CERTIFICATE OF COVERAGE
ILLINOIS

MercyCare Large Group HSA Plan
a product of MercyCare HMO, Inc.
P.O. Box 550
Janesville, Wisconsin 53547-0550

PLAN TYPE:

GROUP NUMBER:

EMPLOYER:

EMPLOYEE:

CERTIFICATE NUMBER:

EFFECTIVE DATE:

MercyCare HMO, Inc. (referred to in this Certificate of Coverage as "MercyCare") has issued and delivered a Policy to Your Group, a copy of which is available for Your review at Your Group's office, to provide You with a health care benefit program. The Policy is guaranteed renewable except as stated in the Policy's termination provisions.

This is Your Certificate as long as you are eligible for insurance and You become and remain insured. This certificate explains the terms and conditions of Your insurance coverage. Read this Certificate carefully. If You have questions, contact Your Group's Insurance Administrator or MercyCare at the address shown above. This Certificate replaces any previous Certificates of Coverage that You may have been issued. This Certificate is incorporated into and forms a part of the Policy issued to Your Group. However, if the terms of this Certificate differ from the terms of the Policy, the Policy will govern.

Your name, as an Employee insured under the Policy, and the names of Your dependents who are also insured under the Policy, are as set forth in the Enrollment Form which You completed and which is made part of the Policy.

The Group Contract, the Certificate of Coverage, the Schedule of Benefits, and any addenda or endorsements thereto, and the applications of the Group and the Employee, constitute the entire Policy. No change in the Policy shall be valid until approved by an executive officer of MercyCare and unless such approval be endorsed hereon or attached hereto. No agent has authority to change the Policy or to waive any of its provisions.

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

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INTRODUCTION

UNDERSTANDING THIS CERTIFICATE

What You should know about this Certificate:

It is important that You understand all parts of this Certificate in order to get the most out of the coverage that You have. Some of the terms that are used in this Certificate have specific meanings. These terms and their meanings can be found in the Glossary section of this Certificate.

How this Certificate is organized:

This Certificate outlines the coverage that You have under the employer Group contract that We have with Your employer. This Certificate of Coverage is divided into the following sections:

- Introduction
- Obtaining Services
- Emergency and Urgent Care
- Benefit Provisions
- Coverage Information
- General Provisions
- Coordination of Benefits
- Claim Provisions
- Consent to Release Information
- Complaint Procedures
- Glossary
- Index

INTERPRETING THIS CERTIFICATE

MercyCare HMO, Inc. has the authority to interpret this Certificate of Coverage and all questions that arise under it. If any benefit in this Certificate of Coverage is subject to a determination of medical necessity, we will make that factual determination.

ABOUT HSA PLANS

A Health Savings Account (HSA) is an alternative to traditional health insurance; it is a savings product that offers a different way for consumers to pay for their health care. HSAs enable you to pay for current health expenses and save for future qualified medical and retiree health expenses on a federally tax-free basis (state taxes may apply).

You must be covered by a High-Deductible Health Plan (HDHP) to be able to take advantage of HSAs. This MercyCare plan is an HDHP.

You own and you control the money in your HSA. Decisions on how to spend the money are made by you without relying on a third party or MercyCare. You will also decide what types of investments to make with the money in the account in order to make it grow.

WHO IS ELIGIBLE FOR AN HSA?

To be eligible for a Health Savings Account, an individual must be covered by a HSA-qualified High-Deductible Health Plan (HDHP) and must not be covered by other health insurance that is not an HDHP. Certain types of insurance are not considered “health insurance” such as auto, dental, vision, disability and long-term care insurance, and will not jeopardize your eligibility for an HSA. **You and your Group are responsible to determine whether or not you are eligible to enroll in this HSA plan.** MercyCare assumes that if you are enrolled, you are eligible.

SOME BASICS ABOUT USING YOUR HSA

(Please refer to the HSA material you received upon enrollment for more specific information.)

- HSA funds can pay for any “qualified medical expense,” even if the expense is not covered by this MercyCare plan. While we cannot provide a list of “qualified medical expenses,” you can obtain information about what can be reimbursed from IRS Pub 502 (available at www.irs.gov).
- You are responsible to decide which of your expenses will be reimbursed using HSA funds.
- If you exhaust your HSA, you would then have to pay deductibles, coinsurance, and copayments out-of-pocket. For example, if you use your HSA to pay for qualified medical expenses that are not covered by this plan, then such payments will reduce the HSA but will not reduce the deductible.
- If Your Group has established a banking relationship for your HSA. You should check with your Group for the proper procedures for submitting claims to get reimbursed from your HSA funds.
- It is expected that you will use reimbursements from your HSA to pay for the portion of your medical expenses that is your responsibility.
- Although most services are subject to the deductible, certain preventive care services may not be subject to the deductible under this plan. Your Schedule of Benefits will indicate whether or not you have this benefit.

QUESTIONS?

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

OBTAINING SERVICES

PRIMARY CARE PHYSICIAN (PCP)

Primary Care Physician means a Participating physician practicing family medicine, internal medicine, gynecology, obstetrics, or pediatrics that has accepted primary responsibility for the MercyCare Member's health care.

You must name Your PCP. We encourage you to enter your PCP on Your Enrollment Form, or notify MercyCare Customer Service at (877 908-6027 of your PCP. You may change Your PCP at any time as long as You notify MercyCare Customer Service.

Each family Member may have a different Primary Care Physician. A Member's Primary Care Physician:

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

When a provider terminates or non-renews with the Plan, you will receive notification at least 60 days before the provider's separation with the Plan.

NOTICE TO ALL FEMALE PLAN MEMBERS

Your right to select a Woman's Principal Health Care Provider:

Illinois law allows You to select a "Woman's Principal Health Care Provider in addition to Your selection of a PCP. A Woman's Principal Health Care Provider is a physician licensed to practice medicine in all its branches specializing in obstetrics or gynecology or specializing in family practice. A Woman's Principal Health Care Provider may be seen for care without Referrals from Your Primary Care Physician. If You have not already selected a Woman's Principal Health Care Provider, You may do so now or at any other time. You are not required to have or to select a Woman's Principal Health Care Provider.

Your Woman's Principal Health Care Provider must be a participating physician. You may get the list of participating obstetricians, gynecologists, and family practice specialists from Your employer's employee benefits coordinator, or for Your own copy of the current list, You may call (877) 908-6027 to obtain a provider directory. The directory will be sent to You within 10 days after Your call. MercyCare reserves the right to modify the list of participating providers at any time. The provider directory can be found online at www.mercycarehealthplans.com. To designate a Woman's Principal Health Care Provider from the list, call (877) 908-6027 and tell our staff the name of the physician You have selected.

REFERRAL REQUIREMENTS

In order to obtain Benefits for specialty services and treatment that cannot be obtained from a Participating Provider listed in our provider directory the following is required:

- A Referral from Participating provider, and
- your referring physician obtain prior approval from the Plan to a physician and other services (i.e. labs, x-rays, etc.) out of the Plan's provider network.

The referring provider and the Quality Health Management Department will determine the duration of the Referral or the number of visits authorized based on what is medically appropriate. If a Referral is not approved by the Quality Health Management Department, it is not considered valid and the services are not considered authorized. The Plan reserves the right to direct You to a specialist of its choice.

If you have an illness or injury that needs ongoing treatment from another Physician or Provider, you may apply for a Standing Referral to that Physician or Provider from your Primary Care Physician or Woman's Principal Health Care Provider. Your Primary Care Physician or Woman's Principal Health Care Provider with notification to the Plan may authorize the Standing Referral which shall be effective for the period necessary to provide the referred services or up to a period of one year. Notwithstanding anything in your Certificate to the contrary, for the services rendered by Providers who are not part of your HMO's network or otherwise contracted with your HMO, you will not be responsible for any charges that exceed the amount you would pay for services received within the Plan's provider network.

Failure to follow the above requirements will result in the non-coverage of claims associated with those services, except in the case of an emergency.

This Plan does not require a Referral for visits to Participating provider specialists.

PRIOR AUTHORIZATION

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 procedure will be denied upon claim submission, unless the service is for a state mandated benefit or an Essential Health Benefit. State mandated and essential health benefit services will be reviewed for medical necessity prior to claim payment.

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
- 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
- Mental Illness, Serious Mental Illness, and Substance Use Disorder, *inpatient treatment*
- Reproductive/Infertility Services
- Surgical services, inpatient, outpatient, and at a free-standing surgical facility
- Skilled nursing facility services
- Temporomandibular disorders (TMJ)
- Transplants

CONCURRENT REVIEW

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

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

The number to call for Prior Authorization is 800-757-6825.

AFTER HOURS CARE

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

TRANSITION OF CARE BENEFITS

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

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

COPAYMENTS AND COINSURANCE

Most Covered Services are subject to a copayment or Coinsurance as shown in Your Schedule of Benefits. The amount of copayment and Coinsurance that applies to charges for Covered Services depends on which benefit is accessed.

Coinsurance payments begin once You meet any applicable Deductible amounts.

DEDUCTIBLES

If You are covered as an eligible Employee, each Contract year You must satisfy the program deductible amount(s) shown in the Schedule of Benefits before receiving benefits, if any.

If You have Family Coverage and Your family has satisfied the program deductible amount shown in the Schedule of Benefits, if any, it will not be necessary for anyone else in Your family to meet a deductible in that Contract year. That is, for the remainder of that Contract year, no other family members will be required to meet the Contract year deductible before receiving benefits.

The deductible amount is subject to change or increase as permitted by applicable law.

When Your Group initially purchased this coverage, if You were a member of the Group at that time You are

entitled to a special credit toward your program deductible for the first benefit period. This special credit applies to eligible expenses incurred for Covered Services within the prior Contract's benefit period, if not completed. Such expenses can be applied toward the program deductible for the first benefit period under this coverage. However, this is only true if Your Group had “major medical” type coverage immediately prior to purchasing this coverage. If You changed carriers during the calendar year, the expenses you incurred which were applied towards the deductible for services covered by the prior carrier will be applied to the deductible of your initial program deductible under this Certificate.

PER HOSPITAL ADMISSION COPAY

Each Hospital admission may be subject to a “Per Hospital Admission Copay” depending on the plan design. However, if two or more family Members are admitted to the Hospital through the emergency room for the same Emergency incident, the per Hospital admission copay is limited to a dollar amount equal to two family Members’ copay for that stay.

OUT-OF-POCKET MAXIMUM

The out-of-pocket maximum is the most You will pay in Coinsurance, Copay and Deductible for Your Covered Services in a Contract Year. The amount of the out-of-pocket maximum is shown in the Schedule of Benefits. The “single” out-of-pocket maximum applies to each Member 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 will pay more than the out-of-pocket maximum amount in a Contract Year if You:

- Receive services that are not covered by the Plan; or
- Receive services that are subject to limitations, and those limits have been exceeded; or
- Receive services that require Prior Authorization that were not authorized by the Plan (see Prior Authorization section of this Certificate); 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.

EMERGENCY AND URGENT CARE

Please refer to your Schedule of Benefits for Copayment information on Emergency Care and Urgent Care services.

EMERGENCY CARE

Emergency means a medical condition manifesting itself by Acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part.
Examples of emergency care situations are 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, drug overdose, and any condition for which You are admitted to the Hospital as an inpatient from the emergency room.

Other Acute conditions are emergencies when these four elements exist:

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

Call Customer Service at (877) 908-6027 for all Emergency or out-of-state inpatient admissions as soon as possible or within 48 hours.

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.

MercyCare covers Emergency care services provided by any provider. Notwithstanding anything in your Certificate to the contrary, for emergency care benefits rendered by Providers who are not part of your HMO's network or otherwise contracted with your HMO, you will not be responsible for any charges that exceed the amount negotiated with Providers for emergency care benefits furnished. If you receive a bill for these services, contact MercyCare's Customer Service Department at (877) 908-6027.

This amount is calculated excluding any Copayment or Coinsurance imposed with respect to the Member.

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

When You receive emergency treatment in a Hospital emergency room, you will be responsible for the deductible amount shown in the Schedule of Benefits section of this Certificate. Thereafter, You will be responsible for paying the Coinsurance amount shown in the Schedule of Benefits section of this Certificate, after You have met your program deductible, if any is applicable. Services provided for the treatment of criminal sexual assault are provided without deductible or cost sharing.

Should You be admitted to the Hospital as an Inpatient, benefits will be paid as explained in the Hospital Benefits and Physician Benefits Sections of this Certificate. If You are admitted to the Hospital as an Inpatient immediately following emergency treatment, the emergency room deductible will be waived.

