)
    - Haemophilus influenza type b
    - Hepatitis A
    - Hepatitis B
    - Hepatitis C virus (HCV)
    - Human papillomavirus

  - Inactivated Poliovirus Vaccine
  - Influenza (Flu shot)
  - Measles, Mumps, Rubella
  - Meningococcal
  - Pneumococcal
  - Rotavirus
  - Varicella (Chickenpox)
  - 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 through 12 months at risk for anemia;
- Lead screening for children at risk for exposure;
- Medical history for all children throughout development ages 0 through 17;
- Newborn Blood Screening for 3-5 days of age according to American Academy of Pediatrics recommendations
- Obesity screening and counseling;
- Oral health risk assessment for young children ages 0 through 10;
- 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;
- Tobacco use counseling and education;
- Tuberculin testing for children at higher risk of tuberculosis;
- 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 SERVICE – OUTPATIENT

Covered Services:
Outpatient Private Duty Nursing services, as follows:

- *Description of Private Duty Nursing services:*
  - Includes teaching and monitoring of complex care skills such as tracheotomy suctioning, medical equipment use and monitoring to home caregivers.
  - Is not intended to provide for long-term supportive care.
- *Coverage conditions:*
  - Covered only when such services can only be provided by a licensed Health Care Provider, and cannot be provided by non-professional personnel.
  - Not covered when 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 are also covered when required because of wear or a change in Your condition.
- 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.
- Medically Necessary Orthotic Devices when obtained by a Participating Provider.

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.
- Replacement of cataract lenses unless a prescription change is required.

REPRODUCTIVE / INFERTILITY SERVICES

Covered Services:

- Diagnosis and treatment of Infertility, as follows:
  - *Description of covered services, which include but are not limited to*:
    - In vitro fertilization (IVF);
    - Uterine embryo lavage;
    - Embryo transfer;
    - Artificial insemination;
    - Gamete intra-fallopian tube transfer (GIFT);
    - Zygote intra-fallopian tube transfer (ZIFT);
    - Low tubal ovum transfer;
    - Intracytoplasmic sperm injection (ICSI).
    - Oocyte removal (maximum 6 per year). The covered individual has not undergone 4 completed oocyte retrievals, except that if a live birth follows a completed oocyte retrieval, then 2 more completed oocyte retrievals shall be covered and the procedures are performed at medical facilities that conform to the American College of Obstetric and Gynecology guidelines for in vitro fertilization clinics or to the American Fertility Society minimal standards for programs of in vitro fertilization.
- Coverage conditions:
  - *IVF, GIFT, ZIFT or ICSI procedures will only be covered 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; and
    - 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.
- 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 provided to a surrogate for purposes of childbirth; however, medical expenses incurred by a surrogate for Infertility-related medical expenses will be covered.
- Costs for an egg or sperm donor which are not Medically Necessary, including any fees paid to the donor for non-medical services;
- 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 a 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, podiatrist, or other Health Care Provider acting within the scope of his or her license. Includes:
  - Surgery for morbid obesity including, but not limited to, bariatric surgery.
  - 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 in connection with a covered surgical procedure performed by a Physician, dentist or podiatrist other than the operating surgeon, or by a certified registered nurse anesthetist.
- 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.

TEMPOROMANDIBULAR DISORDERS

Covered Services:

Diagnostic procedures and Medically Necessary surgical and non-surgical treatment for the correction of temporomandibular disorders (TMJ), including a prescribed intraoral splint therapy device, 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 a Congenital, developmental or acquired deformity, Sickness or Bodily Injury.
- The procedure or device must be reasonable and appropriate for the diagnosis or treatment of the condition, under the accepted standards of the profession of the Health Care Provider providing the service.
- The purpose of the procedure or device is to control or eliminate infection, pain, Disease or dysfunction.

Non-Covered Services:

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

TRANSPLANTS

All transplant-related services, including evaluation, must be Prior Authorized by Us prior to Your receipt of 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 or 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 the 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 Certificate.

Covered Services:

- Organ and tissue transplant surgery, limited to those procedures that are considered by Us to be Medically Necessary and effective. We may deny coverage 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 Certificate are also 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.
- Immunosuppressive drugs
    - When a prescribing Participating Provider Physician 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 Physician 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 Physician 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 Physician may initiate an appeal, and include information regarding the procedure for the prescribing Physician to initiate the Policy appeal process.
- Donor screening and identification costs under approved matched unrelated donor programs. Benefits for Covered Services received will be the same as described in their respective benefit sections.
- 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 Us. If the recipient of the transplant is a Dependent Child under the limiting age of this Certificate, 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 the Plan.
- Transplants and all related expenses that have not been prior authorized by Us.
- Investigational drugs.
- 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 individual 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 Certificate.

VIRTUAL VISITS

Your Plan provides benefits for Covered Services obtained through a Virtual Visit. A Virtual Visit is a real-time audio or visual interaction via the use of technology, between patients and Health Care Providers at different locations for assessment, diagnosis, consultation, treatment, education, care management, and self-management. Services covered under this benefit include Virtual Visits for the treatment of Mental Illness and Substance Use Disorders, and diabetes counseling provided by licensed dietician nutritionists and certified diabetes educators.

Not all conditions can be addressed via a Virtual Visit. If the Virtual Visit provider cannot provide the care that You need, 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 Virtual Visit Provider refers You to another care setting.

VISION CARE

Covered Services:

- Routine vision examinations, including refraction to detect vision impairment, received from a Participating Provider in the provider's office.
- Medical eye examinations provided as part of the treatment for pathological conditions when provided by or at the direction of a Participating Provider Physician.
- Initial eyeglasses or contact lenses after cataract surgery if purchased from a Participating Provider.
- For children under the age of 19, prescription glasses (including lenses and frames) or contact lenses, as limited by the Schedule of Benefits.

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.
  - 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.
- An 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 Health Care 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.
- Cancer therapy. Prescription Drug coverage available for the treatment of cancer must be 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 is 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, coverage will be provided as described in the "Preventive Care Services" provision of this section of Your Certificate.
- Human papillomavirus (HPV) vaccine approved by the FDA.
- Shingles vaccine approved by the federal Food and Drug Administration.
- Allergy testing and treatment.
- Topical eye medication prescribed to treat a Chronic condition of the eye.
- Amino acid-based elemental formulas for the diagnosis and treatment of eosinophilic disorders and short- bowel syndrome.
- Infusion therapy.
- A second opinion from a Health Care 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.
- Treatment for a fibrocystic breast condition is covered in the absence of a breast biopsy demonstrating an increased disposition to the development of breast cancer unless the Member's medical history is able to confirm a chronic, relapsing, symptomatic breast condition.

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 under 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 Certificate.

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" subsection below for information on drugs not covered under the drug plan.

We determine 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 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 Health Care Provider about your Prescription Drug coverage. Doing so can help him or her to make decisions about which prescriptions to prescribe and how they should be filled.
- 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 Prescription Drug coverage.
- 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 in the Formulary that has been prescribed by your Health Care Provider.
- 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 or expense must be all of the following:

- Prescribed by:
  - A Participating Provider; or
  - A Non-Participating Provider for treatment of an Emergency Medical Condition; or
  - A Non-Participating Provider that a Member has been 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;
- 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 Us.

In general, the Plan only cover 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

We require that You obtain Prior Authorization for certain Prescription Drugs before We will cover them. The Formulary indicates which Formulary Prescription 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.** This Prior Authorization review ensures that Prescription Drugs are used in a manner consistent with all criteria cited in the "Covered Drugs" provision above.

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

Standard Review Request
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 72 hours after We receive Your Prior Authorization request. If We approve Your request, 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.

Expedited Review Request
If, due to urgent circumstances, You need a fast response to a Prior Authorization request, You (or Your designee or prescriber) may request an expedited review. Urgent circumstances exist if:

- You are suffering from a health condition that may seriously jeopardize Your life, health or ability to gain maximum function; or
- You are undergoing a 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 Prior Authorization request.

If We approve Your request, 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.

EXCEPTION REQUESTS

You may request a coverage exception for non-covered prescription drugs in the following circumstances:

- The drug is not included on the Formulary and thus is not covered.
- We are discontinuing coverage of the drug.
- The alternative Prescription Drug 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 enrollee's Disease or medical condition; or
    - Is likely to be ineffective or 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 coverage 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 Certificate 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 Member Identification Card is entered into the pharmacist's computer, the pharmacist will be able to:

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

Paying for a Prescription

See 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 mercycarehealthplans.com, or by calling Our Customer Service Department at 1-877-908-6027. 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;
- 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 Limits
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, 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 the following conditions are met:

- The Prescription Drugs must be included on the Formulary or have been approved through the Formulary exceptions process;
- The Prescription Drugs must be maintenance medications and You have available refill quantities at the time of synchronization;
- The medications must 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 must not have special handling or sourcing needs or require a single, designated pharmacy to fill or refill the prescription.

