Mercy Health Corporation™ Employee Health Benefit Plan
Effective January 1, 2023

Mercy Health Corporation™ Employee Health Benefit PLAN

MASTER PLAN DOCUMENT FOR SELF-FUNDED GROUP MEDICAL AND PRESCRIPTION DRUG BENEFITS

Administered by: Mercyhealth™

The Plan

The Plan provides certain health care benefits for Covered Persons who are Partners of Mercy Health Corporation™ and its subsidiaries, and their covered Dependents. Mercy Health Corporation agrees to provide for these covered Partners during the existence of this Plan, the benefits hereinafter described which shall be paid to or on behalf of them in the event they and/or their covered Dependents incur health care expenses covered by the Plan, while covered under the Plan.

The Plan is subject to all terms, provisions and conditions recited on the following pages.

To be effective January 1, 2023, Mercy Health Corporation adopts this Master Plan Document, which includes Group Medical and Prescription Drug Benefits.

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Introduction

This is the Master Plan Document for the Mercy Health Corporation™ Employee Health Benefit Plan

Mercy Health Corporation and its subsidiaries, offers this health Plan, which provides medical and prescription benefits to all benefit-eligible Partners and their eligible Dependents. Partners who wish to participate in this Plan must complete the necessary documentation, satisfy eligibility requirements, and make the required contribution(s) through payroll deduction(s) or other means.

This Plan is self-funded by Mercy Health Corporation. This means that Mercy Health Corporation provides the funds used to pay claims.

The Mercy Health Corporation Employee Health Benefit Plan (the “Plan”) was designed specifically for Partners of Mercy Health Corporation. The Plan is built around a network of Mercy Health Corporation-affiliated Physicians, Hospitals and other health care facilities. When a Covered Person uses the Mercy Health Corporation network, the Covered Person is generally paying less out of his or her own pocket.

This Master Plan Document will explain the provisions of the Plan and benefit tiers. Many provisions are interrelated, so reading just one or two sections may give a Covered Person an inaccurate impression, and many words used to describe coverage have special meanings. Please read this document carefully.

This Plan is effective on January 1, 2023. This Plan shall supersede and replace all previous Plans of your Employer, including any amendments. From time to time this document may be amended.

Eligibility & Enrollment

Eligibility

You and Mercy Health Corporation share responsibility for the cost of the medical care coverage for you, your spouse, and qualified dependents. Under the Affordable Care Act, eligibility is determined by the number of hours you work over a pre-determined eligibility period. Partners who work an average of 30 hours per week or more are considered full-time for health insurance premium purposes.

Partners who work an average of 20-29 hours per week are considered part-time for health insurance premium purposes. Your premium contribution also depends on who is covered and the type of plan you choose.

Partners and their spouse/domestic partner enrolling in health insurance who are tobacco free will be eligible for a reduction in their health insurance premium. To receive the appropriate premium, partners and their spouse/domestic partner must attest they are tobacco-free when enrolling online.

Partners eligible for health insurance who choose not to elect coverage are required to waive coverage. Partners who do not enroll or waive coverage will automatically be enrolled in the MercyCare EPO HDHP plan.

Self-Employed Family Members: MercyCare insurance plans do not cover healthcare costs related to injuries on the job. Mercy Health Corporation partners with self-employed family members are advised to obtain workers compensation coverage of those members who are on their MercyCare Plan.

Mercy Health Corporation Partners are offered the following health insurance options:
EPO
EPO - HDHP
PPO
PPO - HDHP

Qualified Dependent means:

1. your legal spouse, unless you are legally divorced. A legal spouse includes a same-sex or opposite-sex individual who is recognized as your spouse for purposes of federal tax laws (a common-law spouse is eligible if you legally establish the marriage in a state that recognizes common-law marriages and is recognized as your spouse for purposes of federal tax laws);
2. your qualifying same-sex or opposite-sex domestic partner if your relationship satisfies certain criteria (see Domestic Partner Eligibility Requirements in this section); and
3. your children under age 26. Children are further defined as:
    a. your biological children;
    b. your adopted children or children placed with you for adoption;
    c. your stepchildren, regardless of where they live (includes stepchildren from your same-sex or opposite-sex legal spouse);
    d. a child who is recognized under a qualified medical child support order as having a right to health care coverage, if the child meets the other eligibility requirements of the Plan for dependent coverage;
    e. any other child for whom you are the legal guardian and whom you support in a parent-child relationship; and
    f. your domestic partner's children if they qualify as your dependents for income tax purposes according to Section 152 of the Internal Revenue Code.

When Eligibility Begins:

Partners and their dependents become eligible under the Plan as follows:

- Upon hire, a partner can enroll in the Plan. If the partner enrolls within 30 days of the hire date, coverage will be effective the first of the month following 30 days from the date of hire. If the Partner does not enroll in the Plan within 30 days of the hire date, he/she will not be able to enroll until the next open enrollment period or a qualifying event.
- Dependents become eligible:
    - The date the employee becomes eligible for coverage as defined above, for the employee's dependents on that date; or if later,
    - The date of the employee's marriage for any dependent (spouse or stepchild(ren)) acquired on that date; or
    - The date of birth of the employee's natural-born child(ren); or
    - The date a child is placed in the employee's home for adoption, or the date that a court issues a final order granting adoption of the child to the employee, whichever occurs first; or
    - The employer approved effective date of a change indicated on the MercyCare Health Plans Change of Status form that makes a dependent newly eligible.
    - A Partner's grandchild(ren) born to an insured dependent child are eligible through the last day of the calendar month in which the employee's eligible child reaches age 18.

Proof Of Eligibility Requirements

The following is a list of preferred documents that can be used to show proof of eligibility for your health and dental insurance coverage. Please note your insurance applications will not be processed until all documents are received in the Human Resource Department. If documents are not received prior to the start date of your coverage, this may cause a delay in enrollment and require a catch up of insurance premiums to be deducted from your paycheck.

• **Domestic Partner** - Notarized form + 2 proofs that have lived together more than one year; Certificate of Credible Coverage if losing coverage from other insurance
• **Domestic Partner** (adding) child(ren) - Birth certificates
• **Loss of Insuranc**e - Letter from employer stating when coverage ends or Certificate of Credible Coverage; Marriage Certificate or; 1040 tax form (top of form) showing married **if married longer than 1 year;** Birth certificate (children or stepchildren); for dental insurance only, student verification (if over 19 years old)

Domestic Partner Coverage

A domestic partner:
• is a person of the same or opposite gender as the Mercy Health Corporation employee and must be emotionally committed to each other and intend to remain each other's interdependent domestic partner indefinitely. Tangible demonstration of interdependence may be achieved by the following:
    o Common ownership of property
    o Common ownership of a motor vehicle
    o Proof of joint bank accounts or credit accounts
    o Proof of a partner being designated as primary beneficiary for life benefits
    o Assignment to each other of a durable property or health care Power of Attorney
• and Mercy Health Corporation employee must both be at least 18 years of age or older and be mentally competent to enter into a contractual agreement;
• must have the same place of residence as the Mercy Health Corporation employee and have cohabitated there for a minimum of 12 months, with the intent of doing so permanently;
• is not legally married or involved in another domestic partnership within the last 12 months;
• is jointly responsible for each other's welfare and financial obligations; and

• is not related to the Mercy Health Corporation partner by blood closer than would bar marriage in the state where he or she resides.

Children of domestic partners are also eligible for health and dental insurance coverage. Benefit eligibility requirements are the same as those listed on the previous page.

The employer portion of the insurance premium that covers domestic partners and their children will be considered taxable income to the employee.

Domestic partners and children of domestic partners are not eligible for COBRA benefits should they lose coverage for any reason.

Domestic Partner Certification: All Mercy Health Corporation employees wishing to add a domestic partner and any domestic partner children to their health or dental plan will need to complete a "Certification of Domestic Partnership". This form is available in the Human Resource department.

Cancel Date of Domestic Partner Coverage: In the event that the domestic partnership is terminated, you must notify the Human Resource department within 30 days. Insurance coverage will end at the end of the month in which the termination occurred.

Domestic partners of Mercy Health Corporation employees are only eligible for Mercy Health Corporation's health and dental insurance coverage. Domestic partners are not eligible for any other Mercyhealth benefits including flex benefit plans, life insurance and voluntary benefits.

Health Insurance Eligibility for Adult Child(ren)

Your adult child(ren) can be added to the Plan at the time of hire, qualifying event or open enrollment if the following criteria applies:
• Less than 26 years old (regardless of marital status).
• Military Dependent- a child will be able to continue coverage under the Plan if he/she meets all of the following requirements:

- The child is a full-time student, regardless of age; and
- The child was under 27 years of age when he or she was called to federal active duty in the National Guard or in a reserve component of the U.S. Armed Forces while the child was attending, on a full-time basis, an institution of higher education and applied to an institution of higher education as a full-time student within 12 months from the date the child has fulfilled his or her active duty obligation.
- If your child no longer meets the definition of an eligible dependent as indicated above under dependent eligibility because he/she is age 26 or older, your child will have the option to continue coverage until the enrolled unmarried child reaches his/her 30th birthday if he/she meets all of the following criteria:
  - lives within the plan's service area; and
  - has served as an active or reserve member of any branch of the Armed Forces of the United States; and;
  - has received a release or discharge other than a dishonorable discharge

Qualified Medical Child Support Order

A qualified medical child support order (QMCSO) is a legal judgment, decree or order issued under a state domestic relations law by a court or an administrator. A QMCSO recognizes the rights of a child to coverage for health care benefits. Under a medical child support order, the court or an administrative agency can require you to provide coverage to a child under the Medical, Dental or Vision Plans.

You will be notified if any of your children are affected by a QMCSO. You may call Mercy Health Corporation Human Resources for information regarding the procedures governing QMCSOs.

Extended Coverage for Disabled Children

If a dependent child is physically or mentally incapable of self-support after reaching age 26 and was continuously covered under the Plan up to and including the date the child became incapacitated, you may continue coverage for that dependent if the child's physical or mental handicap started before he or she reached age 26. You must provide proof of the disability to the claims administrator within 30 days of when the child's coverage would normally end under the plan. Your child is considered physically or mentally incapable of self-support if the child is not able to earn his or her own living because of mental retardation or physical handicap and if the child is mainly dependent on you for support and maintenance.

If you were just hired or recently became eligible for coverage because of a change in employment status, you must provide this proof within 30 days of your eligibility to cover an adult disabled dependent. You may also need to provide proof of continued disability from time to time to maintain coverage.

Eligibility for Medicare Part D and Retiree Coverage

You (and your covered dependents) are not eligible to participate in the Mercy Health Corporation-sponsored Medical Plan if you or your dependents elect coverage under Medicare Part D. In general, the prescription drug benefits provided under this plan are at least as good as or better than the standard Medicare Part D prescription drug benefits. However, you should review the coverages and premiums for both Medicare Part D and the Mercy Health Corporation Plan to make the best decision for you and your family.

If you decide to enroll in a Medicare drug plan you will no longer be eligible to participate in the Mercy Health Corporation Plan and you permanently forfeit your rights to enroll in this Plan in the future.

- If you have any questions about Medicare Part D prescription drug coverage, contact Medicare at www.healthcare.gov.
- Mercyhealth partners retiring from the system may also qualify for the Mercyhealth Retiree health insurance coverage. See the Mercyhealth policy for additional information on Retiree coverage.

Enrolling & Changes

When Coverage Begins

Coverage under the plan is not automatic; you must enroll. As a new employee or an employee who changes to benefit-eligible status, you have 30 calendar days from your start date or change in benefit eligible status date to enroll. Coverage begins on the first day of the month following 30 days from the date of hire, if you enroll within this 30-day period.

Once made, you generally cannot change your elections during the year. If you miss the 30-day deadline and want to enroll in the plan during the year, you can do so only in limited situations if you experience a qualifying life event or special enrollment event (see Qualifying Life Event and Special Enrollment for more information). If you have a qualifying life event or special enrollment event, you have 30 days from the date of the event to enter the change. Otherwise you must wait until annual

enrollment to make coverage changes, which take effect the next January 1, or until you experience another qualifying life event or special enrollment event.

Annual Enrollment

During annual enrollment, held each fall, you can make changes to your benefit elections. The changes take effect the next January 1. If you have not enrolled in the plan, you can do so during the annual enrollment period. Elections made during annual enrollment remain in effect throughout the calendar year, unless you experience a qualifying life event or special enrollment event (see Qualifying Life Event and Special Enrollment for more information). In general, your elections remain in effect for future years unless you make a change or you are notified by the Company of coverage changes. However, Spending Account elections must be made each year.

Qualifying Life Event

You may make limited changes to your elections during the year if you experience a qualifying life event as described below:

- marriage, divorce, or annulment;
- starting or ending a domestic partnership;
- addition of a new dependent child, such as through birth, adoption or placement for adoption;
- death of your spouse/domestic partner or dependent child;
- a change in your employment status or that of your spouse/domestic partner or a dependent, including starting employment, or if any of the following cause you a loss of insurance: ending employment, a strike or lockout, the start of or return from an unpaid leave of absence; or a change in worksite if it affects insurance eligibility;
- a change in the employment status of you, your spouse/domestic partner or a dependent such that the affected individual becomes eligible or loses eligibility under the plan or another employee benefit plan
- a child reaches the plan limiting age and loses coverage; or
- Entitlement to Medicare or Medicaid.

The change you make in your elections must be consistent with your qualifying life event and is effective on the date of the qualifying life event. For example, if you adopt a child, you can add your child as a covered dependent; however, you cannot drop your spouse from coverage under the plan.

For specific details on changes you may make and how to make them, contact the Human Resources department.

Special Enrollment

Under the Health Insurance Portability and Accountability Act (HIPAA), there are special enrollment rules that let you enroll or add your eligible dependents as long as you enroll within 30 days from the date of one of these events:

- If you become married, even though you may have waived coverage initially, you and your spouse/domestic partner and any newly acquired dependents may take advantage of special enrollment.
- If you choose employee only coverage or are not enrolled and you subsequently acquire a new dependent (whether through birth, placement for adoption or adoption), you may elect special enrollment for your spouse and child, or for the child only, and for yourself (if not previously enrolled).
- If you opt out of coverage under the plan because you are covered under another employer's group health plan and you lose coverage under that plan for a reason other than failing to pay premiums or misrepresentation (for example, a qualifying life event), you may elect special

enrollment for you and any eligible dependents that also lost coverage. You are not required to take COBRA continuation under another plan to elect special enrollment under this plan.

- If you opt out of coverage under the plan (or you opt not to enroll your dependents) because COBRA continuation is in effect on your eligibility date, you (or your dependents) must exhaust the COBRA continuation period before you can elect special enrollment under the plan. This means you (or your dependents) must continue COBRA coverage for the entire COBRA period in order to have a special enrollment right under the Plan. Failure to pay a COBRA premium or voluntary termination of coverage does not result in the exhaustion of COBRA.

Special enrollment is also allowed if your other group health plan ends or the employer sponsoring the other group health plan stops making employer contributions. However, you must give notice and actually enroll in the plan within 30 days of either event. If you fail to do so, you must wait until the next annual enrollment for the plan, unless you have a subsequent qualifying life event or special enrollment event and give notice within 30 days of the subsequent change.

Changes are effective on the date of the qualifying life event and have a 30-day enrollment period from the date of the event.

Children's Health Insurance Program and Medicaid

You have 60 days to enroll for coverage if:

- you or your dependent's coverage under Medicare or a state Children's Health Insurance Program (CHIP) ends as a result of loss of eligibility (not available if the loss of coverage is due to non-payment); or
- you or your dependent becomes eligible for a premium assistance subsidy under Medicaid or CHIP.

How to Change, Add or Cancel Coverage

If you experience a qualifying life event or special enrollment event, you have 30 days from the date of the event to change, add or cancel coverage. If you miss the deadline, your next opportunity to enroll is at annual enrollment, unless another qualifying life event or special enrollment event occurs that would allow a change. You can add, change or cancel coverage by filling out a Change of Status form and submitting it to the Human Resources Department.
The following table contains examples of the changes you can make to your medical elections when certain qualified life events or special enrollment events occur. Changes must be consistent with the event.

If This Happens	You Can Make These Enrollment Changes	
	Add	Drop
Marriage	Yourself, spouse/domestic partner, newly eligible children	Yourself, spouse/ domestic partner, eligible children if newly eligible under another group plan
Divorce/annulment or loss of a domestic partner	Yourself, children	Spouse/domestic partner, children
Birth or adoption of a child	Yourself, spouse/domestic partner, children	Yourself, spouse/domestic partner, children if newly eligible under another group plan
Gain custody of a child	Child	

Lose custody of a child		Child
Child becomes eligible because of a qualified medical child support order	Yourself, child	
Child is no longer eligible for coverage		Child
Death of a covered dependent		Deceased spouse/ domestic partner or child
Gain of spouse's or domestic partner's eligibility for other health care coverage		Yourself, spouse/ domestic partner, children
Loss of spouse's or domestic partner's eligibility for health care coverage	Yourself, spouse/ domestic partner, children (only those who lost the coverage creating the event)	
Change in your employment status (e.g., increase in hours to 20 hours per week.	Yourself, spouse/ domestic partner, children	
Entitlement to Medicare or Medicaid		Yourself, spouse/ domestic partner, children (only if they are the individual receiving the entitlement)

Family and Medical Leave of Absence

You may be able to continue plan coverage for up to 12 weeks during a leave of absence if that leave qualifies under the Family and Medical Leave Act of 1993 (FMLA) and you are eligible under the terms of FMLA.

To continue your coverage, you must continue paying your premiums while on FMLA leave. If your FMLA leave is paid, your premium contributions are deducted from your pay as usual. If your FMLA leave is unpaid, you must arrange payment to Mercy Health Corporation until you return to active pay status. If you fail to pay the premiums, your coverage ends. When you return to work following an FMLA leave, any canceled coverage is reinstated as of the date you return. If, during your FMLA leave, you give notice that you are terminating employment, your coverage ends on the last day of the month. If you do not return to work on your expected return date and do not notify Mercy Health Corporation of your intent either to terminate or extend your leave, your coverage ends on the last day of the month you were expected to return. Also, you can change your plan coverage tier (e.g., Employee Only). For more information about FMLA leave, **contact your human resources department. Note**: Mercyhealth may retroactively terminate your coverage after 3 months of non-payment of the premium.

Military Leave of Absence

If you are on military leave, you can elect to continue plan coverage for yourself and enrolled dependents for up to 24 months during your absence or, if earlier, until the day after the date you are required to apply for or return to active employment with the Company under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). During the first 30 days of coverage, your contributions are the same as for active employees. Thereafter, you will be required to pay the COBRA premium.

Whether or not you decide to continue coverage during military leave, that coverage will be reinstated when you return to employment under USERRA. Your reinstatement will be without any waiting period.

Other Mercyhealth Leave of Absences

- Alternate medical leave covers partners who have an illness or injury that prevents them from performing the essential functions of their position and do not qualify for Family and Medical Leave or have exhausted their FMLA rights.
- Personal leave covers partners who request time away from work for reasons other than vacation.
- Educational leave covers partners who request a leave of absence for educational purposes in their current position that will be mutually beneficial for the partner and Mercyhealth.
- The work sabbatical program is designed to help support partners to undertake special projects and education outside of the health system, through non-profit or disaster relief organizations on a cost-sharing basis.

Mercyhealth will maintain the partner's health coverage while on any approved leave of absence under the current "Group Health Plan" in which the partner was participating at the start of the leave as long as the partner continues to pay the employee premium. Insurance coverage will be continued at active partner rates throughout all approved leave of absences.
See specific Mercyhealth policies for additional information on each of these Mercyhealth leave of absences.

In addition to these leave of absences, Mercyhealth complies with all federal and state coverage provisions such as the Affordable Care Act and partners may qualify for health benefits under these provisions.

Rescissions of Coverage

Once you or any of your dependents are enrolled in the plan, your coverage may not be rescinded unless:

- you or your dependent performs an act, practice or omission that constitutes fraud; or
- you or your dependent makes an intentional misrepresentation of a material fact.

Inadvertent omissions or unintentional misrepresentations are not grounds for rescission of coverage.

SUMMARY OF BENEFITS

Medical Plans Offered For Mercy Health Corporation Partners (non-union)

As mentioned earlier, Mercy Health Corporation offers four options for medical coverage. These are described below.

Terms: MOOP means Maximum Out of pocket limit or Out of Pocket Maximum and is defined in the glossary, and later in the section "How Cost Sharing Works."

- **EPO** – this is an HMO plan that features a provider network consisting primarily of Mercy Health Corporation providers, with some exceptions as noted in the provider directory. Your PCP is required to submit a referral to the Plan Administrator if the care you need cannot be provided within the network. You can review the providers in the EPO network by accessing the website: mercycarehealthplans.com, press Find a Doctor/Facility, select Mercy Health Partners EPO, then follow the instructions. The Schedule of Benefits for this plan is in Appendix A, and is summarized below:

  Maximum OOP Medical benefits = $4000 single/$8000 family
  Maximum OOP Pharmacy benefits = $3600 single/$7200 family
  Deductible = $750 single / $1500 family
  Inpatient Co-pay = $750
  PCP Office visit Co-pay = $30
  Specialist Office visit Co-Pay = $50
  Urgent Care Co-pay = $50 in network/$60 out of network
  Emergency room charge = $200 copay (waived upon admission)
  Four Tier drug plan and formulary

- **EPO/HDHP** – this is MercyCare's High Deductible Health Plan (HDHP). This is an HMO plan that features a provider network consisting primarily of Mercy Health Corporation providers, with some exceptions as noted in the provider directory. Your PCP is required to submit a referral to the Plan Administrator if the care you need cannot be provided within the network. You can review the providers in the EPO network by accessing the website: mercycarehealthplans.com, press Find a Doctor/Facility, select Mercy Health Partners EPO, then follow the instructions. The Schedule of Benefits for this plan is in Appendix B, and is summarized below:

  Medical and Pharmacy deductible and OOP combined = $4000 single/$8000 family
  100% coverage after deductible is met.
  Two Tier drug plan and formulary

- **PPO** – This is a PPO plan that features three tiers of benefits. This plan pays the highest tier of benefits whenever you obtain health care services from a Mercy Health Corporation provider. Tier 1 providers are labeled and located in the provider directory. The highest tier of benefit is described in the Tier 1 Benefits column of the Schedule of Benefits. Tier 2 providers are those who are not Tier 1 providers but are found in the First Health network, with some exceptions. When you use this tier of benefits, you pay a greater share of the cost of health care services you receive. This tier of benefit is described in the Tier 2 Benefits column of the Schedule of Benefits. A Tier 3 provider is any provider who is not listed in the provider directory or on the website, and includes the following First Health provider groups/hospitals: Aurora Health Care, Beloit Health System, SSM Health – formerly Dean Health System/St. Mary's Hospital and Monroe Clinic, OSF HealthCare System, Swedish American Health

System. When you use this tier of benefits, you will pay the greatest share of the cost of health care services you receive. Tier 3 Benefits are subject to usual and customary charge limitations. This tier of benefit is described in the Tier 3 Benefits column of the Schedule of Benefits. The Schedule of Benefits for this plan is in Appendix C, and is summarized below. The provider directory for this plan can be reviewed at www.mercycarehealthplans.com, navigate to and press Find a Doctor/Facility, then select Mercy Health Partners PPO, then follow the instructions.

Maximum Tier1 + Tier2 combined Max OOP Limit for Medical benefits = $4250 single/$8500 family
Maximum Tier3 OOP Medical benefits = $9,000 single/$18,000 family
Maximum OOP Pharmacy benefits = $3600 single/$7200 family
Deductible : Tier1 + Tier2 combined = $750 single/$1500 family; Tier 3 = $750 single/$1500 family
Inpatient Co-pay = Tier1-$800; Tier2-$1600; Tier3-$3500
PCP Office visit Co-pay = Tier1-$30; Tier2-$50; Tier3-$60
Specialist Office visit Co-Pay = Tier1-$50; Tier2-$70; Tier3-$80
Urgent Care Co-pay = Tier1-$50; Tier2-$75; Tier3-$75
Emergency room charge = $200 each benefit Tier
Four Tier drug plan and formulary

- **PPO - HDHP** – This is a Point of Service plan that features two tiers of benefits. This plan pays the highest tier of benefits whenever you obtain health care services from a Mercy Health Corporation, other Tier 1 provider, or First Health provider groups/hospitals (with exceptions as noted below. Tier 1 providers are labeled and located in the provider directory, or in the First Health network. The highest tier of benefit is described in the Tier 1 Benefits column of the Schedule of Benefits. Tier 2 providers are those who are not Tier 1 providers. When you use this tier of benefits, you pay a greater share of the cost of health care services you receive. This tier of benefit is described in the Tier 2 Benefits column of the Schedule of Benefits. A Tier 2 provider is any provider who is not listed in the provider directory or on the website and includes the following First Health provider groups/hospitals: Aurora Health Care, Beloit Health System, SSM Health – formerly Dean Health System/St. Mary's Hospital and Monroe Clinic, OSF HealthCare System, Swedish American Health System. When you use this tier of benefits, you will pay the greatest share of the cost of health care services you receive. Tier 2 Benefits are subject to usual and customary charge limitations. This tier of benefit is described in the Tier 2 Benefits column of the Schedule of Benefits. The Schedule of Benefits for this plan is in Appendix D, and is summarized below. The provider directory for this plan can be reviewed at www.mercycarehealthplans.com, navigate to and press Find a Doctor/Facility, then select Mercy Health Partners PPO, then follow the instructions.