Post-stabilization Services Following an Emergency:
If post-stabilization services, are provided at a facility that is not a Participating Provider and are determined to be Medically Necessary by the Plan, such services will be considered Covered Services if treating physician licensed to practice medicine in all its branches documents in the enrollee's medical record the enrollee's presenting symptoms; emergency medical condition; and time, phone number dialed, and result of the communication for request for authorization of post-stabilization medical services and 1) the Plan authorizes such care or 2) after two documented good faith efforts, the treating physician has attempted to contact the enrollee's health care plan or its delegated health care provider for prior authorization of post-stabilization medical services and neither the plan nor designated persons were accessible or the authorization was not denied within 60 minutes of the request.

EMERGENCY AND URGENT CARE

URGENT CARE/CONVENIENT CARE/IMMEDIATE CARE

Urgent Care is care for a Bodily Injury or Sickness that You need sooner than a routine doctor's visit. Examples of Urgent Care situations are broken bones, sprains, non-severe bleeding, minor cuts and burns, and drug reactions.

In the Service Area:
To be covered, urgent care must be received from a participating provider or at a participating urgent care center. Urgent care locations can be found at www.mercyhealthsystem.org.

Outside the Service Area:
If you require urgent care and you are outside the service area and cannot return home without medical harm, you should seek care by the nearest physician, hospital or clinic.

BENEFIT PROVISIONS

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

AMBULANCE SERVICES

Covered Services:

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

Benefits for emergency ambulance transportation are available when:

1. Such transportation is ordered by your Primary Care Physician or Woman's Principal Health Care Provider; or
2. The need for such transportation has been reasonably determined by a Physician, public safety official or other emergency medical personnel rendered in connection with an Emergency Condition.

Non-Covered Services:

Ambulance service that is used in situations that are not considered life threatening, as described in the Emergency and Urgent Care section of this Certificate.

AUTISM SPECTRUM DISORDER(S)

Covered Services:

- Your benefits for the diagnosis and treatment of Autism Spectrum Disorder(s) are the same as your benefits for any other condition. Treatment for Autism Spectrum Disorder(s) shall include the following care when prescribed, provided or ordered for an individual diagnosed with an Autism Spectrum Disorder by (a) your Primary Care Physician or Woman's Principal Health Care Provider who has determined that such care is medically necessary, or (b) a certified, registered or licensed health care professional with expertise in treating effects of Autism Spectrum Disorder(s) and when the care is determined to be medically necessary and ordered by your Primary Care Physician or Woman's Principal Health Care Provider:

  — psychiatric care, including diagnostic services;
  — psychological assessment and treatment;
  — habilitative or rehabilitative treatment;
  — therapeutic care, including behavioral Occupational Therapy, Physical Therapy and Speech Therapy that provide treatment in the following areas: a) self-care and feeding, b) pragmatic, receptive and expressive language, c) cognitive functioning, d) applied behavior analysis (ABA), intervention and modification, e) motor planning and f) sensory processing.
  — dental care and anesthetics provided by a dentist in a dental office, oral surgeon's office, hospital, or ambulatory surgical treatment center for a member under age 19.

BIOFEEDBACK

Covered Services:

- Biofeedback is covered only for treatment of headaches, spastic torticollis, and urinary incontinence.
- Benefit limitations will be determined based on the provider of services.
- Biofeedback services must have Prior Authorization from the Plan.

BONE MASS MEASUREMENT AND OSTEOPOROSIS

Covered Services:

- Bone mass measurement and the diagnosis and treatment of osteoporosis. Unless otherwise stated, benefits will be provided as described in the Preventive Care Services provision of this section of your Certificate.

CARDIAC REHABILITATION

Covered Services:

- Cardiac Rehabilitation is covered 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
  g) cardiac transplant; or
  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:
- 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.

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) Inpatient coverage following a mastectomy for a length of time determined by the attending physician to be Medically Necessary and in accordance with protocols and guidelines based on sound scientific evidence and upon evaluation of the patient and the coverage for and availability of a post-discharge physician office visit or in-home nurse visit to verify the condition of the patient in the first 48 hours after discharge.
  c) Surgery and reconstruction of the other breast to produce a symmetrical appearance.
  d) 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 , or
  c) Resulting from accidental injuries, scars, tumors, or diseases.

- Removal of breast implants when such removal is Medically Necessary for treatment of Sickness or Bodily injury. However, removal of breast implants that were implanted solely for cosmetic reasons is not covered.

- Benefits will be provided for all medically necessary pain medication and pain therapy related to the treatment of breast cancer. Pain therapy means therapy that is medically-based and includes reasonably defined goals, including, but not limited to stabilizing or reducing pain, with periodic evaluations of the efficacy of the pain therapy against these goals.

- Fibrocystic breast condition in the absence of a breast biopsy demonstrating an increased disposition to the development of breast cancer unless the enrollee's medical history is able to confirm a chronic, relapsing, symptomatic breast condition.

Non-Covered Services:
- Procedures, services, and supplies related to sex transformation surgery and sex hormones related to such treatments.
- Plastic or cosmetic surgery which is undertaken solely to improve the Member's appearance and which is not Medically Necessary for the correction of a functional defect caused by a Bodily Injury or Sickness. Psychological reasons do not represent a medical/surgical necessity.
- Excision of excessive skin, subcutaneous tissue, and/or fat, including but not limited to such surgery to the abdomen, thigh, leg, hop, buttock or arm (except when done as part of post-mastectomy reconstruction).

DENTAL SURGERY

Covered Services:

Treatment with Prior Authorization from the Plan include: Bodily Injury to permanent, Sound and Natural Teeth and bone, but only if:

The Bodily Injury occurs while You are a Member covered by the Plan; and
The Bodily Injury is not caused by chewing or biting; and
The treatment begins within 90 days of the Bodily Injury with a maximum of 180 days from the date of Bodily injury to complete treatment.

- Consultation by an oral surgeon or appropriate specialist. Included with this would be the cost of X-rays or other diagnostic tests performed in conjunction with given evaluation.
- Covered procedures include:
  - Surgical removal of completely-bony-impacted teeth.
  - Excision of tumors or cysts from the jaws, cheeks, lips, tongue, roof or floor of the mouth.
  - Excision of exostoses of the jaws and hard palate (provided that this procedure is not done in preparation for dentures or other prostheses).
  - Treatment of fractures of the facial bones.
  - External incision and drainage of abscesses or cellulitis.
  - Incision or excision of accessory sinuses, salivary glands or ducts;

- Surgical procedures to address congenital deformities and conditions resulting from medical disease or previous medical therapeutic processes affecting the jaws, cheeks, lips, tongue, roof or floor of the mouth.
- Surgical procedures to correct accidental injuries of the jaws, cheeks, lips, tongue, roof or floor of the mouth.
- Surgical treatment of accidental injuries to any teeth which had an intact root or were part of a permanent bridge, prior to the injury. This particular benefit covers complete restoration of the injured teeth.
- Implants to support a dental prosthesis when an integral part of treatment for medical conditions as described above. Any abutment or dental prosthesis resting on these implants is not covered, except to replace a tooth that had originally been injured, as described above.
- Durable medical equipment or prosthetic appliances such as obturators or surgical splints are covered, when an integral part of treatment for conditions described above.
- Charges incurred for Hospital care and anesthesia that is provided in conjunction with dental care provided in a Hospital, ambulatory surgical treatment center, or by a certified anesthesiologist, if the Member:

  a) 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
  b) Has a medical condition that requires Hospital Confinement or general anesthesia for dental care.

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 Certificate. These exclusions include, but are not limited to:
  a) Dental implants.
  b) Services (regardless of cause or complexity) provided for the care, treatment, removal, or replacement of teeth or structures directly supporting teeth.(e.g., preparation of the mouth for dentures, removal of diseased teeth in an infected jaw.) Structures directly supporting the teeth means the periodontium, which includes the gingivae, periodontal membrane, cementum of the teeth, and the alveolar bone (i.e. alveolar process and tooth sockets).
  c) Shortening of the mandible or maxilla
  d) Correction of malocclusion.
  e) 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.
  f) Hospital costs for any of these services except as specifically described in the Certificate.
  g) Oral surgery except as specifically described in this Certificate.
  h) All periodontic procedures.
  i) Any treatment for bruxism – including splint devices.
  j) Braces or oral fixation devices

NOTICE REGARDING PEDIATRIC DENTAL SERVICES

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

DIABETES SERVICES

Covered Services:

- Self-management education programs, including medical nutrition therapy and education programs, and diabetic equipment and supplies.
- Diabetic equipment, if considered Medically Necessary by the Plan.
- Insulin pumps if prior authorized and meets the medical criteria established by the Plan.
- Diabetic supplies, including blood glucose monitors, blood glucose monitors for the legally blind, cartridges for the legally blind, lancets and lancing devices, syringes and needles, test strips for glucose monitors, and glucagon emergency kits.
- Insulin and FDA approved oral agents used to control blood sugar from a participating pharmacy.
- Regular foot care exams by a physician.

DURABLE MEDICAL EQUIPMENT AND MEDICAL SUPPLIES

Durable medical equipment is defined as:

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

f) Is not implantable in the body, and
g) 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 Member's 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 with prior authorization by the Plan and when:

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

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

Examples of DME include:

- Equipment to assist mobility, such as a standard wheelchair.
- A standard Hospital-type bed.
- Oxygen and the rental of equipment to administer oxygen (including tubing, connectors and masks).
- Delivery pumps for tube feedings (including tubing and connectors).
- Braces, including necessary adjustments to shoes to accommodate braces. Braces that stabilize an injured body part and braces to treat curvature of the spine are considered DME and are a Covered Health Service. Braces that straighten or change the shape of a body part are orthotic devices, and are covered. Dental braces are also excluded from coverage.
- Prescription foot orthotics when the Member has a documented diagnosis of diabetes with neuropathy or peripheral vascular disease.
- Mechanical equipment necessary for the treatment of chronic or acute respiratory failure (except that air-conditioners, humidifiers, dehumidifiers, air purifiers and filters, and personal comfort items are excluded from coverage)
- Burn garments.
- Insulin pumps and all related necessary supplies as described under Diabetes Services.
- External cochlear devices and systems. Benefits for cochlear implantation are provided under the applicable medical/surgical Benefit categories in this Certificate.

Benefits under this section also include speech aid devices and tracheo-esophageal voice devices required for treatment of severe speech impediment or lack of speech directly attributed to a sickness or injury. Benefits for the purchase of speech aid devices and tracheo-esophageal voice devices are available only after completing a required three-month rental period. Benefits are limited as stated in the Schedule of Benefits.

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

We will decide if the equipment should be purchased or rented. Benefits are available for repairs and replacement, except that:

- Benefits for repair and replacement do not apply to damage due to misuse, malicious breakage or gross neglect.
- Benefits are not available to replace lost or stolen items.

Non-Covered services:

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

In order to verify whether a specific DME item is covered, please contact the Customer Service Department at:

(877) 908-6027

- 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; eggcrate 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; wigs; alcohol wipes; band-aids; over the counter (OTC) antibiotic ointments; OTC dressing supplies (examples: 4X4 gauze, tape, betadine, etc.); and home remodeling or modifications.
- Prescribed or non-prescribed medical supplies and disposable supplies. Examples include: elastic stockings, ace bandages, gauze and dressings, and urinary catheters. This exclusion does not apply to:
  a) Disposable supplies necessary for the effective use of DME for which Benefits are provided in this Section.
  b) Diabetic supplies for which Benefits are provided as described under Diabetes Services.
  c) Ostomy supplies for which Benefits are provided as described under Ostomy Supplies.
- Tubings and masks except when used with DME as described under this section.

EMERGENCY CARE

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

GENETIC TESTING AND COUNSELING

Covered services:

With prior authorization from 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 and hearing exams are covered when obtained through a Participating Audiology Provider.
- The reconditioning and repair of existing aids is covered when considered Medically Necessary.
- New hearing aids are covered one per ear in a 36-month period.
- Bone anchored hearing aids (osseointegrated auditory implants).
- Benefit is subject to the limitations specified in Your Schedule of Benefits.

Non-Covered Services:

- Hearing aids if more than one per year in any 36-month period.

HOME HEALTH CARE

Covered Services:

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

- 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 weekly cost for care in a skilled nursing facility.

Non-Covered Services:
- Custodial Care.

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

HOSPITAL SERVICES
Covered Services:
- Inpatient and outpatient Hospital services are covered when rendered by a Hospital or Free-standing Surgical Facility.
- 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 Confinement days are covered when care is being directed by a provider and with authorization from the Plan.
d) Rehabilitation Services.