SPECIAL INFORMATION FOR CERTAIN PRESCRIPTION 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 We can help You avoid addiction is to encourage You to get Your prescriptions for narcotics only from the Health Care Provider 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
For many health conditions, treatment involves Prescription Drugs that require special delivery and instructions. These specialty drugs are designated as such in the Formulary. If Prior Authorization is required, coverage will be limited to the quantity or day supply approved in the Prior Authorization. Specialty drugs are only covered when you get them from a designated specialty pharmacy. You can find a list of designated specialty pharmacies at mercycarehealthplans.com.

Immunosuppressant Drugs
When Your prescribing Health Care Provider has indicated "MAY NOT SUBSTITUTE" on an immunosuppressant drug prescription, We will not require You to change or switch to another immunosuppressant drug or formulation without notifying and getting documented consent from the prescribing Health Care Provider. If the Member is a child, We will notify and get consent from the Member's parent or guardian. If the Member's spouse is authorized to consent to the treatment of the Member, We will notify and get consent from the spouse.

Should We make a Formulary change that would alter coverage for a Member receiving immunosuppressant drugs, We will notify the prescribing Health Care Provider and the Member at least 60 days prior to the change. Similar to above, We will notify and obtain consent from the parent or guardian if the Member is a child, and from the spouse if the spouse is authorized to consent on behalf of the Member. The notification will be in writing and will disclose the Formulary change, indicate that the prescribing Health Care Provider may initiate and appeal; and include information regarding how the prescribing Health Care Provider can initiate Our appeal process.

Off-Label Cancer Drugs
If We cover FDA-approved Prescription Drugs for certain types of cancer, We will not deny coverage of a Prescription Drug solely on the basis that the drug was 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 FDA-approved, and one of the following established reference compendia must recognize the Prescription Drug to treat the specific type of cancer for which it has been prescribed:

- The American Hospital Formulary Service Drug
- Information
- National Comprehensive Cancer Network's Drugs & Biologics Compendium;
- Thomson Micromedex's DrugDex
- Elsevier Gold Standard's Clinical Pharmacology
- Authoritative compendia as identified from time to time by the Federal Secretary of Health and Human Services; or 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, We will also cover any Medically Necessary services associated with the administration of such a drug.

Despite what is stated in this provision, We are not be required to cover any Experimental or Investigational drugs or any drug that the FDA has determined to be contraindicated for treating 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 interpreted, 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.

Immune Gamma Globulin
We will cover immune gamma globulin therapy for Members diagnosed with a primary immunodeficiency when prescribed by a Physician due to Medical Necessity.

An initial Prior Authorization will be for no less than three months. Reauthorization may occur every six months after that. For Members who have been in treatment for two years, reauthorization will be no less than every 12 months, unless a Physician indicates that reauthorization needs to occur more frequently.

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 AND EXPENSES

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 to You by the Health Care Provider. Such drugs if Medically Necessary may however be covered under the "Medical Benefit Provisions" of the Policy.
- A brand name Prescription Drug when a Generic is available.
- A Generic or brand name Prescription Drug that:
    - Is available over-the-counter; AND
    - The over-the-counter version is listed as covered in the Formulary.
- A 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 with similar intent;
- Experimental drugs; or FDA-approved drugs used for non-FDA approved uses, or FDA-approved drugs used in non-FDA approved regimens, even if You are charged. This exclusion does not include any Prescription Drug which meets the following criteria:
    - The drug is prescribed for the treatment of HIV infection or an Illness or medical condition arising from or related to HIV infection; and
    - The drug Is FDA-approved, including phase-3 Investigational drugs; and
    - If the drug is an Investigational new drug, it 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 service, or the treatment of a complication from a non-covered procedure or service.
- Any Prescription Drug for a Sickness or Bodily Injury not covered by the Plan.
- Medication, other than Prescription Drugs or preferred OTC drugs, for which a Member does not have a prescription.
- Prescription Drugs which a Member is entitled to get 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 this Policy, or after the Member's Policy 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 a 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 for coverage 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, which are 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 which arose from or was sustained during the course of paid employment (for compensation, profit or gain) if:
    - The services, supplies or expenses were covered, or would have been covered, 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, even if coverage is initially denied, until any 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 Occupational Disease Act or Law.
    - This exclusion does not apply to an Employee who is not required to have coverage under a Worker's Compensation or Occupational Disease Act or Law, and who discloses the lack of such coverage on the Group Application.
- Services or supplies that are furnished to You by the local, state or federal government, or payments or benefits for services or supplies that are provided by or available from the local, state or federal government (for example, Medicare) whether or not You receive those payments or benefits.
    - This exclusion shall not be applicable to medical assistance benefits under Article V, VI, or VII of the Illinois Public Aid Code (305 ILCS 5/ 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
        - Routine Patient Care associated with Experimental or Investigational treatment if You are a qualified individual participating in an Qualified Clinical Trial, if those services or supplies would otherwise be covered under this Certificate if not provided in connection with an Qualified Clinical Trial program.
        - Applied Behavior Analysis used for the treatment of Autism Spectrum Disorder granted at the time the services and supplies are provided.
- Unless otherwise stated in this Certificate, 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 Certificate.
- 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 Certificate.
- Repair or replacement of appliances and/or devices due to misuse or loss, except as specifically stated in this Certificate.
- 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 You are not charged, or for which You would otherwise 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 described in the "Hospice Care" provision of the "Medical Benefit Provisions" section.
- Inpatient Private Duty Nursing services.

- Occupational therapy, physical therapy and speech therapy which are considered Maintenance Therapy, except as specifically described in this Certificate.
- 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 Certificate.
- All services or supplies not specifically covered in the "Medical Benefit Provisions" or the "Prescription Drug Benefit Provisions" sections of this Certificate or in any rider attached to the Policy.
- Any service not provided or received in accordance with the terms and conditions of this Certificate or the Policy.
- Ancillary medical services (including Hospital facility charges, anesthesia charges, 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, services, supplies or devices used to obtain, treat, or enhance sexual performance and/or function.
- Acupuncture.
- Vasectomy reversal.
- Services and/or supplies provided to You outside the United States, unless they are related to treatment of an Emergency Medical Condition, notwithstanding any provision in the Certificate to the contrary.
- Services, supplies and drugs rendered or provided to You outside of the United States, if the purpose for traveling to the location was to obtain medical services, supplies or drugs.
- Dental care, except as directly required to treat a medical condition or as otherwise described as covered in this Certificate.
- 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 which takes place at home (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.

ELIGIBILITY FOR COVERAGE

Eligibility Overview

Subject to the other terms and conditions of this Policy, Employees who meet the following qualifications are eligible for coverage under this Policy:

- Meet the definition of Employee as specified in the Group Policy;
- Have applied for this coverage;
- Have received a MercyCare Identification Card;
- Reside, live or work in Our Service Area.
- You may call Your Group or Our Customer Service at (877) 908-6027 for more information regarding Our Service Area.
- If Medicare eligible, have both Part A and B coverage.

If You choose Employee-Only Coverage, only Your own health care expenses are covered, not the health care expenses of other Members of Your family.

If You choose Family Coverage, Your health care expenses and those of Your enrolled Dependents are covered. Please see the definition of "Dependent" in the Glossary for more information about who is eligible for enrollment as a Dependent in Family Coverage.

Special Dependent Eligibility Provisions

Continued eligibility due to disability

- A covered Dependent child who reaches the limiting age of 26 while covered under this Policy will remain eligible for coverage if he or she is incapable of self-sustaining employment because of an intellectual disability or physician disability which existed before the Dependent Child reached the limiting age.
    - To retain eligibility for coverage under this Policy, the Dependent child must continue to be dependent on his or her parents or other care providers for lifetime care and supervision.
    - Within two months of the Dependent child reaching the limiting age, or at any reasonable time he or she reaches the limiting age, We may inquire whether the Dependent child is in fact a disabled and dependent person.
        - Written proof of disability and dependency must be provided to Us within 31 days after Our inquiry.
        - If written proof is not provided within 31 days, We may terminate the coverage of the Dependent child.
    - At Our sole discretion, We may require the Dependent child to be examined from time to time by a Health Care Provider to determine the existence of the incapacity prior to granting continued coverage.
        - These examinations may occur at reasonable intervals during the first two years after We grant continued coverage, and annually thereafter.