Tier 1 Medical and Pharmacy deductible and OOP combined = $4000 single/$8000 family
100% coverage after deductible is met.
Tier 2 Medical deductible and OOP combined = $8000 single/$16,000 family
100% coverage after deductible is met.

Two Tier drug plan and formulary

How Cost Sharing Works Under Your Plan

COPAYMENTS, COINSURANCE, AND DEDUCTIBLES

All covered services are subject to any copayments, coinsurance, and/or deductible limits shown in your Schedule of Benefits.

The single deductible is the most that each member must pay for covered services each contract year, and the family deductible amount is the most that the employee and his or her covered dependents must pay for covered services each contract year.

You will not receive deductible credit for any amounts paid for services that are not covered by the Plan, including:

- Amounts paid to providers other than participating providers, except when you have an approved referral.
- Amounts paid for certain services as marked in your Schedule of Benefits.
- Any copayments you pay.

Coinsurance payments begin once you meet any applicable deductible amounts. Copayments are applied to the out-of-pocket maximum and will cease to be applied once the out-of-pocket maximum is met.

OUT-OF-POCKET MAXIMUM

The out-of-pocket maximum is the most you will pay in co-insurance, co-pays and deductible for your covered services in a contract year. The out-of-pocket maximum includes any deductibles that apply. The amount of the out-of-pocket maximum is shown in the Schedule of Benefits. The "single" out-of-pocket maximum is the most that each member will pay out-of-pocket each contract year.

The "family" out-of-pocket maximum is the most that the employee and his or her dependents will pay out-of-pocket each contract year.

You may pay more than the out-of-pocket maximum amount in a contract year if you:

- Receive services that are not covered services;
- Receive services from non-participating providers that are not authorized by the Plan; or
- Receive services that are subject to limitations, and those limits have been exceeded
- Receive services that require prior authorization that were not authorized by the Plan (see Prior Authorization section of this SPD); or
- Receive services that require a referral and prior approval was not given by the Plan.

In these circumstances, you may be responsible for charges even if you have met your out-of-pocket maximum for the contract year.

How Savings And Spending Accounts Work

You can use a Health Savings Account (HSA) to help cover the cost sharing (deductible) in the HDHP plans. MercyCare's EPO/HDHP and PPO/HDHP plans are designed to be high deductible health plans (HDHP) that are HSA compatible plans. In general, a HDHP is one in which the annual deductible is higher than the deductible in more traditional health plans. The term "high deductible health plan" is almost always used in the context of Health Savings Accounts (HSAs). HSAs are a special kind of tax-advantaged savings account used to accumulate funds for medical expenses. If you choose MercyCare's EPO/HDHP or PPO/HDHP plan, you may enroll in the HSA plan Mercy Health Corporation offers through Health Equity.

Mercy Health Corporation partners that are hired to work 20 or more hours per week (.5 FTE) are eligible to participate in the flexible benefit plan, also known as Flexible Spending Account (FSA). The FSA plan allows you to set aside pre-tax dollars from your paycheck to pay for qualified medical and childcare/dependent care expenses. Mercyhealth will deduct pre-tax dollars from your paycheck if you enroll in the FSA program by filling out the Health Equity enrollment form during open enrollment. The FSA is administered by Health Equity. To get reimbursed from your FSA account, you will need

to submit claims to the Health Equity website at www.healthequity.com. You must re-enroll in the FSA program each year.

Partners choosing the HSA have the option to participate and make contributions to a Health Savings Account. The money you contribute to your HSA is portable, meaning that it is not subject to the "use it or lose it" rules that Flex Spending Accounts (FSA) have and can be carried over from year to year. Partners who choose to participate in the HSA and also participate in the FSA will be required to participate in a limited purpose FSA.

PLAN COST/PREMIUMS

Plan Cost

Mercy Health Corporation pays a significant portion of the cost for coverage under the Medical Plan.

Providing health care coverage to employees is very expensive, and one way you are asked to share the cost is in the form of premiums. The amount of your premiums depends on which coverage option you choose and how many eligible dependents you enroll for coverage. Premiums may include administrative costs to administer the Plan. These premiums are subject to change each year.

Tax-Saving Advantage

You pay your portion of the cost of coverage with pretax dollars deducted from your paycheck. "Pretax" means that your premium is taken from your paycheck before Social Security, federal and most state taxes are deducted, thereby lowering your taxable income. This in turn lowers the actual cost you pay for coverage and the amount you pay in taxes.

If you enroll a tax dependent domestic partner, the additional premium is equal to that for a spouse. However, if you enroll a non-tax dependent partner, you pay the premium on an after-tax basis and it creates imputed income.

Tobacco Premium Incentive

If you or your spouse/domestic partner does not smoke or use tobacco products, your plan will be discounted $50 per month. You will automatically be charged the tobacco-user premium unless you certify that no one covered under your health plan uses tobacco or has used tobacco within the last 6 months.

Once the tobacco premium is applied, it will be charged every month until you certify (through the tobacco attestation form) that you or your dependent has been tobacco free for 6 months. Another alternative for tobacco users is you, your spouse or dependents may participate in the Wellness Program reasonable alternative standard for partners and their covered spouses/domestic partners who (1) elect MercyCare health plan coverage for the applicable year, (2) have not timely ceased their tobacco use in accordance with MercyCare's wellness program, and (3) would otherwise be required to pay a higher health plan premium ("tobacco surcharge") as a result of their tobacco use. By participating in this program, you may earn the same discount by enrolling in and completing an approved tobacco cessation program. Details of the Tobacco Cessation Policy and the reasonable alternative program may be found on the Mercyhealth Partner Intranet under the HR policy section.

HOW YOUR MEDICAL COVERAGE WORKS

Prior Authorization Requirements

To assure proper medical management, the following services require prior authorization from the Plan before they will be covered services, regardless of whether they are rendered by a participating or non-participating provider. Failure to get prior authorization means the services are not covered, so you will be responsible for the payment of such services. The services requiring prior authorization are also notated in the Schedules of Benefits documents found in the appendices.

Categories of services and supplies requiring prior authorization are:

Autism Treatment
Biofeedback services
Cardiac rehabilitation
Dental surgery
Durable medical equipment
Genetic testing and counseling
Home health care
Hospice care
Hospital services, inpatient and outpatient
Infertility treatment
Insulin pumps
Magnetic Resonance Imaging (MRI)
Maternity services received out of the service area in the last 30 days of pregnancy
Medical supplies
Non-participating provider services and supplies
Pharmaceuticals administered in provider's office
Positron emission tomography (PET) imaging
Prosthesis
Psychological disorder and chemical dependency, inpatient and transitional treatment
Reproductive services, inpatient
Surgical services, inpatient, outpatient, and at a free-standing surgical facility
Skilled nursing facility services
Temporomandibular disorders (TMJ)
Transplants

The method for filing a request for prior authorization, also known as a pre-service claim, is set out in the Claims Provisions section of this SPD.

For questions about the prior authorization process, please call the Customer Service Department at 1-800-895-2421.

Concurrent Review

Concurrent review occurs at intervals during the course of the Covered Person'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 Physician will be asked to provide additional medical information to evaluate the need for additional services.

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

Alternative Benefits

In addition to the benefits specified, the Plan may elect to offer benefits for services furnished by any provider pursuant to a Plan-approved alternative treatment plan, in which case those charges incurred for services provided to a Covered Person through the duration of the alternate treatment plan, subject to the Benefit Maximums, will be more cost effective than those charges to be incurred for services to be provided under the current treatment plan to its end. Coverage may be provided for the less costly alternative treatment plan, even if such care is not specifically stated as covered under the Plan. An alternative treatment plan may not, however, cover expenses that are considered Experimental or Investigational as defined in the Plan or expenses that are provided only as a convenience to the Covered Person, the Covered Person's family or the health care provider. Coverage for alternative care is subject to the same overall Benefit Maximums (except as noted in the paragraph below), Co-pays, Deductible and/or Co-insurance requirements that apply to the medical care being replaced.

The Plan shall provide such alternative benefits at its sole discretion and only when and for so long as it determines that alternative care services are Medically Necessary and cost effective.

If the Plan elects to provide alternative benefits for a Covered Person in one instance, it shall not be obligated to provide the same or similar benefits for other Covered Persons under this Plan in any other instance, nor shall it be construed as a waiver of the Plan Administrator's rights to administer this Plan thereafter in strict accordance with its express terms.

IMPORTANT: The utilization of managed care is not a guarantee of benefits under the Plan.

Charges are subject to all Plan provisions.

Claims Provisions

1. The Plan will pay participating providers directly for covered services you receive, 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 within 60 days after the services are received, or as soon as possible. If the Plan does not receive the claim as soon as reasonably possible and within 12 months after the date it was otherwise required, the Plan may deny coverage of the claim.

2. How you file a claim for benefits depends on the type of claim it is. You or your authorized representative may file a claim. There are several categories of claims for benefits:

    a. **Pre-service Claim** – a claim for a benefit under the plan with respect to which the terms of the policy require approval of the benefit in advance of obtaining medical services

    b. **Urgent Care Claim** – any claim for medical care or treatment with respect to which, in the opinion of the treating physician, lack of immediate processing of the claim could seriously jeopardize the life or health of you or your insured dependent or subject you or your insured dependent to sever pain that cannot be adequately managed without the care or treatment that is the subject of the claim. This type of claim generally includes those situations commonly treated as emergencies.

    c. **Concurrent Care Claim** – a claim for an extension of the duration or number of treatments provided through a previously approved claim. Where possible, this type of claim should be filed at least 24 hours in before the expiration of any course of treatment for which an extension is being sought.

d. Post-service Care Claim – a claim for payment ore reimbursement after services have been rendered

e. Disability Claim – a claim reviewed under the policy's definition of total disability, e.g., extended benefits.

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

3. To submit a claim, send an itemized bill from the physician, hospital, or other provider to the following address:

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

Written proof of your claim includes: (1) the completed claim forms if required by us; (2) the actual itemized bill for each service; and (3) all other information that we need to determine our liability to pay benefits under the policy, including, but not limited to, medical records and reports. Be sure to include your name and identification card number. 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.

An incomplete claim is a correctly filed claim that requires additional information, including but not limited to, medical information, coordination of benefits questionnaire, or a subrogation questionnaire. An incorrectly filed claim is one that lacks information which enables us to determine what, if any, benefits are payable under the terms and conditions of the policy. Examples include, but are not limited to, claims filed that are missing procedure codes, diagnosis information or dates of service.

4. Procedures for Appointing an Authorized Representative. You or your dependent may have someone act on your behalf for purposes of filing claims, making inquiries and filing appeals. Please contact the Customer Service Department at 1-800-895-2421 for more information about appointing someone to represent you.

5. Timing of Claims Determinations

a. Urgent Care Claims. If your claim involves urgent care, you or your authorized representative will be notified of MercyCare's initial decision on the claim as soon as feasible, but in no event more than 72 hours after receiving the claim. If the claim does not include sufficient information for us to make a decision, you or your representative will be notified within 24 hours after receipt of the claim of the need to provide additional information. If you do not respond within 48 hours to MercyCare's request, your claim may be denied.

b. Concurrent Care Claims. If your claim is one involving concurrent care, we will notify you of this decision within 72 hours after receiving the claim, if the claim was for urgent care and was received by MercyCare at least 24 hours before the expiration of the previously approved time period for treatment or number of treatments. You will be given time to provide any additional information required to reach a decision. If your concurrent care claim does not involve urgent care or is filed less than 24 hours before the expiration of

the previously approved time period for treatment or number of treatments, we will respond according to the type of claim involved (i.e., urgent, pre-service or post-service.).

c. Pre-service Claims. A pre-service claim is any claim for a benefit under the policy, which requires prior approval or precertification before obtaining medical care. If your claim is for pre-service authorization, we will notify you of our initial determination as soon as possible, but not more than 15 days from the date we receive the claim. This 15-day period may be extended by MercyCare for an additional 15 days if the extension is required due to matters beyond our control. You will have at least 45 days to provide any additional information requested of you by MercyCare.

If you fail to follow MercyCare's procedures for filing a pre-service claim, you or your authorized representative shall be notified orally or in writing not later than 5 days (24 hours in the case of urgent care) following the failure. This notice, however, applies only when you submit a claim to the appropriate claims unit with the requested identifying claim information.

d. Post-service Claim. If your claim is for a post-service reimbursement or payment of benefits, we will notify you within 30 days of receipt of the claim if the claim has been denied or if further information is required. The 30 days can be extended to 45 if MercyCare notifies you within the initial 30 days of the circumstances beyond our control that require an extension of the time period, and the date by which we expect to render a decision.

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

e. Disability Claims. If your claim requires us to decide whether you have a disability as defined by MercyCare, you will be notified of our decision no later than 45 days after our receipt of the claim. If we determine that an extension of time is needed to process your claim due to matters beyond the control of MercyCare, you will be notified before the end of the 45-day period after filing of the claim. The extended period may not exceed 75 days after the filing of the claim. If another extension is required for reasons beyond the control of MercyCare, you will be notified before the end of the 75-day period after filing the claim. The second extended period may not exceed 75 days after the filing of the claim. Any notice of extension will explain the standard on which the entitlement to a disability benefit under the policy is based and the unresolved issues that prevent a decision in the claim as well as additional information needed to resolve the claim. You will have at least 45 days from the receipt of the notice to submit the requested information. We will make a decision after the requested information has been received within the required time period.

6. Notice of Claims Denial

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

7. The Plan 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.

8. Benefits accrued on your behalf upon death shall be paid, at the Plan's option, to any one of more of the following:

    a. your spouse; or
    b. your dependent children, including legally adopted children; or
    c. your parents; or
    d. your brothers and sisters; or
    e. your estate.

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

9. In the event of a question or dispute concerning the provision of health care services or payment for such services under the policy, the Plan may require that you be examined, at the expense of the Plan, by a participating provider designated by the Plan.

DESCRIPTION OF MEDICAL BENEFITS

Eligible charges shall be the charges actually made to the Covered Person, and unless otherwise shown, will be considered eligible only if the expenses are:

- Due to Illness or Injury;
- Ordered or performed by a Physician;
- Medically Necessary; and
- Subject to the Usual and Customary fee for that type of service (when applicable).

Reimbursement for eligible expenses will be made directly to the provider of the service, unless a receipt showing payment is submitted. Deductible, Co-payment and Co-insurance amounts for which the Covered Person is not obligated to pay by a provider shall not be considered eligible or covered expenses.

Deductibles, Co-pays and Co-insurance will apply to medical services as specified in Appendix A, B, C or D. Once the Deductible is satisfied (where applicable) covered charges are payable at the percentage specified in the SCHEDULE OF BENEFITS. All limitations and exclusions of the Plan apply.

The following covered benefits are listed in alphabetical order:

Acupuncture Services

Your schedule of benefits will indicate whether or not you have coverage for acupuncture. Participating acupuncturists can be found in your provider directory.

Covered Services:

- Acupuncture services performed by a certified or licensed participating acupuncturist are covered without a referral.
- Services are subject to the coinsurance, copayments, and other terms as specified in your Schedule of Benefits.

Non-Covered Services:

- Acupuncture services provided by non-participating providers.
- Acupuncture services provided by non-certified or non-licensed providers.

Ambulance

Covered Services:

- Professional ground or air ambulance service is covered in an emergency as described in the Emergency and Urgent Care section of this SPD.
- Ambulance transportation is also covered from a hospital to the nearest hospital equipped to provide treatment that was not available at the original facility.

Non-Covered Services:

- Ambulance service that is used in situations that are not considered life threatening.

Autism Treatment

Your schedule of benefits will indicate the effective date and limitations of this coverage. Refer to the glossary for definitions of terms used in this section.
Autism Spectrum Disorder Treatment means treatment for members who have a primary verified diagnosis of autism spectrum disorder when made by a provider skilled in testing and in the use of empirically validated tools specific for autism spectrum disorders. MercyCare reserves the right to require a second opinion in establishing the diagnosis of autism.

Covered Services:
- Diagnostic testing and evaluation by a provider approved by MercyCare.
- Intensive-level services for up to 4 cumulative years for members between the age of 2 and 9 years;
- Nonintensive-level services that are provided:
  1. after the completion of intensive level services treatment, or
  2. to a member who has not and will not receive intensive level services, but for whom nonintensive-level services will improve the member's condition.
- Nonintensive-level services that include direct or consultative services when provided by qualified providers, qualified supervising providers, qualified professionals, qualified paraprofessionals or qualified therapists.

Coverage Provisions:
- To be covered, intensive-level services must:
  1. Have prior authorization from the Plan, and
  2. Be provided by one of these participating providers: qualified provider, qualified supervising provider, qualified professional, qualified paraprofessional or qualified therapist, and
  3. Be deemed to be evidence-based and efficacious, and
  4. Be part of the member's treatment plan that was subject to prior authorization, and
  5. Be provided when the parent or guardian is present the majority of the time.
- To be covered, nonintensive-level services must:
  1. Have prior authorization from the Plan, and
  2. Be provided by one of these participating providers: qualified provider, qualified supervising provider, qualified professional, qualified paraprofessional or qualified therapist, and
  3. Be part of the member's treatment plan that was subject to prior authorization, and
  4. Be deemed to be evidence-based and efficacious.

Non-Covered Services
- Any services that do not have prior authorization from the Plan.
- Custodial or respite care.
- Travel time for qualified providers, supervising providers, professionals, therapists, or paraprofessionals.
- Animal-based therapy, including hippotherapy.
- Auditory integration training.
- Chelation therapy.
- Child care fees.
- Cranial sacral therapy.
- Hyperbaric oxygen therapy.
- Special diets or supplements.
- Treatment provided by parents or legal guardians.
- Autism therapy, treatment or services provided to a member who is residing in a residential treatment center, inpatient treatment or day treatment facility.
- The cost for the facility or location when treatment, therapy or services are provided outside a member's home.

Biofeedback

Covered Services:
- Biofeedback is covered only for treatment of headaches, spastic torticollis, urinary incontinence, and post-traumatic stress disorder.
- Benefit limitations will be determined based on the provider of services.
- Biofeedback services must have prior authorization from the Plan.

Cardiac Rehabilitation

Covered Services:
- Cardiac Rehabilitation is covered when obtained through a participating provider, when medically necessary and with prior authorization by the Plan.
- Phase II Cardiac Rehabilitation is subject to prior authorization by the Plan and 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) a heart attack;
  b) coronary bypass surgery;
  c) onset of angina pectoris;
  d) heart valve surgery;
  e) onset of decubital angina;
  f) percutaneous transitional angioplasty, or
  g) cardiac transplant
  h) 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:
- Chiropractic services performed by a participating chiropractor are covered without a referral. Services must be medically necessary.

Non-Covered Services:
- Maintenance or long term therapy as determined by MercyCare after reviewing an individual's case history or treatment plan submitted by a provider.

Clinical Trials

Qualified Clinical Trial

Services rendered during the course of a Qualified Clinical Trials are covered the same as such

services would be covered if the Covered Person was not enrolled in a Qualified Clinical Trial, so long as the services are considered Patient Care Services as defined below. Pre-notification and Plan approval is required at least 4 days in advance of the start of the trial.

A Qualified Clinical Trial is defined as a clinical trial that meets all the following conditions:

1. The clinical trial is intended to treat a patient who has been diagnosed with cancer, and
2. The clinical trial is offered by an accredited Healthcare entity provider approved by the plan, and
3. The clinical trial is a Phase II, III or IV clinical trial, and
4. The clinical trial has been peer reviewed and is approved by at least one of the following:
   a. One of the United States National Institutes of Health,
   b. A cooperative group or center of the National Institutes of Health,
   c. A qualified nongovernmental research entity identified in guidelines issued by the National Institutes of Health for center support grants,
   d. The United States Food and Drug Administration pursuant to an investigational new drug exemption,
   e. The United States Departments of Defense or Veterans Affairs, or
   f. A qualified institutional review board.
5. The facility and personnel conducting the clinical trial are capable of doing so by virtue of their experience and training and treat a sufficient volume of patients to maintain that expertise, and
6. The patient meets the patient selection criteria described in the study protocol for participation in the clinical trial, and
7. The patient has provided informed consent for participation in the clinical trial in a manner that is consistent with current legal and ethical standards, and
8. The available clinical or pre-clinical data provide a reasonable expectation that the patient's participation in the clinical trial will provide a medical benefit that outweighs the risks of participation in the clinical trial, and
9. The clinical trial does not unjustifiably duplicate existing studies, and
10. The clinical trial must have a therapeutic intent and must, to some extent, assess the effect of the intervention on the patient.
11. Registry Trials (those clinical trials that do not involve treatment and are designed to only collect data) must meet the conditions outlined in items 1 through 7 and item 9 above. Items 8 and 10 do not apply.

Patient Care Services for Qualified Clinical Trial - Definition

Patient Care Services are defined as health care items or services that are furnished to an individual enrolled in a Qualified Clinical Trial, which is consistent with the usual and customary standard of care for someone with the patient's diagnosis, is consistent with the study protocol for the clinical trial, and would be covered if the patient did not participate in the Qualified Clinical Trial. Patient Care Services must be services covered by the Plan.

Patient Care Services do not include any of the following:

1. An FDA approved drug or device shall be a Patient Care Service only if that the drug or device is not paid for by the manufacturer, the distributor or the provider of the drug of device, or
2. Non-health care services that a patient may be required to receive as a result of being enrolled in the Qualified Clinical Trial, or
3. Costs associated with managing the research associated with the Qualified Clinical Trial, or
4. Any item, service or cost that is reimbursed or otherwise provided by the sponsor of the Qualified Clinical Trial, or

5. The costs of services which are not provided as part of the Qualified Clinical Trial's stated protocol.

Approved Clinical Trial under PPACA

The Plan will not deny participation in an Approved Clinical Trial, nor will the Plan deny (or limit or impose additional conditions on) the coverage of routine patient costs for items and services furnished in connection with participation in the trial. For these purposes, "routine patient costs" does not include: (1) the investigational item, device or service itself; (2) items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the Covered Person's direct clinical management; or (3) a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

An Approved Clinical Trial will be covered, subject to all other Plan provisions and limitations, under the following criteria:

1. Only a Qualified Individual, as defined in this subsection, may receive Approved Clinical Trial benefits. A Qualified Individual is a Covered Person who:

a. is eligible to participate in an approved clinical trial according to the trial protocol with respect to treatment of cancer or other life-threatening disease or condition. For this purpose, "life-threatening condition" means any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted; and

b. either

(i) the referring health care professional is a participating health care provider and has concluded that the individual's participation in such trial would be appropriate based upon the individual meeting the conditions noted in subsection (a); or

(ii) the Covered Person provides medical and scientific information establishing that his or her participation in the trial would be appropriate based upon the individual meeting the conditions noted in subsection (a).

2. If an In-Network provider is participating in a clinical trial, the Qualified Individual must participate in the trial through such In-Network provider, if the provider will accept the Qualified Individual as a participant in the trial. However, if an approved clinical trial is conducted outside the State in which the Qualified Individual resides, and if no In-Network provider who is participating in the trial is available in the State in which the Qualified Individual resides, this In-Network provider requirement shall not apply.

3. Routine patient care services provided in connection with the trial shall be subject to all other typical Plan provisions (including but not limited to limitations applicable to out-of-network providers -- Tiers C and D).

4. A clinical trial will be an Approved Clinical Trial only if the trial is 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 described in any of the following:

a. The study or investigation is approved or funded by one or more of the following:
   i. The National Institutes of Health;
   ii. The Centers for Disease Control and Prevention;
   iii. The Agency for Health Care Research and Quality;
   iv. The Centers for Medicare & Medicaid Services;

v. A cooperative group or center of any of the above entities or the Department of Defense or the Department of Veterans Affairs;
vi. A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants;
vii. Any of the following, if certain federal guidelines for peer review and unbiased review have been met: [1] Department of Veteran Affairs; [2] Department of Defense; and [3] Department of Energy.

b. The study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration, or is a drug trial that is exempt from having such an investigational new drug application.