- 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 Certificate.
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:
- Inpatient Hospital services for days that are NOT authorized by the Plan as being Medically Necessary.

- Continued Hospital stay(s), if a Participating Provider has documented that care could effectively be provided in a less Acute care setting.
- Take-home drugs dispensed prior to Your release from Confinement, whether billed directly or separately by the Hospital.
- Inpatient and outpatient Hospital services for non-covered treatment.
- Durable medical equipment. Please see the Durable Medical Equipment section of this Certificate of Coverage.

KIDNEY DISEASE TREATMENT

Covered Services:

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

MASSAGE THERAPY

Massage Therapy to treat muscle pain or dysfunction. When provided by licensed health care provider or under the direct supervision of a licensed health care provider, limit 2 massages per year.

NEWBORN BENEFITS

Covered Services:

- Newborn benefits include the following services when received or authorized by the newborn's Primary Care Physician:

  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, OCCUPATIONAL THERAPY, and/or PULMONARY THERAPY

Covered Services:

- Both habilitative and rehabilitative outpatient physical therapy, speech therapy, occupational therapy and pulmonary rehabilitation are covered services as shown in the Schedule of Benefits when rendered by a participating provider.
- Services must be medically necessary for restoration of a function or ability that was present and has been lost due to bodily injury or sickness in the case of rehabilitative services, or necessary to help a member keep, learn or improve skills and functioning for daily living in the case of habilitative services.
- Therapy must be necessitated by a medical condition and not be primarily educational in nature.
- Services are limited to therapy which is expected to result in significant improvement within two months in the condition for which it is rendered, except as specifically provided for (a) under the Autism Spectrum Disorder(s) provision and the plan must be established before treatment is begun and must relate to the type, amount, frequency and duration of the therapy and indicate the diagnosis and anticipated goals, or (b) prescribed as preventive or Maintenance Physical Therapy for members affected by multiple sclerosis, or (c) a child under 19 years of age diagnosed by a physician with a Congenital, Genetic or Early Acquired Disorder for medically necessary and therapeutic and not experimental or investigational.
- Provider must be a registered physical, occupational, pulmonary or speech therapist and must not live in the patient's home or be a family Member.
- Medically necessary Preventative Physical Therapy for insureds diagnosed with multiple sclerosis. For the purposes of this Section, "Preventative Physical Therapy" means physical therapy that is prescribed by a physician licensed to practice medicine in all of its branches for the purpose of treating parts of the body affected by multiple sclerosis, but only where the physical therapy includes reasonably defined goals, including, but not limited to, sustaining the level of function the person has achieved, with periodic evaluation of the efficacy of the physical therapy against those goals. The coverage required under this Section shall be subject to the same deductible, coinsurance, waiting period, cost sharing limitation, treatment limitation, contract year maximum, or other limitations as provided for other physical or rehabilitative therapy benefits covered by the Policy.

Non-Covered Services:

- Any form of therapy or treatment for learning or developmental disabilities, including: hearing therapy for a Learning Disability and communication delay; therapy for perceptual disorders, mental retardation and related conditions; evaluation and therapy for behavior disorders; special evaluation and treatment of multiple disabilities, hyperactivity, or sensory deficit and motor dysfunction; developmental and neuro-educational testing or treatment; and other special therapy except as specifically listed in this Certificate.

- Vocational testing and counseling, including evaluation and treatment and work hardening programs.
- Special education therapy such as music therapy, animal therapy including hippotherapy, or recreational therapy, except as specifically provided for in this Certificate.
- Speech and hearing screening examinations are limited to the Routine or Preventive screening tests performed by a 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, except as specifically provided for in this Certificate.

PHYSICIAN SERVICES

Covered Services:

Physician services include in office services, Routine or Preventive physicals, inpatient/outpatient visits, and home visits.

Non-Covered Services:

Any services and/or supplies given primarily at the request of, for the protection of, or to meet the requirements of, a party other than the Member when such services and/or supplies are not otherwise Medically Necessary or appropriate, unless the services and/or supplies are state-mandated. Excluded services and supplies include physical exams, disease immunizations, services and supplies for employment, licensing, marriage, adoption, insurance, camp, school, sports, and travel.

PODIATRY SERVICES

Covered Services:

- Routine or Preventive exams when Medically Necessary.

Non-Covered Services:

- The following services are non-covered except when prescribed by a 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:

- Treatment of pregnancy is covered for an Employee, an Employee's covered dependent spouse, or an Employee's covered dependent child.
- Pregnancy benefits include coverage for inpatient Hospital care and pre- and post-natal care, including pre-natal HIV testing ordered by an attending physician, physician assistant, or advance practice registered nurse.
- A minimum of 48 hours inpatient care following a vaginal delivery for the mother and the newborn, and a minimum of 96 hours inpatient care following a delivery by caesarian section for the mother and newborn, provided, however, that a shorter length of Hospital inpatient stay for services related to maternity and newborn care may be provided if the attending physician licensed to practice medicine in all of its branches determines, in accordance with the protocols and guidelines developed by the American College of Obstetricians and Gynecologists or the American Academy of Pediatrics, that the mother and the newborn meet the appropriate guidelines for that length of stay based upon evaluation of the mother and newborn and the coverage and availability of a post-discharge physician office visit or in-home nurse visit to verify the condition of the infant in the first 48 hours after discharge.

Non-Covered Services:

- Surrogate mother services.
- Elective abortions.
- 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 DRUGS

Please see Your Prescription Drug Rider.

PREVENTATIVE SERVICES

Covered Services:

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

  a) Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force ("USPSTF");
  b) Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention ("CDC") with respect to the individual involved;

c) Evidenced-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration ("HRSA") for infants, children, and adolescents; and
d) With respect to women, such additional preventive care and screenings, not described in item 1. above, as provided for in comprehensive guidelines supported by the HRSA.

For purposes of this benefit, the current recommendations of the USPSTF regarding breast cancer screening and mammography and prevention will be considered the most current (other than those issued in or around November, 2009). The preventive care services described in items 1 through 4 above may change as USPSTF, CDC and HRSA guidelines are modified. For more information, you may access the MercyCare Web site at www.mercycarehealthplans.com or contact customer service at the toll-free number on your identification card.

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

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

Preventive Care Services for Adults:

a) Abdominal aortic aneurysm screening for men who have ever smoked;
b) Alcohol misuse screening and counseling;
c) Aspirin use for men and women of certain ages;
d) Blood pressure screening;
e) Cholesterol screening for adults of certain ages or at higher risk;
f) Colorectal cancer screening for adults over age 50;
g) Depression screening;
h) Type 2 diabetes screening for adults with high blood pressure;
i) Diet and physical activity counseling for adults at higher risk for chronic disease (e.g. cardiovascular disease;
j) Hepatitis B screening for all adutls with high risk for infection
k) HIV screening for all adults at higher risk;
l) The following immunization vaccines for adults (doses, recommended ages, and recommended populations vary):
   i Hepatitis A
   ii Hepatitis B
   iii Herpes Zoster
   iv Human papillomavirus
   v Influenza (Flu shot)
   vi Haemophilus influenzae type b (HIB)
   vii Measles, Mumps, Rubella
   viii Meningococcal
   ix Pneumococcal
   x Tetanus, Diphtheria, Pertussis
   xi Varicella
m) Lung cancer screening for adults 55 to 80 years with 30 pack-year smoking history
n) Obesity screening and counseling;
o) Sexually transmitted infections (STI) prevention counseling;
p) Skin cancer behavioral counseling for fair skin adults under under age 25;
q) Tobacco Use Cessation Program for Tobacco Users;
r) Syphilis screening for adults at higher risk;
s) Physical Therapy or exercise to prevent falls in adults age 65 years and older who are at increased risk for falls;
t) Tuberculin screening for adults at higher risk
u) Vitamin D supplementation to prevent falls in adults 65 years and older

v) Hepatitis C virus (HCV) screening for persons at high risk for infection; and
w) One time HCV screening for adults born between 1945 and 1965.

Preventive Care Services for Men:

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

Preventive Care Services for Women (including pregnant women):

a) Anemia screening on a routine basis for pregnant women;
b) Aspirin use for women after 12 weeks gestation with high risk for preeclampsia;
c) Bacteriuria urinary tract screening or other infection screening for pregnant women;
d) BRCA counseling about genetic testing and counseling for women at higher risk;
e) Breast cancer mammography screenings;
f) Breast cancer medication prevention counseling for women at higher risk;
g) Breastfeeding comprehensive support and counseling from trained providers, as well as access to breastfeeding supplies and equipment

including breast pumps, for pregnant and nursing women;

h) Cervical cancer screening;
i) Chlamydia infection screening for younger women and women at higher risk;
j) Contraception: FDA-approved contraceptive; methods, sterilization procedures, and patient education and counseling;
k) Domestic and interpersonal violence screening and counseling for all women;
l) Folic acid supplements for women who may become pregnant;
m) Gestational diabetes screening for women after 24 weeks pregnant and those at high risk of developing gestational diabetes;
n) Gonorrhea screening for all women at higher risk;
o) Hepatitis B screening for pregnant women at their first prenatal visit;
p) HIV screening and counseling for sexually active women and pre-natal HIV testing;
q) Human papillomavirus (HPV) DNA test: high risk HPV DNA testing every 3 years for women with normal cytology results who are age 30 or older;
r) Osteoporosis screening for women over age 65, depending on risk factors;
s) Preeclampsia screening;
t) Rh incompatibility screening for all pregnant women and follow-up testing for women at higher risk;
u) Tobacco Use Cessation Program for all women, and expanded counseling for pregnant Tobacco Users;
v) Sexually transmitted infections (STI) counseling for sexually active women;
w) Syphilis screening for all pregnant women or other women at increased risk;
x) Well-woman visits to obtain recommended preventive services;
y) Intrauterine device (IUD) services related to follow-up and management of side effects, counseling for continued adherence and device removal; and
z) Hepatitis C virus (HCV) screening for women at high risk for infection.

Preventive Care Services for Children:

a) Alcohol and drug use assessment for adolescents;
b) Behavioral assessments for children of all ages;
c) Blood pressure screenings for children of all ages;
d) Height, weight, and body mass measurements children of all ages;
e) Cervical dysplasia screening for sexually active females;
f) Congenital hypothyroidism screening for newborns;
g) Dental caries prevention with fluoride treatments for children 6 months to 6 years;
h) Depression screening for adolescents;
i) Development screening for children under age 3, and surveillance throughout childhood;
j) Dyslipidemia screening for children 24 months through 21 years;
k) Ocular topical medication for all newborns for gonococcal ophthalmia neonatorum;
l) Hearing loss screening for all newborns;
m) Hemoglobin screening for all children from 4 months through age 21;
n) Hemoglobinopathies or sickle cell screening for all newborns;
o) Hepatitis B screening for non-pregnant adolescents at high risk for infection;
p) HIV screening for adolescents at higher risk;
q) The following immunization vaccines for children from birth to age 18 (doses, recommended ages, and recommended populations vary):
   - Hepatitis A
   - Hepatitis B
   - Hepatitis C virus (HCV)
   - Human papillomavirus
   - Influenza (Flu shot)
   - Measles, Mumps, Rubella
   - Meningococcal
   - Pneumococcal
   - Tetanus, Diphtheria, Pertussis
   - Varicella
   - Haemophilus influenzae type b
   - Rotavirus
   - Inactivated Poliovirus Vaccine
r) Iron supplements for children ages 6 to 12 months at risk for anemia;
s) Lead screening for children at risk for exposure;
t) Autism screening for children 18 and 24 months;
u) Medical history for all children throughout development;
v) Obesity screening and counseling;
w) Oral health risk assessment for younger children up to ten years old;
x) Phenylketonuria (PKU) screening for newborns;
y) Sexually transmitted infections (STI) prevention and counseling for adolescents at higher risk;
z) Tuberculin testing for children at higher risk of tuberculosis;
aa) Tobacco use education and counseling
bb) Skin cancer behavioral counseling for fair skin children birth to age 18;
cc) Vision screening for all children; and
dd) Any other immunization that is required by law for a child. Allergy injections are not considered immunizations under this benefit provision.
ee) Newborn Blood Screening for 3-5 days of age according to American Academy of Pediatrics recommendations

PRIVATE DUTY NURSING SERVICE—OUTPATIENT
Benefits for Outpatient Private Duty Nursing Service will be provided to You in Your home only when the services are of such a nature that they cannot be provided by non-professional personnel and can only be provided by a licensed health care Provider. No benefits will be provided when a nurse ordinarily resides in your home or is a member of your immediate family. Outpatient Private Duty Nursing includes teaching and monitoring of complex care skills such as tracheotomy suctioning, medical equipment use and monitoring to home caregivers and is not intended to provide for long term supportive care. Benefits for Outpatient Private Duty Nursing Service will not be provided due to the lack of willing or available non-professional individuals.