Continued eligibility due to U.S. Armed Forces service

- An enrolled, unmarried Dependent child will continue to be eligible for coverage under this Policy until reaching the age of 30 if he or she:
    - Lives within the Service Area;
    - 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.

Continued eligibility for college student on Medical Leave of Absence

- A Dependent child who is a college student and who is on a medical leave of absence, or who reduces his or her course load to part-time status because of a catastrophic Illness or Injury, may continue coverage under this Policy subject to all of the Policy's terms and conditions for a limited period of time.
    - Continuation of coverage shall terminate 12 months after We receive notice of the Dependent child's Sickness or Bodily Injury, or until the coverage would have otherwise ended pursuant to the terms and conditions of the Policy, whichever comes first.

- For coverage to continue, the need for a medical leave of absence or the need for part-time status must be supported by clinical documentation from a Physician.

Replacement of Discontinued Group Coverage – Total Disability
When Your Group initially purchased this coverage to replace coverage offered by another Carrier, those persons who are Totally Disabled on the effective date of this coverage and who were covered by the previous carrier will be considered eligible for coverage under this Policy.

Your Totally Disabled Dependents will be considered eligible if they meet the definition of "Dependent" listed in the Glossary of this Certificate.

Your Dependent children who have reached the limiting age will be considered eligible Dependents if they were covered by the previous carrier and, because of a disability condition, are incapable of self-sustaining employment and are Dependent upon You or other care providers for lifetime care and supervision.

If You are Totally Disabled, You will be entitled to all of the benefits of this Policy. These benefits will be coordinated with the benefits offered by the previous carrier. If this Policy does not cover the services you receive for your disabling condition, Your previous carrier will be considered the primary payer for those services.

The provisions of this Policy regarding Primary Care Provider Referral remain in effect for Totally Disabled Members.

Individuals Ineligible for Coverage
The following individuals are not eligible for coverage:

- Incarcerated individuals, other than incarcerated individuals pending disposition of charges.
- Individuals that do not live, reside or work in the network Service Area.
- Individuals that do not meet the Plan's eligibility requirements or residency standards, as appropriate.

The list of individuals who are ineligible for coverage is subject to change by the Us and/or applicable law, as appropriate.

INITIAL ENROLLMENT

How To Enroll
You may apply for coverage for yourself and any eligible Dependents by submitting the Enrollment Form, along with any exhibits, appendices, addenda and/or other required information, to Us. You can get the Enrollment Form from Your Group Administrator.

Please note: Your request for coverage may or may not be accepted. Some Employers only offer coverage to their Employees, not to their Employee's spouses, parties to a Civil Union, Domestic Partners, or Dependent children. In those circumstances, any references in this Certificate to an Employee's Dependents or family members are not applicable.

Enrollment Effective Date
The effective date of coverage for the Employee and any enrolled Dependents is indicated on a Member's Identification Card.

Enrollment Nondiscrimination Policy
No eligibility rules or variations in premium will be imposed based on Your health status, medical condition, Claims experience, receipt of health care, medical history, genetic information, evidence of insurability, disability or any other health status related factor.

You will not be discriminated against for coverage under this Policy on the basis of race, color, national origin, disability, age, sex, gender identity or sexual orientation.

Variations in the administration, processes or benefits of this Policy that are based on clinically indicated, reasonable medical management practices, or are part of permitted wellness incentives, disincentives and/or other programs do not constitute discrimination.

This section “Initial Enrollment” is subject to change by the Plan, and/or applicable law, as appropriate.

ANNUAL ENROLLMENT PERIODS

Annual Open Enrollment and Dual Choice Enrollment Periods
Your Group will designate an annual Open Enrollment Period or Dual Choice Enrollment Period, during which You may apply for or change coverage for yourself and/or Your Dependents.

If you did not enroll yourself and/or Your Dependents in coverage when You were initially eligible, You may enroll yourself and/or Your Dependents during Your Group’s Open Enrollment Period or Dual Choice Enrollment Period. You may enroll yourself and/or any eligible Dependents by submitting a completed Enrollment Form. You can get an Enrollment Form from Your Group.

If You did enroll yourself and/or your eligible Dependents when You were when initially eligible, You may make changes to Your or coverage during Your Group’s Open Enrollment Period or Dual Choice Enrollment Period. You may make enrollment changes by submitting a Change of Status Form. You can get a Change of Status Form from Your Group.

When You enroll during the annual Open Enrollment Period or Dual Choice Enrollment Period, You and/or Your eligible Dependents effective date will be the following January 1, unless otherwise designated by the Plan, as appropriate.

Adding a Newborn
You do not need to submit an Enrollment Form or Change of Status Form to add a newborn to Family Coverage if an additional premium amount is not required. You must notify Your Group within 31 days of the newborn’s birth for coverage to continue beyond the 31-day period. If you do not, You will have to wait until Your Group's next Open Enrollment Period to enroll the child.

This section “Annual Enrollment Periods” is subject to change by the Plan, and/or applicable law, as appropriate.

SPECIAL ENROLLMENT PERIODS

Special Enrollment Periods / Effective Dates
Special enrollment periods have been designated during which You may apply for or change coverage for yourself and/or Your Dependents. To qualify for the changes described in this Special Enrollment Periods section, You must apply for or request a change in coverage within 30 days from the date of a special enrollment event, except as described below.

Except as otherwise described below, Your effective date will be no later than the first day of the first calendar month following Your request for special enrollment.

Special Enrollment Events
- You gain or lose a Dependent, or become a Dependent through marriage, becoming a party to a Civil Union or establishment of a Domestic Partnership, if Your Group covers Domestic Partners. New coverage for You and/or Your eligible spouse, party to a Civil Union or Domestic Partner and/or Dependents will be effective no later than the first day of the first calendar month following Your request for special enrollment.
- You gain a Dependent through birth, placement of a foster child, adoption or placement of adoption or court-ordered Dependent Coverage. New coverage for You and/or Your eligible spouse, party to a Civil Union or Domestic Partner, provided Your Group covers Domestic Partners, and/or Dependents will be effective from the moment of birth, placement of a foster child, adoption, or placement of adoption. However, the effective date for court-ordered eligible child coverage will be determined by Us in accordance with the provisions of the court order.
- You lose eligibility for coverage under a Medicaid plan or a state child health plan under title XXI of the Social Security Act. You must request coverage within 60 days of the loss of coverage.

- You become eligible for assistance, with respect to coverage under the Group health plan or health insurance coverage, under such Medicaid plan or state child health plan. You must request coverage within 60 days of such eligibility.

This section “Special Enrollment Periods/Effective Dates” is subject to change by Plan and/or applicable law, as appropriate.

Other Special Enrollment Events / Effective Dates of Coverage
You must apply for or request a change in coverage within 30 days from the date of the below other special enrollment events in order to qualify for the changes described in this Other Special Enrollment Events/Effective Dates of Coverage section. You can do this by submitted a completed Enrollment Form or Change in Status Form.

Except as otherwise provided below, Your effective date will be no later than the first day of the first calendar month following Your request for special enrollment.

- Loss of eligibility as a result of:
  - Legal separation, divorce, or dissolution of a Civil Union or a Domestic Partnership, provided Your Group covers Domestic Partners;
  - Cessation of Dependent status (such as attaining the limiting age to be eligible as a Dependent child under this Certificate);
  - Death of an Employee;
  - Termination of employment, reduction in the number of hours of employment.
- Loss of coverage through an HMO in the individual market because You and/or Your eligible spouse, party to a Civil Union, Domestic Partner and/or Dependents no longer reside, live or work in the network Service Area.
- Loss of coverage through an HMO, or other arrangement, in the group health insurance market because You and/or Your eligible spouse, party to a Civil Union or Domestic Partner and/or Dependents no longer reside, live or work in the network Service Area, and no other coverage is available to You and/or Your eligible spouse, party to a Civil Union, Domestic Partner and/or Dependents.
- Loss of coverage due to a plan no longer offering benefits to the class of similarly situated individuals that include You.
- Your Group ceases to contribute towards Your or Your Dependent's coverage (excluding COBRA continuation coverage).
- COBRA continuation coverage is exhausted.

Coverage resulting from any of the special enrollment events outlined above is contingent upon timely completing an Enrollment Form or Change of Status Form and paying the appropriate premium in accordance with the guidelines as established by the Us. Your spouse, party to a Civil Union or Domestic Partner (provided Your Group covers Domestic Partners) and other Dependents are not eligible for a special enrollment period if the Group does not cover Dependents.