Cosmetic And Reconstructive Surgery

Covered Services:

- Coverage for the treatment of breast cancer includes:

  a) Reconstruction of the breast on which a mastectomy was performed.
  b) Surgery and reconstruction of the other breast to produce a symmetrical appearance.
  c) Prosthesis and physical complications of all stages of mastectomy, including lymphedemas.

- Reconstructive surgery which is medically necessary and which is either:

  a) Incidental to or following surgery necessitated by bodily injury or sickness, or
  b) Caused by congenital disease or abnormality of a dependent child which results in a functional defect.

Non-Covered Services:

- Plastic or Cosmetic Surgery 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.

Dental Surgery

Covered Services:

- Treatment with prior authorization from the Plan for bodily injury to permanent, sound and natural teeth and bone, but only if:

  a) the bodily injury occurs while you are a member covered by the Plan; and
  b) the bodily injury is not caused by chewing or biting; and
  c) the treatment begins within 90 days of the bodily injury with a maximum of 180 days from the date of injury to complete treatment.

- With required prior authorization, inpatient hospital and free-standing surgical facility services. and anesthetics provided in conjunction with dental care in a hospital or free-standing surgical facility, if the member:

  a) Is under age 5; or
  b) 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

c) Has a medical condition that requires hospital confinement or general anesthesia for dental care.

- Oral surgery with prior authorization from the Plan for gum or bone tumors and cysts.
- Surgical removal of impacted wisdom teeth (third molars).

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 SPD. These exclusions include, but are not limited to:

a) Dental implants.
b) Shortening or lengthening of the mandible or maxillae.
c) Correction of malocclusion.
d) Treatment for any jaw joint problems, other than temporomandibular disorders including craniomaxillary, craniomandibular disorder, or other conditions of the joint linking the jaw bone and skull.
e) Hospital costs for any of these services except as specifically described in the SPD.
f) Any treatment for Bruxism-including splint devices.
g) Braces or oral fixation devices.

- Oral surgery except as specifically described in this SPD.
- All periodontic procedures.

Diabetes Services

All equipment and supplies must be purchased from a participating durable medical supplier and/or a participating pharmacy.

Covered Services:
- Self-management education programs and diabetic equipment and supplies.
- Diabetic equipment, if considered medically necessary by the Plan.
- Insulin pumps with prior authorization and meeting the medical criteria established by the Plan.
- Diabetic supplies.
- Insulin.

Durable Medical Equipment and Medical Supplies

Durable medical equipment is defined as:

a) Able to withstand repeated use, and
b) Primarily and customarily used to serve a medical purpose, and
c) Not generally useful except for the treatment of a bodily injury or sickness, and
d) Is appropriate for use in the home, and
e) 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.

Coverage for durable medical equipment is subject to the limitations specified in the Schedule of Benefits.

Medical Supply is defined as a disposable, consumable, medically necessary item which usually has a one time or limited time use and is then discarded.

Covered Services:

- Durable medical equipment (DME) is covered only

  a) With prior authorization by the Plan and when:
  b) Determined to be medically necessary, and
  c) Purchased at a participating DME provider or other provider authorized by the Plan, and
  d) Ordered or prescribed by a participating provider, or a non-participating provider with an active referral authorized by the Plan and
  e) Not generally available over the counter (OTC).

- Orthotics are covered for acute conditions only.
- Foot orthotics are covered only when all the preceding conditions are met and the following conditions are met:

  a) Are a prescription orthotic, and
  b) The member has a documented diagnosis of diabetes with neuropathy or peripheral vascular disease.

- Orthopedic shoes that are an integral part of a covered brace.
- Home monitoring equipment for the treatment of diabetes, infant apnea, or premature labor.
- Compression stockings, when ordered by a participating provider, are limited by compression weight (greater than 30 mmhg) and to two pairs per contract year.
- Injectable medication given in an office or outpatient setting.
- Rental of cervical and/or lumbar traction devices is limited to a three month rental.
- Mechanical Devices used to treat sleep apnea require a three month rental to establish that there is a regular and consistent use, and a medical benefit prior to purchase.
- Oxygen therapy and other inhalation therapy and related items for home use.
- Wigs for cancer patients.

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 of supplies without prior authorization from the Plan.
- Replacement for damaged, lost or stolen items.
- Repairs and replacement of durable medical equipment without prior authorization from the Plan.
- 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.)
- 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 the Plan.
- 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.
- Durable medical equipment for comfort, personal hygiene, and convenience items including but not limited to: air conditioners; air cleaners, purifiers, humidifiers, or dehumidifiers; alternative communication devices; self-help devices not medical in nature; automobile modifications or lifts; baskets for wheelchairs and walkers; bath benches, or chairs; bath systems or lifts; car seats; cervical pillows; dressing sticks or aids; diapers; disposable gloves; disposable undergarments; eating utensils; egg-crate mattress pads; electric patient lifts; ergonomic chairs; orthotic socks; oral hygiene products; oral nutritional supplements and infant formula available over the counter; pillows; portable care or travel nebulizers; raised toilet seats; reachers; safety equipment such as

gait belts, helmets, knee and elbow pads, or safety glasses; shower chairs; strollers; feeding aids; grab bars; grooming aids; heating pads; home bathtub spas; home massage equipment; lamb's wool sheepskin padding; lap trays not used for trunk support; lumbar rolls or cushion; massagers or Theracane; occipital release boards; stroller or wheelchair canopies; toileting systems or lifts; tongue depressors; vaporizers; vehicle travel or safety tie down restraints; wheelchair attendant controls; wheelchair backpacks or clips; wheelchair swing-aways; wheelchair or removable hardware when not needed for slide transfers; wheelchair work or cut-out trays; alcohol wipes; band-aids; over the counter (OTC) antibiotic ointments; OTC dressing supplies (examples: 4X4 gauze, tape, betadine, etc.); and home remodeling or modifications.

Emergency Care

Emergency means a medical condition that manifests itself by acute symptoms of sufficient severity, including severe pain, to lead a prudent layperson with an average knowledge of health and medicine reasonably to conclude that a lack of immediate medical attention will likely result in death or serious injury to your body. Examples of emergency care situations include but are not limited to heart attacks, strokes, loss of consciousness, significant blood loss, suffocation, attempted suicide, convulsions, epileptic seizures, acute allergic reactions, acute asthmatic attacks, acute hemorrhages, acute appendicitis, coma, and drug overdose.

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.

Call Customer Service at 1-800-895-2421 for all emergency or out-of-state inpatient admissions as soon as possible or within 48 hours.

If you require emergency care, you should seek care from the nearest physician, hospital or clinic. You must contact your primary care physician within 48 hours of the emergency or as soon as reasonably possible in order to arrange follow-up care.

The Plan has the right to transfer you (at no expense to you) to the facility of the Plan's choice upon receiving confirmation from your attending physician that you are able to travel.

In addition to the emergency room copay, emergency treatment provided by non-participating providers may be subject to usual and customary charges.

To be covered, non-emergency or follow-up care must be provided by a participating provider.

Urgent Care

Urgent care is care for a bodily injury or illness 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.

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.

To be covered, non-emergency or follow-up care must be provided by a participating provider.

Services and supplies from non-participating providers are covered services only with prior authorization from the Plan.

Essential Health Benefits (as defined by federal law)

The Plan will not impose any dollar-based lifetime limits for covered services for a Covered Person, to the extent the covered service is an essential health benefit under federal law. Note that the Plan may not cover all of these services (see Schedule of Benefits for details). Essential health benefits include the following:

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance use disorder benefits, 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

As a self-funded health plan, in some situations the definition of "essential health benefits" will refer to a state law definition of that term. In that situation, this Plan shall use the definition of "essential health benefits" as defined under Wisconsin law.

Genetic Testing And Counseling

Covered Services:
With prior authorization from the Plan, 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 the Plan, genetic counseling is covered when:

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

Non-Covered Services:
- Direct-to-consumer genetic testing.
- Paternity testing.
- Fetal sex determination.
- Genetic testing of a non-plan member.
- Genetic counseling that is associated with non-covered genetic tests.
- Genetic testing when the results do not provide direct medical benefit to the Plan member.

Hearing Exams And Hearing Aids

Covered Services:

- Hearing aids, hearing exams and hearing aid procedures are covered when obtained through a participating provider and with prior authorization from the Plan.
- The reconditioning and repair of existing aids is covered when considered medically necessary.
- New hearing aids are covered once per ear in a 36-month period.
- Benefit is subject to the limitations specified in your Schedule of Benefits.
- Cochlear implants are covered for children under the age of 18 with prior authorization from the Plan.
- Implantable bone conduction hearing aid, also called bone-anchored hearing aid (Baha®) is covered for patients with conductive hearing losses (unilateral or bilateral), or mixed hearing losses, if the patient has a bone conduction pure tone average up to 45 dBHL and a speech discrimination score better than 60% (in the indicated ear) who additionally has any one or more of the following conditions:

    a) Congenital or surgically induced malformations of the external ear canal and/or middle ear (example: atresia) or
    b) Tumors of the external ear canal and/or tympanic cavity, or
    c) Severe chronic external otitis or otitis media, or
    d) Otosclerosis in those who are not suitable candidates for stapedectomy, or
    e) Dermatitis of the external ear canal, including reactions from ear molds used for typical air conduction hearing aids, or
    f) Other conditions in which an air conduction hearing aid is contraindicated (example: relapsing polychondritis).

- Implantable bone conduction hearing aid, also called bone-anchored hearing aid (Baha®) is covered for the treatment of unilateral sensorineural hearing loss (single sided deafness) when there is normal hearing in the opposite ear (defined as a 20 dBHL air conduction pure tone average).
- The procedure and related services to implant a bone conduction hearing aid are covered as medical/surgical benefits; the device itself (bone anchored aid) is covered under the hearing aid benefit portion of your Plan. See your schedule of benefits for coverage limits.

Non-Covered Services:

- Hearing aids if more than one per ear in any 36-month period.
- Cochlear implants for members age 18 and older.
- Coverage for services in excess of the limits stated in your schedule of benefits.

Home Healthcare

Home health care means one or more of the following:

a) The evaluation of the need for home care when approved or requested by the attending physician.
a) Home nursing care that is provided Necessary care and treatment is not available from the member's immediate family, or others living with the member without undue hardship.
b) The home health care services are provided and coordinated by a state licensed or Medicare certified home health agency or certified rehabilitation agency.

Covered Services:

- Home health care benefits are covered with prior authorization, when the attending physician certifies that:

A) Confinement in a hospital or skilled nursing facility would be necessary if home care were not provided.
b) Necessary care and treatment is not available from the member's immediate family, or others living with the member without undue hardship.
c) 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.

- If you were hospitalized immediately before the home health care services began, the physician who was the primary provider of care during the hospital confinement must approve an initial home care plan.
- Each visit by a qualified person providing services under a home care plan or evaluating the need for or developing a plan is considered one home care visit.
- Up to 4 consecutive hours in a 24-hour period of home health service are considered one home care visit. The maximum weekly benefit for such coverage may not exceed the usual and customary weekly cost for care in a skilled nursing facility.

Non-Covered Services:
- Custodial care.
- Respite care.
- Home care provided to a non-homebound individual.

Hospice Care

Covered Services:
- Hospice Care services are covered with prior authorization from the plan and if a member's life expectancy is six months or less, and 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 the Plan.

Non-Covered Services:
Hospice room and board expenses.

Hospital Services

Covered Services:
- Inpatient and outpatient hospital services are covered with prior authorization by the Plan when rendered by a hospital or freestanding surgical facility.
- Inpatient hospital services include the following:

a) 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 the Plan to be medically necessary.
b) Hospital services and supplies determined to be medically necessary furnished for your treatment during confinement, including drugs administered to you as an inpatient.
c) Inpatient participating hospital confinement days are covered when care is being directed by a participating provider and with authorization from the Plan.

- Outpatient hospital services include services and supplies, including drugs, when incurred for the following:

  a) Emergency room treatment provided in accordance with the Emergency Care section of this SPD.
  b) Surgical day care.
  c) Regularly scheduled treatment such as chemotherapy, inhalation therapy, and radiation therapy.
  d) Diagnostic testing which includes laboratory, x-ray, and other diagnostic testing.

Non-Covered Services:

- continued hospital Inpatient hospital services for days that are NOT certified by the Plan as being medically necessary
- stay(s), if the 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 is not covered under the Hospital services benefit. Please see the Durable Medical Equipment and Medical Supplies section of this SPD of Coverage. For discharge equipment and supplies, refer to the Durable Medical Equipment and Medical Supplies section of this SPD of Coverage.

Kidney Disease Treatment

Covered Services:

Services and supplies directly related to the treatment of kidney disease, including but not limited to, inpatient, outpatient, dialysis, transplantation, donor-related services, and related physician charges.

Newborn Benefits

Covered Services:

- Newborn benefits include the following services

  a) Nursery room, board, and care.
  b) Routine or preventative exam and other routine or preventative professional services when received by the newborn child before release from the hospital.
  c) Circumcisions when rendered prior to discharge from the hospital.
  d) Plastic surgery, in order to reconstruct or restore function to a body part with a functional defect present at birth.
  e) Well child care rendered after release from the hospital.

A primary care physician should be chosen for the newborn before delivery so that the chosen physician can be notified upon delivery.

Physical Therapy, Speech Therapy, and/or Occupational Therapy

Covered Services:

- Outpatient physical therapy, speech therapy, and/or occupational therapy are covered services as shown in the Schedule of Benefits when rendered by a participating provider.
- Services must be medically necessary due to bodily injury or sickness.
- The care must be for restoration of a function or ability that was present and has been lost due to bodily injury or sickness.
- Therapy must be necessitated by a medical condition and not be primarily educational in nature.
- Provider must be a registered physical, occupational or speech therapist and must not live in the patient's home or be a family member.
- For speech and occupational therapy services for the treatment of autism, please refer to the Autism Treatment section of this SPD.

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 handicaps, hyperactivity, or sensory deficit and motor dysfunction; developmental and neuro-educational testing or treatment; and other special therapy except as specifically listed in this SPD.
- Vocational testing and counseling, including evaluation and treatment and work hardening programs.
- Speech and hearing screening examinations are limited to the routine or preventive screening tests performed by a participating provider for determining the need for correction.
- Services rendered by a masseuse.
- 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.

Physician Services

Covered Services:

- In office services unless otherwise excluded by this SPD or the Schedule of Benefits.
- Routine or preventive physicals
- Inpatient and outpatient visits
- Home Visits
- Surgical services with prior authorization by the Plan

Non-Covered Services:

Any services and/or supplies given primarily at the request of, for the protection of, or to meet the requirements of, a party other than the member when such services and/or supplies are not otherwise

medically necessary or appropriate, unless the services and/or supplies are state-mandated. Excluded services and supplies include physical exams, disease immunizations, services and supplies for employment (including travel for employment), licensing, marriage, adoption, insurance, camp, school, sports, and travel.

Podiatry Services

Covered Services:

- Routine or preventive exams when medically necessary and provided by a participating provider.

Non-Covered Services:

- The following services are non-covered except when prescribed by a participating provider who is treating a member for metabolic or peripheral vascular disease:

  a) 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.
  b) Services related to the cutting, trimming or other non-operative partial removal of toenails.
  c) Treatment of flexible flat feet.

Pregnancy Benefits

Covered Services:

- Only services and supplies for the pregnancy of an employee, an employee's covered dependent spouse, or an employee's covered dependent child are covered.
- Pregnancy benefits include coverage for inpatient hospital care and pre- and post-natal care received from a participating provider.
- Please refer to the Continuity of Care section of this SPD.

Non-Covered Services:

- Elective abortions.
- Treatment, services or supplies required as the result of a written or unwritten agreement for the benefit of a party other than the member, or as a volunteer for such a party.
- Maternity services received out of the service area in the last 30 days of pregnancy without prior authorization from the Plan except in an emergency. Prior authorization is based on medical necessity.
- Amniocentesis or chorionic villi sampling (CVS) solely for sex determination.

Prescription Drug Benefits

The Pharmacy Benefit Manager will administer the claims payment of the Prescription Drug Plan. All prescription drug claims should be submitted directly to the Pharmacy Benefit Manager for reimbursement. The prescription drug benefit applies if the Covered Person has the prescription filled

by a participating pharmacy. If you choose to access non-network pharmacies, the prescription will be paid at your expense. Under this benefit, the Covered Person is responsible for the Co-payment or Co-insurance as specified on the Schedule of Benefits.

Four-Tiered Drug Plan

This four-tiered drug plan is used with the PPO and EPO plans, and incorporates four tiers of benefits.

- Tier 1 is for preferred generic drugs and has the lowest co-payment.
- Tier 2 covers our preferred brand name drugs and some select generics, and has the second lowest co-payment.
- Tier 3 represents all non-preferred drugs.
- Tier 4 represents specialty drugs and will have coinsurance.

This drug plan uses a defined formulary, which lists the covered drugs and tier placement, and all drugs listed are available to our members unless otherwise determined to be excluded. Our designated Pharmacy Benefit Manager (PBM) and/or MercyCare determine the placement of drugs within each tier of this formulary. Other changes may occur to this formulary as determined by MercyCare or the PBM. A current formulary is available online at http://www.mercycarehealthplans.com.

Two-Tiered Drug Plan

This two-tiered drug plan is used with the HDHP plans and incorporates two tiers of benefits.

- Tier 1 is for preferred generic drugs and has the lowest co-payment.
- Tier 2 covers our preferred brand name drugs and some select generics.

This drug plan uses a defined formulary, which lists the covered drugs and tier placement, and all drugs listed are available to our members unless otherwise determined to be excluded. Our designated Pharmacy Benefit Manager (PBM) and/or MercyCare determine the placement of drugs within each tier of this formulary. Other changes may occur to this formulary as determined by MercyCare or the PBM. A current formulary is available online at http://www.mercycarehealthplans.com.

General Guidelines

To ensure that you take full advantage of this prescription drug plan, you should follow these guidelines:

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

Obtaining a Prescription

To fill a prescription, your pharmacist will need:

- Your prescription written by your network practitioner.
- Your member identification card.

Once the information from your member card is entered into the pharmacist's computer, the pharmacist will be able to:

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

Mercyhealth Pharmacy Extended Supply Program
All Mercyhealth pharmacies will offer the three-month supply for the price of two months copay (copays do not apply in HDHP). Partners will have the option to pick up their 90-day prescription at any Mercyhealth Retail Pharmacy, if the drug is eligible for 90 days per fill. If they choose to have their 90-day supply mailed, the Mercy Mall Pharmacy will continue to be the mail order pharmacy. For members of the EPO and PPO HDHP plans a 90 day supply is only available through Mercyhealth pharmacies. No other pharmacy discounts or incentives are available under this plan.

Not all medications are good candidates for extended supply, such as antibiotics, medications that are taken on an "as needed" basis and medications that require special handling, such as refrigeration. This includes the Specialty drugs, which are only covered as a 30-day supply maximum.

Extended supply co-pay reductions cannot be combined and are not additive with other co-pay reduction programs, such as pill splitting. Partners can benefit from the incentive that reduces their co-pays to the greatest degree, but unfortunately cannot combine incentive programs. For more information or to sign up; call 608-755-8700 or 877-597-6627. Information is also available on the website: http://www.mercycarehealthplans.com.

Paying For Your Prescription
See the Schedule of Benefits for the various plan options to see the cost sharing components associated with the prescription drug plan benefits.

At Participating Pharmacies:
If the price of your prescription drug is less than the copay stated in the Schedule of Benefits, you will only be required to pay the amount of the prescription drug.

At Non-Participating Pharmacies:
Most of the time, you will be required to pay the member portion at the time you purchase your prescription drugs. However, you may be required to pay for the entire amount of the prescription if for example, you go to a non-participating pharmacy. When you are required to pay in full for the prescription, you can be reimbursed for the amount that you are entitled to by filling out a Prescription Drug Claim Form. You may request this form by calling the Customer Service Department at 1-800-895-2421, or you can download the form from our website at http://www.mercycarehealthplans.com. If the drug you purchased is reimbursable, you should receive a check promptly.

Covered Drugs

This prescription drug program provides coverage for drugs that satisfy the following criteria:

1. Any prescription drug or insulin listed in the Four Tier Drug Plan for PPO and EPO, or the Two Tier Drug Plan for the HDHPs, or
2. Insulin syringes, or
3. Any medication compounded by the participating pharmacy that contains a covered prescription drug.

And also must be:

1. Medically necessary for your medical condition and appropriate given your medical history; and
2. Prescribed in a manner consistent with its FDA approval and manufacturer recommendations; and
3. Prescribed in its most cost-effective dosing regimen; and

4. Used in a manner consistent with any and all guidelines and criteria developed, adopted, or researched by Mercy.

Prior Approval

Certain formulary drugs and clinically-appropriate drugs that are not shown in the Drug Formulary require prior approval from MercyCare before coverage is provided. This ensures that these drugs are used in a manner consistent with all of the criteria cited in the section marked COVERED DRUGS. Your physician will need to send a prior approval form and documentation to Mercy for our review.

In exigent circumstances, you (or your designee or prescriber) may request an expedited review of your request for prior approval. An exigent circumstance exists if you are suffering from a health condition that may seriously jeopardize your life, health or ability to regain maximum function, or when you are undergoing a current course of treatment using a non-formulary drug. We will notify you (and your designee or prescriber) of our decision no later than 72 hours after we receive your request for prior approval.

Drug Quantity

The maximum quantity of medication you may receive in a single prescription is a supply sufficient for 30 days, in the least quantity possible to meet the prescribed dose (for example, a 15 mg tablet is covered instead of three 5 mg tablets). You may receive a prescription of a non-specialty covered drug up to 90 days if prescribed by your physician, if the drug is eligible for a 90 day supply; however, you will be required to pay 3 co-pays at the time of purchase, unless you are using the Mercyhealth Plarmacy Extended Supply Program. In the HDHP, deductibles will always apply, regardless.

Pain Management and Narcotics

If you are prescribed narcotics for chronic pain you are at risk of becoming addicted. One of the important ways for us to help you avoid this complication is to encourage you to obtain prescriptions for narcotics only from the physician who is managing your pain. The use of long-acting narcotics or large quantities of short-acting narcotics for chronic pain is limited to those prescribed by Mercy pain specialists or pre-approved non-network pain specialists. In cases in which the Plan becomes aware of patients who have chronic pain and are on narcotics, the Plan has the right to limit the coverage of narcotics prescription to the one physician who has the primary responsibility for managing your condition.

Specialty Drugs

Medications included in this designation are required to be dispensed by a specialty pharmacy as noted in the formulary. To ensure that you receive the service you need, these specialty drugs are covered only when you obtain them from the specialty pharmacy designated in the most current provider directory. These medications will be limited to the quantity limit listed in the formulary, or to the day's supply that was approved in the prior authorization.

Preventive Care Benefit

The Preventive Services benefit is consistent with grade A and B recommendations of the U.S Preventive Services Task Force:
http://www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm)
and the Bright Futures/American Academy of Pediatrics (www.brightfutures.org). The frequency of services is based on current national guidelines.