PROSTHETIC AND ORTHOTIC DEVICES
Covered Services:
- Replacement of natural or artificial limbs and eyes no longer functional due to physiological change or malfunction beyond repair, if Medically Necessary.
- Prosthetic devices must be approved in advance by the Plan.
- Adjustments, repairs and replacements of these devices, appliances and implants are also covered when required because of wear or a change in Your condition.
- Prescription foot orthotics when the Member has a documented diagnosis of diabetes with neuropathy or peripheral vascular disease

Orthotic Device is a supportive device for the body or a part of the body, head, neck or extremities including, but not limited to leg, back, arm and neck braces.
- Benefits will be provided for adjustments, repairs or replacement of the device because of a change in your physical condition as determined by your Participating Provider.
- Benefits for foot orthotics will be limited to a maximum of two devices or one pair of devices per contract year.

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.
- Dental appliances.
- The replacement of cataract lenses unless a prescription change is required.

MENTAL ILLNESS, SERIOUS MENTAL ILLNESS, AND SUBSTANCE USE DISORDER TREATMENT
Covered Services are the same as those provided for any other condition, as specified in the other benefit sections of this Certificate.

Outpatient Treatment
Treatment received while not Confined to a Hospital or Qualified Treatment Facility up to the benefit maximums specified in the Schedule of Benefits.

Inpatient Treatment
Treatment received while Confined as a registered bed patient in a Hospital or Qualified Treatment Facility up to the benefit maximum specified in the Schedule of Benefits.

Partial Hospitalization Treatment Program
Therapeutic treatment program in a Hospital for patients with Mental Illness up to the benefit maximum specified in the Schedule of Benefits.

Intensive Outpatient Treatment Program
A Hospital-based program that provides services for at least 3 hours per day, 2 or more days per week, to treat Mental Illness or Substance Use Disorders or specializes in the treatment of co-occurring Mental Illness and Substance Use Disorders. Dual diagnosis programs offer integrated and aligned assessment, treatment and discharge planning services for treatment of severe or complex co-occurring conditions which make it unlikely that you will benefit from programs that focus solely on Mental Illness conditions. Dual diagnosis programs are delivered by Behavioral Health Practitioners who are cross-trained.

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

Detoxification
Covered Services received for detoxification are not subject to the Substance Use Disorder Treatment provisions specified above. Benefits for Covered Services received for detoxification will be provided under the HOSPITAL BENEFITS and PHYSICIAN BENEFITS sections of this Certificate, as for any other condition.

Prescription Drugs
Prescription Drug charges used for the treatment of Mental Illness, Serious Mental Illness, and Substance Use Disorder will not be applied to the maximum benefit available for any psychological disorder or Substance Use Disorder services.

Substance Use Disorder Treatment
- Acute Treatment Services: 24-hour medically supervised addiction treatment that provides evaluation and withdrawal management and may include biopsychosocial assessment, individual & group counseling, psychoeducational groups, and discharge planning.
- Clinical Stabilization Services: 24-hour treatment, usually following acute treatment services for substance abuse, which may include intensive education and counseling regarding the nature of addiction and its consequences, relapse prevention, outreach to families & significant others, and aftercare planning for individuals beginning to engage in recovery from addiction.

Covered Services:
- Outpatient and inpatient treatment, including psychological testing and neuropsychological testing, of mental illness and/or Substance Use Disorder each have specific benefit limits stated in the Schedule of Benefits.
- Services must be provided by a provider whose services have been prior authorized by the Plan. The services must be considered Medically Necessary.
- Court ordered mental health and/or substance use disorders services are covered, subject to the benefit maximums described above, if provided by a provider to whom the Plan has issued a Referral.
- 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.
- Family therapy is covered only if the diagnosed Member is present at the family therapy session.
- Services are covered if rendered by a physician licensed to practice medicine in all its branches, licensed clinical psychologist, licensed clinical social worker, or licensed clinical professional counselor if the condition or disorder is covered by the Policy, and the providers are authorized to provide said services under the statutes of Illinois and in accordance with accepted principles of their professions.

Non-Covered Services:
- Maintenance or Long Term Therapy.
- Biofeedback, except that provided by a licensed healthcare provider for treatment of headaches, spastic torticollis and urinary incontinence, or by a behavioral health practitioner for the treatment of post-traumatic stress disorder.
- Hypnotherapy, marriage counseling,
- In-home treatment services, except those for treatment of autism with prior authorization.
- Halfway houses, supervised living, group homes, boarding houses or other facilities that provide primarily a supportive environment and that address long term social needs.
- Custodial 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/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).

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.

SKILLED NURSING FACILITY
Covered Services:

- Charges for daily room and board and general nursing services provided during a Skilled Nursing Facility Confinement if You entered the facility within 24 hours after discharge from a covered Hospital Confinement for continued treatment of the same condition. Confinement in a swing bed in a Hospital is considered the same as a Skilled Nursing Facility.
- Coverage is provided for physical therapy, occupational therapy, speech therapy, and durable medical equipment if Medically Necessary.
- 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 a 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 PROGRAM
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 adult physical fitness, wellness, and lifestyle programs such as smoking cessation, Lamaze classes or weight loss. 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.

SURGERY
Covered Services:
Surgery — when performed by a Physician, Dentist or Podiatrist or other Provider acting within the scope of his/her license.

However, benefits for oral Surgery are limited to the following services:

a. Surgical removal of completely bony impacted teeth;
b. Excision of tumors or cysts from the jaws, cheeks, lips, tongue, roof or floor of the mouth;
b) Surgical procedures to correct accidental injuries of the jaws, cheeks, lips, tongue, roof or floor of the mouth;
c) Excision of exostoses of the jaws and hard palate (provided that this procedure is not done in preparation for dentures or other prostheses); treatment of fractures of facial bone; external incision and drainage of cellulitis; incision of accessory sinuses, salivary glands or ducts; reduction of dislocation of, or excision of, the temporomandibular joints.

The following services are also part of your surgical benefits:

— Anesthesia — if administered in connection with a covered surgical procedure by a Physician, Dentist or Podiatrist other than the operating surgeon or by a Certified Registered Nurse Anesthetist.
In addition, benefits will be provided for anesthesia administered in connection with dental care treatment rendered in a Hospital or Ambulatory Surgical Facility if (a) a child is age 6 and under, (b) you have a chronic disability that is the result of a mental or physical impairment, is likely to continue and that substantially limits major life activities such as self-care, receptive and expressive language, learning, mobility, capacity for independent living or economic self-sufficiency or (c) you have a medical condition requiring hospitalization or general anesthesia for dental care.
— An assistant surgeon — that is, a Physician, Dentist or Podiatrist who actively assists the operating surgeon in the performance of a covered surgical procedure.
— Additional Surgical Opinion — following a recommendation for elective Surgery. Your benefits will be limited to one consultation and any related Diagnostic Service by a Physician.
— Surgery for morbid obesity including, but not limited to, bariatric Surgery.
— Elective Sterilization procedures

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) All Temporomandibular related services, including evaluation, must be authorized prior to the Member's receipt of any such services.
  b) The condition is caused by Congenital, developmental or acquired deformity, Sickness or Bodily Injury.

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

- This includes coverage for prescribed intraoral splint therapy devices.

Non-Covered Services:

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

TRANSPLANTS

Covered Services:

Coverage is limited to those procedures that are considered by the Plan to be Medically Necessary and effective. Coverage may be denied for procedures that are determined to be Experimental or Investigational if such determination is supported by the Office of Health Care Technology Assessment within the Agency for Health Care Policy and Research within the federal Department of Health and Human Services, or if the Office of Health Care Technology determines that there is insufficient data or experience to determine whether an organ transplantation procedure is clinically acceptable.

The Plan requires that all transplant-related services, including evaluation, be authorized prior to the Member's receipt of any such services. Services must be performed at a facility approved by the Plan.
When a prescribing Participating Physician has indicated on a prescription "may not substitute" for immunosuppressant drugs, the Plan will not require the interchange of another immunosuppressant drug or formulation without notification and the documented consent of the prescribing Participating Physician and the Member, or the parent or guardian if the Member is a child, or the spouse of a patient who is authorized to consent to the treatment of the person.

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

Kidney: See "Kidney Disease Treatment" section of this Certificate.

Benefits are available for services related to the procurement of transplant organs, including surgical removal procedures, storage, and transportation of the procured organ.

All of the benefits specified in the other benefit sections of this Certificate are available for Surgery performed to the transplant an organ or tissue. In addition, benefits will be provided for transportation of the donor organ to the location of the transplant Surgery, limited to transportation in the United States or Canada. Benefits will also be available for immunosuppressive drugs, donor screening and identification costs, under approved matched unrelated donor programs. Payment for Covered Services received will be the same as that specified in those benefit sections.

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

- If both the donor and recipient have coverage with MercyCare, each will have his/her benefits paid by his or her own program.
- If you are the recipient and your donor does not have coverage from any other source, the benefits of this Certificate will be provided for both you and your donor. The benefits provided for your donor will be charged against your coverage under this Certificate.
- If you are the donor and coverage is not available to you from any other source, the benefits of this Certificate will be provided for you. However, benefits will not be provided for the recipient.

Whenever a heart, lung, heart/lung, liver, pancreas or pancreas/kidney transplant is recommended by your physician and approved by MercyCare, and you are the recipient of the transplant, benefits will be provided for transportation and lodging for you and a companion. If the recipient of the transplant is a dependent child under the limiting age of this Certificate, benefits for transportation and lodging will be provided for the transplant recipient and two companions. For benefits to be available, your place of residency must be more than 50 miles from the Hospital where the transplant will be performed.

- Benefits for transportation and lodging are limited to a combined maximum of $10,000 per transplant. The maximum amount that will be provided for lodging is $50 per person per day.

Non-Covered Services:

- Procedures involving non-human and artificial organs.
- Organ transplants, and/or services or supplies rendered in connection with an organ transplant, which are Investigational as determined by the appropriate technological body.

- Any Prescription Drug Copayment.
- Transplant services from providers and/or facilities not approved by the Plan.
- Transplants and all related expenses that have not been prior authorized by MercyCare.
- Drugs which are investigational.
- Retransplantation. (except for kidney transplants).
- Purchase price of bone marrow, organ, or tissue that is sold rather than donated.
- Storage fees
- Services provided to any individual who is not the recipient or actual donor, unless otherwise specified in this provision.
- Travel time or related expenses incurred by a Provider.
- Meals.

URGENT CARE

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

VISION CARE

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.

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

- Routine or preventive eye exams are covered when rendered by a participating ophthalmologist or optometrist.
- Prescription glasses (including lenses and frames) or contact lenses.

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.
- The Plan covers mammograms for Members as follows:
  a) Age 35-39: 1 baseline mammogram;
  b) Age 40 and over, annually.
- Any mammography examinations including breast tomosynthesis and screening MRI for Members of any age if such exams are deemed medically appropriate by a provider.
- Comprehensive ultrasound screening of an entire breast or breasts if a mammogram demonstrates heterogeneous or dense breast tissue, when medically necessary as determined by a physician.
- An annual cervical smear or Pap smear test for female insureds.
- Surveillance tests for ovarian cancer for women at risk for ovarian cancer.
- An annual digital rectal examination and a prostate-specific antigen test, for: asymptomatic men age 50 and over when recommended by a provider; African-American men age 40 and over; and men age 40 and over with a family history of prostate cancer.
- Colorectal cancer screening with sigmoidoscopy or fecal occult blood testing once every 3 years for persons age 50 and over, and once every 3 years for persons age 30 and over and who may be classified as high risk for colorectal cancer because the person or a first degree family Member of the person has a history of colorectal cancer.

OTHER MEDICAL SERVICES

Covered Services:

- The administration of blood and blood products including blood extracts or derivatives and autologous donations (self to self).
- Cancer therapy. Prescription drug coverage available for the treatment of cancer must be approved by the federal Food and Drug Administration and must be recognized for the treatment of the specific type of cancer for which the drug has been prescribed in any one of the following established reference compendia:

  (a) The American Hospital Formulary Service Drug Information;
  (b) National Comprehensive Cancer Network's Drugs & Biologics Compendium;
  (c) Thomson Micromedex's Drug Dex;
  (d) Elsevier Gold Standard's Clinical Pharmacology.