This section “Other Special Enrollment Periods/Effective Date of Coverage” is subject to change by the Plan and/or applicable law, as appropriate.

LATE ENROLLMENT

If You do not apply for Family Coverage or add Dependents within the allotted time, You will have to wait until Your Group's annual Open Enrollment Period or Dual Choice Enrollment Period to do so.

REINSTATEMENT

Group Reinstatement
Reinstatement: In the event this Policy is terminated for non-payment, the Plan reserves the right to reinstate this Policy. Reinstatement by the Plan includes, but is not limited to the following conditions: payment of all past due premiums, a reinstatement fee is paid by policy holder, payment for current and following months premium are paid in advance.

Employee Reinstatement
If an employee is eligible for reinstatement they must follow their employer's eligibility guidelines as established in the group contract.

NOTIFICATION OF CHANGES

It is the Employee's responsibility to notify Us of any changes to the Employee's or Dependents' enrollment information, such as name, address, or other information included on the Enrollment Form. Any such changes may result in coverage/benefit changes for You and Your eligible Dependents.

BENEFIT CHANGES

Any increase in benefits will become effective on the date the benefits change if the Employee is in Active Status. Otherwise, the change will be effective on the day following the date that the Employee returns to Active Status.

If Dependent Coverage is in effect, an increase in benefits will be delayed for covered Dependents if the Dependent is Confined in an institution operated for the care of mentally or physically sick, injured or disabled persons. An increase in the Dependent's coverage will be effective on the day after discharge from Confinement. Discharge from Confinement must be certified by a Physician.

Any decrease in benefits will become effective on the date the benefits change.

MEDICARE-ELIGIBLE COVERED PERSONS

A series of federal laws collectively referred to as the ``Medicare Secondary Payer'' (MSP) laws regulate the manner in which certain Employers may offer Group health care coverage to Medicare-eligible Employees, spouses, and in some cases, Dependent children.

References to "spouse" under this section do not include a party to a Civil Union with the eligible Employee or the Domestic Partner (provided Your Employer covers Domestic Partners) of the eligible Employee or their children.

The statutory requirements and rules for MSP coverage vary depending on the basis for Medicare and employer Group health plan ("GHP") coverage, as well as certain other factors, including the size of the employers sponsoring the GHP. In general, Medicare pays secondary to the following:

- GHPs that cover individuals with end-stage renal Disease ("ESRD") during the first 30 months of Medicare eligibility or entitlement. This is the case regardless of the number of Employees employed by the employer or whether the individual has "current employment status."
- In the case of individuals age 65 or over, GHPs of employers that employ 20 or more Employees if that individual or the individual's spouse (of any age) has "current employment status." If the GHP is a multi-employer or multiple employer plan, which has at least one Participating employer that employs 20 or more Employees, the MSP rules apply even with respect to employers of fewer than 20 Employees (unless the plan elects the small employer exception under the statute).
- In the case of disabled individuals under age 65, GHPs of employers that employ 100 or more Employees, if the individual or a Member of the individual's family has "current Employee status." If the GHP is a multi-employer or multiple employer plan, which has at least one Participating employer that employs 100 or more Employees, the MSP rules apply even with respect to employers of fewer than 100 Employees.

Please see Your employer or Group administrator if You have any questions regarding the ESRD primary period or any other provisions of the MSP laws and their application to You, Your spouse or Your Dependents.

TERMINATION OF COVERAGE

Coverage terminates for Employees and covered Dependents on the date when one of the following happens:

- The Policy terminates; or
- A Covered Expense is no longer covered by the Policy, except that termination then relates only to that Covered Expense.

Your Group has the authority to terminate, amend or modify the coverage described in this Policy. If this coverage is terminated, You will not receive benefits. If it is amended or modified, You may not receive the same benefits.

Coverage also terminates for Employees and covered Dependents for any of the reasons listed below. The termination date for these reasons may be on the date the event happens, or it may be at the end of the month after it happens, depending on which date the Group chooses on the Group Application. (You may consult the Group to determine which date applies to You.)

- The Employee's employment terminates;
- The Employee ceases to meet eligibility requirements under the Policy;
- The Member requests voluntary disenrollment;
- The Employee retires, or;
- The Dependent no longer qualifies as an eligible Dependent.

Coverage for a Dependent child will end on the last day of the calendar month in which he or she reaches the limiting age.

If one of Your Dependents no longer qualifies as an eligible Dependent for a reason other than reaching the limiting age, his or her coverage will end as of the date the event occurs which makes him/her ineligible (for example, the date of divorce).

DISCONTINUATION OF COVERAGE

If We decide to discontinue offering a particular group health plan:

- We will notify You and Your Group of the discontinuation at least 90 calendar days before we discontinue coverage.
- We will give Your Group the option to purchase any other health insurance coverage that we are offering at the time we discontinue coverage.

If We decide to stop doing business in the Illinois large employer group market, We will notify You, Your Group and the Illinois Department of Insurance of the discontinuation at least 180 calendar days before we discontinue coverage.

EXTENSION OF BENEFITS

Extension of Benefits in Case of Discontinuance of Coverage

If You are Totally Disabled at the time Your entire Group terminates, We will continue to cover the Covered Expenses described in the Policy which are related to Your disability. Coverage will be limited to those disability-related Covered Expenses only.

We will continue to cover those disability-related Covered Expenses when no coverage is available under the succeeding carrier's Policy due to the absence of coverage in the Policy. This coverage will continue until the earliest of the following occurs:

- The end of twelve months; or
- The end of Total Disability.

These extended benefits are subject to all of the terms and conditions of this Policy. It is Your responsibility to notify Us, and to provide, when requested, written documentation of Your disability.

RIGHT TO CONTINUE GROUP MEDICAL COVERAGE - COBRA

If Your coverage ends for certain reasons listed in the Termination of Coverage section, You may be eligible to continue coverage under federal and/or state laws, as stated below. While a Member is entitled to all of the benefits under the federal or state laws that apply, the Member is not entitled to a duplication of those benefits.

Overview of Federal COBRA Continuation Coverage
The Federal Consolidated Omnibus Budget Reconciliation Act (COBRA) applies to employers with 20 or more Employees.

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, Your spouse, and Your Dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If You are an Employee, You will become a qualified beneficiary if You lose Your coverage under the Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced; or
- Your employment ends for any reason other than Your gross misconduct.

If You are the spouse of an Employee, You will become a qualified beneficiary if You lose Your coverage under the Plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes enrolled in Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from Your spouse.

Your Dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happen:

- The parent-Employee dies;
- The parent-Employee's hours of employment are reduced;
- The parent-Employee's employment ends for any reason other than his or her gross misconduct;
- The parent-Employee becomes enrolled in Medicare benefits (under Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "Dependent child."

If the Plan provides health care coverage to retired Employees, certain circumstances related to bankruptcy could trigger a qualifying event for those covered retired Employees. Sometimes, filing a proceeding in bankruptcy under Title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to Your employer, and that bankruptcy results in the loss of coverage of any retired Employee covered under the Plan, the retired Employee will become a qualified beneficiary with respect to the bankruptcy. The retired Employee's spouse, surviving spouse, and Dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred.

The employer must notify the Plan Administrator that a qualifying event has occurred under the following circumstances:

- When the qualifying event is the end of employment or reduction of hours of employment;
- Death of the Employee;

- In the event of retired Employee health coverage, commencement of a proceeding in bankruptcy with respect to the employer; or
- The Employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event.

For the other qualifying events (divorce or legal separation of the Employee and spouse or a Dependent child losing eligibility for coverage as a Dependent child), You must notify the Plan Administrator within 60 days after the qualifying event occurs. Contact Your employer and/or COBRA Administrator for procedures regarding how to provide this notice, including a description of any required information or documentation.

Terms of Federal COBRA Continuation Coverage

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered Employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the Employee, the Employee becoming entitled to Medicare benefits (under Part A, Part B, or both), Your divorce or legal separation, or a Dependent child losing eligibility as a Dependent child, COBRA continuation coverage lasts for up to 36 months.

When the qualifying event is the end of employment or reduction of the Employee's hours of employment, and the Employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the Employee lasts until 36 months after the date of Medicare entitlement.

There are two ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability Extension of 18-Month Period of Continuation Coverage:
If You or anyone in Your family covered under the Plan is determined by the Social Security Administration to be disabled and You notify the Plan Administrator in a timely fashion, You and Your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the18-month period of continuation coverage. Contact Your employer and/or the COBRA Administrator for procedures for this notice, including a description of any required information or documentation.