Preventive care services listed below and health screening office visits are covered at 100% of allowable charges when you see in network providers according to the wellness visit schedules listed below for children and adults. **An office visit charge will apply for preventive services rendered outside of the wellness visit schedules if the office visit is billed separately from the preventive service.**

For Children

- Well-child care
  - Eleven (11) visits birth to age 2
  - Once per Calendar Year - ages 2 to 21 years
  - X-ray and laboratory services related to covered physical
- Immunizations
  - All immunizations
- Vision Screening
  - Screening test of visual acuity and ocular photo screening with interpretation and report - ages 3,4, 5, 6, 8, 10, 12, 15, 18 and once per Calendar Year at any age if determined to be at risk
  - Screening to detect amblyopia and strabismus in children younger than age 5 years
- Hearing Screening
  - Hearing Screening
    - Newborn and ages 4, 5, 6, 8, 10 years
    - Diagnostic audiologic assessment is covered once per Calendar Year at any age if determined to be at risk
- Other Screenings
  - Newborn metabolic hemoglobin screening and screening for phenylketonuria (PKU)
  - Newborn hypothyroidism screening
  - Hematocrit or hemoglobin at 12 months
    - For at risk of anemia - at 4, 18, and 24 months, and once per Calendar Year ages 3 to 21 years
  - Lead screening
    - For at risk - at 6, 9, 12, 18 and 24 months and once per Calendar Year ages 3 to 5 years
  - Tuberculosis Skin Test (PPD Skin Test/Tuberculin Test)
    - For at risk - at 1, 6, 12, 18, and 24 months and once per Calendar Year ages 3 to 21 years
  - High Cholesterol (Dyslipidemia) screening - ages 18-21
    - For at risk - at 24 months and ages 4, 6, 8 years and once per Calendar Year ages 10-17
  - Sexually transmitted infection screening
  - For at risk - once per Calendar Year ages 11-21
  - Cervical dysplasia screening (females)
    - For at risk - once per Calendar Year ages 11-21
  - Structured Developmental Screen during preventive care physical examination at 9, 18 and 24 months
  - Developmental Surveillance at every preventive care physical examination according to the well- child care visit schedule
  - Psychosocial Behavioral Assessment at every well-child care visit

- Autism Specific Screen during well-child care visit at 18 and 24 months
- Alcohol and drug use assessment well-child care visit - ages 11-21 years
- Screening of children aged 6 years and older for obesity
  - Offer/referral to comprehensive behavioral interventions to promote improvement of weight status
- Screening for HIV for all adolescents at increased risk
- High-intensity behavioral counseling to prevent sexually transmitted infections (STIs) for all sexually active adolescents
- Depression screening of adolescents (12-18 years of age) for major depressive disorder when systems are in place to ensure accurate diagnosis, psychotherapy (cognitive-behavioral or interpersonal), and follow-up

For Adults

- Physical Exam & Health History
  - Physical and gynecological examinations - one each annually
  - X-ray and laboratory services related to covered physical and gynecological exams
- Immunizations
  - All immunizations
- Hearing Screening – specialist office visit charges apply
  - Routine hearing examinations - limited to one exam every 2 years
- Other Screenings
  - Women
    - Pap smears annually.
    - Mammograms (one baseline age 35-39, annually after age 40) under this wellness benefit; purpose of exam can be for screening or diagnostic purposes. If outside these age ranges, an annual mammogram will be covered at 100% if done at an in network or Tier 1 provider, subject to deductible/coinsurance if at a Tier 2 provider with no coverage at an out of network provider.
    - Genetic counseling and evaluation for breast cancer (BRCA) gene test with an increased risk for deleterious mutations in BRCA1 or BRAC2 genes
    - Breast cancer preventive medication: Clinicians discuss chemoprevention with women at high risk for breast cancer and at low risk for adverse effects of chemoprevention. Clinicians should inform patients of the potential benefits and harms of chemoprevention
    - Screening for gonorrhea infection and for syphilis infection if they are at increased risk for infection
    - Screening for Chlamydia infection for all sexually active women aged 24 and younger and for older women who are at increased risk
    - Osteoporosis screening for women age 65 and older; beginning at age 60 for women at increased risk for osteoporotic fractures
    - Screening for lipid disorders for women age 20 and older if at increased risk for coronary heart disease
- Pregnant Women
  - Screening for asymptomatic bacteriuria with urine culture at 12 to 16 weeks gestation or at first prenatal visit
  - Screening for hepatitis B virus (HBV) infection at first prenatal visit
  - Screening for syphilis infection and for gonorrhea infection if they are at increased risk for infection

- Screening for Chlamydia infection for all pregnant women aged 24 and younger and for older pregnant women who are at increased risk
- Screening for iron deficiency anemia in asymptomatic pregnant women
- Screening for tobacco use and provide augmented pregnancy-tailored counseling
- Rh (D) blood typing and antibody testing at their first prenatal visit
- Repeated Rh (D) antibody testing for all unsensitized Rh (D) - negative women at 24-28 weeks gestation, unless the biological father is known to be Rh (D) - negative
- Screening and behavioral counseling interventions to reduce alcohol misuse
- Breastfeeding counseling and supplies – intervention during pregnancy and after birth to promote and support breastfeeding
- Standard prenatal and postnatal office visits
- Screening for gestational diabetes mellitus in asymptomatic pregnant women after 24 weeks gestation
- Screening for HIV

- Men
  - Screening once for abdominal aortic aneurysm (AAA) by ultrasonography aged 65 to 75 who have ever smoked
  - Prostate screenings; one baseline age 45-49, annually beginning age 50
  - Screening for lipid disorders for men age 35 and older or 20-35 if at increased risk for coronary heart disease

- All Adults
  - Colonoscopy every 10 years, sigmoidoscopy every 5 years, FITand FIT DNA (Cologuard) testing every three years, or fecal occult blood testing (annually), beginning at age 49 years and continuing until age 75 years (if first colonoscopy performed on or after January 1, 2008 was intended to be for screening purposes, but becomes diagnostic in nature due to findings during the exam, the service will be paid under this wellness benefit; does not include virtual colonoscopy unless determined to be Medically Necessary)
  - Screening and behavioral counseling interventions to reduce alcohol misuse
  - Depression screening when staff-assisted depression care supports are in place to assure accurate diagnosis, effective treatment, and follow-up
  - Intensive behavioral dietary counseling for adult patients with hyperlipidemia and other known risk factors for cardiovascular and diet-related chronic disease. Intensive counseling can be delivered by primary care clinicians or by referral to other specialists such as nutritionists or dieticians
  - Screening for obesity and offer intensive counseling and behavioral interventions to promote sustained weight loss for obese adults
  - Screening for high blood pressure in adults aged 18 and older
  - Tobacco cessation screening, counseling and medication for those using tobacco products
  - Screening for human immunodeficiency virus (HIV) for those at increased risk for HIV infection
  - High-intensity behavioral counseling to prevent sexually transmitted infections (STIs) when at increased risk for STIs
  - Screening for type 2 diabetes in asymptomatic adults with sustained blood pressure (either treated or untreated) greater than 135/80 mm Hg
  - Blood Glucose (Glycohemoglobin) test every 5 years beginning age 40
  - Screening for hepatitis B and hepatitis C in persons at high risk for infection

- Annual lung cancer screening for ages 55-80 who have a 30 pack/year smoking history and currently smoke or have quit within the past 15 years until smoke-free for 15 years or limited ability to have curative lung surgery

Prosthesis

Covered Services:

- Replacement of natural or artificial limbs and eyes no longer functional due to physiological change or malfunction beyond repair, if medically necessary
- With prior authorization by the Plan and when obtained from 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 the Plan.

Psychological Disorder and Chemical Dependency

Covered Services:

- Outpatient Treatment – Treatment received while not confined to a hospital or qualified treatment facility. This includes outpatient visits.

- Intensive Outpatient/Partial Hospitalization Programs – Treatment received in a setting that is more intensive than traditional outpatient care but less restrictive than traditional inpatient care.

  Treatment is limited to medically necessary intensive outpatient programs certified by the American Society of Addiction Medicine for the treatment of psychoactive substance abuse disorders; and the following programs certified by the Department of Health Services: mental health services and treatment for alcoholism and other drug problems in day treatment programs; services for chronic mental illness in community support programs; services for alcohol or drug dependent members in certified residential treatment programs; services for the treatment of psychological disorders in certified residential treatment programs; and programs to provide coordinated emergency mental health services for members who are experiencing a mental health crisis or who are in a situation likely to turn into a mental health crisis if support is not provided by the period of time the member is experiencing a mental health crisis until the member is stabilized or referred to other providers for stabilization. Programs providing coordinated emergency mental health services for members must provide timely notice to MercyCare to facilitate coordination of such services.

- Residential Programs: covered up to the benefit maximum specified in the Schedule of Benefits. Services are covered for alcohol or drug dependent members in certified residential treatment programs, or for the treatment of psychological disorders in certified residential treatment programs.

- Inpatient Treatment – Treatment received while confined as a registered bed patient in a hospital or qualified treatment facility is covered the same as any medical illness, according to federal mental health parity law.

Coverage Provisions:

- Residential treatment of psychological disorders and/or chemical dependency each have specific benefit limits stated in the Schedule of Benefits.
- Inpatient and residential treatment services require prior authorization by the Plan. The services must be considered medically necessary as determined by the Plan.
- Court ordered mental health services are covered, subject to the benefit maximums described above, if provided by a participating provider, or a nonparticipating provider with prior authorization from the Plan.
- Services rendered pursuant to an emergency detention situation are covered, subject to the benefit maximums described in the Schedule of Benefits, when rendered by any provider as long as the Plan has been notified within 72-hours so that continuing care may be arranged. Emergency detention services provided by a non-participating provider are not covered after the Plan has arranged for services by a participating provider in a more appropriate setting.
- Family therapy is covered only if the diagnosed member is present at the family therapy session.
- For behavioral health services related to the treatment of autism spectrum disorder, see the Autism Treatment section of this.

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.
- Inpatient treatment of nicotine habit or addiction.
- Inpatient treatment of being overweight or obese.
- Methadone maintenance therapy.
- 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.

Reproductive Services

REPRODUCTIVE: INFERTILITY SERVICES

Coverage includes the diagnosis and treatment of Infertility including, but 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, and
- Intracytoplasmic sperm injection (ICSI).

- Diagnostic testing and treatment for fertility/infertility is subject to the limitations specified in the member's Schedule of Benefits. All services provided after the maximum amount payable has been reached are the member's responsibility.
- Services subject to the limitations specified in the Schedule of Benefits include but are not limited to related hospital, professional and diagnostic services, and medications that are incidental to such insemination or fertilization methods.

Coverage for procedures for IVF, GIFT, ZIFT, or ICSI shall be provided only if:

a) The covered individual 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;
b) 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.

Non-Covered Services:
- Costs incurred for reversing a tubal ligation or vasectomy.
- Costs for medical services rendered to a surrogate for purposes of childbirth; however, medical expenses incurred by a surrogate for Infertility related services must be covered.
- Costs of preserving and storing sperm, eggs and embryos.
- Costs for an egg or sperm donor which are not Medically Necessary; any fees for non-medical services paid to the donor are not covered.
- Experimental treatments.
- Costs for procedures which violate the religious and moral teachings or beliefs of MercyCare or the covered Group.

REPRODUCTIVE: OTHER SERVICES

COVERED SERVICES
- Covered services include consultation, tubal ligation, diaphragms, intrauterine devices (IUD), Depo Provera shots, implantable birth control devices and vasectomy.

NON-COVERED SERVICES
- Reversal of voluntarily induced sterilization procedures.
- Revision of scarring caused by implantable birth control devices.
- Elective abortions.
- Treatment, services or supplies required as the result of a written or unwritten agreement for the benefit of a party other than the member, or as a volunteer for such a party.

Second Surgical Opinion - Voluntary

Voluntary second surgical opinions for elective, non-Emergency surgery **are a covered expense under the Plan** when recommended for a Covered Person.

Benefits for the second opinion will be payable only if the opinion is given by a specialist who:
1. is certified in the field related to the proposed surgery; and
2. is not affiliated in any way with the Physician recommending the surgery.

Skilled Nursing Facility

Covered Services:

- Charges for daily room and board and general nursing services provided during a skilled nursing facility confinement are covered 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.
- Coverage is provided for physical therapy, occupational therapy, speech therapy, and durable medical equipment if medically necessary and provided by a participating provider.
- Your primary care physician must certify that your skilled nursing facility confinement is medically necessary for care or treatment of the bodily injury or sickness that caused the hospital confinement.
- Skilled nursing facility services require prior authorization from the Plan and the Plan must consider the services to be at a skilled level of care and medically necessary.

Non-Covered Services:

- Custodial care.
- Skilled nursing facility days in excess of the number specified in the Schedule of Benefits per confinement.

Stay Healthy Benefit

Covered Services:

- Health education or physical fitness programs are covered (up to the maximum specified in the Schedule of Benefits) for an employee and his or her covered dependents age 18 and over.
- Examples of covered classes include Mercyhealth Acceleration, adult physical fitness, wellness, and lifestyle programs such as smoking cessation, weight loss, or massage. This benefit can also apply to a health club membership. Proof of fee payment must be submitted to the Plan with the appropriate forms, available from the Customer Service Department.

Non-Covered Services:

- Entrance fees for competitive sports.
- Purchases of home exercise equipment or supplies.
- Any food, liquid, and/or nutritional supplements and any weight loss program that incorporates these items.

Temporomandibular Disorders

Covered Services:

- Diagnostic procedures and medically necessary surgical and non-surgical treatment for the correction of temporomandibular disorders (TMJ) are covered if all of the following apply:

a) You have prior authorization from the Plan for all temporomandibular related evaluation and other services and for the facilities where services are performed.
b) The condition is caused by congenital, developmental or acquired deformity, sickness or bodily injury.

Under the accepted standards of the profession of the health care provider rendering the service, the procedure or device is reasonable and appropriate for the diagnosis or treatment of this condition

c) The purpose of the procedure or device is to control or eliminate infection, pain, disease or dysfunction.

- Benefit includes coverage for prescribed intraoral splint therapy devices.

Non-Covered Services:

- Cosmetic or elective orthodontic care, periodontic care or general dental care.
- Any treatment or supplies for Bruxism
- Braces

Transplants

Covered Services:

Coverage is limited to those organ transplant procedures that are considered by the Plan to be non-experimental, medically necessary, and effective. “Organ” includes bone marrow and stem cells. All transplant-related services, including evaluation, and the facilities where the services are performed, required prior authorization by the Plan.

Except for kidney transplants, there is no coverage for transplants for the first 90 days after the member’s enrollment date if the need for a transplant arises from a preexisting condition. A preexisting condition is one for which medical advice; diagnosis, care or treatment was recommended or received within 6 months prior to the member’s enrollment date. This paragraph does not apply to a dependent child under the age of 19. Also, the 90-day exclusion is reduced by the member’s period of creditable coverage that ended less than 63 days before the member’s enrollment date. Creditable coverage means a group health plan; health insurance; Medicare, Medicaid; a medical care program of the armed forces of the United States, the federal Indian health service, or an American Indian tribal organization; a state health benefits risk pool; a health insurance program for Federal Government employees and their dependents; a public health plan as defined by the federal department of health and human services; and the health coverage plan for Peace Corps volunteers.

Creditable coverage does not include the limited or special purpose coverage excluded by law, such as accident-only, disability income, workers compensation, auto medical payment, credit-only, dental or vision benefits offered separately, specified illness, hospital or other fixed indemnity, and Medicare supplement. A member’s enrollment **date** is the member’s effective date of coverage under this SPD, if earlier, or the first day of the waiting period for such effective date.

Kidney: See “Kidney Disease Treatment” in this section of the SPD.

Benefits related to the procurement of transplant organs, including surgical removal procedures, storage, and transportation of the procured organ, will be available in the amount not to exceed the amount per organ stated in the Schedule of Benefits.

Non-Covered Services:

- Procedures involving non-human and artificial organs, except those approved by QHM..
- Lodging expenses.
- Transportation expenses except for medically necessary ambulance services.
- Any prescription drug copayment.
- Transplant services from providers and/or facilities not approved by the Plan.
- Transplants and all related expenses without prior authorization by the Plan.
- Organ transplant expenses of donor if the recipient is not an eligible Plan member (except for kidney transplants).
- Re-transplantation. (Except for kidney transplants).
- Purchase price of bone marrow, organ, or tissue that is sold rather than donated.
- All separately billed donor-related services (except for kidney transplants).
- Storage and collection fees for cord blood and stem cells for possible and/or indefinite or undetermined need for transplant.

Vision Services

Covered services:

For all individuals, the following services as limited by the Schedule of Benefits.

- Routine vision examinations, including refraction to detect vision impairment, received from a health care provider in the provider's office.
- Medical eye examinations provided as part of the treatment for pathological conditions when rendered by or at the direction of a participating physician.
- Initial eyeglasses or contact lenses are covered after cataract surgery if purchased from a participating provider.

Non-Covered services:

- Eyeglass frames, lenses, or contact lenses 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 Testing

Covered Services:

- Inpatient and outpatient diagnostic x-ray, laboratory and diagnostic tests are covered services when rendered by and at the direction of a participating provider.
- The Plan covers mammograms in accordance with the recommendations described in the “Preventive Care” provision of this SPD and in accordance with Wisconsin state law. Please see your Schedule of Benefits for additional details.
- Blood lead tests for members under age 6 conducted in accordance with rules of the Wisconsin Department of Health Services are covered services

Other Medical Services

Covered Services:

- The administration of blood and blood products including blood extracts or derivatives and autologous donations (self to self).
- Registered dietitian services at a hospital or participating provider's office.
- Allergy injections and disease immunizations.
- Infusion therapy.
- A second opinion from a participating provider regarding covered services

LIMITATIONS AND EXCLUSIONS OF THE MEDICAL PLAN

The following services are not covered by the Plan. No medical benefits will be paid for charges relating to the following, except as specified:

1. charges for dental services, unless otherwise specified by the Plan;
2. charges for dental implantology unless otherwise specified in the Plan;
3. travel for health;
4. 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.
5. reduction mammoplasty except when it is Medically Necessary and only after all appropriate non-surgical methods of treatment have been exhausted, to include professional fitting with appropriate support garment, physical therapy, and treatment by a board-certified dermatologist if a skin condition resulting from excess breast tissue is one of the medical reasons given to support the need for the surgery. Reduction mammoplasty is covered without restriction when performed as part of post-mastectomy reconstruction;
6. mastopexy and any other breast-lift procedure (except when done as part of post-mastectomy reconstruction);
7. failure to keep a scheduled visit, phone consultations, completion of claim forms or return to work or school forms;
8. purchase or rental of: exercise equipment, whirlpools, saunas, spas, swimming pools, electric beds, water beds, lift chairs, home elevator, air conditioners, purifiers, filters, grab bars, shower seating, cervical pillows, massagers or heel lifts;
9. charges for room, board, and general nursing care for Hospital admissions mainly for physical therapy or for diagnostic studies;
10. charges for non-surgical treatment to induce weight loss including, weight control or reduction programs such as, but not limited to food supplements, Jenny Craig and Weight Watchers, membership in health clubs or YMCAs; and exercise equipment for use in the home or elsewhere.
11. charges for prescription drugs, medications or supplies except those which are administered in or dispensed at a Physician's office, a Hospital, Skilled Nursing Facility or other inpatient setting. Refer to the pharmacy benefit section for coverage provisions if your plan covers pharmacy.
12. charges by a provider or facility for pre-admission certification or concurrent stay review;
13. charges for medical record fees that are over the Usual and Customary.
14. charges related to surrogate parenthood
15. charges related to childbirth in the home setting (home delivery);
16. charges for an elective abortion and any complications resulting thereof. However, operations, treatments and medications which do not directly intend termination of pregnancy but have as their purpose the cure of a proportionately serious pathological condition of the mother, are covered when they cannot be safely postponed until the fetus is viable, even though they may or will result in the death of the fetus;
17. any charges incurred for Hospital services for those days the Covered Person is on leave from the Hospital, but has not been discharged;
18. non-medical diagnostic evaluation and treatment of learning disabilities or developmental delays.

19. separate surgical procedures that are normally included in the total service of another procedure performed, unless such surgical procedures are performed by a surgeon other than the primary surgeon; and
20. charges for treatment of Conduct Disorders for Covered Persons.
21. Treatment for a bodily injury or sickness arising from or sustained in the course of any occupation or employment for compensation, profit or gain except when such occupation or employment is as a domestic servant; employee of a farmer or other employer that is not required to have Worker's Compensation coverage; volunteer; or partner in or sole proprietor or LLC member of a business on a substantially part-time basis. This exclusion applies whether or not you have Worker's Compensation coverage, or file a claim or receive benefits under any coverage you have.
22. Treatment, services and supplies for any bodily injury or sickness as the result of war, declared or undeclared, enemy action of armed forces of the United States, or any state of the United States, or any of its allies, or while serving in the armed forces of any country.
23. Services and supplies that are, in the Plan's judgment, experimental or investigative. These services include any that are not recognized as conforming to commonly accepted medical practice within the service area or any for which the required approval of a government agency has not been granted at the time the services and supplies are provided, except that coverage shall be provided for any covered drug with the following criteria:
    a. It is prescribed for the treatment of HIV infection or an illness or medical condition arising from or related to HIV infections; and
    b. It is approved by the federal Food and Drug Administration, including phase-3 investigational drugs; and
    c. If the drug is an investigational new drug, it is prescribed and administered in accordance with the treatment protocol approved by the Federal Food and Drug Administration for the investigational new drug.
24. Any service rendered AFTER the date your coverage under the policy terminates or AFTER you are dis-enrolled from the Plan, except as provided in the Extension of Benefits provision of this SPD or any service rendered BEFORE the member's effective date in the Plan.
25. Medical expense due to your commission or attempted commission of a civil or criminal battery or felony.
26. Any treatment or services rendered by or at the direction of:

    a) A person residing in your household; or
    b) 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).

27. Services and supplies not medically necessary for diagnosis and treatment of a covered bodily injury or sickness.
28. Services and supplies for which no charge is made or for which you would not have to pay without this coverage.
29. The amount of any copayment, coinsurance, and/or deductible that you must pay as shown in the Schedule of Benefits and/or in any rider attached to this SPD.
30. All services not specifically covered in the Benefit Provisions section of this SPD or by any rider attached to the policy and any service not provided or received in accordance with the terms and conditions of this SPD and policy.
31. 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 Benefit Provisions section.
32. Expenses for medical reports, including preparation and presentation.

33. Services to the extent the member is eligible for Medicare benefits, regardless of whether or not the member is actually enrolled in Medicare.
34. Treatment, services, and supplies furnished by the U.S. Veterans Administration, except when the Plan is the primary payer under applicable federal law.
35. Services for holistic medicine, including homeopathic medicine, or other programs with an objective to provide complete personal fulfillment.
36. Coma stimulation/recovery programs.
37. Treatment, services and supplies provided while 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.
38. Skin tag removal.
39. Services of a blood donor.
40. Sublingual (under the tongue) allergy testing and/or treatment.
41. Work or education related preventive treatment.
42. Sexual counseling services.
43. Any treatment, therapy or devices used to obtain, treat, or enhance sexual performance and/or function. This includes dysfunction caused by organic diseases.
44. Genetic counseling, except as specifically covered in this SPD of benefits.
45. Acupuncture, unless the Plan covers it.
46. The removal by any method of common warts and plane flat warts.
47. Any service and/or supply given primarily at the request of, for the protection of, or to meet the requirements of a party other than the member when such services and/or supplies are not otherwise medically necessary or appropriate, unless the services and/or supplies are state mandated. Excluded services and supplies include physical exams, disease immunizations, and services and supplies for employment (including travel for employment), licensing, marriage, adoption, insurance, camp, school, sports or travel.
48. Any drug or treatment used to treat hyperhidrosis
49. Animal-based therapy, including hippotherapy.
50. Auditory integration training.
51. Cranial sacral therapy.

LIMITATIONS AND EXCLUSIONS OF THE PRESCRIPTION DRUG PLAN

Prescription drug benefits are not available for the following:

1. Medications prescribed by a non-network provider except in emergencies or when prior authorized. This exclusion does not apply in the PPO plans.
2. Drugs not listed in the published formulary, or newly FDA approved drugs that have not been evaluated by MercyCare.
3. Replacement of any lost, stolen, or destroyed medications.
4. Therapeutic devices or appliances, including hypodermic needles or syringes (except for diabetic supplies)
5. Any drug or medicine that is administered or delivered by the health care provider to you.
6. A brand name drug when it is available as a generic.
7. A generic or brand name drug when it is covered as OTC.
8. A specialty drug that is not obtained from the designated specialty pharmacy.
9. 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.
10. Any drug labeled “Caution: limited by Federal Law to investigational use” or other wording having similar intent, experimental drugs, FDA approved drugs used for non-FDA approved uses, or FDA approved drugs used in non-FDA approved regimens, even though a charge is made to you, except that coverage shall be provided for any prescription drug which meets the following criteria:
    a. Is prescribed for the treatment of HIV infection or an illness or medical condition arising from or related to HIV infection; AND
    b. Is approved by the Federal Food and Drug Administration, including phase-3 investigational drugs; AND
    c. If the drug is an investigational new drug, is prescribed and administered in accordance with the treatment protocol approved by the Federal Food and Drug Administration for the investigational new drugs.
11. Anabolic steroids.
12. Brand name anti-obesity and anorexients.
13. Any prescription drug that is not medically necessary.
14. Growth hormones.
15. Any prescription drug for a non-covered procedure or the treatment of a complication from a non-covered procedure/service.
16. Any prescription drug for a sickness or bodily injury not covered by the Plan.
17. Medication other than prescription drugs or preferred OTC drugs with or without a prescription order.
18. Prescription drugs, which the eligible person is entitled to receive without charge under any Worker’s Compensation laws or any municipal state or federal program.
19. Nutritional supplements.
20. Any prescription drugs dispensed to a member prior to the member’s effective date of coverage under the plan or after the member’s termination date.
21. Any drug when used for cosmetic treatment.
22. Any drug when used for treatment of hair loss or hair growth.
23. Any medication used to obtain, treat, or enhance sexual performance and/or function, even if the problem is caused by organic diseases or mental health condition.
24. Any prescription drugs administered by injection except for insulin injections and injections approved by the Plan’s Pharmacy and Therapeutics Committee to be covered under the Pharmacy Benefit.
25. Homeopathic Medications.
26. Special formulations of covered drugs such as sustained release intended primarily for convenience of the patient, as determined by MercyCare, are not covered.
27. Special packaging of covered drugs intended primarily for convenience of the patient, as determined by MercyCare, are not covered.