- Injected Medicines that cannot be self-administered and which must be administered by injection. Benefits will be provided for the drugs and the administration of the injection. This includes routine immunizations and injections that you may need for traveling. Unless otherwise stated, benefits will be provided as described in the Preventive Care Services provision of this section of your Certificate.

In addition, benefits will be provided for a human papillomavirus (HPV) vaccine and a shingles vaccine approved by the federal Food and Drug Administration.

- Allergy testing and treatment.
- Topical eye medication prescribed to treat a chronic condition of the eye.
- Benefits will be provided for amino acid-based elemental formulas for the diagnosis and treatment of eosinophilic disorders or short-bowel syndrome.
- Infusion therapy.
- A second opinion from a provider regarding Covered Services.
- Oxygen and its administration.
- Electroconvulsive therapy including benefits for anesthesia administered with the electroconvulsive therapy if the anesthesia is administered by a Physician other than the one administering the therapy.

GENERAL EXCLUSIONS and LIMITATIONS

Expenses for the following are not covered under your Plan:

- Treatment for a Bodily Injury or Sickness arising from or sustained in the course of any occupation or employment for compensation, profit or gain if:
  - Benefits are provided or payable, or would have been provided or payable if You had applied for coverage, under any Worker's Compensation or Occupational Disease Act or Law. Benefits are considered payable under any Worker's Compensation or Occupational Disease Act or Law, in spite of any denial of coverage, until such denial has been upheld by any available independent review); or
  - You fail to file a Claim for benefits for which You are eligible under any Worker's Compensation or any Occupational Disease Act or Law.
    This exclusion does not apply to an Employee who is not required to have coverage under a Worker's Compensation or Occupational Disease Act or Law, and who discloses the lack of such coverage on the Group Application.
  - Services or supplies that are furnished to you by the local, state or federal government and services or supplies to the extent payments or benefits for such services or supplies are provided by or available from the local, state or federal government (for example, Medicare) whether or not those payments or benefits are received, except, however, this exclusion shall not be applicable to medical assistance benefits under Article V, VI, or VII of the Illinois Public Aid Code (Ill. Rev. Stat. ch. 23 § 1-1 et seq.) or similar Legislation of any state, benefits provided in compliance with the Tax Equity and Fiscal Responsibility Act or as otherwise provided by law.
- Any loss caused by:
  - War or any act of war declared or not; or
  - Any act of international armed conflict or any conflict involving armed forces of any international authority.
- Services or supplies that do not meet accepted standards of medical or dental practice including, but not limited to, services which are Experimental/Investigational in nature. This exclusion however does not apply to a) the cost of routine patient care associated with Experimental/ Investigational treatment if you are a qualified individual participating in an Approved Clinical Trial, if those services or supplies would otherwise be covered under this Certificate if not provided in connection with an Approved Clinical Trial program and b) applied behavior analysis used for the treatment of Autism Spectrum disorder(s) granted at the time the services and supplies are provided.
- Services or supplies that were received prior to the date Your coverage began or after the date Your coverage under the Policy terminates or after You are disenrolled from the Plan, unless otherwise stated in this Certificate.
- Medical expense due to Your commission or attempted commission of a civil or criminal battery or felony.
- Charges for any treatment related to a non-covered service.
  - Cosmetic Surgery and related services and supplies, except as specifically stated in this Certificate.
  - Repair or replacement of appliances and/or devices due to misuse or loss, except as specifically mentioned in this Certificate.
- 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).
- Services or supplies for which no charge is made or for which You would not have to pay without this coverage.
- Services and supplies not medically necessary for diagnosis and treatment of a covered Bodily Injury or Sickness.
- Long Term Care Services
- Respite Care Services, except as specifically mentioned in the Hospice Care section of Benefit Provisions.
- Inpatient Private Duty Nursing Service
- Maintenance Therapies for Occupational, Physical Therapy and Speech Therapy, except as specifically mentioned in this Certificate.
- Maintenance Care.

- 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 Certificate.
- All services or supplies not specifically covered in the Benefit Provisions section of this Certificate or by any rider attached to the Policy and any service not provided or received in accordance with the terms and conditions of this Certificate and Policy.
- Ancillary medical services (including Hospital facility charges, anesthesia charges, lab and x-ray charges) provided during the course of a non-covered Bodily Injury or Sickness. This exclusion does not apply to benefits for Dental Surgery as described in the Benefit Provisions section.
- Expenses for medical reports, including preparation and presentation.
- Services or supplies for holistic medicine, including homeopathic medicine, or other programs with an objective to provide complete personal fulfillment.
- Charges for missed appointments.
- Coma stimulation/recovery programs.
- Treatment, services or supplies provided while held, detained or imprisoned in a local, state or federal penal or correctional institution, or while in the custody of law enforcement officials. Persons on work release are exempt from this exclusion.
- Sexual counseling services are limited to those techniques commonly used by providers for conditions producing significant physical and mental symptoms.
- Any treatment or devices used to obtain, treat, or enhance sexual performance and/or function.
- Acupuncture.
- Reversal of vasectomies.
- Services and supplies rendered or provided outside of the United States, if the purpose of the travel to the location was for receiving medical services, supplies or drugs.
- Dental care, except as directly required for the treatment of a medical condition or as otherwise provided for in this Certificate.
- Any services and/or supplies provided to you outside the United States, unless they are received for an Emergency Condition, notwithstanding any provision in the Certificate to the contrary.
- Any drug or treatment used to treat hyperhidrosis.
- Animal-based therapy, including hippotherapy.
- Auditory integration training.
- The removal by any method of common warts and plane flat warts.
- Skin tag removal.
- Services for holistic medicine, including homeopathic medicine, or other programs with an objective to provide complete personal fulfillment.
- Charges related to childbirth in the home setting (home delivery).
- Excision of excessive skin, subcutaneous tissue, and/or fat, including but not limited to such surgery to the abdomen, thigh, leg, hip, buttock or arm (except when done as part of post-mastectomy reconstruction.
- Non-medical diagnostic evaluation and treatment of learning disabilities for developmental delays.

COVERAGE INFORMATION

ELIGIBILITY

Changes in state or federal law or regulations or interpretations thereof may change the terms and conditions of coverage.

Subject to the other terms and conditions of the Group Policy, the benefits described in this Certificate will be provided to persons who:

— Meet the definition of Employee as specified in the Group Policy;
— Have applied for this coverage;
— Have received a MercyCare identification card; and
— Live within the MercyCare service area. (Contact your Group or customer service at (877) 908-6027 for information regarding service area.); or
— Reside, live or work in the geographic network service area served by MercyCare for this Certificate of coverage. You may call customer service at (877) 908-6027 to determine if you are in the network service area or log on to the Web site at *www.mercycarehealthplans.com*.
— If Medicare eligible, have both Part A and B coverage.

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

Employee Coverage:

- The date the Employee qualifies for health coverage under the Plan, specified by the Group and MercyCare. However, if the Employee is not in Active Status on this date, coverage for the Employee and his or her dependents will not become effective until he or she returns to Active Status.

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

Family Coverage:

Under Family Coverage, Your health care expenses and those of Your enrolled spouse and Your (and/or Your spouse's) enrolled children who are under the limiting age specified in the Schedule of Benefits will be covered. All of the provisions of this Certificate that pertain to a spouse also apply to a party of a Civil Union unless specifically noted otherwise. A Domestic Partner and his or her children who have not attained the limiting age specified in the Schedule of Benefits section of this Certificate may also be eligible dependents, provided Your Employer covers Domestic Partners. All of the provisions of this Certificate that pertain to a spouse also apply to a Domestic Partner unless specifically noted otherwise, provided Your Employer covers Domestic Partners.

"Child(ren)" used hereafter in this Certificate, means a natural child(ren), a stepchild(ren), adopted child(ren), foster child(ren), a child(ren) of Your Domestic Partner (provided Your Employer covers Domestic Partners), a child(ren) who is in Your custody under an interim court order prior to finalization of adoption or placement of adoption vesting temporary care, whichever comes first, a child(ren) of Your child(ren), grandchild(ren), child(ren) for whom You are the legal guardian of a child under 26 years of age, regardless of presence or absence of a child's financial dependency, residency, student status, employment status, marital status, eligibility for other coverage or any combination of those factors; except that a covered dependent child who attains the limiting age while insured under the Plan shall remain eligible for benefits if he or she is incapable of self-sustaining employment because of intellectual disability or physical disability which existed before the dependent attained the limiting age. The dependent must continue to be dependent on his or her parents or other care providers for lifetime care and supervision.

Within 2 months prior to attainment by a dependent of the limiting age, or at any reasonable time after attainment of the limiting age, MercyCare may inquire whether the dependent is in fact a disabled and dependent person. Written proof of disability and dependency must be provided to MercyCare in a form satisfactory to MercyCare within 31 days after such inquiry. If written proof is not provided within 31 days, MercyCare may terminate the coverage of the dependent. MercyCare, at its sole discretion, may require the dependent to be examined from time to time by a provider for the purpose of determining the existence of the incapacity prior to granting continued coverage. Such examinations may occur at reasonable intervals during the first two years after continuation under this section is granted and annually thereafter.

In addition, enrolled unmarried children will be covered up to the age of 30 if they:

- Live within the Service Area of the Plan network for this Certificate; and
- Have served as an active or reserve Member of any branch of the Armed Forces of the United States; and
- Have received a release or discharge other than a dishonorable discharge.

For children who are college students and are on medical leave of absence, coverage for such dependent college student who takes a medical leave of absence or reduces his or her course load to part-time status because of a catastrophic illness or injury may continue such coverage subject to all of the Plan's terms and conditions. Continuation of coverage shall terminate 12 months after notice of the Sickness or Bodily Injury or

until the coverage would have otherwise lapsed pursuant to the terms and conditions of the Plan, whichever comes first, provided the need for part-time status or medical leave of absence is supported by a clinical certification of need from a physician licensed to practice medicine in all its branches.

Coverage for children will end on the last day of the period for which premium has been accepted.

If You have Family Coverage, newborn children will be covered from the moment of birth. Please notify the Plan within 31 days of the birth so that Your membership records can be adjusted. Your Group Administrator can tell You how to submit the proper notice through the Plan.

Children who are under Your legal guardianship or who are in Your custody under an interim court order prior to finalization of adoption or placement of adoption vesting temporary care, whichever comes first, and foster children will be covered. In addition, if You have children for whom You are required by court order to provide health care coverage, those children will be covered.

REPLACEMENT OF DISCONTINUED GROUP COVERAGE

When your Group initially purchases this coverage and such coverage is purchased as replacement of coverage under another carrier's group policy, those persons who are Totally Disabled on the effective date of this coverage and who were covered under the prior group policy will be considered eligible for coverage under this Certificate.

Your Totally Disabled dependents will be considered eligible dependents under this Certificate provided such dependents meet the description of an eligible family member as specified herein.

Your dependent children who have reached the limiting age of this Certificate will be considered eligible dependents under this Certificate if they were covered under the prior group policy and, because of a disability condition, are incapable of self-sustaining employment and are dependent upon you or other care providers for lifetime care and supervision.

If you are Totally Disabled, you will be entitled to all of the benefits of this Certificate. The benefits of this Certificate will be coordinated with benefits under your prior group policy. Your prior group policy will be considered the primary coverage for all services rendered in connection with your disabling condition when no coverage is available under this Certificate due to the absence of coverage in this Certificate. The provisions of this Certificate regarding Primary Care Physician referral remain in effect for such Totally Disabled persons.

APPLYING FOR COVERAGE

You may apply for coverage for yourself and/or your spouse, party to a Civil Union, Domestic Partner and/or dependents (see below) by submitting the application(s) for medical insurance form, along with any exhibits, appendices, addenda and/or other required information (“Application(s)”) to the Plan.

You can get the application form from your Group Administrator. An application to add a newborn to Family Coverage is not necessary if an additional premium is not required. However, you must notify your Group Administrator within 31 days of the birth of a newborn child for coverage to continue beyond the 31 day period or you will have to wait until your Group's open enrollment period to enroll the child.

The Application(s) for coverage may or may not be accepted. Please note, some Employers only offer coverage to their employees, not to their employees' spouses, parties to a Civil Union, Domestic Partners or dependents. In those circumstances, the references in this Certificate to an employee's family members are not applicable.