Second Qualifying Event Extension of 18-Month Period of Continuation Coverage:
If Your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and Dependent children in Your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and Dependent children receiving continuation coverage if the Employee or former Employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated or if the Dependent child stops being eligible under the Plan as a Dependent child, but only if the event would have caused the spouse or Dependent child to lose coverage under the Plan had the first qualifying event not occurred.

RIGHT TO CONTINUE GROUP MEDICAL COVERAGE - FEDERAL USERRA

The federal Uniformed Services Employment and Reemployment Rights Act (USERRA) applies to an Employee who is absent from employment due to service in the military. Such Employees and their Dependents are entitled to continue coverage for the lesser of:

- 24 months from the beginning of the Employee’s absence from employment; and
- The day after the date on which the Employee fails to apply for or return to employment.

RIGHT TO CONTINUE GROUP MEDICAL COVERAGE – ILLINOIS STATE LAW

The purpose of this section of Your Certificate is to explain the options available for continuing Your coverage after termination, as it relates to Illinois state legislation. The provisions which apply to You will depend upon Your status at the time of termination.

The provisions described in Article A will apply if You are the eligible Employee (as specified in the Group Policy) at the time of termination.

The provisions described in Article B will apply if You are the spouse of a retired eligible Employee or the party to a Civil Union with a retired eligible Employee and are at least 55 years of age. They also apply if you are the former spouse of an eligible Employee or the former party to a Civil Union with a retired eligible Employee who has died or from whom You have been divorced or from whom Your Civil Union has been dissolved.

The provisions described in Article C will apply if You are the Dependent child of an eligible Employee who has died or if You have reached the limiting age under this Policy and are not eligible to continue coverage as provided under Article B.

Your continued coverage under this Policy will be provided only as described below. Therefore, after You have determined which Article applies to You, please read the provisions very carefully.

ARTICLE A - Continuation of Coverage if You are the Eligible Employee

If the eligible Employee covered under this Policy should terminate because of termination of employment or membership or because of a reduction in hours below the minimum required for eligibility, an eligible Employee will be entitled to continue the Hospital, Physician and Supplemental coverage provided under this Policy for himself/herself and his/her eligible Dependents (if he/she had Family Coverage on the date of termination). However, this continuation of coverage option is subject to the following conditions:

- **Continuously Insured:** Continuation of coverage will be available to You only if You have been continuously insured under the Group Policy (or for similar benefits under any Group Policy which it replaced) for at least 3 months prior to Your termination date or reduction in hours below the minimum required for eligibility.

- **Continuation Not Available:** Continuation of coverage will not be available to You if: (a) You are covered by Medicare or (b) You have coverage under any other health care program which provides Group Hospital, surgical or medical coverage and under which You were not covered immediately prior to such termination or reduction in hours below the minimum required for eligibility, or (c) You decide to become a Member of the Plan on a “direct pay" basis.

- **You Must Notify Your Group:** Within 10 days of Your termination of employment or membership or reduction in hours below the minimum required for eligibility, Your Group will provide You with written notice of this option to continue Your coverage. If You decide to continue Your coverage, You must notify Your Group, in writing, no later than 30 days after Your coverage has terminated or reduction in hours below the minimum required for eligibility or 30 days after the date You received notice from Your Group of this option to continue coverage. However, in no event will You be entitled to Your continuation of coverage option more than 60 days after Your termination or reduction in hours below the minimum required for eligibility.

- **You Must Pay Charge:** If You decide to continue Your coverage under this Policy, You must pay Your Group on a monthly basis, in advance, the total charge required by the Plan for Your continued coverage, including any portion of the charge previously paid by Your Group. Payment of this charge must be made to the Plan (by Your Group) on a monthly basis, in advance, for the entire period of Your continuation of coverage under this Policy.

- **End of Continuation Coverage:** Continuation of coverage under this Policy will end on the date You become eligible for Medicare, become a Member of the Plan on a ``direct pay'' basis or become covered under another health care program (which You did not have on the date of Your termination or reduction in hours below the

minimum required for eligibility) which provides Group Hospital, surgical or medical coverage. However, Your continuation of coverage under this Policy will also end on the first to occur of the following:

- Twelve months after the date the eligible Employee's coverage under this Policy would have otherwise ended because of termination of employment or membership or reduction in hours below the minimum required for eligibility.
- If You fail to make timely payment of required charges, coverage will terminate at the end of the period for which Your charges were paid.
- The date on which the Group Policy is terminated. However, if this Policy is replaced by similar coverage under another Group Policy, the eligible Employee will have the right to become covered under the new coverage for the amount of time remaining in the continuation of coverage period.

ARTICLE B: Continuation of Coverage If You Are the Former Spouse of an Eligible Employee or Spouse of a Retired Eligible Employee:

If the coverage of the spouse of an eligible Employee should terminate because of the death of the eligible Employee, a divorce from the eligible Employee, dissolution of a Civil Union from the eligible Employee, or the retirement of an eligible Employee, the former spouse or retired eligible Employee 's spouse if at least 55 years of age, will be entitled to continue the coverage provided under this Policy for himself/herself and his/her eligible Dependents (if Family Coverage is in effect at the time of termination). However, this continuation of coverage option is subject to the following conditions:

- **You Must Provide Written Notice of Event:** Continuation will be available to You as the former spouse of an eligible Employee or spouse of a retired eligible Employee only if You provide the employer of the eligible Employee with written notice of the dissolution of marriage or Civil Union, or the death or retirement of the eligible Employee, within 30 days of such event.

- **Group Must Provide Written Notice:** Within 15 days of receipt of such notice, the employer of the eligible Employee will give written notice to the Plan of the dissolution of Your marriage or Civil Union to the eligible Employee, the death of the eligible Employee or the retirement of the eligible Employee, as well as notice of Your address. Such notice will include the Group number and the eligible Employee's Identification Number under this Policy. Within 30 days of receipt of notice from the employer of the eligible Employee, the Plan will advise You at Your residence, by certified mail, return receipt requested, that Your coverage and Your covered Dependents under this Policy may be continued. The Plan's notice to You will include the following:

  - A form for election to continue coverage under this Policy.
  - Notice of the amount of monthly charges to be paid by You for such continuation of coverage and the method and place of payment.
  - Instructions for returning the election form within 30 days after the date it is received from the Plan.

- **Your Failure to Provide Written Notice:** In the event You fail to provide written notice to the Plan within the 30 days specified above, benefits will terminate for You on the date coverage would normally terminate for a former spouse or spouse of a retired eligible Employee under this Policy as a result of the dissolution of marriage or Civil Union, the death or the retirement of the eligible Employee. Your right to continuation of coverage will then be forfeited.

- **Plan's Failure to Provide Written Notice:** If the Plan fails to notify You as specified above, all charges shall be waived from the date such notice was required until the date such notice is sent and benefits shall continue under the terms of this Policy from the date such notice is sent, except where the benefits in existence at the time of the Plan's notice was to be sent are terminated as to all eligible Employees under this Policy.

- **Continuation Coverage Charge Before Age 55:** If You have not reached age 55 at the time Your continued coverage begins, the monthly charge will be computed as follows:
  - An amount, if any, that would be charged to You if You were an eligible Employee, with Individual or Family Coverage, as the case may be, plus
  - An amount, if any, that the employer would contribute toward the charge if You were the eligible Employee under this Policy.

- Failure to pay the initial monthly charge within 30 days after receipt of notice from the Plan as required in this Article will terminate Your continuation benefits and the right to continuation of coverage.

- **Continuation Coverage Charge Age 55 and Beyond:** If You have reached age 55 at the time Your continued coverage begins, the monthly charge will be computed for the first 2 years as described above. Beginning with the third year of continued coverage, an additional charge, not to exceed 20% of the total amounts specified in "COBRA Charge Before Age 55," above, will be charged for the costs of administration.

- **End of Continuation Coverage Before Age 55:** If You have not reached age 55 at the time Your continued coverage begins, Your continuation of coverage shall end on the first to occur of the following:
  - If You fail to make any payment of charges when due (including any grace period specified in the Group Policy).
  - On the date coverage would otherwise terminate under this Policy if You were still married to or in a Civil Union with the eligible Employee; however, Your coverage shall not be modified or terminated during the first 120 consecutive days following the eligible Employee's death or entry of judgment dissolving the marriage or Civil Union existing between You and the eligible Employee, except in the event this entire Policy is modified or terminated.
  - The date on which You remarry or enter another Civil Union.
  - The date on which You become an insured Employee under any other Group health plan.
  - The expiration of 2 years from the date Your continued coverage under this Policy began.