28. Tretinoin topical (example: Retin A), for members over the age of 40.
29. Any drug used to treat hyperhidrosis.

COORDINATION OF BENEFITS

The Coordination of Benefits section is intended to determine which plan provides benefits when there are two or more plans providing coverage to an individual.

Definitions

For purposes of this Coordination of Benefits section, “Plan” means any plan providing medical benefits or services by a: (a) group, blanket, or franchise insurance coverage; (b) group practice, and other group prepayment coverage; (c) any coverage under labor-management trusted plans, union welfare plans, employer organization plans, or employee benefit organization plans; (d) any coverage under governmental programs such as, but not limited to, Medicare, and any coverage required or provided by any Statute; (e) individual automobile “no-fault” and traditional auto insurance; (f) individual or family insurance; (g) subscriber contracts; (h) individual or family coverage through Health Maintenance Organizations (HMO); (i) limited service organizations or any other prepayment; (j) student accident insurance provided through or by an educational institution; (k) group practice or individual practice plan; and (l) this Plan.

The term “Plan” is construed separately with respect to each Plan, contract, or other arrangement for benefits or services, and separately with respect to that portion of any such Plan, contract, or other arrangement which reserves the right to take the benefits or services of other Plans into consideration in determining its benefits and that portion which does not.

“Allowable Expense” means any Usual and Customary fee, at least a portion of which is covered under at least one of the Plans covering the person for whom claim is made. When a Plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered will be considered as both an Allowable Expense and a benefit paid.

“Claim Determination Period” means Calendar Year, except that if in any Calendar Year the person is not covered under the Plan for the full Calendar Year, the Claim Determination Period for that year will be that portion during which the person was covered under the Plan.

“Claim” means a request that benefits of a Plan be provided or paid.

“Primary Plan” means a Plan whose benefits are determined without regard to any other Plan.

“Secondary Plan” means a plan which is not a primary Plan according to the Order of Benefit Determination rules, and whose benefits are determined after those of another Plan and may be reduced because of the other Plan's benefits.

For purposes of this Coordination of Benefits section, “This Plan” means the **Mercy Health Corporation Employee Health Benefit Plan.**

Effect on Benefits

The MercyCare Plan will only pay benefits if the dollar amount paid by the MercyCare Plan in absence of COB is greater than what the Primary Plan paid. In that circumstance, it would only be the difference being paid out.

Non-duplication of Benefits
When a claim is made, the Primary Plan pays its benefits without regard to any other Plan. The Secondary Plan adjusts its benefits so that the total benefits available do not exceed the amount the Secondary Plan would have paid in the absence of Coordination of Benefits. No Plan pays more than it would have without the coordinating provision. This Plan will not administer the Coordination of Benefits with a reserve amount.

How Non-duplication of Benefits Coordination of Benefits Works
MercyCare would determine what the MercyCare Plan would have paid in absence of Coordination of Benefits.

Example:

Step 1

What would the MercyCare Plan pay as a Secondary Plan in the absence of COB?

$1,000.00 Allowable

$400.00 Deductible

$600.00 paid at 85% = $510.00 (would have been paid in absence of COB)

Step 2

Determine what the Primary Plan paid, by reviewing the Explanation of Benefits.

$1,000.00 Allowable

$300.00 Deductible

$700.00 paid @ 80% = $560.00

Since the Primary Plan paid a dollar amount which is greater than what the MercyCare Plan would have paid in absence of COB, the MHS Plan benefit payment would be $0.

Order of Benefits Determination

The rules establishing the Order of Benefits Determination are:

1. If the other plan does not have Coordination of Benefits, that plan pays first.
2. The benefits of a plan which covers the person as an employee, member, or subscriber (other than as a Dependent) are determined before the benefits of a plan which covers the person as a Dependent.
3. Birthday Rule: The benefits of a plan which covers a child as a Dependent are determined according to which parent's birth date occurs first in a Calendar Year (day and month, not year). The plan covering the Dependent's parent pays first if the parent's birthday (month and day of birth, not year) falls earlier in the year than the birthday of the Dependent's other parent. The plan covering the Dependent's parent pays second if the parent's birthday falls later in the year than the birthday of the Dependent's other parent. If the birth dates of both parents are the same, the plan that has covered a child for the longer period of time will be determined first. If the other plan does not contain the birthday rule but has a rule that coordinates benefits based on gender and the plans do not agree on the Order of Benefits, the rule in the other plan will determine the Order of Benefits.
4. If two or more plans cover a person as a Dependent child of divorced or separated parents, benefits for the Dependent are determined in this order:
    a) when parents are separated or divorced and the parent with physical custody of the child has not remarried, the benefits of a plan which covers the child as a Dependent of the parent with custody will be the Primary plan;
    b) when parents are divorced and the parent with physical custody of the child has remarried, the benefits of a plan which covers the child as a Dependent of the parent with custody are determined before the benefits of the plan which covers that child as a Dependent of the stepparent. In addition, the benefits of a plan which covers that child as a Dependent of the stepparent are determined before the benefits of a plan which covers that child as a Dependent of the parent without custody; and
    c) notwithstanding the provisions of the above, if there is a court decree which should otherwise establish financial responsibility for the medical, dental or other health care expenses with respect to a child, the benefits of a plan which covers the child as a Dependent of the parent with such financial responsibility are determined before the benefits of any other plan which covers the child as a Dependent child.
5. When rules 1., 2., and 3.do not establish an Order of Benefits Determination, the benefits of a plan which covers the person as a laid-off or retired employee, or as a Dependent of such

person, are determined after the benefits of a plan which covers such person through his or her own present employment or through the present employment of another person.

6. When rules 1., 2., 3., and 4. do not establish an Order of Benefits Determination, the benefits of a plan which has covered the person for the longer period of time are determined before the benefits of a plan which has covered such person the shorter period of time.

Right To Necessary Information

This Plan may require or may need to disclose certain information in order to apply and coordinate these provisions with other plans. To secure the needed information, this Plan, without the Covered Person's consent, will release to, or obtain from, any insurance company, organization or person, information needed to implement this provision. The Covered Person shall agree to furnish any information required to apply these provisions.

Coordination of Benefits With Medicare

In all cases, Coordination of Benefits with Medicare will conform with Federal Statutes and Regulations. If the Covered Person is eligible for Medicare Benefits, but not necessarily enrolled, the benefits under this Plan will be coordinated to the extent benefits would have been payable under Medicare, as allowed by Federal Statutes and Regulations.

Facility of Payment

Payment made under any other Plan which, according to these provisions, should have been made by this Plan, will be adjusted. This Plan may pay to the organization which made a payment the amount which is determined to be warranted. Any amount paid is deemed to be a benefit paid under this Plan.

TERMINATION OF COVERAGE

Coverage terminates for partners and covered dependents on the date when one of the following happens:

1. The Plan terminates; or
2. The partner or a dependent is otherwise terminated from the Plan (for example, due to failure to pay required premiums, failure to work a required number of hours or for a violation of Plan terms).

Mercy Health Corporation has the authority to terminate, amend or modify the Plan and all benefits hereunder. If the Plan is terminated, you will not receive any benefits. If it is amended or modified, you may not receive the same benefits.

Coverage also terminates for partners and covered dependents for any of the reasons listed below. The termination date for these reasons will be the end of the month in which the event or reason occurred:

- The partner's employment terminates.
- The partner ceases to meet eligibility requirements under the Plan.
- The partner requests voluntary disenrollment.
- The partner retires.
- The dependent no longer qualifies as an eligible dependent.

Note: Mercyhealth may retroactively terminate your coverage after 3 months of non-payment of the premium.

CONTINUATION OF COVERAGE UNDER COBRA

The pronoun "you" is used in the following paragraphs regarding COBRA to refer to each person covered under the Plan who is or may become a Qualified Beneficiary.

This section contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This section generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the Plan and under federal law, you should contact the Plan Administrator.

The description of COBRA coverage contained in this SPD applies only to the group health plan benefits offered under this Plan and not to any other benefits offered under the Plan or by Mercy Health Corporation (such as life insurance, disability, or accidental death or dismemberment benefits), except as described in such Plan document or SPD. The Plan provides no greater COBRA rights than what COBRA requires–nothing in this SPD is intended to expand your rights beyond COBRA's requirements.

There may be other coverage options for you and your family through the Health Insurance Marketplace. In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Being eligible for COBRA does not limit your eligibility for coverage for a tax credit through the Marketplace. Additionally, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees, if you request enrollment within 30 days.

Definitions

For purposes of this COBRA Continuation Coverage section, the following terms shall have the following meanings:

1. **Covered Partner:** A Covered Partner is a Partner or former Partner who was covered by the Plan on the day before a Qualifying Event.
2. **Covered Dependent:** A Covered Dependent is a "Dependent", as that word is defined in the Plan, who was covered by the Plan on the day before a Qualifying Event, including children born to or placed for adoption with a Covered Partner at any time during the COBRA continuation coverage period for whom coverage is elected in accordance with the requirements of the Plan.
3. **Loss of Coverage:** Loss of Coverage means to cease to be covered under the Plan or to cease to be covered under the terms and conditions in effect immediately before the Qualifying Event, including an increase in Partner premium or contribution resulting from a Qualifying Event. (Note: The actual Loss of Coverage need not occur at the same time as the Qualifying Event. It is sufficient that the Loss of Coverage occurs any time before the end of the maximum coverage period.)

What is COBRA Continuation Coverage?

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.

Who is Entitled to COBRA Coverage?

Covered Partner.

If you are a Partner, you will become a Qualified Beneficiary if you lose your coverage under the Plan because either one of the following Qualifying Events happens:

1. Your hours of employment are reduced, or
2. Your employment ends for any reason other than your gross misconduct.

Covered Dependent Spouse.

If you are the spouse of a Partner, you will become a Qualified Beneficiary if you lose your coverage under the Plan because any of the following Qualifying Events happens:

1. Your spouse dies;
2. Your spouse's hours of employment are reduced;
3. Your spouse's employment ends for any reason other than his or her gross misconduct;
4. Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
5. You become divorced or legally separated from your spouse. Also, if your spouse (the Partner) reduces or eliminates your group health coverage in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the divorce or legal separation

may be considered a Qualifying Event for you even though your coverage was reduced or eliminated before the divorce or separation.

Covered Dependent Children.
Your Dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following Qualifying Events happens:

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

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 the Employer, and that bankruptcy results in the loss of coverage of any retired Partner covered under the Plan, the retired Partner will become a qualified beneficiary with respect to the bankruptcy. The retired Partner's spouse, surviving spouse, and Dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When is COBRA Continuation Coverage Available?
The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a Qualifying Event has occurred. When the Qualifying Event is the end of employment or reduction of hours of employment, death of the Partner, commencement of a proceeding in bankruptcy with respect to Mercy Health Corporation, or the Partner's becoming entitled to Medicare benefits (under Part A, Part B, or both), the Employer must notify Mercy Health Corporation of the Qualifying Event.

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce or legal separation of the Partner and spouse, a Dependent child's losing eligibility for coverage as a Dependent child, a second Qualifying Event after a Qualified Beneficiary has become entitled to continuation coverage with a maximum duration of 18 or 29 months, a determination from the Social Security Administration that, under Title II or XVI of the Social Security Act, the Qualified Beneficiary has been determined to be disabled at any time during the first sixty (60) days of continuation coverage or a determination from the Social Security Administration that a Qualified Beneficiary who was determined to be disabled is no longer disabled), you generally must notify Mercy Health Corporation within 60 days after the qualifying event occurs (30 days for a cessation of disability). See below for information on the time frame for notifying Mercy Health Corporation. You must notify Mercy Health Corporation upon the occurrence of any of these Qualifying Events.
No COBRA coverage will be available unless you follow the Plan's COBRA's Notice Procedures and meet the notice deadlines.

Qualifying Event: FMLA

If a Partner does not return to work at the end of the Partner's leave under the Family and Medical Leave Act or states that he/she will not be returning at the end of the leave period and the Partner was covered under the Plan on the day before the first day of the leave or became covered during the leave, the Partner will, on the first day after the end of his/her leave of notice of intention not to return to employment (as appropriate), be deemed to have experienced a "Qualifying Event" for purposes of COBRA continuation coverage if in the absence of COBRA continuation coverage the Partner would lose coverage under the Plan before the end of the maximum coverage period. A Qualifying Event will not occur if coverage is eliminated under the Plan on or before the last day of the Partner's leave

for the class of Partners (while continuing to employ that class of Partners) to which the Partner would have belonged if the Partner had not taken leave. COBRA coverage elected in these circumstances will begin on the last day of FMLA leave, with the same 18 month maximum coverage period (subject to extension or early termination) generally applicable to the COBRA Qualifying Events of termination of employment and reduction of hours.

How is COBRA Coverage Provided?
Once Mercy Health Corporation 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 Partners may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

Length of COBRA Coverage
COBRA continuation coverage is a temporary continuation of coverage.

When the qualifying event is the death of the Partner, the Partner's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a Dependent child's losing eligibility as a Dependent child, COBRA continuation coverage for the qualified beneficiary spouse or qualified beneficiary Dependent child lasts for up to a total of 36 months.

When the qualifying event is the end of employment or reduction of the Partner's hours of employment, and the Partner became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the Partner lasts until 36 months after the date of Medicare entitlement. For example, if a covered Partner becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months).

Otherwise, when the qualifying event is the end of employment or reduction of the Partner’s hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. 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 Mercy Health Corporation 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 61st day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage.

You Must Notify Your Employer of a Qualified Beneficiary’s Disability

The disability extension is available only if you notify your Employer in writing of the Social Security Administration’s determination of disability within 60 days after the latest of:

- the date of the Social Security Administration’s disability determination;
- the date of the covered Partner’s termination of employment or reduction of hours; and
- the date on which the Qualified Beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the covered Partner’s termination of employment or reduction of hours.

You must also provide this notice within 18 months after the covered Partner’s termination of employment or reduction of hours in order to be entitled to a disability extension.

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 any Dependent children receiving continuation coverage if the Partner or former Partner dies, 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. (This extension is not available under the Plan when a covered Partner becomes entitled to Medicare.)

You Must Notify Mercy Health Corporation of a Second Qualifying Event

This extension due to a second Qualifying Event is available only if you notify Mercy Health Corporation in writing of the second Qualifying Event within 60 days after the later of (1) the date of the second Qualifying Event; and (2) the date on which the Qualified Beneficiary would lose coverage under the terms of the Plan as a result of the second Qualifying Event (if it had occurred while the Qualified Beneficiary was originally covered under the Plan).

No extension will be available unless you follow the Plan's COBRA Notice Procedures and meet the notice deadline.

How to Elect COBRA Coverage

To elect COBRA, you must complete the Election Form that is part of the Plan's COBRA election notice and submit it to Mercy Health Corporation. (An election notice will be provided to qualified beneficiaries at the time of a Qualifying Event. Legacy Mercy: You may also obtain a copy of the Election Form from Mercy Health Corporation Human Resource Department, 1000 Mineral Point Ave., Janesville, WI 53548. Legacy Rockford: You may obtain a copy of the election form from Mercy Health Corporation human resource department, 2400 N. Rockton Ave., Rockford, IL 61103.

Under federal law, you must have 60 days after the date of the COBRA election notice provided to you at the time of your Qualifying Event to decide whether you want to elect COBRA under the Plan.

Mail or hand delivers the completed Election Form to the Mercy Health Corporation Human Resources Department, in either Janesville or Rockford.

The Election Form must be completed in writing and mailed or hand delivered to the address specified above. The following are NOT acceptable as COBRA elections and will not preserve COBRA rights: oral communications regarding COBRA coverage, including in-person or telephone statements about an individual's COBRA coverage; and electronic communications, including e-mail and faxed communications.

Deadline for COBRA Election

If mailed, your election must be postmarked (and if hand-delivered, your election must be received by Human Resources at the address specified above) no later than 60 days after the date of the COBRA election notice provided to you at the time of your Qualifying Event. IF YOU DO NOT SUBMIT A COMPLETED ELECTION FORM BY THIS DUE DATE, YOU WILL LOSE YOUR RIGHT TO ELECT COBRA.

If You Reject COBRA

If you reject COBRA before the due date, you may change your mind as long as you furnish a completed Election Form before the due date.

Premium payments are due later, not with Election Form

You do not have to send any payment with your Election Form when you elect COBRA.

Independent Election Rights

Each Qualified Beneficiary will have an independent right to elect COBRA. For example, the Partner's spouse may elect COBRA even if the Partner does not. COBRA may be elected for only one, several, or for all Dependent children who are qualified beneficiaries. Covered Partners and spouses (if the

spouse is a Qualified Beneficiary) may elect COBRA on behalf of all of the qualified beneficiaries, and parents may elect COBRA on behalf of their children.
Any Qualified Beneficiary for whom COBRA is not elected within the 60-day election period specified in the Plan's COBRA election notice WILL LOSE HIS OR HER RIGHT TO ELECT COBRA COVERAGE.

Election of Coverage: Special Circumstances and Rules
If either the Covered Partner or the Qualified Beneficiary who is the spouse of a Covered Partner makes an election for COBRA continuation coverage but does not specify whether the election is for single or other coverage, then the election will be deemed to cover all eligible Qualified Beneficiaries. If the Qualified Beneficiary is totally incapacitated and is not legally competent to make an election for COBRA continuation coverage, the 60 day election period is tolled until such time as the Qualified Beneficiary is able to make an election or a guardian or legal representative is appointed who is able to make the election on behalf of the Qualified Beneficiary.

In general, a Qualified Beneficiary is only entitled to elect the same type of coverage in effect immediately before the Qualifying Event. However, a Qualified Beneficiary has the same right to change from family to single coverage.

A Qualified Beneficiary is entitled to the same coverage that is available to other similarly situated non-COBRA beneficiaries covered under the Plan. However, COBRA continuation coverage is subject to the Qualified Beneficiary's eligibility for coverage. Mercy Health Corporation reserves the right to terminate a Qualified Beneficiary's COBRA continuation coverage retroactively if the Qualified Beneficiary is determined to be ineligible.

If coverage under the Plan is modified for non-COBRA Beneficiaries the coverage under the Plan will be modified in the same manner for all Qualified Beneficiaries covered under the Plan.

COBRA continuation coverage commences on the day of the Qualifying Event if COBRA continuation coverage is properly elected and the applicable premium is paid as specified herein.

If a Qualified Beneficiary initially elects not to continue coverage under COBRA, the Qualified Beneficiary may revoke that non-election of COBRA continuation coverage at any time during the 60-day election period. The Plan, however, will only provide COBRA continuation coverage beginning with the date of the revocation of the non-election and not retroactively to the date of the actual Qualifying Event. This will result in a lapse of continuous coverage under the Plan. Qualified Beneficiaries must provide notice of the election of COBRA continuation coverage in writing.

If COBRA Continuation Coverage is rejected in favor of alternate coverage under the Plan, COBRA Continuation Coverage will not be offered at the end of that period. If alternate coverage is offered, the COBRA Continuation Coverage period will be reduced to the extent such coverage satisfies the requirement of COBRA. Alternate Coverage may include, for example, continuation by USERRA or any other Plan provision or retiree coverage.

When you complete the Election Form, you must notify your Employer if any Qualified Beneficiary has become entitled to Medicare (Part A, Part B, or both) and, if so, the date of Medicare entitlement. If you become entitled to Medicare (or first learn that you are entitled to Medicare) after submitting the Election Form, immediately notify Mercy Health Corporation of the date of your Medicare entitlement at the address specified above for delivery of the Election Form.

Special Considerations in Deciding Whether to Elect COBRA
In considering whether to elect COBRA, you should take into account that a failure to elect COBRA will affect your future rights under federal law. First, you can lose the right to avoid having preexisting condition exclusions applied to you by other group health plans if you have a 63-day (or longer) gap in health coverage, and election of COBRA may help you not have such a gap. Second, you will lose the guaranteed right to purchase individual health insurance policies that do not impose such preexisting condition exclusions if you do not get COBRA coverage for the maximum time available to you. Finally, you should take into account that you may have special enrollment rights under federal law. You may have the right to request special enrollment in another group health plan for which you

are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage under the Plan ends because of one of the Qualifying Events listed above. You may also have the same special enrollment right at the end of COBRA coverage if you get COBRA coverage for the maximum time available to you.

Special Second Election Period for Certain Partners

Special COBRA continuation coverage rights apply to Partners who have been terminated or experienced a reduction of hours and who qualify for a "trade readjustment allowance" or "alternative trade adjustment assistance" under a federal law called the Trade Act of 1974. These Partners are entitled to a second opportunity to elect COBRA continuation coverage for themselves and certain Family Members (if they did not already elect COBRA continuation coverage), but only within a limited period of sixty (60) days (or less) and only during the six (6) months immediately after their group health coverage under the Plan term.

Partners who qualify for assistance under the Trade Act of 1974 should contact Mercy Health Corporation for additional information. The Partner must contact Mercy Health Corporation promptly after qualifying for assistance under the Trade Act of 1974 or he/she will lose these special COBRA continuation coverage rights.

Termination of COBRA Continuation Coverage

COBRA continuation coverage will be terminated prior to the end of the maximum coverage period for the following reasons:

1. The Employer no longer provides group health coverage to any of its Partners.
2. The premium for COBRA continuation coverage is not paid by the Qualified Beneficiary on a timely basis or within any applicable grace period.
3. The Qualified Beneficiary becomes covered under another group health plan after the date of the Qualified Beneficiary's election, even if that coverage is different than coverage currently in place (but only after any preexisting condition exclusions for that other Plan for a preexisting condition of the Qualified Beneficiary have been exhausted or satisfied).
4. The Qualified Beneficiary becomes entitled to Medicare (either Medicare Part A or Part B, whichever comes first, or both) after the date of the Qualified Beneficiary's election. You must notify Mercy Health Corporation within 30 days if this occurs. You must follow the procedures specified below in the section entitled "Notice Procedures for Notice of Other Coverage, Medicare Entitlement, or Cessation of Disability."
5. For a Qualified Beneficiary who has continued COBRA continuation coverage due to Social Security Administration Disability status as a Covered Partner or as a Covered Dependent of a Covered Partner, the date on which the Qualified Beneficiary is no longer considered to be disabled by the Social Security Administration. However, such a determination does not allow termination of the COBRA continuation coverage of a Qualified Beneficiary before the end of the maximum coverage period that would apply without regard to the disability extension. You must notify Mercy Health Corporation of that fact within 30 days after the Social Security Administration's determination. You must follow the procedures specified below in the section entitled "Notice Procedures for Notice of Other Coverage, Medicare Entitlement, or Cessation of Disability."
6. The Qualified Beneficiary is determined to have been ineligible for coverage under the Plan or is determined not to be a Qualified Beneficiary.
7. Any other reason allowed by applicable law.

COBRA coverage will terminate (retroactively if applicable) as of the date of Medicare entitlement or as of the beginning date of the other group health coverage (after exhaustion or satisfaction of any preexisting condition exclusions for a preexisting condition of the qualified beneficiary). The Plan will require repayment to the Plan of all benefits paid after the termination date, regardless of whether or when you provide notice of Medicare entitlement or other group health plan coverage.

If the Social Security Administration's determination that the Qualified Beneficiary is no longer disabled occurs during a disability extension period, COBRA coverage for all qualified beneficiaries will terminate (retroactively if applicable) as of the first day of the month that is more than 30 days after the Social Security Administration's determination that the Qualified Beneficiary is no longer disabled. The Plan will require repayment to the Plan of all benefits paid after the termination date, regardless of whether or when you provide notice that the disabled Qualified Beneficiary is no longer disabled.

Payment of Premium

The Plan may require payment of a premium for COBRA continuation coverage. The premium will not exceed 102% of the applicable premium for the period in question except for the 11 months of a disability extension. If the disabled Qualified Beneficiary is qualified for and elects the disability extension, a premium not to exceed 150% of the applicable premium may be charged. If only the non-disabled Family Members of the disabled Qualified Beneficiary elect the disability extension, then they will be charged a premium not to exceed 102% of the applicable premium.
In addition, the premium payment for the first 30 days for a Partner who is eligible for coverage under the Uniformed Services Employment and Re-employment Rights Act of 1994 must be the same as for an active Partner. Thereafter, the premium amount will not exceed 102% of the applicable premium for the remaining months of coverage. Determination of the applicable premium will be made in advance and will apply for a period of 12 months, the date being established by Mercy Health Corporation, unless: 1.) The Plan has previously charged less than the maximum amount it is permitted to charge and the increased amount does not exceed the maximum amount permitted to be charged; or 2.) The increase occurs during the disability extension and the increased amount to be paid does not exceed the maximum amount permitted to be charged; or 3.) A Qualified Beneficiary changes the coverage being received.

The premium will be based in part, on a reasonable estimate of the cost of providing coverage for the period for similarly situated active Partners or on the basis of past costs of providing such coverage.