No eligibility rules or variations in premium will be imposed based on your health status, medical condition, Claims experience, receipt of health care, medical history, genetic information, evidence of insurability, disability or any other health status related factor. You will not be discriminated against for coverage under this Certificate on the basis of race, color, national origin, disability, age, sex, gender identity or sexual orientation. Variations in the administration, processes or benefits of this Certificate that are based on clinically indicated, reasonable medical management practices, or are part of permitted wellness incentives, disincentives and/or other programs do not constitute discrimination.

You may enroll in or change coverage for yourself and/or your eligible spouse and/or dependents during one of the following enrollment periods. Your and/or your eligible spouse and/or dependents' effective date will be determined by the Plan depending upon the date your application is received and other determining factors.
The Plan may require acceptable proof (such as copies of legal adoption or legal guardianship papers, or court orders) that an individual qualifies as an eligible Employee or dependent under this Certificate.

ENROLLMENT AND EFFECTIVE DATES

Enrollment Periods:
An eligible Employee may enroll in the Plan by submitting a completed Enrollment Form available from the Group during an Open Enrollment Period or Dual Choice Enrollment Period. At the same time, the Employee may enroll his or her eligible dependents eligible spouse, party to a Civil Union, Domestic Partner and/or dependents with the Enrollment Form. The effective date of coverage for the Employee and any enrolled dependents is indicated on the first page of this Certificate inserted after the front cover.

Your Group will designate annual open enrollment periods during which you may apply for or change coverage for yourself and/or your eligible spouse, party to a Civil Union, Domestic Partner and/or dependents. When you enroll during the annual open enrollment period, You and/or Your eligible dependents effective date will be the following January 1, unless otherwise designated by the Plan, as appropriate.

This section "Enrollment and Effective Dates" is subject to change by the Plan, and/or applicable law, as appropriate.

SPECIAL ENROLLMENT PERIODS

Special Enrollment Periods/Effective Dates of Coverage:
Special enrollment periods have been designated during which you may apply for or change coverage for yourself and/or your eligible spouse, party to a Civil Union, Domestic Partner and/or dependents. You must apply for or request a change in coverage within 30 days from the date of a special enrollment event, except as otherwise provided below, in order to qualify for the changes described in this Special Enrollment Periods/Effective Dates of Coverage section.

Except as otherwise provided below, if you apply between the 1st day and the 15th day of the month, your effective date will be no later than the 1st day of the following month, or if you apply between the 16th day and the end of the month, you and your eligible spouse, party to a Civil Union, Domestic Partner and/or dependents' effective date will be no later than the 1st day of the second following month.

Special Enrollment Events:

a) You gain or lose a dependent or become a dependent through marriage, becoming a party to a Civil Union or establishment of a Domestic Partnership, provided your Employer covers Domestic Partners. New coverage for you and/or your eligible spouse, party to a Civil Union or Domestic Partner and/or dependents will be effective no later than the 1st day of the following month.

b) You gain a dependent through birth, placement of a foster child, adoption or placement of adoption or court-ordered dependent coverage. New coverage for you and/or your eligible spouse, party to a Civil Union or Domestic Partner, provided your Employer covers Domestic Partners, and/or dependents will be effective on the date of the birth, placement of a foster child, adoption, or placement of adoption. However, the effective date for court-ordered eligible child coverage will be determined by the Plan in accordance with the provisions of the court-order.

c) You lose eligibility for coverage under a Medicaid plan or a state child health plan under title XXI of the Social Security Act. You must request coverage within 60 days of the loss of coverage.

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

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

Other Special Enrollment Events/Effective Dates of Coverage:
You must apply for or request a change in coverage within 30 days from the date of the below other special enrollment events in order to qualify for the changes described in this Other Special Enrollment Events/Effective Dates of Coverage section. Except as otherwise provided below, if you apply between the 1st day and the 15th day of the month, your effective date will be the 1st day of the following month, or if you apply between the 16th day and the end of the month, your and your eligible spouse, party to a Civil Union, Domestic Partner and/or dependent's effective date will be the 1st day of the second following month.

a) Loss of eligibility as a result of:
   - Legal separation, divorce, or dissolution of a Civil Union or a Domestic Partnership, provided your Employer covers Domestic Partners;
   - Cessation of dependent status (such as attaining the limiting age to be eligible as a dependent child under this Certificate);
   - Death of an Employee;
   - Termination of employment, reduction in the number of hours of employment.

b) Loss of coverage through an HMO in the individual market because you and/or your eligible spouse, party to a Civil Union, Domestic Partner and/or dependents no longer reside, live or work in the network service area.

c) Loss of coverage through an HMO, or other arrangement, in the group market because you and/or your eligible spouse, party to a Civil Union or Domestic Partner and/or dependents no longer reside, live or work in the network service area, and no other coverage is available to you and/or your eligible spouse, party to a Civil Union, Domestic Partner and/or dependents.

d) Loss of coverage due to a plan no longer offering benefits to the class of similarly situated individuals that include you.

e) Your Employer ceases to contribute towards your or your dependent's coverage (excluding COBRA continuation coverage).

f) COBRA continuation coverage is exhausted.

Coverage resulting from any of the special enrollment events outlined above is contingent upon timely completion of the Application(s) and remittance of the appropriate premiums in accordance with the guidelines as established by the Plan. Your spouse, party to a Civil Union or Domestic Partner (provided your Employer covers Domestic Partners) and other dependents are not eligible for a special enrollment period if the Group does not cover dependents.

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

BENEFIT CHANGES

An increase in benefits will become effective on the date of change in benefits if the employee is in active status. Otherwise, the change will be effective on the day following the date that the employee returns to active status. If dependent coverage is in effect, an increase in benefits will be delayed for covered dependents if the dependent is confined in an institution operated for the care of mentally or physically sick, injured or disabled persons. An increase in the dependent's coverage will be effective on the day after discharge from confinement. Discharge from confinement must be certified by a medical physician.

A decrease in benefits will become effective on the date of change of benefits.

NOTIFICATION OF ELIGIBILITY CHANGES

It is the eligible Employee's responsibility to notify the Plan of any changes to an eligible Employee's name or address or other changes to eligibility. Such changes may result in coverage/benefit changes for you and your eligible dependents. For example, if you move out of the Plan's "network service area". You must reside, live or work in the geographic "network service area" designated by the Plan. You may call the customer service number shown on the back of your identification card to determine if you live in the network service area, or log on to the Web site at: *www.mercycarehealthplans.com*.

MEDICARE ELIGIBLE COVERED PERSONS

A series of federal laws collectively referred to as the ``Medicare Secondary Payer'' (MSP) laws regulate the manner in which certain Employers may offer group health care coverage to Medicare eligible Employees, spouses, and in some cases, dependent children. Reference to spouse under this section do not include a party to a Civil Union with the eligible Employee or the Domestic Partner (provided your Employer covers Domestic Partners) of the eligible Employee or their children.

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

a) GHPs that cover individuals with end-stage renal disease ("ESRD") during the first 30 months of Medicare eligibility or entitlement. This is the case regardless of the number of employees employed by the employer or whether the individual has "current employment status."

b) In the case of individuals age 65 or over, GHPs of employers that employ 20 or more employees if that individual or the individual's spouse (of any age) has "current employment status." If the GHP is a multi-employer or multiple employer plan, which has at least one participating employer that employs 20 or more employees, the MSP rules apply even with respect to employers of fewer than 20 employees (unless the plan elects the small employer exception under the statute).

c) In the case of disabled individuals under age 65, GHPs of employers that employ 100 or more employees, if the individual or a member of the individual's family has "current employee status." If the GHP is a multi-employer or multiple employer plan, which has at least one participating employer that employs 100 or more employees, the MSP rules apply even with respect to employers of fewer than 100 employees.

Please see your employer or group administrator if you have any questions regarding the ESRD Primary Period or any other provisions of the MSP laws and their application to you, your spouse or your dependents.

LATE ENROLLMENT

FAMILY COVERAGE:
If you do not apply for Family Coverage or to add dependents within the allotted time, you will have to wait until your Group's annual open enrollment period to do so.

CHANGES TO ENROLLMENT FORM

Changes to the original Enrollment Form, other than physician or address changes, must be made by completing a Change of Status Form, which will be made available by the Plan to the Group for distribution to its Employees.

TERMINATION OF COVERAGE

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

1. The policy terminates; or
2. A covered service is no longer covered by the policy, except that termination then relates only to that covered service.

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

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

- The employee's employment terminates; or
- The employee ceases to meet eligibility requirements under the policy; or
- The member requests voluntary disenrollment; or
- The employee retires, or;
- The dependent no longer qualifies as an eligible dependent.

Termination of a Dependent's Coverage:
If one of your dependents no longer meets the description of an eligible family member as given above under the heading "Family Coverage," his/her coverage will end as of the date the event occurs which makes him/her ineligible (for example, date of divorce). Coverage for children will end on the last day of the calendar month in which they reach the limiting age as shown in the Schedule of Benefits section of this Certificate.

WHO IS NOT ELIGIBLE

a) Incarcerated individuals, other than incarcerated individuals pending disposition of charges.
b) Individuals that do not live, reside or work in the network service area.
c) Individuals that do not meet the Plan's eligibility requirements or residency standards, as appropriate.

This section "WHO IS NOT ELIGIBLE" is subject to change by the Plan and/or applicable law, as appropriate.

EXTENSION OF BENEFITS

Extension of Benefits in Case of Discontinuance of Coverage:
If you are Totally Disabled at the time your entire Group terminates, benefits will be provided for (and limited to) the Covered Services described in this Certificate which are related to the disability. Benefits will be provided when no coverage is available under the succeeding carrier's policy due to the absence of coverage in the policy. Benefits will be provided for a period of no more than 12 months from the date of termination. These benefits are subject to all of the terms and conditions of this. It is your responsibility to notify the Plan, and to provide, when requested by the Plan, written documentation of your disability.

RIGHTS TO CONTINUE GROUP MEDICAL COVERAGE

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

Federal COBRA Continuation:
The Federal Consolidated Omnibus Budget Reconciliation Act (COBRA) applies to employers with 20 or more employees.

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

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

a) Your hours of employment are reduced; or

b) Your employment ends for any reason other than your gross misconduct.

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

a) Your spouse dies;

b) Your spouse's hours of employment are reduced;

c) Your spouse's employment ends for any reason other than his or her gross misconduct;

d) Your spouse becomes enrolled in Medicare benefits (under Part A, Part B, or both); or

e) You become divorced or legally separated from your spouse.

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

a) The parent-employee dies;

b) The parent-employee's hours of employment are reduced;

c) The parent-employee's employment ends for any reason other than his or her gross misconduct;

d) The parent-employee becomes enrolled in Medicare benefits (under Part A, Part B, or both);

e) The parents become divorced or legally separated; or

f) The child stops being eligible for coverage under the Plan as a “dependent child.”

If the Plan provides health care coverage to retired employees, the following applies: Sometimes, filing a proceeding in bankruptcy under Title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to your employer, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, in the event of retired employee health coverage, commencement of a proceeding in bankruptcy with respect to the employer, or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event.

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. Contact your employer and/or COBRA Administrator for procedures for this notice, including a description of any required information or documentation.

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

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee'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 lasts for up to 36 months.

When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

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

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

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

1. 24 months from the beginning of the employee's absence from employment; and
2. the day after the date on which the employee fails to apply for or return to employment.

CONTINUATION OF COVERAGE AFTER TERMINATION (Illinois State Laws):
The purpose of this section of your Certificate is to explain the options available for continuing your coverage after termination, as it relates to Illinois state legislation. The provisions which apply to you will depend upon your status at the time of termination. The provisions described in Article A will apply if you are the eligible Employee (as specified in the Group Policy) at the time of termination. The provisions described in Article B will apply if you are the spouse of a retired eligible Employee or the party to a Civil Union with a retired eligible Employee and are at least 55 years of age or the former spouse of an eligible Employee or the former party to a Civil Union with a retired eligible Employee who has died or from whom you have been divorced or from whom your Civil Union has been dissolved. The provisions described in Article C will apply if you are the dependent child of an eligible Employee who has died or if you have reached the limiting age under this Certificate and not eligible to continue coverage as provided under Article B.

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

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

a) Continuation of coverage will be available to you only if you have been continuously insured under the Group Policy (or for similar benefits under any group policy which it replaced) for at least 3 months prior to your termination date or reduction in hours below the minimum required for eligibility.