- **End of Continuation Coverage Age 55 and Beyond:** If You have reached age 55 at the time Your continued coverage begins, Your continuation of coverage shall end on the first to occur of the following:
  - If You fail to make any payment of charges when due (including any grace period specified in the Group Policy).
  - On the date coverage would otherwise terminate, except due to the retirement of the eligible Employee under this Policy if You were still married to or in a Civil Union with the eligible Employee; however, Your coverage shall not be modified or terminated during the first 120 consecutive days following the eligible Employee 's death, retirement or entry of judgment dissolving the marriage or Civil Union existing between You and the eligible Employee, except in the event this entire Policy is modified or terminated.
  - The date on which You remarry or enter another Civil Union.
  - The date on which You become an insured Employee under any other Group health plan.
  - The date upon which You reach the qualifying age or otherwise establish eligibility under Medicare.

- **Same Rights Under Continuation Coverage:** If You exercise the right to continuation of coverage under this Policy, You shall not be required to pay charges greater than those applicable to any other eligible Employee covered under this Policy, except as specifically stated in these provisions.

- **Continuation Coverage Will Continue Under New Policy:** If this entire Policy is cancelled and another insurance company contracts to provide Group health insurance at the time Your continuation of coverage is in effect, the new insurer must offer continuation of coverage to You under the same terms and conditions described in this Policy.

ARTICLE C: Continuation of Coverage if You are the Dependent Child of an Eligible Employee:

If the coverage of a Dependent child should terminate because of the death of the eligible Employee and the Dependent child is not eligible to continue coverage under Article B or the Dependent child has reached the limiting age under this Policy, the Dependent child will be entitled to continue the coverage provided under this Policy for himself/herself. However, this continuation of coverage option is subject to the following conditions:

- **You Must Provide Written Notice of Death:** Continuation will be available to You as the Dependent child of an eligible Employee only if You, or a responsible adult acting on Your behalf as the Dependent child, provide the employer of the eligible Employee with written notice of the death of the eligible Employee within 30 days of the date the coverage terminates.

- **You Must Provide Written Notice of Reaching Limiting Age:** If continuation of coverage is desired because You have reached the limiting age under this Policy, You must provide the employer of the eligible Employee with written notice of the attainment of the limiting age within 30 days of the date the coverage terminates.

- **Group Must Provide Written Notice:** Within 15 days of receipt of such notice, the employer of the eligible Employee will give written notice to the Plan of the death of the eligible Employee or of the Dependent child reaching the limiting age, as well as notice of the Dependent child's address. Such notice will include the Group number and the eligible Employee's Identification Number under this Policy.

- **Plan Must Provide Written Notice:** Within 30 days of receipt of notice from the employer of the eligible Employee, the Plan will advise You at Your residence, by certified mail, return receipt requested, that Your coverage under this Policy may be continued. The Plan's notice will include the following:
    - A form for election to continue coverage under this Policy.
    - Notice of the amount of monthly charges to be paid by You for such continuation of coverage and the method and place of payment.
    - Instructions for returning the election form within 30 days after the date it is received from the Plan.

- **Your Failure to Provide Written Notice:** In the event You, or the responsible adult acting on Your behalf as the Dependent child, fail to provide written notice to the Plan within the 30 days specified above, benefits will terminate for You on the date coverage would normally terminate for a Dependent child of an eligible Employee under this Policy as a result of the death of the eligible Employee or the Dependent child attaining the limiting age. Your right to continuation of coverage will then be forfeited.

- **Plan's Failure to Provide Written Notice:** If the Plan fails to notify You as specified above, all charges shall be waived from the date such notice was required until the date such notice is sent and benefits shall continue under the terms of this Policy from the date such notice is sent, except where the benefits in existence at the time of the Plan's notice was to be sent are terminated as to all eligible Employees under this Policy.

- **Failure to Pay Continuation Coverage Charge:** Failure to pay the initial monthly charge within 30 days after receipt of notice from the Plan as required in this Article will terminate Your continuation benefits and the right to continuation of coverage. The monthly charge will be computed as follows:
    - An amount, if any, that would be charged to You if You were an eligible Employee, plus
    - An amount, if any, that the employer would contribute toward the charge if You were the eligible Employee under this Policy.

- **End of Continuation Coverage:** Continuation of Coverage shall end on the first to occur of the following:
    - If You fail to make any payment of charges when due (including any grace period specified in the Group Policy).
    - On the date coverage would otherwise terminate under this Policy if You were still an eligible Dependent child of the eligible Employee.
    - The date on which You become an insured Employee, after the date of election, under any other Group health plan.
    - The expiration of 2 years from the date Your continued coverage under this Policy began.

- **Same Rights Under Continuation Coverage:** If You exercise the right to continuation of coverage under this Policy, You shall not be required to pay charges greater than those applicable to any other eligible Employee covered under this Policy, except as specifically stated in these provisions.

- **Continuation Coverage Will Continue Under New Policy:** If this entire Policy is cancelled and another insurance company contracts to provide Group health insurance at the time Your continuation of coverage is in effect, the new insurer must offer continuation of coverage to You under the same terms and conditions described in this Policy.

Other options that may be available for continuation of coverage are explained in the Continuation of Coverage sections of this Certificate.

MercyCare HMO, Inc.

Continuation of Coverage for Parties to a Civil Union

The purpose of this provision of Your Certificate is to explain the options available for temporarily continuing Your coverage after termination if You are covered under this Policy as the party to a Civil Union with an eligible Employee or as the Dependent child of a party to a Civil Union with an eligible Employee. Your continued coverage under this Policy will be provided only as specified below. Please read the provisions very carefully.

Continuation of Coverage

If You are a Dependent who is a party to a Civil Union or their child and You lose coverage under this Policy, the options available to a spouse or to a Dependent child as described in the ”Right to Continue Group Medical Coverage (Illinois State Laws)” provision of this Certificate are available to You. In addition, coverage similar to the options described in the ”Right to Continue Group Medical Coverage – COBRA” provision of this Certificate, will also be available to You.

NOTE: Certain employers may not be required to offer COBRA continuation coverage. See Your Group Administrator if You have any questions about COBRA, or Your continuation of coverage options.

In addition to the events listed in the ”Right to Continue Group Medical Coverage (Illinois State Laws)” provision, if applicable, continuation of coverage is available to You and Your Dependent children in the event You lose coverage because Your Civil Union partnership with the eligible Employee terminates. Your Civil Union will terminate if Your partnership no longer meets the criteria described in the definition of “Civil Union” in the Glossary section of this Certificate.

You are entitled to continue coverage for the same period of time as a spouse or child who loses coverage due to divorce.

Continuation of Coverage for Domestic Partners

The purpose of this provision of Your Certificate is to explain the options available for temporarily continuing Your coverage after termination, if You are covered under this Policy as the Domestic Partner of an eligible Employee or as the Dependent child of a Domestic Partner. Your continued coverage under this Policy will be provided only as specified below. Please read the provisions very carefully.

NOTE: Domestic Partner coverage is available at Your employer's discretion. Contact Your employer for information on whether Domestic Partner coverage is available for Your Group.

Continuation of Coverage

If You are the Domestic Partner or the Dependent child of a Domestic Partner and You lose coverage under this Policy, You have the same options as the spouse or Dependent child of an eligible Employee to continue Your coverage. The options available to a spouse or to a Dependent child as described in the ”Right to Continue Group Medical Coverage (Illinois State Laws)” provision of this Certificate are available to You, if applicable to Your Group. In addition, coverage similar to the options described in the ”Right to Continue Group Medical Coverage – COBRA” provision of this Certificate, will also be available to You.

NOTE: Certain employers may not be required to offer COBRA continuation coverage. See Your Group Administrator if You have any questions about COBRA, or Your continuation of coverage options.

In addition to the events listed in the ”Right to Continue Group Medical Coverage – COBRA” provision and the ”Right to Continue Group Medical Coverage (Illinois State Laws)” provision, if applicable, continuation of coverage is available to You and Your Dependent children in the event You lose coverage because Your Domestic Partnership with the eligible Employee terminates. Your Domestic Partnership will terminate if Your partnership no longer meets the criteria described in the definition of “Domestic Partnership” in the Glossary section of this Certificate. You are entitled to continue coverage for the same period of time as a spouse or child who loses coverage due to divorce.