First Payment
The Employer must allow the Qualified Beneficiary or a third party to pay for such COBRA continuation coverage on a monthly basis. The Qualified Beneficiary has 45 days from the date on which the Qualified Beneficiary makes a written election of COBRA continuation coverage to pay for the first month's premium. The initial premium payment must include all past amounts to the date of election and shall apply to the period of COBRA continuation coverage beginning immediately after the coverage under the Plan terminates except for cases where the Qualified Beneficiary does not elect to continue coverage and then revokes that non-election.

The Plan is not required to pay for any claims incurred prior to a timely election of COBRA continuation coverage and proper premium payment for such COBRA continuation coverage, however, such claims shall be eligible for payment upon timely election of such COBRA continuation coverage and proper premium payment for the COBRA continuation coverage.

If you do not make your first payment for COBRA coverage in full within 45 days after the date of your election, you will lose all COBRA rights under the Plan.

Monthly or Periodic Payments
After you make your first payment for continuation coverage, you will be required to make periodic payments for each subsequent coverage period. The amount due for each coverage period for each qualified beneficiary will be shown in the notice you receive after you elect COBRA coverage. The periodic payments can be made on a monthly basis. Under the Plan, each of these periodic payments for continuation coverage is due on the first day of each month for that coverage period. You may instead make payments for continuation coverage ahead of time for future months. If you

make a periodic payment on or before the first day of the coverage period to which it applies, your coverage under the Plan will continue for that coverage period without any break. You will be sent monthly invoices of payments due.

How to Make Payments
Payments must be sent to the Mercy Health Corporation Human Resources Department. 1000 Mineral Point Ave., Janesville, WI 53548 for legacy Mercy partners, and to Mercy Health Corporation human resources department, 2400 N. Rockton Ave., Rockford, IL 61103 for legacy Rockford partners.

Grace Period for periodic COBRA Premium Payments
Although periodic payments are due on the dates shown in the notice, you will be given a grace period of 30 days after the first day of the coverage period to make each periodic payment. Your continuation coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment.

If you fail to make a periodic payment before the end of the grace period for that coverage period, you will lose all rights to continuation coverage under this Plan.

More Information About Individuals Who May Be Qualified Beneficiaries

Children Born to or Placed For Adoption With The Covered Partner During a Period of COBRA Coverage
A child born to, adopted by, or placed for adoption with a covered Partner during a period of COBRA coverage is considered to be a Qualified Beneficiary provided that, if the covered Partner is a Qualified Beneficiary, the covered Partner has elected COBRA coverage for himself or herself. The child's COBRA coverage begins when the child is enrolled in the Plan, whether through special enrollment or annual enrollment, and it lasts for as long as COBRA coverage lasts for other Family Members of the Partner. To be enrolled in the Plan, the child must satisfy the otherwise applicable Plan eligibility requirements (for example, regarding age).

Alternate Recipients Under QMCSOS
A child of the covered Partner who is receiving benefits under the Plan pursuant to a qualified medical child support order (QMCSO) received by Mercy Health Corporation during the covered Partner's period of employment with Mercy Health Corporation is entitled to the same rights to elect COBRA as an eligible Dependent child of the covered Partner.

If You Have Questions
Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Keep Your Plan Informed of Address Changes
In order to protect your family's rights, you should keep Mercy Health Corporation informed of any changes in the addresses of Family Members. You should also keep a copy, for your records, of any notices you send to Mercy.

Plan Contact Information
Information about the Plan and COBRA continuation coverage can be obtained from Mercy Health Corporation at the Human Resources Department, 1000 Mineral Point Ave., Janesville, WI 53548 1-608-756-6721for legacy Mercy partners, and from Mercy Health Corporation human resources

department, 2400 N. Rockton Ave., Rockford, IL 61103, 1-815-971-6110 for legacy Rockford partners.

COBRA NOTICE PROCEDURES

Notice Procedures for Notice of Qualifying Event

Deadline for Notice of Qualifying Event

As discussed elsewhere, you may be required to provide notice of a Qualifying Event. If so, the deadline for providing this notice generally is 60 days after the later of (1) the Qualifying Event (i.e., a divorce or legal separation or a child's loss of Dependent status); and (2) the date on which the covered spouse or Dependent child would lose coverage under the terms of the Plan as a result of the Qualifying Event.

How to Provide Notice of Qualifying Event

You must mail or hand deliver this notice to Mercy Health Corporation.

Your notice must be in writing (using the Plan's form described below) and must be mailed or hand-delivered. Oral notice, including notice by telephone, is not acceptable. Electronic (including e-mailed or faxed) notices are not acceptable. If mailed, your notice must be postmarked no later than the deadline described above. If hand-delivered, your notice must be received by the individual at the address specified above no later than the deadline described above.

Required Form and Information for Notice of Qualifying Event

You must use the Plan's form entitled "Notice of Qualifying Event" to notify your Employer of a Qualifying Event (e.g., a divorce or legal separation or a child's loss of Dependent status), and all of the applicable items on the form must be completed.

Your notice must contain the following information:

- the name of the Plan;
- the name and address of the Partner or former Partner who is or was covered under the Plan;
- the name(s) and address(es) of all Qualified Beneficiary(ies) who lost coverage due to the Qualifying Event (divorce, legal separation, or child's loss of Dependent status);
- the Qualifying Event (divorce, legal separation, or child's loss of Dependent status);
- the date that the divorce, legal separation, or child's loss of Dependent status happened; and
- the signature, name, and contact information of the individual sending the notice.

If you are notifying Mercy Health Corporation of a divorce or legal separation, your notice must include a copy of the decree of divorce or legal separation.

If your coverage is reduced or eliminated and later a divorce or legal separation occurs, and you are notifying Mercy Health Corporation that your Plan coverage was reduced or eliminated in anticipation of the divorce or legal separation, you must provide notice within 60 days of the divorce or legal separation in accordance with these Notice Procedures for Notice of Qualifying Event and must in addition provide evidence satisfactory to Mercy Health Corporation that your coverage was reduced or eliminated in anticipation of the divorce or legal separation.

Incomplete Notice of Qualifying Event

If you provide a written notice that does not contain all of the information and documentation required by these Notice Procedures for Notice of Qualifying Event, such a notice will nevertheless be considered timely if all of the following conditions are met:

- the notice is mailed or hand-delivered to the individual and address specified above;
- the notice is provided by the deadline described above;

- from the written notice provided, your Employer is able to determine that the notice relates to the Plan;
- from the written notice provided, your Employer is able to identify the covered Partner and Qualified Beneficiary(ies), the Qualifying Event (the divorce, legal separation, or child's loss of Dependent status), and the date on which the Qualifying Event occurred; and
- the notice is supplemented in writing with the additional information and documentation necessary to meet the Plan's requirements (as described in these Notice Procedures for Notice of Qualifying Event) within 15 business days after a written or oral request from Mercy Health Corporation for more information (or, if later, by the deadline for the Notice of Qualifying Event described above).

If any of these conditions is not met, the incomplete notice will be rejected and COBRA will not be offered. If all of these conditions are met, the Plan will treat the notice as having been provided on the date that the Plan receives all of the required information and documentation but will accept the notice as timely.

Who May Provide Notice of Qualifying Event
The covered Partner (i.e., the Partner or former Partner who is or was covered under the Plan), a Qualified Beneficiary with respect to the Qualifying Event, or a representative acting on behalf of either may provide the notice. A notice provided by any of these individuals will satisfy any responsibility to provide notice on behalf of all qualified beneficiaries who lost coverage due to the Qualifying Event described in the notice.

Additional evidence of the date of a child's loss of Dependent status may be required

If your notice was regarding a child's loss of Dependent status, you must, if your Employer requests it, provide documentation of the date of the Qualifying Event that is satisfactory to your Employer (for example, a birth certificate to establish the date that a child reached the limiting age, a marriage certificate to establish the date that a child married, or a transcript showing the last date of enrollment in an educational institution). This will allow Mercy Health Corporation to determine if you gave timely notice of the Qualifying Event and were consequently entitled to elect COBRA. If you do not provide satisfactory evidence within 15 business days after a written or oral request from Mercy Health Corporation that the child ceased to be a Dependent on the date specified in your Notice of Qualifying Event, his or her COBRA coverage may be terminated (retroactively if applicable) as of the date that COBRA coverage would have started. Mercy Health Corporation will require repayment to the Plan of all benefits paid after the termination date.

Notice Procedures for Notice of Disability

Deadline for Notice of Disability
The deadline for providing the Notice of Disability is 60 days after the latest of (1) the date of the Social Security Administration's disability determination; (2) the date of the covered Partner's termination of employment or reduction of hours; and (3) the date on which the Qualified Beneficiary would lose coverage under the terms of the Plan as a result of the termination of employment or reduction of hours. Your Notice of Disability must also be provided within 18 months after the covered Partner's termination of employment or reduction of hours.

How to Provide Notice of Disability
You must mail or hand delivers the Notice of Disability to Mercy Health Corporation Human Resources.

Your notice must be in writing (using the Plan's form described below) and must be mailed or hand-delivered. Oral notice, including notice by telephone, is not acceptable. Electronic (including e-mailed or faxed) notices are not acceptable. If mailed, your notice must be postmarked no later than the deadline described above. If hand-delivered, your notice must be received by Human Resources at the address specified above no later than the deadline described above.

Required Form and Information for Notice of Disability

You must use the Plan's form entitled "Notice of Disability" to notify Mercy Health Corporation of a Qualified Beneficiary's disability, and all of the applicable items on the form must be completed.

Your notice must contain the following information:

- the name of the Plan;
- the name and address of the Partner or former Partner who is or was covered under the Plan;
- the initial Qualifying Event that started your COBRA coverage (the covered Partner's termination of employment or reduction of hours);
- the date that the covered Partner's termination of employment or reduction of hours happened;
- the name(s) and address(es) of all Qualified Beneficiary(ies) who lost coverage due to the termination or reduction of hours and who are receiving COBRA coverage at the time of the notice;
- the name and address of the disabled Qualified Beneficiary;
- the date that the Qualified Beneficiary became disabled;
- the date that the Social Security Administration made its determination of disability;
- a statement as to whether or not the Social Security Administration has subsequently determined that the Qualified Beneficiary is no longer disabled; and
- the signature, name, and contact information of the individual sending the notice.

Your Notice of Disability must include a copy of the Social Security Administration's determination of disability.

Incomplete Notice of Disability

If you provide a written notice to your Employer that does not contain all of the information and documentation required by these Notice Procedures, such a notice will nevertheless be considered timely if all of the following conditions are met:

- the notice is mailed or hand-delivered to the individual and address specified above;
- the notice is provided by the deadline described above;
- from the written notice provided, Mercy Health Corporation is able to determine that the notice relates to the Plan and a Qualified Beneficiary's disability;
- from the written notice provided, Mercy Health Corporation is able to identify the covered Partner and Qualified Beneficiary(ies) and the date on which the covered Partner's termination of employment or reduction of hours occurred; and
- the notice is supplemented in writing with the additional information and documentation necessary to meet the Plan's requirements (as described in these Notice Procedures for Notice of Disability) within 15 business days after a written or oral request from Mercy Health Corporation for more information (or, if later, by the deadline for the Notice of Disability described above).

If any of these conditions is not met, the incomplete notice will be rejected and COBRA will not be extended. If all of these conditions are met, the Plan will treat the notice as having been provided on the date that the Plan receives all of the required information and documentation but will accept the notice as timely.

Who May Provide Notice of Disability

The covered Partner (i.e., the Partner or former Partner who is or was covered under the Plan), a Qualified Beneficiary who lost coverage due to the covered Partner's termination or reduction of hours and is still receiving COBRA coverage, or a representative acting on behalf of either may provide the Notice of Disability. A notice provided by any of these individuals will satisfy any

responsibility to provide notice on behalf of all qualified beneficiaries who may be entitled to an extension of the maximum COBRA coverage period due to the disability reported in the notice.

Notice Procedures for Notice of Second Qualifying Event

Deadline for Notice of Second Qualifying Event
The deadline for providing a Notice of Second Qualifying Event is 60 days after the later of (1) the date of the second Qualifying Event (i.e., a divorce or legal separation, the covered Partner's death, or a child's loss of Dependent status); and (2) the date on which the covered spouse or Dependent child would lose coverage under the terms of the Plan as a result of the second Qualifying Event (if this event had occurred while the Qualified Beneficiary was still covered under the Plan).

How to Provide Notice of Second Qualifying Event
You must mail or hand deliver the Notice of Second Qualifying Event to Mercy Health Corporation Human Resources.

Your notice must be in writing (using the Plan's form described below) and must be mailed or hand-delivered. Oral notice, including notice by telephone, is not acceptable. Electronic (including e-mailed or faxed) notices are not acceptable. If mailed, your notice must be postmarked no later than the deadline described above. If hand-delivered, your notice must be received by the individual at the address specified above no later than the deadline described above.

Required Form and Information for Notice of Second Qualifying Event
You must use the Plan's form entitled "Notice of Second Qualifying Event" to notify Mercy Health Corporation of a second Qualifying Event (e.g., a divorce or legal separation, the covered Partner's death, or a child's loss of Dependent status), and all of the applicable items on the form must be completed.

Your notice must contain the following information:

- the name of the Plan;
- the name and address of the Partner or former Partner who is or was covered under the Plan;
- the initial Qualifying Event that started your COBRA coverage (the covered Partner's termination of employment or reduction of hours);
- the date that the covered Partner's termination of employment or reduction of hours happened;
- the name(s) and address(es) of all Qualified Beneficiary(ies) who lost coverage due to the termination or reduction of hours and who are receiving COBRA coverage at the time of the notice;
- the second Qualifying Event (e.g., a divorce or legal separation, the covered Partner's death or a child's loss of Dependent status);
- the date that the second Qualifying Event happened; and
- the signature, name, and contact information of the individual sending the notice.

If you are notifying your Employer of a divorce or legal separation, your notice must include a copy of the decree of divorce or legal separation.

Incomplete Notice of Second Qualifying Event
If you provide a written notice to your Employer that does not contain all of the information and documentation required by these Notice Procedures for Notice of Second Qualifying Event, such a notice will nevertheless be considered timely if all of the following conditions are met:

- the notice is mailed or hand-delivered to Mercy Health Corporation Human Resources at the address specified above;

- the notice is provided by the deadline described above;
- from the written notice provided, Mercy Health Corporation is able to determine that the notice relates to the Plan;
- from the written notice provided, Mercy Health Corporation is able to identify the covered Partner and Qualified Beneficiary(ies), the first Qualifying Event (the covered Partner's termination of employment or reduction of hours), the date on which the first Qualifying Event occurred, the second Qualifying Event, and the date on which the second Qualifying Event occurred; and
- the notice is supplemented in writing with the additional information and documentation necessary to meet the Plan's requirements (as described in these Notice Procedures for Notice of Second Qualifying Event) within 15 business days after a written or oral request from Mercy Health Corporation for more information (or, if later, by the deadline for this Notice of Second Qualifying Event described above).

If any of these conditions are not met, the incomplete notice will be rejected and COBRA will not be extended. If all of these conditions are met, the Plan will treat the notice as having been provided on the date that the Plan receives all of the required information and documentation but will accept the notice as timely.

Who May Provide Notice of Second Qualifying Event

The covered Partner (i.e., the Partner or former Partner who is or was covered under the Plan), a Qualified Beneficiary who lost coverage due to the covered Partner's termination or reduction of hours and is still receiving COBRA coverage, or a representative acting on behalf of either may provide the Notice of Second Qualifying Event. A notice provided by any of these individuals will satisfy any responsibility to provide notice on behalf of all qualified beneficiaries who may be entitled to an extension of the maximum COBRA coverage period due to the second Qualifying Event reported in the notice.

Additional evidence of the date of a child's loss of Dependent status may be required

If your Notice of Second Qualifying Event was regarding a child's loss of Dependent status, you must, if Mercy Health Corporation requests it, provide documentation of the date of the Qualifying Event that is satisfactory to Mercy Health Corporation (for example, a birth certificate to establish the date that a child reached the limiting age, a marriage certificate to establish the date that a child married, or a transcript showing the last date of enrollment in an educational institution). This will allow Mercy Health Corporation to determine if you gave timely notice of the second Qualifying Event and were consequently entitled to an extension of COBRA coverage. If you do not provide satisfactory evidence within 15 business days after a written or oral request from Mercy Health Corporation that the child ceased to be a Dependent on the date specified in your Notice of Second Qualifying Event, his or her COBRA coverage may be terminated (retroactively if applicable) as of the date that COBRA coverage would have ended without an extension due to loss of Dependent status. Mercy Health Corporation will require repayment to the Plan of all benefits paid after the termination date.

Additional evidence of the date of the covered Partner's death may be required

If your Notice of Second Qualifying Event was regarding the death of the covered Partner, you must, if Mercy Health Corporation requests it, provide documentation of the date of death that is satisfactory to Mercy Health Corporation (for example, a death certificate or published obituary). This will allow Mercy Health Corporation to determine if you gave timely notice of the second Qualifying Event and were consequently entitled to an extension of COBRA coverage. If you do not provide satisfactory evidence within 15 business days after a written or oral request from Mercy Health Corporation that the date of death was the date specified in your Notice of Second Qualifying Event, the COBRA coverage of all qualified beneficiaries receiving an extension of COBRA coverage as a result of the covered Partner's death may be terminated (retroactively if applicable) as of the date that COBRA coverage would have ended without an extension due to the covered Partner's death. Mercy Health Corporation will require repayment to the Plan of all benefits paid after the termination date.

Notice Procedures for Notice of Other Coverage, Medicare Entitlement, or Cessation of Disability

Deadline for Notice of Other Coverage

If you are providing a Notice of Other Coverage (a notice that a Qualified Beneficiary has become covered, after electing COBRA, under other group health plan coverage), the deadline for this notice is 30 days after the other coverage becomes effective or, if later, 30 days after exhaustion or satisfaction of any preexisting condition exclusions for a preexisting condition of the Qualified Beneficiary.

Deadline for Notice of Medicare Entitlement

If you are providing a Notice of Medicare Entitlement (a notice that a Qualified Beneficiary has become entitled, after electing COBRA, to Medicare Part A, Part B, or both), the deadline for this notice is 30 days after the beginning of Medicare entitlement (as shown on the Medicare card).

Deadline for Notice of Cessation of Disability

If you are providing a Notice of Cessation of Disability (a notice that a disabled Qualified Beneficiary whose disability resulted in an extended COBRA coverage period is determined by the Social Security Administration to be no longer disabled), the deadline for this notice is 30 days after the date of the Social Security Administration's determination.

How to Provide Notice of Other Coverage, Medicare Entitlement, or Cessation of Disability

You must mail or hand deliver this notice to Mercy Health Corporation Human Resources. Your notice must be provided no later than the deadline described above.

Information and Form Required for Notice of Other Coverage, Medicare Entitlement, or Cessation of Disability

You should use the Plan's form entitled "Notice of Other Coverage, Medicare Entitlement, or Cessation of Disability" to notify Mercy Health Corporation of any of these events, and all of the applicable items on the form should be completed.

Your notice should contain the following information:

- the name of the Plan;
- the name and address of the Partner or former Partner who is or
- was covered under the Plan;
- the name(s) and address(es) of all Qualified Beneficiary(ies);
- the Qualifying Event that started your COBRA coverage;
- the date that the Qualifying Event happened; and
- the signature, name, and contact information of the individual sending the notice.

Additional Information Required for Certain Notices

If you are providing a Notice of Other Coverage, your notice should include the name and address of the Qualified Beneficiary who obtained other coverage, the date that the other coverage became effective (and, if there were any preexisting condition exclusions applicable to the Qualified Beneficiary, the date that these were exhausted or satisfied), and evidence of the effective date of the other coverage (such as a copy of the insurance card or application for coverage).

If you are providing a Notice of Medicare Entitlement, your notice should include the name and address of the Qualified Beneficiary who became entitled to Medicare, the date that Medicare entitlement occurred, and a copy of the Medicare card showing the date of Medicare entitlement.

If you are providing a Notice of Cessation of Disability, your notice must include the name and address of the disabled Qualified Beneficiary, the date of the Social Security Administration's

determination that he or she is no longer disabled, and a copy of the Social Security Administration's determination.

Who May Provide Notice of Other Coverage, Medicare Entitlement, or Cessation of Disability
The covered Partner (i.e., the Partner or former Partner who is or was covered under the Plan), a Qualified Beneficiary with respect to the Qualifying Event, or a representative acting on behalf of either may provide the notice. A notice provided by any of these individuals will satisfy any responsibility to provide notice on behalf of all related qualified beneficiaries with respect to the other coverage, Medicare entitlement, or cessation of disability reported in the notice.

COBRA coverage will terminate regardless of whether or when Notice of Other Coverage, Medicare Entitlement, or Cessation of Disability is provided.

If a Qualified Beneficiary first becomes covered by other group health plan coverage after electing COBRA, that Qualified Beneficiary's COBRA coverage will terminate (retroactively if applicable) as described above in the section entitled "Termination of COBRA Continuation Coverage," regardless of whether or when a Notice of Other Coverage is provided.

If a Qualified Beneficiary first becomes entitled to Medicare Part A, Part B, or both after electing COBRA, that Qualified Beneficiary's COBRA coverage will terminate (retroactively if applicable) as described above in the section entitled "Termination of COBRA Continuation Coverage," regardless of whether or when a Notice of Medicare Entitlement is provided.

If a disabled Qualified Beneficiary is determined by the Social Security Administration to be no longer disabled, COBRA coverage for all qualified beneficiaries whose COBRA coverage is extended due to the disability will terminate (retroactively if applicable) as described above in the section entitled "Termination of COBRA Continuation Coverage," regardless of whether or when a Notice of Cessation of Disability is provided.

HIPAA Certificate of Creditable Coverage Request Procedures

Under HIPAA, the Plan is required to provide a certificate of Creditable Coverage (HIPAA Certificate) to each individual who requests one so long as it is requested while the individual is covered under the Plan or within 24 months after the individual's coverage under the Plan ends. The request also can be made by someone else on behalf of an individual (e.g., an individual who previously was covered under the Plan may authorize a new plan in which the individual enrolls to request a certificate of the individual's Creditable Coverage from the Plan). An individual is entitled to receive a Certificate upon request even if the Plan has previously issued a Certificate to that individual.

Requests for Certificates should be directed to the Plan Administrator.

Telephone requests are accepted only if the Certificate is to be mailed to the address that the Plan has on file for the individual to whom the request relates. Other requests must be made in writing.

All requests must include:

- The name of the individual for whom the Certificate is requested;
- The last date that the individual was covered under the Plan;
- The name of the participant that enrolled the individual in the Plan; and
- A telephone number to reach the individual for whom the Certificate is requested, in the event of any difficulties.

Requests that are required to be made in writing must also include:

- The name of the person making the request and evidence of that person's authority to request and receive the Certificate on behalf of the individual;
- The address to which the Certificate should be mailed; and
- The requester's signature.

After receiving a request that meets these requirements, the Plan will act in a reasonable and prompt fashion to provide the Certificate.

The Plan normally will provide a HIPAA Certificate of Coverage to any Covered Person automatically after the individual loses coverage in the Plan. The HIPAA Certificate will contain the following information:

- the date the Certificate was issued;
- the name of the Plan that provided the coverage;
- the name of the Participant or Dependent to whom the certificate applies;
- the name, address, and telephone number of the Plan Administrator or issuer providing the certificate;
- a telephone number for further information (if different);
- either (i) a statement that the Participant or Dependent has at least 18 months (546 days) of Creditable Coverage, not counting days of coverage before a Significant Break in Coverage (which means a period of 63 or more consecutive days during all of which an individual did not have any Creditable Coverage, exclusive of Waiting Periods and affiliation periods); or (ii) the date any Waiting Period (and affiliation period, if applicable) began and the date Creditable Coverage began; and
- the date Creditable Coverage ended, unless the Certificate indicates that coverage is continuing as of the date of the Certificate.

If the Plan is requested to provide a Certificate for a Dependent, the Plan will make reasonable efforts to obtain and provide that person's name. The Plan will not issue an automatic Certificate for Dependents until the Plan has reason to know that a Dependent has lost coverage under the Plan.

For these purposes: (1) “Certificate of Coverage” means a written certification of the period of Creditable Coverage of the individual under the Plan and the coverage (if any) under the COBRA continuation coverage section of the Plan, and the Waiting Period imposed with respect to the individual for any coverage under this Plan; and (2) “Creditable Coverage” means prior medical coverage that an individual had from any of the following sources: a group health plan (including this Plan), health insurance coverage, Medicare, Medicaid, medical and dental care for members and former members of the Uniformed Services and their Dependents, a medical care program of the Indian Health Service or a tribal organization, a state health benefits risk pool, certain other state-sponsored arrangements established primarily to provide medical benefits to persons who have difficulty in obtaining affordable coverage because of a medical condition, a health plan offered under the Federal Employees Health Benefits Program, a public health plan, a health benefit plan under the Peace Corps Act or coverage under the State Children’s Health Insurance Program.