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

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

reduction in hours below the minimum required for eligibility.

d) If you decide to continue your coverage under this Certificate, you must pay your Group on a monthly basis, in advance, the total charge required by the Plan for your continued coverage, including any portion of the charge previously paid by your Group. Payment of this charge must be made to the Plan (by your Group) on a monthly basis, in advance, for the entire period of your continuation of coverage under this Certificate.

e) Continuation of coverage under this Certificate will end on the date you become eligible for Medicare, become a member of the Plan on a ``direct pay'' basis or become covered under another health care program (which you did not have on the date of your termination or reduction in hours below the minimum required for eligibility) which provides group hospital, surgical or medical coverage. However, your continuation of coverage under this Certificate will also end on the first to occur of the following:

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

ARTICLE B: Continuation of Coverage if you are the former spouse of an eligible Employee or spouse of a retired eligible Employee:

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

a) Continuation will be available to you as the former spouse of an eligible Employee or spouse of a retired eligible Employee only if you provide the employer of the eligible Employee with written notice of the dissolution of marriage or Civil Union, the death or retirement of the eligible Employee within 30 days of such event.

b) Within 15 days of receipt of such notice, the employer of the eligible Employee will give written notice to the Plan of the dissolution of your marriage or Civil Union to the eligible Employee, the death of the eligible Employee or the retirement of the eligible Employee as well as notice of your address. Such notice will include the Group number and the eligible Employee 's identification number under this Certificate. Within 30 days of receipt of notice from the employer of the eligible Employee, the Plan will advise you at your residence, by certified mail, return receipt requested, that your coverage and your covered dependents under this Certificate may be continued. The Plan's notice to you will include the following:

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

c) In the event you fail to provide written notice to the Plan within the 30 days specified above, benefits will terminate for you on the date coverage would normally terminate for a former spouse or spouse of a retired eligible Employee under this Certificate as a result of the dissolution of marriage or Civil Union, the death or the retirement of the eligible Employee. Your right to continuation of coverage will then be forfeited.

d) If the Plan fails to notify you as specified above, all charges shall be waived from the date such notice was required until the date such notice is sent and benefits shall continue under the terms of this Certificate from the date such notice is sent, except where the benefits in existence at the time of the Plan's notice was to be sent are terminated as to all eligible Employees under this Certificate.

e) If you have not reached age 55 at the time your continued coverage begins, the monthly charge will be computed as follows:

- an amount, if any, that would be charged to you if you were an eligible Employee, with Individual or Family Coverage, as the case may be, plus

- an amount, if any, that the employer would contribute toward the charge if you were the eligible Employee under this Certificate.

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

f) If you have reached age 55 at the time your continued coverage begins, the monthly charge will be computed for the first 2 years as described above. Beginning with the third year of continued coverage, an additional charge, not to exceed 20% of the total amounts specified in (5) above will be charged for the costs of administration.

g) Termination of Continuation of Coverage:

If you have not reached age 55 at the time your continued coverage begins, your continuation of coverage shall end on the first to occur of the following:

- if you fail to make any payment of charges when due (including any grace period specified in the Group Policy).
- on the date coverage would otherwise terminate under this Certificate if you were still married to or in a Civil Union with the eligible Employee; however, your coverage shall not be modified or terminated during the first 120 consecutive days following the eligible Employee's death or entry of judgment dissolving the marriage or Civil Union existing between you and the eligible Employee, except in the event this entire Certificate is modified or terminated.
- the date on which you remarry or enter another Civil Union.
- the date on which you become an insured employee under any other group health plan.
- the expiration of 2 years from the date your continued coverage under this Certificate began.

h) If you have reached age 55 at the time your continued coverage begins, your continuation of coverage shall end on the first to occur of the following:

- if you fail to make any payment of charges when due (including any grace period specified in the Group Policy).
- on the date coverage would otherwise terminate, except due to the retirement of the eligible Employee under this Certificate if you were still married to or in a Civil Union with the eligible Employee; however, your coverage shall not be modified or terminated during the first 120 consecutive days following the eligible Employee 's death, retirement or entry of judgment dissolving the marriage or Civil Union existing between you and the eligible Employee, except in the event this entire Certificate is modified or terminated.
- the date on which you remarry or enter another Civil Union.
- the date on which you become an insured employee under any other group health plan.
- the date upon which you reach the qualifying age or otherwise establish eligibility under Medicare.

i) If you exercise the right to continuation of coverage under this Certificate, you shall not be required to pay charges greater than those applicable to any other eligible Employee covered under this Certificate, except as specifically stated in these provisions.

j) If this entire Certificate is cancelled and another insurance company contracts to provide group health insurance at the time your continuation of coverage is in effect, the new insurer must offer continuation of coverage to you under the same terms and conditions described in this Certificate.

ARTICLE C: Continuation of Coverage if you are the dependent child of an eligible Employee:
If the coverage of a dependent child should terminate because of the death of the eligible Employee and the dependent child is not eligible to continue coverage under ARTICLE B or the dependent child has reached the limiting age under this Certificate, the dependent child will be entitled to continue the coverage provided under this Certificate for himself/herself. However, this continuation of coverage option is subject to the following conditions:

a) Continuation will be available to you as the dependent child of an eligible Employee only if you, or a responsible adult acting on your behalf as the dependent child, provide the employer of the eligible Employee with written notice of the death of the eligible Employee within 30 days of the date the coverage terminates.

b) If continuation of coverage is desired because you have reached the limiting age under this Certificate, you must provide the employer of the eligible Employee with written notice of the attainment of the limiting age within 30 days of the date the coverage terminates.

c) Within 15 days of receipt of such notice, the employer of the eligible Employee will give written notice to the Plan of the death of the eligible Employee or of the dependent child reaching the

limiting age, as well as notice of the dependent child's address. Such notice will include the Group number and the eligible Employee's identification number under this Certificate. Within 30 days of receipt of notice from the employer of the eligible Employee, the Plan will advise you at your residence, by certified mail, return receipt requested, that your coverage under this Certificate may be continued. The Plan's notice to will include the following:

- a form for election to continue coverage under this Certificate.
- notice of the amount of monthly charges to be paid by you for such continuation of coverage and the method and place of payment.
- instructions for returning the election form within 30 days after the date it is received from the Plan.

d) In the event you, or the responsible adult acting on your behalf as the dependent child, fail to provide written notice to the Plan within the 30 days specified above, benefits will terminate for you on the date coverage would normally terminate for a dependent child of an eligible Employee under this Certificate as a result of the death of the eligible Employee or the dependent child attaining the limiting age. Your right to continuation of coverage will then be forfeited.

e) If the Plan fails to notify you as specified above, all charges shall be waived from the date such notice was required until the date such notice is sent and benefits shall continue under the terms of this Certificate from the date such notice is sent, except where the benefits in existence at the time of the Plan's notice was to be sent are terminated as to all eligible Employees under this Certificate.

f) The monthly charge will be computed as follows:

- an amount, if any, that would be charged to you if you were an eligible Employee, plus
- an amount, if any, that the employer would contribute toward the charge if you were the eligible Employee under this Certificate.

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

g) Continuation of Coverage shall end on the first to occur of the following:

- if you fail to make any payment of charges when due (including any grace period specified in the Group Policy).
- on the date coverage would otherwise terminate under this Certificate if you were still an eligible dependent child of the eligible Employee.
- the date on which you become an insured employee, after the date of election, under any other group health plan.
- the expiration of 2 years from the date your continued coverage under this Certificate began.

h) If you exercise the right to continuation of coverage under this Certificate, you shall not be required to pay charges greater than those applicable to any other eligible Employee covered under this Certificate, except as specifically stated in these provisions.

i) If this entire Certificate is cancelled and another insurance company contracts to provide group health insurance at the time your continuation of coverage is in effect, the new insurer must offer continuation of coverage to you under the same terms and conditions described in this Certificate.

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

CONTINUATION OF COVERAGE FOR PARTIES TO A CIVIL UNION

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

Continuation of Coverage:
If you are a dependent who is a party to a Civil Union or their child and you lose coverage under this Certificate, the options available to a spouse or to a dependent child as described in the CONTINUATION OF COVERAGE AFTER TERMINATION (Illinois State Laws) provision of this Certificate are available to you. In addition, coverage similar to the options described in the CONTINUATION COVERAGE RIGHTS UNDER COBRA provision of this Certificate, will also be available to you.

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

In addition to the events listed in the CONTINUATION OF COVERAGE AFTER TERMINATION (Illinois State Laws) provision, if applicable, continuation of coverage is available to you and your dependent children in the event you lose coverage because your Civil Union partnership with the eligible Employee terminates. Your Civil Union will terminate if your partnership no longer meets the criteria described in the definition of "Civil Union" in the DEFINITIONS section of this Certificate.

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

CONTINUATION OF COVERAGE FOR DOMESTIC PARTNERS

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

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

Continuation of Coverage:
If you are the Domestic Partner or the dependent child of a Domestic Partner and you lose coverage under this Certificate, you have the same options as the spouse or dependent child of an eligible Employee to continue your coverage. The options available to a spouse or to a dependent child as described in the CONTINUATION OF COVERAGE AFTER TERMINATION (Illinois State Laws) provision of this Certificate are available to you, if applicable to your Group. In addition, coverage similar to the options described in the CONTINUATION COVERAGE RIGHTS UNDER COBRA provision of this Certificate, will also be available to you.

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

In addition to the events listed in the CONTINUATION COVERAGE RIGHTS UNDER COBRA provision and the CONTINUATION OF COVERAGE AFTER TERMINATION (Illinois State Laws) provision, if applicable, continuation of coverage is available to you and your dependent children in the event you lose coverage because your Domestic Partnership with the eligible Employee terminates. Your Domestic Partnership will terminate if your partnership no longer meets the criteria described in the definition of "Domestic Partnership" in the DEFINITIONS section of this Certificate. You are entitled to continue coverage for the same period of time as a spouse or child who loses coverage due to divorce.

DISENROLLMENT

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

a) The Member commits acts of physical or verbal abuse that pose a threat to providers or to other Members of the Plan; or

b) The Member is unable to establish or maintain a satisfactory physician-patient relationship with a participating Primary Care Physician. (If a Member refuses to follow the recommended treatment of his/her Primary Care Physician, this may constitute an unsatisfactory physician-patient relationship.) Disenrollment for this reason is permitted only if MercyCare can demonstrate that it has provided the Member an opportunity to select another participating Primary Care Physician; made a reasonable effort to assist the Member in establishing a satisfactory physician-patient relationship; and properly communicated the complaint, appeal, and Grievance procedures to the Member. See the Complaint Procedures section in this Certificate of Coverage for more information.

GENERAL PROVISIONS

ADVANCE DIRECTIVES

If You are over the age of 18 and of sound mind, You may execute a living will or durable power of attorney for health care. The documents tell others what Your wishes are if You are physically and mentally unable to express Your wishes in the future. If You do have an advance directive, a copy should be given to Your Primary Care Physician. Also, please notify us in writing, as We are required, by law, to advise Your primary care provider and the clinic, that You have an advance directive. You are not required to send the forms to the Plan.

CASE MANAGEMENT/ALTERNATIVE TREATMENT

Case management is a program the Plan offers to Members. The Plan employs a professional staff to provide case management services. As part of this case management, the Plan reserves the right to direct treatment to the most effective option available.

CLERICAL ERRORS

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

CONFIDENTIALITY OF INFORMATION

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

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

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

CONFORMITY WITH STATE STATUTES

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

TIME LIMIT ON CERTAIN DEFENSES

After 2 years from the date of issue of this Policy no misstatements, except fraudulent misstatements, made by You in the application for the Policy shall be used to void the Policy or to deny a Claim for loss incurred or disability commencing after the expiration of such 2 year period. All statements made by Your employer or by You shall (in the absence of fraud) be deemed representations and not warranties. No such statement shall be used in defense to a Claim under the Policy unless it is contained in a written application. No Claim for loss incurred or disability commencing after 2 years from the date of issue of the Policy shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss had existed prior to the effective date of coverage of this Policy.

LEGAL ACTIONS

No civil action shall be brought to recover on this Policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of this Policy. No such action shall be brought after the expiration of 3 years after the time written proof of loss is required to be furnished.

PHYSICAL EXAMINATION

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

PROOF OF COVERAGE

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

QUALITY ASSURANCE

MercyCare's Medical Management Program is designed to ensure that quality medical care is accessible and appropriate to your needs, and to identify problems with care and correct those problems. There are many elements to this Program, including a process for choosing and deciding whether to retain participating providers; guidelines and education for providers regarding medical management and quality of care; review of medical data to monitor provision of care and treatment results; and consideration of member complaints and grievances to detect problems in provision of care. If you have any questions about this Program, please contact the MercyCare Customer Service Department.