DISENROLLMENT

Disenrollment means that a Member's coverage under the Plan is revoked. We can disenroll a Member only for the reasons listed below:

- The Member commits acts of physical or verbal abuse that pose a threat to providers or to other Members of the Plan; or
- The Member is unable to establish or maintain a satisfactory Physician-patient relationship with a Participating Primary Care Provider.
    - If a Member refuses to follow the recommended treatment of his/her Primary Care Provider, this may constitute an unsatisfactory Physician-patient relationship.
    - Disenrollment for this reason is permitted only if We can demonstrate that we:
        - Provided the Member an opportunity to select another Participating Primary Care Provider;
        - Made a reasonable effort to assist the Member in establishing a satisfactory Physician-patient relationship; and
        - Properly communicated the complaint, appeal, and Grievance procedures to the Member. See the Complaint Procedures section in this Certificate for more information.

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 a 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 or the Group 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

We are 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 We may use and disclose this information and how You can access this information. The Notice is available at mercycarehealthplans.com.

CONFORMITY WITH STATE STATUTES

Any provision of the Policy which, on its effective date, is in conflict with the statutes of the state in which the Policyholder resides, on such date is hereby amended to conform to the minimum requirements of such statutes.

TIME LIMIT ON CERTAIN DEFENSES

After two years from the date of issue of the 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 Your employer or 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 2 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 get 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 the Our Customer Service Department.

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 Certificate, in the event MercyCare makes 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. We are assigned the right to recover from the negligent third party, or his or her insurer, to the extent of the benefits we paid for that Sickness or Injury. 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.

If You recover expenses for Sickness or Injury that occurred due to the negligence of a third party, We have the right to first reimbursement for all benefits We paid from any and all damages collected from the negligent third party for those same expenses whether by action at law, settlement, or compromise, by the covered person, the covered person's parents if the covered person is a minor, or the covered person's legal representative as a result of that Sickness or Injury.

You are required to furnish any information or assistance, or provide any documents that we may reasonably require in order to exercise Our rights under this provision. This provision applies whether or not the third party admits liability.

Our rights of subrogation and reimbursement apply to any recoveries that You make to a third party. These recoveries from a third party include 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 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 its representatives deem necessary.

You agree to do nothing to prejudice MercyCare's 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 the Plan 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 the Plan has paid.

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 the 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, whether or not You actually obtained such coverage or received benefits under any coverage You obtained. If the Plan paid for the treatment of any such Bodily Injury or Sickness, and We determine that You also received Worker's Compensation benefits for the same incident, We have the right to recover such payments as described under the "Right to Recovery" provision of the "Coordination of Benefits" section of this Certificate. You must reimburse Us, and We will exercise the right to recover against You.

The recovery rights will be applied even if:

- The 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, or resulted from Your employment; or
- The amount of Workers' Compensation due to medical or health care is not agreed upon or defined by You or the Workers' Compensation carrier; or
- The medical or health care benefits are specifically excluded from the Workers' Compensation settlement or compromise.

In the event that Workers' Compensation benefits are in dispute or when the amount of Workers' Compensation due for medical or health care is not agreed upon, Claims processing will be suspended. The involved parties will be notified as to

the reason for the delay in processing. Upon resolution of such questions or problems, Claims processing will be resumed and any recovery rights will be applied.

In the event that Workers' Compensation denies a Claim, the Plan will cover the resulting charges only if You have obtained any available independent review of that denial. For example, You must appeal the denial to the state agency that reviews Workers' Compensation Claims, if such an appeal is available. No benefits are available from the Plan unless the denial is upheld on appeal. Also note that, as with any other Claim, no benefits are available from the Plan for a Claim denied by Workers' Compensation unless coverage is provided under the guidelines outlined in this Certificate. For example, the Plan is not obligated to cover treatment by a Non-Participating Provider and/or facility without an approved Referral from the Plan.

You hereby agree that, in consideration for the coverage provided by the Policy, You will notify MercyCare of any Workers' Compensation Claim You make, and that You agree to reimburse Us as described above.

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 Contract Period. 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 Group health plan offered by MercyCare and described in this Certificate.

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 benefit 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 services are received, or as soon as possible. To submit a Claim, send an itemized bill from the Physician, Hospital, or other Health Care Provider to the following address:

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

Be sure to include Your name and Identification Card number. Notice given to Us at the address above, or to any authorized agent of Us, with information sufficient to identify the insured, shall be deemed notice to Us.

If We do not receive a written notice of 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 the services were received outside the United States, please be sure to indicate the appropriate exchange rate at the time the services were received.

You Must Provide All Relevant Information
You agree to provide to Us any additional information regarding the occurrence and extent of the event for which the Claim is made which We shall reasonably require in order to process the Claim.

Required Forms
We, upon receipt of a notice of Claim, will furnish to the Claimant such forms as are usually furnished by Us for filing proofs of loss. If We do not furnish within 15 days after the giving of such notice the Claimant shall be deemed to have complied with the requirements of this Policy as to proof of loss upon submitting, within the time fixed in the Policy for filing proofs of loss, written proof covering the occurrence, the character and the extent of the loss for which Claim is made.

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

All Claims will be paid within 30 days following Our receipt of due written proof of loss. We will notify You within 30 days after receiving of Your Claim if You have failed to provide sufficient documentation for Your Claim. If We do not pay a Claim within such period, You will be entitled to interest at the rate of nine percent per annum from the 30th day after receipt of such proof of loss to the date of We pay 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.

Benefit Payment Upon Death
Benefits accrued on Your behalf upon death shall be paid, at Our option, to any one or 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 the Plan in good faith will fully discharge the Plan 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 Our expense, by a Participating Provider designated by Us.

If You have any questions about a Claim, call 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 MercyCare for himself or herself and for his/her covered Dependents when he/she signs the Enrollment Form 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.

We also have the right to review any employment records, including those maintained by the Group, to make certain that the Group and Members are entitled to coverage under the Plan.

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 MercyCare 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; and
- 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.

CLAIMS 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 the 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.

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. 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.

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 the Plan in accordance with the benefits and procedures detailed in this Certificate.

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

MercyCare 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 MercyCare.

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 is 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 post-service appeal, We will render a decision as soon as is 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 or administrative basis 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; and
- Contact information for the Department of Insurance complaint division as stated in the "Department of Insurance" provision in the "Complaint Procedures" section of this Certificate.
- 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:

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)
(217) 557-8495 (Fax number)
Email: DOI.externalreview@illinois.gov
Website: 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 the 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 of Request for Standard External Review

Within one business day after completing 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 MercyCare 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 receiving the notice:

- Assign an IRO on a random basis from those IROs approved by the Director; and
- 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 receiving of the notice provided by the Director of assignment of an IRO, MercyCare 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. MercyCare 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 receiving the 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 (or 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 Claims 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, a continued stay or a health care service for which You received Emergency Care services, but You 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 of Request for Expedited External Review
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 the 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 health 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.

The Illinois Department of Insurance can be contacted at:

Illinois Department of Insurance
Office of Consumer Health Insurance
320 W. Washington Street
Springfield, IL 62767-0001
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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.

ACTIVE STATUS
Performing Your job on a regular, full-time basis as defined in the Group Application. Each day of a regular paid vacation and any regular non-working holiday and any approved sick leave absence shall be deemed Active Status if You were in an Active Status on Your last regular working day.

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.

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.

CERTIFICATE
This Certificate of Coverage which has been issued to You and which summarizes the terms, conditions, and limitations of Your health care coverage.

CHANGE OF STATUS FORM
The form You must complete if You wish to add or delete Dependents or change the information contained on Your Enrollment Form. Change of Status Forms are provided by Us and are available from the Group.

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.

COBRA
Those sections of the Consolidated Omnibus Budget Reconciliation Act of 1985 P.L. 99-272, as amended which regulate the conditions and manner under which an employer can offer continuation of Group health insurance to Employees and their family Members whose coverage would otherwise terminate under the terms of this Certificate.

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 provided 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 12-month period beginning on the effective date of the Group's Policy.

COPAYMENT
A fixed dollar amount that You are required to pay for certain Covered Services provided under the 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 the 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 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 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 Employee and his or her Dependents must pay each Contract Period .