COMPLAINT PROCEDURES AND APPEALS

Benefit Claim Procedures and Appeal Procedures

Urgent, Concurrent or Pre-service claim appeals will be processed by MercyCare. For purposes of this section only, MercyCare shall be referred to as the Appeals Processor.

Claims for medical and pharmacy benefits under the Plan should be directed to the Complaint Coordinator at the address listed below. Urgent Care claims and appeals of Urgent Care claim determinations can be made in writing to the address listed below or, during normal business hours, by fax or telephone at the numbers listed below.

In order to receive a benefit under this Plan, the Plan Administrator may require you to complete a particular form or series of forms. Your application will then be considered under the following procedures. For the purposes of the Claims and Appeals Procedures described herein, the words "you" and "your" refer to any Covered Person or former Covered Person (or any Dependent of the Covered Person where applicable). You should complete all the information requested on the form(s).

Procedures upon Initial Filing of a Claim

The following procedures apply to an initial filing of a claim with the Plan:

1. Time Limits on Decisions. The time frame for processing your initial claim depends on the type of claim it is: urgent care, concurrent care, pre-service or post-service. Your claim will be processed according to the highest priority category that applies to it.
    a. **Urgent Care Claims.** If your claim is an urgent care claim, the Plan Administrator must notify you as soon as possible, taking into account the medical exigencies. This notice must be sent to you no later than 72 hours after the Plan's receipt of your claim.

        If you fail to provide sufficient information to allow the Plan Administrator to determine whether or to what extent benefits are covered, the Plan Administrator must notify you as soon as possible, but not later than 24 hours after the Plan receives your claim. You will have a reasonable period of time (not less than 48 hours) to respond and provide the additional information. After the Plan receives this additional information, the Plan Administrator must notify you as soon as possible whether your benefit claim has been granted or denied. This notification must occur no later than 48 hours after the earlier of:
        i. the Plan's receipt of the specified information; or
        ii. the end of the period granting you additional time to provide the additional information.

        An "**urgent care claim"** is any claim for medical care or treatment where using the non-urgent care claim timeframes:
        i. could seriously jeopardize the claimant's life or health or ability to regain maximum function; or
        ii. would, in the opinion of a Physician with knowledge of the claimant's medical condition, subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.
    b. **Concurrent Care Conditions**. If you are currently receiving ongoing treatment or the treatment is going to be provided over a number of sessions, special rules apply.
        i. Any notice of reduction or termination (except by Plan amendment or termination) must be given to you by the Plan Administrator at a time sufficiently in advance of the reduction or termination to allow you to appeal and obtain a determination on review before the benefit is reduced or terminated.
        ii. If the claim is an urgent care claim, the Plan Administrator must decide the claim as soon as possible taking into account medical exigencies. Notice to you must be made within 24 hours after the Plan receives the claim, as long as the Plan receives your

claim at least 24 hours prior to the expiration of the prescribed period of time or number of treatments.

c. **Pre-Service Claim**. A pre-service claim means any claim for a benefit under the Plan where the Plan conditions receipt of the benefit (in whole or in part) on approval of the benefit in advance of obtaining medical care. For a pre-service claim, the Plan Administrator must notify you of the decision within a reasonable period of time appropriate to the medical circumstances. This notification must be made not later than 15 days after the Plan receives your claim. This 15-day period can be extended for an additional 15 days if:
   i. The Plan Administrator determines that the extension is necessary due to matters beyond the control of the Plan; and
   ii. The Plan Administrator notifies you, prior to the end of the initial 15-day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.
   iii. If the 15-day extension is necessary because you failed to submit the information necessary to decide the claim, the Plan Administrator must provide notice to you of this 15-day extension and must describe the required information necessary to decide the claim. You will have at least 45 days from receipt of this notice to provide the requested information.

d. **Post-Service Claims**. A post-service claim is any claim under the Plan that does not satisfy the definitions of the other types of claims. For a post-service claim, the Plan Administrator must notify you of the decision within a reasonable period of time. This notification must be made not later than 30 days after receipt of the claim by the Plan. This 30-day period can be extended for an additional 15 days if:
   i. The Plan Administrator determines that the extension is necessary due to matters beyond the control of the Plan; and
   ii. The Plan Administrator notifies you, prior to the end of the 30-day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.
   iii. If the 15-day extension is necessary because you failed to submit the information necessary to decide the claim, the Plan Administrator must provide notice to you of this 15-day extension and must describe the required information necessary to decide the claim. You will have at least 45 days from receipt of this notice to provide the requested information.

Failing to Follow the Plan's Procedures for Filing a Claim

If you fail to follow the Plan's procedures for filing a pre-service claim, the Plan Administrator must notify you as soon as possible, but not later than 5 days after the failure (24 hours if the failure involved an urgent care claim). This notification can be oral, unless you request that it be in writing.

Manner and Content of Notification of Benefit Determination

If the Plan Administrator or its designee denies your claim for benefits, the Plan Administrator or its designee shall provide you with a written or electronic notification of this determination. This notification will:

1. State the specific reason(s) for the adverse determination;
2. Refer to the specific Plan provisions on which the determination is based;
3. Describe any additional material or information you need to perfect your claim and an explanation of why such material or information is necessary;
4. Describe the Plan's review procedures and the time limits applicable to such procedures, including a statement regarding your right to bring a civil action under Section 502(a) of the Employee Retirement Income Security Act of 1974 ("ERISA") following an adverse benefit determination on review;

5. Note that if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criteria will be provided to you, or provide a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to you upon your request;
6. Note that if the adverse benefit determination is based on a medical necessity, Experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances will be provided to you, or a statement that such an explanation will be provided to you free of charge upon request; and
7. If the adverse benefit determination concerns an urgent care claim, the notice will provide a description of the expedited review process for urgent claims.

Appeal of Adverse Benefit Determinations

If the Plan Administrator or its designee issued an adverse benefit determination against you, you have a right to appeal the adverse benefit determination to the named Fiduciary of the Plan.

The Plan provides for one level of appeal that must be completed before you will be considered to have exhausted your remedies under the Plan. The appeal is made to MercyCare, for medical and pharmacy benefits under the Plan.

Urgent Care appeals of claim determinations can be made in writing to the address listed above or, during MercyCare's normal business hours, by fax or telephone at the numbers listed above.

This review will:

1. Provide you the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits;
2. Provide that you shall be provided, upon request and free of charge, reasonable access to, or any copies of, all documents, records, and other information relevant to your claim for benefits;
3. Take into account all comments, documents, records, and other information submitted by you relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination;
4. Provide that you have at least 60 days following receipt of a notification of the initial adverse benefit determination to appeal the initial adverse determination;
5. Not afford deference to the initial adverse benefit determination and provide that the review will be conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;
6. Provide that, in deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is Experimental, Investigational, or not Medically Necessary or appropriate, an appropriate named fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment;
7. Identify the medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination;
8. Provide that the health care professional who provides consulting services shall be an individual who is neither an individual who was consulted in connection with the adverse benefit determination nor the subordinate of any such individual;

9. Provide, in the case of an urgent care claim, for an expedited review process pursuant to which:
   a) A request for an expedited appeal of an adverse benefit determination may be submitted orally or in writing by you; and,
   b) All necessary information, including the Plan's benefit determination on review, shall be transmitted between the Plan and you by telephone, facsimile, or other available similarly expeditious method.

Timing of Notification of Benefit Determination on Review

If you appeal an adverse benefit determination, MercyCare, or the Committee, as applicable, must respond to your appeal within certain time limits.

1. Urgent Care Claims. In the case of an urgent care claim, MercyCare, or the Committee, as applicable, shall notify you of the Plan's benefit determination on review as soon as possible, taking into account the medical exigencies, but not later than 72 hours after the Plan receives your request for review of an adverse benefit determination.
2. Pre-Service Claims. For pre-service claims, MercyCare, or the Committee, as applicable, shall notify you of the decision within a reasonable period of time appropriate to the medical circumstances. Because the Plan provides for two appeals of an adverse benefit determination this notification will be provided not later than 15 days after the Plan receives your request for review of an adverse benefit determination.
3. Post-Service Claims. For post-service claims, MercyCare, or the Committee, as applicable, will notify you of the decision within a reasonable period of time. Because the Plan provides for two appeals of an adverse benefit determination this notification will be provided not later than 30 days after the Plan receives your request for review of an adverse benefit determination.

Manner and Content of Notification of Benefit Determination on Review

MercyCare, or the Committee, as applicable, will provide you with written or electronic notification of the Plan's benefit determination and review. An adverse benefit determination will:

1. State the specific reason(s) for the adverse determination;
2. Refer to the specific Plan provisions on which the benefit determination is based;
3. Provide a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits;
4. Provide a statement describing any voluntary appeal procedures offered by the Plan and your right to obtain the information about such procedures;
5. Provide a statement of your right to bring an action under Section 502(a) of ERISA;
6. Note that if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criteria will be provided to you, or provide a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to you upon your request;
7. Note that if the adverse benefit determination is based on a medical necessity, Experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances will be provided to you, or a statement that such an explanation will be provided to you free of charge upon request; and
8. Provide the following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

Claims and Appeals Authority

The appeal will be determined by MercyCare, as a named fiduciary of the Plan.

The Plan Administrator has the complete and sole discretionary authority to determine all questions arising in connection with the administration, interpretation, and application of the Plan (and any related documents and underlying policies). Any such determination by the Plan Administrator shall be conclusive and binding upon all persons.

If any time limitation stated in this section is less than that required by law, the limitation is extended to agree with the minimum period permitted by law.

The Plan will not be liable for any benefits after the date the Plan has terminated.

Procedural Requirements

Only a Covered Person, or a person or entity who has received written assignment of a Covered Person's right to coverage or reimbursement under the Plan will have standing to appeal benefit determinations by the Plan Administrator. No action may be brought against the Plan, the Employer, the Plan Administrator, or any other entity to whom insurance, administrative or claims processing functions have been delegated until the Covered Person or other entity seeking payment of a claim first fully follows the above claims procedures (and appeals procedures) and receives a final determination from the Plan Administrator or its delegate. If a Covered Person or other entity elects to challenge the Plan Administrator's final determination its exclusive means of doing so is by commencing a legal action under the Employee Retirement Income Security Act of 1974 (ERISA). These procedures for appealing benefit determinations are the exclusive means for addressing such issues.

Absolute Limitation Period Following Plan Administrator's Determination

If a Covered Person or any other individual or entity elects to challenge the Plan Administrator's final determination in any forum, including judicial or administrative proceedings, the action must be filed within one year following the day the Plan Administrator (or its delegate) makes its final determination on the claim. A determination is considered a final determination as of the earlier of the date the Plan Administrator (or its delegate) issues its determination of appeal or the last date an appeal can be timely filed pursuant to the terms of these Claims and Appeals Procedures.

The limitations and requirements of this Claims and Appeals Procedures section apply to any former Covered Person (or a person or entity who has received written assignment of a former Covered Person's right to coverage or reimbursement under the Plan) seeking coverage or reimbursement under the Plan.

Right to External Review

Following completion of the internal appeals process, you may be eligible to submit a request for external review, which will be conducted by an independent physician external review group. Your request for external review will have no effect on other benefits available under your plan. If you wish to pursue an external review, please send a written request to the following address: Complaint Coordinator; PO Box 550, Janesville, WI 53547-0550.

Your written request should include: 1) your specific request for an external review; 2) the employee's name, address, and member ID number; 3) your designated representative's name and address, when applicable; 4) the service that was denied; and 5) any new, relevant information that was not provided during the internal appeal. Your written request must be received by UMR within four (4) months after the date you receive this notice. You will be provided more information about the external review process at the time we receive your request.

GENERAL INFORMATION

Administration of the Plan

The Plan Administrator administers the Plan. This plan is Self-administered, meaning that Mercy Health Corporation is the Plan Administrator. The Plan is a legal entity and legal service of process directed to the Plan may be filed with the company identified in the Plan Information section as the Agent for Service of Legal Process.

Annual Enrollment Requirements

Every Partner must re-enroll for this Plan's benefits for the following year during Annual Enrollment, generally held each year in October/November. Failure to enroll during the Annual Enrollment will result in denial of coverage for the following year.

Calculation of Plan Maximum Amounts

Amounts paid by the Plan shall be used in calculating any Plan Maximum amounts under the Plan.

Clerical Error

Clerical error on the part of the Plan Administrator or third party administrator will not invalidate or extend coverage otherwise in force, nor continue coverage otherwise terminated. Upon the discovery of a clerical error, an equitable adjustment may be made as determined by the Third Party Administrator. The Covered Person agrees to reimburse the Plan for any payment made to or for the Covered Person in error.

Cost Sharing Provisions

Typically, these terms are used in the “Schedule of Benefits” section of the Plan. The Plan may use one or more of these terms.

“Deductible” is defined in the “Glossary” section of the Plan.

“Co-insurance” is defined in the “Glossary” section of the Plan.

“Co-payment” is defined in the “Glossary” section of the Plan.

Other Charges Not Covered by the Plan. The Covered Person will also be responsible to pay for charges that the Plan will not cover such as those that exceed the Usual and Customary amount covered by the Plan for a service or supply, charges for amounts that relate to services or supplies that are not covered by the Plan and charges for amounts that exceed the Plan’s Benefit Maximums.

Co-insurance and Co-Payment Non-Billing Forgiveness

Expenses for which the Covered Person is not obligated to pay by a provider shall not count towards the applicable Co-insurance percentages, Deductible or Out-of-Pocket Limits.

Documentation Required by the Plan

The Plan requires specific documentation when first enrolling in the Plan and when making certain changes to your coverage. The Plan also conducts periodic audits to verify dependent eligibility that may require additional documentation. Failure to submit required documentation within the time-frame requested by the Plan will result in a loss of the Dependent’s eligibility beginning on the date the Dependent would otherwise have started coverage. The Partner’s next opportunity to enroll the Dependent is during the next Annual Enrollment (unless the Dependent again becomes eligible before the next Annual Enrollment due to a Qualifying Life Event.)

Depending on your unique situation, the documentation required includes, but is not limited to:

- Marriage Certificate

- Divorce Decree
- Birth Certificate
- Social Security Number of Partner and all Dependents (including spouse)
- Qualified Medical Child Support Order
- Certificate of Adoption
- Letter of Guardianship
- Student Status Verification
- Stepchild Verification
- Overage Disabled Dependent Verification
- Copy of most recent Federal Tax Form (to validate at least 50% support of a dependent or to determine eligibility for the Premium Subsidy Program)
- Verification from spouse's employer of loss of coverage
- Verification from Partner that spouse is not employed and therefore has no available medical coverage
- Verification from spouse's employer that employer does not offer medical benefits or that spouse is not eligible for medical benefits

Duplication of Benefits

If any eligible charge is described as covered under two or more provisions within this Plan, the Plan will provide benefits based on the greater benefit. Only one benefit will be provided per covered expense.

Financing and Administration

No insurance company, insurance service, HMO or other state licensed entity is responsible for the financing or administration of the Plan. Benefits under the Plan are not guaranteed by a policy of insurance.

Master Plan Document

The Master Plan Document, including all its schedules, provisions, exclusions, limitations, appendices and any amendments contained thereto, constitutes the entire Plan.

New Drugs, Medical Tests, Devices and Procedures

The Plan does not distinguish between "new" drugs or pharmaceuticals, medical tests, devices and procedures and existing drugs or pharmaceuticals, medical tests, devices and procedures when determining whether the drugs or pharmaceuticals, medical tests, devices and procedures are covered. New and existing drugs or pharmaceuticals, medical tests, devices and procedures are covered as specified in the Schedule of Benefits or other medical services sections of the Plan, provided they are not excluded by any provision of the Plan.

Newborns' and Mothers' Health Protection Act Notice

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). Maternity stays exceeding either the 48 hour or 96 hour period, require pre-notification through QHM or benefits may not be payable for the remainder of the Hospital stay.

Payments Made Prior To Determining Final Liability

The Covered Person shall reimburse the Plan for any payments made by the Plan which are subsequently determined by the Plan to be in excess of the amount required to be paid by the terms of the Plan.

Physical Examination

The Plan at its expense shall have the right and opportunity to have the Covered Person examined for evaluation and verification of an Illness or Injury as often as it may be required during the pending of a claim.

Plan Amendment or Termination

While the Plan Sponsor expects and intends in good faith to continue the Plan for an indefinite period of time, it reserves the right to amend, modify or terminate the Plan, in whole or in part, at any time. Such amendment or termination of the Plan shall be performed in writing and executed by an officer or other authorized individual of the Plan Sponsor.

In the event the Plan is terminated, any covered expenses which have been incurred prior to the date of termination will be payable in accordance with the terms and conditions of the Plan. Plan assets will be allocated first to the payment of claims, and thereafter in a manner that is for the exclusive benefit of the participants, except that any taxes and administration expenses may be paid from Plan assets.

Plan Interpretation

The Plan Administrator shall have full and discretionary authority to interpret and apply and construe all the Plan provisions, including, but not limited to, all factual issues and all issues concerning eligibility for and determination of benefits. Benefits under this Plan will be paid only if the Plan Administrator (or its delegate) decides in its full and absolute discretion that the applicant is entitled to such benefits.

Plan Is Not A Contract

The Plan shall not be deemed or constitute a contract between Mercy Health Corporation and any Partners or other persons or to be a consideration for, or an inducement or condition of, the employment of any Partner. Nothing in the Plan shall be deemed to give any Partner the right to be retained in the service of Mercy Health Corporation, or to interfere with or abridge the right of, Mercy Health Corporation to discharge any Partner at any time.

Plan Maximums and Benefit Maximums

“Plan Maximums” generally means the total amount the Plan will pay for any Covered Person while he or she is a participant in the Plan, regardless of whether such coverage is continuous. (See the Schedule of Benefits section of the Plan for additional information.)

“Benefit Maximums” generally means the Plan limits an amount payable by the Plan for a service or supply. The limitation may be based, for example, on the number of services provided while the person is covered by the Plan or it may be determined on a periodic basis such as a set period of time or per occurrence of an Illness or Injury. These limitations may also be expressed in other terms, for example, a number of days, visits or Confinements. (See the Schedule of Benefits section of the Plan for additional information.)

Preventive Services

The Plan provides information on coverage provided or excluded by the Plan for preventive health benefits or wellness benefits. This information is located in the Schedule of Benefits, Medical Benefits or Limitations and Exclusions sections of the Plan. As is the case with all benefits of the Plan, these

services are subject to all the provisions of the Plan including but not limited to, the limitation that such services not be “Experimental or Investigational”.

Rescission of Coverage

The Plan has the right to retroactively terminate coverage if a Partner or Covered Person performs an act, practice or omission that constitutes fraud, or if such individual makes an intentional misrepresentation of material fact. If such a rescission of coverage will occur, we will provide at least 30 days written notice. To rescind means to cancel coverage effective on the date coverage was granted in reliance on the material misrepresentation. A misrepresentation of material fact is an untrue statement which leads the Plan to cover the Partner or a Covered Person or cover a medical condition of the Partner or a Covered Person when it would not have done so if it had known the truth.

Subrogation and Reimbursement

The Plan has a right to subrogation and reimbursement.

Subrogation applies when we have paid Benefits on your behalf for a Sickness or Injury for which a third party is considered responsible. The right to subrogation means that we are substituted to and shall succeed to any and all legal claims that you may be entitled to pursue against any third party for the Benefits that we have paid that are related to the Sickness or Injury for which a third party is considered responsible.

The right to reimbursement means that if it is alleged that a third party caused or is responsible for a Sickness or Injury for which you receive a settlement, judgment, or other recovery from any third party, you must use those proceeds to fully return to us 100% of any Benefits you received for that Sickness or Injury.

The following persons and entities are considered third parties:

- A person or entity alleged to have caused you to suffer a Sickness, Injury or damages, or who is legally responsible for the Sickness, Injury or damages.
- Any insurer or other indemnifier of any person or entity alleged to have caused or who caused the Sickness, Injury or damages.
- The Plan Sponsor in a workers’ compensation case or other matter alleging liability.
- Any person or entity who is or may be obligated to provide benefits or payments to you, including benefits or payments for underinsured or uninsured motorist protection, no-fault or traditional auto insurance, medical payment coverage (auto, homeowners or otherwise), workers' compensation coverage, other insurance carriers or third party administrators.
- Any person or entity that is liable for payment to you on any equitable or legal liability theory.

You agree as follows:

- You will cooperate with us in protecting our legal and equitable rights to subrogation and reimbursement in a timely manner, including, but not limited to:
    - Notifying us, in writing, of any potential legal claim(s) you may have against any third party for acts which caused Benefits to be paid or become payable.
    - Providing any relevant information requested by us.
    - Signing and/or delivering such documents as we or our agents reasonably request to secure the subrogation and reimbursement claim.
    - Responding to requests for information about any accident or injuries.
    - Making court appearances.

- Obtaining our consent or our agents' consent before releasing any party from liability or payment of medical expenses.
- Complying with the terms of this section.

Your failure to cooperate with us is considered a breach of contract. As such, we have the right to terminate your Benefits, deny future Benefits, take legal action against you, and/or set off from any future Benefits the value of Benefits we have paid relating to any Sickness or Injury alleged to have been caused or caused by any third party to the extent not recovered by the Plan due to you or your representative not cooperating with us. If we incur attorneys' fees and costs in order to collect third party settlement funds held by you or your representative, we have the right to recover those fees and costs from you. You will also be required to pay interest on any amounts you hold which should have been returned to the Plan.

- We have a first priority right to receive payment on any claim against a third party before you receive payment from that third party. Further, our first priority right to payment is superior to any and all claims, debts or liens asserted by any medical providers, including but not limited to hospitals or emergency treatment facilities, that assert a right to payment from funds payable from or recovered from an allegedly responsible third party and/or insurance carrier.
- The Plan's subrogation and reimbursement rights apply to full and partial settlements, judgments, or other recoveries paid or payable to you or your representative, no matter how those proceeds are captioned or characterized. Payments include, but are not limited to, economic, non-economic, and punitive damages. The Plan is not required to help you to pursue your claim for damages or personal injuries and no amount of associated costs, including attorneys' fees, shall be deducted from our recovery without the Plan's express written consent. No so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall defeat this right.
- Regardless of whether you have been fully compensated or made whole, we may collect from you the proceeds of any full or partial recovery that you or your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, no matter how those proceeds are captioned or characterized. Proceeds from which we may collect include, but are not limited to, economic, non-economic, and punitive damages. No "collateral source" rule, any "Made-Whole Doctrine" or "Make-Whole Doctrine," claim of unjust enrichment, nor any other equitable limitation shall limit our subrogation and reimbursement rights.
- Benefits paid by us may also be considered to be benefits advanced.
- 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 and owed 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.
- The Plan's rights to recovery will not be reduced due to your own negligence.
- Upon our request, you will assign to us all rights of recovery against third parties, to the extent of the Benefits we have paid for the Sickness or Injury.
- We may, at our option, take necessary and appropriate action to preserve our rights under these provisions, including but not limited to, providing or exchanging medical payment information with an insurer, the insurer's legal representative or other third party; filing an ERISA reimbursement lawsuit to recover the full amount of medical benefits paid on your behalf out of any settlement, judgment or other recovery from any third party considered responsible; and filing suit in your name, which does not obligate us in any way to pay you part of any recovery we might obtain. Any ERISA reimbursement lawsuit stemming from a refusal to refund benefits as required under the terms of the Plan is governed by a six-year statute of limitations.
- You may not accept any settlement that does not fully reimburse the Plan, without its written approval.

- We have the authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.
- In the case of your wrongful death or survival claim, the provisions of this section apply to your estate, the personal representative of your estate, and your heirs or beneficiaries.
- No allocation of damages, settlement funds or any other recovery, by you, your estate, the personal representative of your estate, your heirs, your beneficiaries or any other person or party, shall be valid if it does not reimburse the Plan for 100% of its interest unless the Plan provides written consent to the allocation.
- The provisions of this section apply to the parents, guardian, or other representative of a Dependent child who incurs a Sickness or Injury caused by a third party. If a parent or guardian may bring a claim for damages arising out of a minor's Sickness or Injury, the terms of this subrogation and reimbursement clause shall apply to that claim.
- If a third party causes or is alleged to have caused you to suffer a Sickness or Injury while you are covered under this Plan, the provisions of this section continue to apply, even after you are no longer covered.
- The Plan and all Administrators administering the terms and conditions of the Plan's subrogation and reimbursement rights have such powers and duties as are necessary to discharge its duties and functions, including the exercise of its discretionary authority to (1) construe and enforce the terms of the Plan's subrogation and reimbursement rights and (2) make determinations with respect to the subrogation amounts and reimbursements owed to the Plan.

Rights With Respect To Medicaid

Payment of benefits with respect to a Covered Person under the Plan will be made in accordance with any assignment of rights made by, or on behalf of, such Covered Person as required by a State plan for medical assistance approved under title XIX of the Social Security Act pursuant to section 1912(a)(1)(A) of such Act (as in effect on the date of the enactment of the Omnibus Budget Reconciliation Act of 1993).

In enrolling an individual as a Covered Person in the Plan or in determining or making any payments for benefits of an individual as a Covered Person, the fact that the individual is eligible for or is provided medical assistance under a State plan for medical assistance approved under title XIX of the Social Security Act will not be taken into account.

To the extent that payment has been made under a State plan for medical assistance approved under title XIX of the Social Security Act for supplies, services or treatments for a Covered Person in those situations where the Plan has a legal liability to make such payment, the Plan will make payment for such benefits in accordance with any State laws which provide that the State has acquired the rights of a Covered Person for payment for such supplies, services or treatments.

Selection of Providers

Generally, the Co-insurance amount paid by the Plan is greater when services are paid at the In-Network tier of Benefits and depending upon the Tier of the Provider. Generally, the Co-payment amount paid by the Covered Person is less when services are paid at the In-Network tier of Benefits and depending upon the Tier of the Provider.

Self-funding

This is a self-funded Plan which means claims are paid directly by the Plan Administrator from its assets. The Plan Administrator will ensure accurate, impartial and timely payment of benefits to, and on behalf of, covered Partners and their covered Dependents.

Unclaimed Property

If any payment or other benefit to which an individual is entitled under this Plan is unclaimed for 6 months or otherwise not subject to payment to the person or persons so entitled, such amounts representing such payment or payments shall be retained by the Plan and shall not escheat to any state or revert to any party, but may be used for the exclusive benefit of the Plan's participants. Such forfeitures shall be subject to reinstatement upon the request of the individual who was entitled to the benefit.

Usual and Customary Procedure

The Plan Administrator will only treat as an eligible expense the amount which is usually and customarily charged for that type of service. The amount in excess of the Usual and Customary fee may be pended for additional information. The Partner will be notified on the Explanation of Benefits or by letter that the Plan Administrator is requesting additional information. The Plan Administrator will then contact the provider, which will give the provider the opportunity to supply the Plan Administrator with additional information which may explain the higher fee. This may include an operative report or medical records if signed authorization is received from the Partner. If after receiving the additional information, the higher amount cannot be justified, the Plan Administrator will outline the reasons for the denial.

Workers' Compensation

The Plan is not issued in lieu of, nor does it affect any requirement of coverage under any act or law which provides benefits for any Injury or Illness occurring during, or arising from, the Partner's course of employment. This Plan does not cover healthcare costs related to injuries on the job. Mercy Health Corporation partners with self-employed family members are advised to obtain workers compensation coverage of those members who are on their MercyCare plan.

HIPAA Privacy

Protected health information may be disclosed to an Employer only if:

1. the Employer certifies to the Plan that the Master Plan Document has been amended to incorporate this section on "HIPAA Privacy" and that the Employer agrees to abide by such section;
2. Employer will:
    a. not use or further disclose the information other than as permitted or required by the Master Plan Document or as required by law;
    b. ensure that any agents, including a subcontractor, to whom it provides protected health information received from the Plan agrees to the same restrictions and conditions that apply to Employer with respect to such information;
    c. not use or disclose the protected health information for employment-related actions and decisions or in connection with any other benefit or employer benefit plan of an Employer;
    d. report to the Plan any use or disclosure of the protected health information that is inconsistent with the uses or disclosures provided for under the HIPAA Privacy Regulations which it becomes aware of;
    e. make available protected health information in accordance with HIPAA Regulations Section 164.524;
    f. make available protected health information for amendment and incorporate any amendments to protected health information in accordance with HIPAA Regulations Section 164.526;
    g. make available the protected health information required to provide an accounting of disclosures in accordance with HIPAA regulations Section 164.528;
    h. make its internal practices, books, and records relating to the use and disclosure of protected health information received from the Plan available to the Department of Health

and Human Services ("HHS") for purposes of determining the compliance by the Plan with the HIPAA Privacy Regulations;

i. if feasible, return or destroy all protected health information received from the Plan that the Employer still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible;

j. permit only those Partners of the Employer who assist with Plan administration (including but not limited to, the Human Resources department and to the extent necessary, Information Systems, appeals committees) to access protected health information. Plan administration includes any type of payment or health care operation of the Plan, or other matters pertaining to the Plan in the ordinary course of business and shall include, but not be limited to, reviewing of claims or appeals, assistance with questions from Partners and assistance with controlling Plan costs. Individuals not involved in such plan administration activities cannot receive protected health information pursuant to this subsection 2(j);

k. restrict the access to protected health information by, and the use of protected health information by, the Partners described in (j) above, to the plan administration functions that the Employer performs for the Plan, except as otherwise allowed by the HIPAA Privacy Regulations; and

l. resolve any issues on non-compliance with the HIPAA Privacy Regulations through intervention by an appropriate officer of the Employer; and

3. the Plan and any business associate servicing it will disclose protected health information to the Employer pursuant to this section:

   a. to permit the Employer to perform plan administration functions for the Plan;

   b. pursuant to a valid authorization under 45 C.F.R. Section 164.508; or

   c. as otherwise allowed under the HIPAA Privacy Regulations

PLAN INFORMATION

Plan Administrator and Named Fiduciary:
Mercy Health Corporation™

Employer Identification Number:
47-2158680

The Following Coverage is Included in this Plan:
Comprehensive Medical and Prescription Drug Benefits

Type of Administration:
Self-Funded Self-Administered Group Health Plan

Agent for Service of Legal Process:
c/o Mercy Health Corporation
3401 N Perryville Road, Suite 303
Rockford, IL 61114

Cost:
This Plan is financed through contributions made by covered Partners and Mercy Health Corporation and its affiliates.

Financial Records:
The financial records of the Plan are kept on a Plan Year basis ending on each December 31.

STATEMENT OF ERISA RIGHTS

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

- Examine, without charge, at the Plan administrator's office, and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Plan administrator is required by law to furnish each participant with a copy of this summary annual report.
- Continue health care coverage for yourself, spouse or Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing your COBRA Continuation Coverage rights.
- Reduction or elimination of exclusionary periods of coverage for pre-existing conditions under your group health plan, if you have Creditable Coverage from another plan. You should be provided a certificate of Creditable Coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA continuation Coverage, when you COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of Creditable Coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for Late Enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your Employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied in whole or in part you must receive a written explanation of the reason for the denial. You have the right to have the Plan review and reconsider your claim. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If, after you have applied for benefits under the claims procedures and the appeals procedures required under the Plan, you still have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

STATEMENT OF ERISA RIGHTS

If you have any questions about your Plan, you should contact the Plan administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, DC 20210.

Legal Effect of ERISA Rights Section on the Plan

The ERISA Rights statement is required to be included in the summary plan description by operation of law. However, nothing in the ERISA Rights statement may be read to modify your rights and responsibilities under this Plan, except as required by law.

GLOSSARY

ACTIVE STATUS
Active status means performing your job on a regular, full-time basis as defined in the group application On your first day of coverage, you are deemed to be in active status even if you were absent from work (a) on a regular paid vacation or any regular non-working holiday. if you were in an active status on your last regular working day, or (b) due to a health factor.

ACUTE ILLNESS/INJURY
Illness or injuries that are of rapid onset with an expected short-term duration.

Adverse benefit determination
An adverse benefit determination includes any of the following:

(i) denial, reduction or termination of, or failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a your eligibility to participate in a plan, including resulting from the application of any utilization review,
(ii) the 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,
(iii) any rescission, including any cancellation or discontinuance of coverage that has a retroactive effect, or
(iv) any decision to deny coverage in an initial eligibility determination.

AUTISM SPECTRUM DISORDER
Autism spectrum disorder means autism disorder, Asperger's syndrome, or pervasive developmental disorder not otherwise specified.

BODILY INJURY
Bodily injury means an injury resulting from an accident, independent of all other causes.

CHANGE OF STATUS FORM
Change of Status Form means 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 MercyCare and are available from Human Resources.

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

CLAIM
Claim means a demand for payment due in exchange for health care services rendered. Definition of Claim does not include an inquiry about the availability of benefits.

COINSURANCE
Coinsurance means the member's portion, expressed as a percentage of the fee for covered services that you are required to pay for certain covered services provided under the policy.

CONFINEMENT/CONFINED

Confinement or confined means (a) the period of time between admission as an inpatient or outpatient to a hospital, alcohol and other drug abuse (AODA) or mental health residential treatment center, qualified treatment facility, skilled nursing facility or licensed ambulatory surgical center, and discharge therefrom; or (b) 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
Congenital means a condition that exists at birth but is not hereditary.

COPAYMENT
Copayment means the member's portion, expressed as a fixed dollar amount, that you are required to pay for certain covered services provided under this policy.

COVERED PERSON
Covered person means a person meeting the eligibility requirements for coverage as specified in the Plan, who has satisfied any applicable waiting periods and who is properly enrolled in the Plan.

COVERED SERVICE
Covered service means a service or supply specified in this SPD and the Schedule of Benefits for which benefits will be provided.

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

DEDUCTIBLE
Deductible means 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 year, and the family deductible amount is the most that the employee and his or her dependents must pay each contract year.

DEVELOPMENTAL DISABILITY
Developmental disability means mental retardation or a related condition such as cerebral palsy, epilepsy or autism, but excluding mental illness and infirmities of aging, which is:

a) Manifested before the individual reaches age 22,
b) Likely to continue indefinitely, and
c) Results in substantial functional limitations in 3 or more of the following areas of major life activity:

1. Self-care.
2. Understanding and use of language.
3. Learning.
4. Mobility.
5. Self-direction.
6. Capacity for independent living.
7. Economic self-sufficiency.

DRUG FORMULARY

MercyCare Drug Formulary means the comprehensive listing of prescription medications available to you as a member.

EFFICACIOUS TREATMENT OR STRATEGY
Efficacious treatment means treatment or strategies designed to address cognitive, social or behavioral conditions associated with autism spectrum disorders; to sustain and maximize gains made during intensive-level services; or to improve the condition of an individual with autism spectrum disorder.

EMERGENCY
Emergency means a medical condition that manifests itself by acute symptoms of sufficient severity, including severe pain, to lead a prudent layperson with an average knowledge of health and medicine reasonably to conclude that, a lack of immediate medical attention will likely result in death or serious injury to your body.

EMPLOYEE / PARTNER
Employee means an individual whose employment or other status, except for family dependency, is the basis for eligibility for enrollment under the policy.

ENROLLMENT FORM
Enrollment form means the form completed by a potential member requesting coverage from Mercy Health Corporation and listing all dependents to be covered on the effective date of coverage.

EVIDENCE-BASED THERAPY
Evidence-based therapy means therapy that is based upon medical and scientific evidence; is determined to be an efficacious treatment or strategy; has been approved by the federal food and drug administration (FDA), if the treatment is subject to the approval of the FDA; and medically and scientifically accepted evidence clearly demonstrates that the treatment is proven safe.

EXPERIMENTAL/INVESTIGATIVE
Experimental or investigative means the use of any service, treatment, procedure, facility, equipment, drug, devices or supply for a member's bodily injury or sickness that:

a) Requires the approval by the appropriate federal or other governmental agency that has not been granted at the time it is used; or
b) 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:

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

FREE-STANDING SURGICAL FACILITY
Free-standing surgical facility means 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 generic equivalent means 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

Genetic counseling means 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 genetic test is 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.

HOSPITAL

Hospital means an institution that:

1. a) Is licensed and run according to Wisconsin laws, or other applicable jurisdictions, that apply to hospitals;

b) Maintains at its location all the facilities needed to provide diagnosis of, and medical and surgical care for, bodily injury or sickness;

c) Provides this care for fees;

d) Provides such care on an inpatient basis; and

e) Provides continuous 24-hour nursing services by registered graduate nurses; or

2. a) Qualifies as a psychiatric or tuberculosis hospital.

b) Is a Medicare provider; and

c) Is accredited as a hospital by the Joint Commission on Accreditation of Healthcare Organizations.

Hospital does not mean an institution that is chiefly:

a) A place for treatment of chemical dependency;

b) A nursing home; or

c) A federal hospital.

IDENTIFICATION CARD

Identification card means the card that MercyCare issues to you that indicates your eligibility to receive covered services from participating providers.

INFERTILITY

Infertility means 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.

INTENSIVE-LEVEL SERVICES

Intensive-level services means 1) evidence-based behavioral therapy that is designed to help an individual with autism spectrum disorder overcome the cognitive, social, and behavioral deficits associated with that disorder, and 2) therapies that are directly based on, and related to, a member's therapeutic goals and skills as prescribed by a physician familiar with the member.

LEARNING DISABILITY
Learning Disability means 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.

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

MEDICALLY NECESSARY
Medically necessary means a service, treatment, procedure, equipment, drug, device, or supply provided by a hospital, physician, or other provider of health care that is required to identify or treat a member's bodily injury or sickness and which is determined by MercyCare to be:

1. Consistent with the symptom(s) or diagnosis and treatment of the member's bodily injury or sickness;
2. Appropriate under the standards of acceptable medical practice to treat that bodily injury or sickness;
3. Not solely for the convenience of the member, physician, hospital or other provider of health care;
4. The most appropriate service, treatment, procedure, equipment, drug, device or supply which can be safely provided to the member;
5. The most economical manner of accomplishing the desired end result.

MEDICAID
Medicaid means 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.

MEDICARE
Medicare means 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
Member means the employee/partner and his/her dependents who have been enrolled and are entitled to benefits under the plan.

NON-EXPERIMENTAL
Non-experimental means:

a) Any discrete and identifiable technology; regimen or modality regularly and customarily used to diagnose or treat bodily injury or sickness; and
b) For which there is conclusive, generally accepted evidence that such technology, regimen or modality is safe, efficient and effective as determined by MercyCare.

NON-INTENSIVE LEVEL SERVICES

Non-intensive level services means evidence-based therapy that occurs after the completion of treatment with intensive level services and that is designed to sustain and maximize gains made during treatment with intensive level services, or, for an individual who has not and will not receive intensive level services, evidence-based therapy that will improve the individual's condition.

NON-PARTICIPATING PHARMACY
Non-participating pharmacy means any pharmacy that does not have a contractual relationship with MercyCare for the provision of pharmacy services or supplies to members.

NON-PARTICIPATING PROVIDER
Non-participating provider means a provider not listed in the most current provider directory.

NON-PREFERRED DRUG
All drugs not on MercyCare's preferred drug list.

ORTHOTIC
Orthotic means an externally applied device used to modify the structural and functional characteristics of the neuromuscular and skeletal systems.

OTC (Over the Counter)
Over the counter (OTC) drugs on the preferred drug list are covered only with a prescription.

OUT-OF-POCKET MAXIMUM
The out-of-pocket maximum is the most you will pay in coinsurance for your covered services in a contract year. The out-of-pocket maximum may or may not include any deductibles that apply, depending on your Schedule of Benefits. The amount of the out-of-pocket maximum is shown in the Schedule of Benefits.

PARTICIPATING PHARMACY
Participating pharmacy means any pharmacy that has contracted with MercyCare to provide pharmacy services or supplies to members.

PARTICIPATING PROVIDER
Participating provider refers to any provider listed in the most current provider directory.

PARTNER
A Partner means an employee of Mercy Health Corporation who has met the eligibility requirements of the Plan.

PLAN
Plan means the group health plan, and iterations thereof, offered by Mercy Health Corporation as described in this SPD.

PREFERRED DRUG
Name brand, generic or OTC drugs in our preferred drug list as determined by MercyCare.

PRESCRIPTION DRUG
Prescription drug means any medicinal substance, the label of which, under the Federal Food, Drug and Cosmetic Act, is required to bear the legend: "Caution: Federal Law prohibits dispensing without prescription."

PRIMARY CARE PHYSICIAN

Primary care physician means a physician practicing in general practice, family medicine, internal medicine, or pediatrics that has accepted primary responsibility for the member's health care, OB/GYN, and a nurse practitioner or physician assistant working in the primary care setting.

You must name your primary care physician on your enrollment form or on a later physician change form.

Each family member may have a different primary care physician. A member's primary care physician:

- Provides entry into the plan'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 providers of health care when appropriate.

PRIOR AUTHORIZATION
Prior authorization means obtaining the Plan's approval before you receive a service or supply. Any prior authorization requirement will be stated in this SPD or in the Schedule of Benefits. To obtain prior authorization, contact MercyCare at the address on the first page of this SPD or at the telephone number printed on your identification card.

PROVIDER NETWORK
A provider network is a group of providers contracted with the Plan to provide services for members within a specific geographic location. The primary care physician you select directly determines the provider network with which you will be associated.

PROVIDERS OF HEALTH CARE
Providers of health care include:

a) Medical or osteopathic physicians, hospitals, and clinics.
b) Podiatrists, physical therapists, physician's assistants, psychologists, chiropractors, nurse practitioners, and dentists licensed by the State of Wisconsin, or other applicable jurisdiction to provide covered services.
c) Nurses licensed by the State of Wisconsin and certified as a nurse anesthetist to provide covered services.
d) Nurse midwives licensed by the State in which they practice to provide covered services.

QUALIFIED PARAPROFESSIONAL
Qualified paraprofessional means an individual working under the active supervision of a qualified supervising provider and who complies with all of the following:

1. Attains at least 18 years of age.
2. Obtains a high school diploma.
3. Completes a criminal background check.
4. Obtains at least 20 hours of training that includes subjects related to autism, evidence-based treatment methods, communication, teaching techniques, problem behavior issues, ethics, special topics, natural environment, and first aid.
5. Obtains at least 10 hours of training in the use of behavioral evidence-based therapy including the direct application of training techniques with an individual who has autism spectrum disorder present.
6. Receives regular, scheduled oversight by a qualified provider in implementing the treatment plan for the member.

QUALIFIED PROFESSIONAL

Qualified professional means an individual working under the supervision of an outpatient mental health clinic who is a licensed treatment professional as defined in s. DHS 35.03 (9g), and who has completed at least 2080 hours including all of the following:

1. 1500 hours supervised training involving direct 1:1 work with individuals with autism spectrum disorders using evidence-based, efficacious therapy models.
2. Supervised experience with all of the following:

    a. Working with families as part of a treatment team and ensuring treatment compliance.
    b. Treating individuals with autism spectrum disorders who function at a variety of cognitive levelss and exhibit a variety of skill deficits and strengths.
    c. Treating individuals with autism spectrum disorders with a variety of behavioral challenges.
    d. Treating individuals with autism spectrum disorders who have shown improvement to the average range in cognitive functioning, language ability, adaptive and social interaction skills.

3. Academic coursework from a regionally accredited higher education institution with demonstrated coursework in the application of evidence-based therapy models consistent with best practice and research on effectiveness for individuals with autism spectrum disorders.

QUALIFIED PROVIDER

Qualified provider means an individual acting within the scope of a currently valid state-issued license for psychiatry or psychology or a social worker licensed or certified to practice psychotherapy and who has completed at least 2080 hours that includes all of the following:

1. Fifteen hundred hours supervised training involving direct one on one work with individuals with autism spectrum disorders using evidence-based, efficacious therapy models.
2. Supervised experience with all of the following:

    a. Working with families as the primary provider and ensuring treatment compliance.
    b. Treating individuals with autism spectrum disorders who function at a variety of cognitive levelss and exhibit a variety of skill deficits and strengths.
    c. Treating individuals with autism spectrum disorders with a variety of behavioral challenges.
    d. Treating individuals with autism spectrum disorders who have shown improvement to the average range in cognitive functioning, language ability, adaptive and social interaction skills.
    e. Designing and implementing progressive treatment programs for individuals with autism spectrum disorders.

3. Academic coursework from a regionally accredited higher education institution with demonstrated coursework in the application of evidence-based therapy models consistent with best practice and research on effectiveness for individuals with autism spectrum disorders.

QUALIFIED SUPERVISING PROVIDER

Qualified supervising provider means a qualified provider that is a currently valid state-licensed psychiatrist, psychologist or a social worker licensed or certified as a psychotherapist and the qualified provider has completed at least 4160 hours of experience as a supervisor of less experienced providers, professionals and paraprofessionals.

QUALIFIED THERAPIST

Qualified therapist means a speech-language pathologist or occupational therapist acting within the scope of a currently valid state issued license and who has completed at least 1200 hours of training including all of the following:

1. Seven hundred fifty (750) hours supervised training involving direct 1:1 work with individuals, including pediatric individuals, with autism spectrum disorders using evidence-based, efficacious therapy models.
2. Supervised experience with all of the following:

    a. Working with families as the direct speech or occupational therapist and ensuring treatment compliance.
    b. Treating individuals with autism spectrum disorders who function at a variety of cognitive levelss and exhibit a variety of skill deficits and strengths.
    c. Treating individuals with autism spectrum disorders with a variety of behavioral challenges.
    d. Treating individuals with autism spectrum disorders who have shown improvement to the average range in language ability and adaptive and social interaction skills.

QUALIFIED TREATMENT FACILITY
Qualified treatment facility means a facility, institution, or clinic duly licensed to provide mental health or substance abuse treatment; primarily established for that purpose; and operating within the scope of its license.

RESIDENTIAL TREATMENT FACILITY
A licensed non-acute residential facility that cares for patients who have a mental illness and/or substance abuse dependency that provides 24 hour individualized treatment to a group of individuals and at a minimum provides admission by a Physician, has on-site licensed behavioral health providers who provide at a minimum: supervision 24 hours per day, clinical assessment at least once per day, individual and group therapy, and family support therapy.

REFERRAL
A referral is the process by which any service that requires prior authorization will be reviewed by MercyCare's Quality Health Management Department. Your doctor will complete a referral form, which will function as a request for authorization for any services that require prior authorization (for example, visits to a non-participating provider). This form is submitted to MercyCare, where the Quality Health Management Department will determine whether or not the requested services will be approved. See page 2 for referral process requirements.

ROUTINE OR PREVENTIVE
Routine or preventive care means 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.

SCHEDULE OF BENEFITS
Schedule of Benefits means a summary of coverage and limitations provided under the policy.

SKILLED CARE
Skilled care means medical services that are ordered by a participating provider and given by or under the direct supervision of a registered nurse, licensed practical nurse, licensed physical, occupational or speech therapist. Skilled care is usually necessary for only a limited period of time. It does not include maintenance or long term care. Daily care such as assistance with getting out of bed, bathing, dressing, eating, maintenance of bowel and bladder function, preparing special diets, assisting patients with taking their medicines, or 24 hour supervision for potentially unsafe behavior, do not require skilled care and are considered custodial care.

SKILLED NURSING FACILITY

Skilled nursing facility means an institution, which is licensed by the State of Wisconsin, or other applicable jurisdiction.

SOUND AND NATURAL TEETH
Sound and natural teeth means 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.

SPECIALIST
A specialist is any practitioner who is not a primary care physician as defined in this glossary.

TOTAL DISABILITY OR TOTALLY DISABLED
Total disability or totally disabled means, for an employee or his or her employed covered spouse, that the person is at all times prevented from engaging in any job or occupation for wage or profit for which he or she is reasonably qualified by education, training, or experience. For a covered spouse who is not employed and a covered dependent child, total disability means a disability preventing the person from engaging in substantially all of the usual and customary activities of a person in good health and of the same age and sex.

Total disability will be determined based upon the medical opinion of MercyCare's Medical Director and other appropriate sources.

UNPROTECTED SEXUAL INTERCOURSE
Unprotected Sexual Intercourse means 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
Urgent care is care for an accident or illness 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.

USUAL AND CUSTOMARY CHARGE
Usual and customary charge is the greater of: (1) the dollar amount for a treatment, service, or supply provided by a health care provider that is reasonable, as determined by the Plan, when taking into consideration among other factors, determined by MercyCare, amounts charged by health care providers for similar treatment, services, and supplies when provided in the same geographic area under similar or comparable circumstances; (2) the participating provider reimbursement amount as defined by applicable law, or (3) the Medicare reimbursement amount as defined by applicable law.

WE
We means MercyCare.

YOU/YOUR
You/your means any member enrolled in the Plan

Appendix A - EPO SCHEDULE OF BENEFITS

See separate document titled “Appendix A – EPO Schedule of Benefits”

Appendix B - EPO/HDHP SCHEDULE OF BENEFITS

See separate document titled “Appendix B – EPO/HDHP Schedule of Benefits”

Appendix C - MERCYCARE PPO SCHEDULE OF BENEFITS

See separate document titled “Appendix C – MercyCare PPO Schedule of Benefits”

Appendix D - PPO HDHP SCHEDULE OF BENEFITS

See separate document titled “Appendix D – PPO HDHP Schedule of Benefits”