DEPENDENT

- The Employee's lawful spouse;
  - Unless specifically noted otherwise, all of the provisions that pertain to a spouse also apply to a party of a Civil Union.
  - If Your Employer covers Domestic Partners, all of the provisions that pertain to a lawful spouse also apply to a Domestic Partner.
- The Employee's Dependent child until he or she reaches 26 years of age (the limiting age), unless an exception to the limiting age applies.
  - "Child" includes, regardless of financial dependency, residency, student status, employment status, marital status, eligibility for other coverage, or any combination of those factors, all of the following:
    - Natural child;
    - Stepchild;
    - Adopted child;
    - Child in Your custody under an interim court order prior to finalization of adoption or placement of adoption vesting temporary care, whichever comes first;
    - Foster child;
    - Child of Your Domestic Partner (if Your Employer covers Domestic Partners);
    - Child of Your child (grandchild); or
    - Child who is under 26 years of age for whom the Employee is the legal guardian.
    - Child for whom the Employee is required by court order to provide health care coverage.
  - A covered Dependent child who reaches the limiting age of 26 while covered under this Policy will remain eligible for coverage if he or she is incapable of self-sustaining employment because of an intellectual disability or physician disability which existed before the Dependent Child reached the limiting age.
    - To retain eligibility for coverage under this Policy, the Dependent child must continue to be dependent on his or her parents or other care providers for lifetime care and supervision.
    - Within two months of the Dependent child reaching the limiting age, or at any reasonable time he or she reaches the limiting age, We may inquire whether the Dependent child is in fact a disabled and dependent person.
      - Written proof of disability and dependency must be provided to Us within 31 days after Our inquiry.
      - If written proof is not provided within 31 days, We may terminate the coverage of the Dependent child.
    - At Our sole discretion, We may require the Dependent child to be examined from time to time by a Health Care Provider to determine the existence of the incapacity prior to granting continued coverage.
      - These examinations may occur at reasonable intervals during the first two years after We grant continued coverage, and annually thereafter.
  - An enrolled unmarried child will continue to be eligible for coverage under this Policy until reaching the age of 30 if he or she:
    - Lives within the Service Area;
    - 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.
  - A Dependent child who is a college student and who is on a medical leave of absence, or who reduces his or her course load to part-time status because of a catastrophic Illness or Injury, may continue coverage under this Policy subject to all of the Policy's terms and conditions for a limited period of time.
    - Continuation of coverage shall terminate 12 months after We receive notice of the Dependent child's Sickness or Bodily Injury, or until the coverage would have otherwise ended pursuant to the terms and conditions of the Policy, whichever comes first.
    - For coverage to continue, the need for a medical leave of absence or the need for part-time status must be supported by clinical documentation from a Physician.

DEPENDENT COVERAGE

Coverage for Your eligible spouse and/or Dependent child under this Policy.

DIAGNOSIS OF AUTISM SPECTRUM DISORDER
One or more tests, evaluations, or assessments to diagnose whether an individual has autism spectrum disorder that is prescribed, performed, or ordered by (a) a licensed Physician or (b) a licensed clinical Psychologist with expertise in diagnosing Autism Spectrum Disorders. See also “Autism Spectrum Disorder” in this Glossary.

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.

DOMESTIC PARTNER
A person with whom You have entered into a Domestic Partnership.

DOMESTIC PARTNERSHIP
A long-term committed relationship of indefinite duration with a person which meets the following criteria:

- You and Your Domestic Partner have lived together for at least six months;
- Neither You nor Your Domestic Partner is married to anyone else or has another Domestic Partner;
- Both You and Your Domestic Partner are at least 18 years of age and mentally competent to consent to contract;
- You and Your Domestic Partner reside together and intend to do so indefinitely;
- You and Your Domestic Partner have an exclusive mutual commitment similar to marriage; and
- You and Your Domestic Partner are jointly responsible for each other's common welfare and share financial obligations.

DUAL CHOICE ENROLLMENT PERIOD
A period each year when the Group and MercyCare agree to allow Members who are currently enrolled in any of the Group's other benefit plans to enroll for coverage under MercyCare's Plan.

DURABLE MEDICAL EQUIPMENT
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 and cerebral palsy.

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, 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 Hospital, 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.

EMERGENCY MEDICAL CONDITION
A medical condition manifesting itself by Acute symptoms of sufficient severity (including, but not limited to, severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in any of the following:

- Serious jeopardy to the person's health or, with respect to a pregnant woman, the health of the woman or her unborn child;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

EMPLOYEE
An individual whose employment or other status, except for family dependency, is the basis for eligibility for enrollment under the Policy.

EMPLOYEE-ONLY COVERAGE
Coverage which only includes yourself (the Employee).

ENROLLMENT FORM
The form completed by a potential Member requesting coverage from Us and listing all Dependents to be covered on the effective date of coverage.

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/INVESTIGATIVE
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.

FAMILY COVERAGE
Coverage for You and Your eligible Dependents under this Policy.

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 Certificate for more information.

GROUP
The employer which includes any individual, partnership, association, corporation, business trust, or any person or group of persons acting directly or indirectly in the interest of an employer in relation to an Employee, for which one or more persons is gainfully employed.

GROUP APPLICATION
The form completed by a Group requesting coverage from MercyCare for individuals in their Group.

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 that MercyCare issues to You that indicates Your eligibility for coverage under the 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. Infertility also includes fertility preservation services when a necessary medical treatment may directly or indirectly cause iatrogenic infertility to an enrollee.

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 Us 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 Employee 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.

OPEN ENROLLMENT PERIOD
A period (each year) when We and the Group agree to allow potential Members to enroll for coverage, regardless of whether they are currently enrolled in any of the Group's other medical benefit plans.

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.

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.

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 EXPENSES
The portion of Covered Expenses for which the Member is responsible because of applicable Coinsurance and/or Deductible provisions, or non-Covered Services.

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.

PHYSICIAN CHANGE FORM
The form available through Our Customer Service Department that enables a Member to change his or her selection of Primary Care Provider. Refer to the “Primary Care Provider Selection” provision in the “Obtaining Services” section of this Certificate for more information.

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

POLICY
The agreement between the Group and MercyCare setting forth the contractual rights and obligations of the parties and wherein MercyCare agrees to provide a health benefit program to eligible Employees and their Dependents of the Group. The Group Contract, the Certificate of Coverage, the Schedule of Benefits, and any addenda or endorsements thereto, and the applications of the Group and the Employee, constitute the entire Policy.

POLICYHOLDER
Policyholder means the Group.

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.”

PREVENTIVE PHYSICAL THERAPY
Physical therapy that is prescribed by a Physician for the purpose of treating parts of the body affected by multiple sclerosis. It only applies in situations 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. This definition only applies as it relates to physical therapy services for the treatment of multiple sclerosis.

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 Certificate 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 or funded by one or more of the following:
    - The National Institutions of Health (NIH). (Includes National Cancer Institute).
    - The Centers for Disease Control and Prevention.
    - The Agency for Health Care Research and Quality.
    - The Centers for Medicare & Medicaid Services.
    - A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
    - The Department of Veterans Affairs.
      The Department of Defense.
    - The 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 a Participating Provider, for You to obtain specialty services or treatment from a Non-Participating Provider.

REHABILITATION / 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.

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 a 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 that are provided solely to satisfy data collection and analysis needs and that are not used in Your direct clinical management; or
- 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.

See also the definition of "Mental Illness."

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

SICKNESS (or ILLNESS)
Any condition or Disease that causes loss of, or affects, 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:

- Substance abuse disorders;
- Substance dependence disorders; and
- 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

TREATMENT FOR AUTISM SPECTRUM DISORDER
The following care when prescribed, provided, or ordered for an individual with a Diagnosis of Autism Spectrum Disorder; deemed Medically Necessary; and ordered by a Physician:

- Psychiatric care, mean direct, consultative, or diagnostic services provided by a licensed psychiatrist.
- Psychological care, meaning direct or consultative services provided by a licensed Psychologist.
- Habilitative or Rehabilitative care, meaning professional, counseling, and guidance services and treatment programs, including Applied Behavior Analysis, that are intended to develop, maintain, and restore the functioning of an individual.
- Therapeutic care, including behavioral, speech, occupational, and physical therapies that provide treatment in the following areas:
    - Self-care and feeding;
    - Pragmatic, receptive, and expressive language;
    - Cognitive functioning;
    - Applied Behavior Analysis, intervention, and modification
    - Motor planning; and
    - Sensory Processing.

See also “Autism Spectrum Disorder” and “Diagnosis of Autism Spectrum Disorder” in this Glossary.

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. It includes education and medical treatment components designed to assist a person in ceasing the use of tobacco products.

It 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.

TOTALLY DISABLED
With respect to an Employee, the inability by reason of Illness, Injury or physical condition to perform the material duties of any occupation for which the Employee is or becomes qualified by reason of experience, education or training or with respect to a covered person other than an Employee, the inability by reason of Illness, Injury or physical condition to engage in the normal activities of a person of the same age and sex who is in good health.

The condition of being Totally Disabled 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 of Urgent Care situations include, but are not limited to, broken bones, sprains, non-severe bleeding, minor cuts and burns, and drug reactions.

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.