RIGHTS OF RECOVERY: SUBROGATION AND REIMBURSEMENT

Except as otherwise provided in the Coordination of Benefits section of this certificate, in the event the Plan makes payment on your behalf for covered services, the Plan shall be subrogated to all of your rights of recovery against any person or organization for such payments. The Plan's subrogation and reimbursement rights apply to full and partial settlements, judgments, or other recoveries paid or payable to your or your representative, no matter how those proceeds are captioned or characterized.

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

By making payment for covered services, the Plan is granted a lien on the proceeds of any settlement, judgment, or other payment, which you receive, and you consent to said lien. The Plan is not required to help you pursue your claim for damages or personal injuries and no amount of associated costs, including attorney's fees, shall be deducted from our recovery without the Plan's express written consent. No so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall defeat this right unless applicable state law provides otherwise. You agree to take whatever steps are necessary to help the Plan secure said lien and to execute and deliver all instruments and papers and do whatever else is necessary to secure the Plan's rights of subrogation and reimbursement. You agree to cooperate with the Plan's representatives in completing such forms and in giving such information surrounding any Sickness or Bodily Injury as its representatives deem necessary.

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

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

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

WORKERS COMPENSATION

The Policy is not issued in lieu of nor does it affect any requirement for coverage by Workers' Compensation. If You are eligible for Workers' Compensation coverage for a Bodily Injury or Sickness arising from or sustained in the course of any occupation or employment for compensation, profit or gain that Bodily Injury or Sickness is not covered under this Policy, whether or not You actually obtained such coverage or received benefits under any coverage You obtained. If the Plan paid for the treatment of any such Bodily Injury or Sickness, and the Plan determines that You also received Worker's Compensation benefits for the same incident, the Plan has the right to recover such payments as described under the Right to Recovery provision of the Coordination of Benefits section of this Certificate. You must reimburse the Plan, and the Plan will exercise the right to recover against You.

The recovery rights will be applied even though:

a) The Workers' Compensation benefits are in dispute or are made by means of settlement or compromise; or
b) No final determination is made that the Bodily Injury or Sickness arose from, or was sustained in the course of, or resulted from Your employment; or
c) The amount of Workers' Compensation due to medical or health care is not agreed upon or defined by You or the Workers' Compensation carrier; or
d) The medical or health care benefits are specifically excluded from the Workers' Compensation settlement or compromise.

In the event that Workers' Compensation benefits are in dispute or when the amount of Workers' Compensation due for medical or health care is not agreed upon, Claims processing will be suspended. The involved parties will be notified as to the reason for the delay in processing. Upon resolution of such questions or problems, Claims processing will be resumed and any recovery rights will be applied.

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

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

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

COORDINATION OF BENEFITS

The Coordination of Benefits provision applies when you have health care coverage under more than one health plan.

DEFINITIONS

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

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

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

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

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

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

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

This Plan means the Group health Plan offered by MercyCare and described in this Certificate.

ORDER OF BENEFIT DETERMINATION

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

1. ***No coordination of benefits provision***: If the other plan does not have a coordination of benefits provision, that plan will be considered primary.
2. ***Non-dependent/Dependent:*** The Plan that covers a person as an employee, member or subscriber, other than a dependent, is considered primary. The Plan that covers a person as a dependent of an employee, member or subscriber is considered secondary.
3. ***Dependent Children:*** When a dependent child has coverage under both parents' plans, the Birthday Rule is used to determine which plan will be considered primary.
4. **Birthday Rule:** The Plan of the parent whose birth date occurs first in a calendar year is considered primary. If both parents have the same birth date, the Plan that has covered the parent for a longer period of time will be considered primary. If the other plan does not use the Birthday Rule to determine the coordination of benefits, the other plan's rule will determine the order of benefits.
5. ***Dependent Children with Divorced or Separated Parents**:* When a dependent child has coverage under both parents' plans and a court order awards custody of the child to one parent, benefits for the child are determined in this order:

    a. First, the Plan of the parent with custody of the child;
    b. Then, the Plan of the spouse of the parent who has custody of the child; and
    c. Finally, the Plan of the parent who does not have custody of the child.

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

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

6. ***Dependent Child if Parents Share Joint Custody:*** If the specific terms of a court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules outlined in 4 above.

7. ***Young Adults as a Dependent:*** For a dependent child who has coverage under either or both parents' plans and also has his or her own coverage as a dependent under a spouse's plan, rule 9, "Longer/Shorter Length of Coverage" applies. In the event the dependent child's coverage under the spouse's plan began on the same date as the dependent child's coverage under either or both parents' plans, the order of benefits shall be determined by applying the birthday rule of rule 4 to the dependent child's parent or parents and the dependent's spouse.

8. ***Active/Inactive Employee:*** The benefits of either a plan that covers a person as an employee who is neither laid off nor retired (or as that employee's dependent) are determined before those of a plan that covers that person as a laid-off or retired employee (or as that employee's dependent). If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule shall not apply.

9. ***Continuation of Coverage:*** If a person whose coverage is provided under a right of continuation pursuant to federal or state law also is covered under another plan, the following shall be the order of benefit determination:

    a. First, the benefits of a plan covering the person as an employee, member or subscriber (or as that person's dependent);

    b. Second, the benefits under the continuation coverage. If the other plan does not contain the order of benefits determination described within this section, and if, as a result, the programs do not agree on the order of benefits, this requirement shall be ignored.

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

EFFECT ON BENEFITS WHEN THIS PLAN IS SECONDARY

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

1. The benefits that would be payable for the allowable expenses under this Plan in the absence of this Coordination of Benefits provision; and
2. The benefits that would be payable for the allowable expenses under the other plans, in the absence of provisions with a purpose like that of this Coordination of Benefits provision, whether or not a Claim is made.

Under this provision, the benefits of this Plan will be reduced so that they and the benefits payable under the other plans do not total more than those allowable expenses.

MERCYCARE'S RIGHTS UNDER THE COORDINATION OF BENEFITS PROVISION

Right to Necessary Information:
In order to apply and coordinate benefits appropriately, MercyCare may require certain information. MercyCare has the right to decide what information We need in order to determine our payment, and to obtain that information from any organization or person. MercyCare may obtain the information without Your consent, but will do so only as it is needed to apply the coordination of benefits rules. We also have the right to give necessary information to another organization or person in order to coordinate benefits. Medical records remain confidential as required by state law.

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

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

COORDINATION OF BENEFITS WITH MEDICARE

In all cases, coordination of benefits with Medicare will conform to Federal Statutes and Regulations. If You are eligible for Medicare benefits, but not necessarily enrolled, Your benefits under this Plan will be coordinated to the extent benefits otherwise would have been paid under Medicare as allowed by Federal

Statutes and Regulations. Except as required by Federal Statutes and Regulations, this Plan will be considered secondary to Medicare.

Please note, you may be entitled to receive additional benefits:
The amount by which your benefits under this Plan have been reduced is called your ``savings.'' Savings can be used to pay for services that are not covered under this Plan provided that the services are covered under another plan and were not completely paid for under that plan. Savings can only be used to pay for services rendered in the same calendar year in which the Claim that earned the savings is actually processed. Please notify the Plan, by calling customer service, if there are expenses incurred during this calendar year which may entitle you to these additional benefits.

CLAIM 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, written notice of the Claim must be given to the company within 20 days after the occurrence or commencement of any loss covered by the Policy, or as soon thereafter as is reasonably possible. To submit a Claim, send an itemized bill from the physician, Hospital, or other provider to the following address:

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

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

   If the Plan does not receive a written notice of 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.

   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.

2. You agree to provide to the Plan any additional information regarding the occurrence and extent of the event for which the Claim is made which the Plan shall reasonably require in order to process the Claim.

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

4. 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.

5. All Claims will be paid within 30 days following receipt by MercyCare of due proof of loss. MercyCare will notify You within 30 days after receipt of Your Claim if You have failed to provide sufficient documentation for Your Claim. If MercyCare does not pay a Claim within such period, You will be entitled to interest at the rate of 9 per cent per annum from the 30th day after receipt of such proof of loss to the date of MercyCare pays the Claim, provided that interest amounting to less than one dollar need not be paid. Any required interest payments shall be made within 30 days after the payment.

6. 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.

7. 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.

If you have any questions about a Claim, call customer service at (877) 908-6027.

CONSENT TO RELEASE INFORMATION

CONSENT AND AUTHORIZATION

A Member consents to the release of medical and/or legal information to the Plan for himself or herself and for his/her covered dependents when he/she signs the Enrollment Form and when his/her Identification Card is used to receive health care services. The Plan has the right to deny coverage for the health services of any Member who will not consent to release information to the Plan.

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

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

PHYSICIAN and HOSPITAL REPORTS

Physicians and Hospitals must give the Plan reports to help the Plan determine contract benefits due to You. You agree to cooperate with the Plan to execute releases that authorize physicians, Hospitals, and other Providers of Health Care to release all records to the Plan regarding services You receive. It is also a condition of the Plan paying benefits. All information must be furnished to the extent the Plan deems it necessary in a particular situation and as allowed by pertinent statutes.

RIGHT TO COLLECT NEEDED INFORMATION

You must cooperate with the Plan and when asked will assist the Plan by:

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

COMPLAINT PROCEDURES

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

VERBAL COMPLAINT

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

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

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

CLAIM APPEAL PROCEDURES

Definitions:

Adverse Benefit Determination means

a) A denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or
b) Failure to provide in response to a Claim or make payment for, a benefit resulting from the application of utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate; or,
c) If an ongoing course of treatment had been approved by the Plan and the Plan reduces or terminates such treatment (other than by amendment or termination of the Group's benefit plan) before the end of the approved treatment period, that is also an Adverse Benefit Determination; or
d) A rescission of coverage is also an Adverse Benefit Determination. A Rescission does not include a termination of coverage for reasons related to non-payment of premium.

In addition, an Adverse Benefit Determination also includes an “Adverse Determination.”

An “Adverse Determination” means:

a) a determination by the Plan or its designated utilization review organization that, based upon the information provided, a request for a benefit under the Plan’s health benefit plan upon application of any utilization review technique does not meet the Plan’s requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness or it is determined to be experimental or investigational and the requested benefit is therefore denied, reduced, or terminated or payment is not provided or made, in whole or in part, for the benefit; or
b) a rescission of coverage determination, which does not include a cancellation of discontinuance of coverage that is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage. For purposes of the benefit program we will refer to both an Adverse Determination and an Adverse Benefit Determination as an Adverse Benefit Determination, unless indicated otherwise.

Standard Appeal of an Adverse Benefit Determination

You have the right to seek and obtain a full and fair review of any adverse benefit determination or any other determination made by the Plan in accordance with the benefits and procedures detailed in this certificate. An appeal of an Adverse Benefit Determination may be filed by you or a person authorized to act on your behalf. In some circumstances, a Health Care Provider may appeal on his/her own behalf. Your appeal maybe filed concurrently with the Health Care Provider appeal. Deadlines for filing appeals or external review requests are not delayed by appeals made by a Health Care Provide. Your designation of a representative must be in writing as it is necessary to protect against disclosure of information about you except to your authorized representative. To obtain an Authorized Representative Form, you or your representative may call the Plan at the number on the back of your identification card.
You must submit an appeal request in writing within 180 days after you receive notice of an Adverse Benefit Determination. You may give a written explanation of why you think we should change our decision and you or your authorized representative or provider may give any additional information or documents you want to add to make your point. You and your authorized representative may ask to review your file and any relevant documents.

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

The Plan will provide you or your authorized representative with any new or additional evidence or rationale and any other information and documents used in the denial or the review of your Claim without regard to whether such information was considered in the initial adverse benefit determination. Such new or additional evidence or rationale and information will be provided to you or your authorized representative sufficiently in advance of the date a final decision on appeal is made in order to give you a chance to respond. If the initial benefit determination regarding the Claim is based in whole or in part on a medical judgment, the appeal will be conducted by individuals associated with the Plan and/or by external advisors, but who were not involved in making the initial determination. Before you or your authorized representative may bring any action to recover benefits the claimant must exhaust the appeal process and must raise all issues with respect to a Claim and must file an appeal or appeals and the appeals must be finally decided by the Plan.

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

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

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

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

a) The reasons for the determination;
b) A reference to the benefit plan provisions on which the determination is based, and the contractual, administrative or protocol for the determination;
c) Subject to privacy laws and other restrictions, if any, the identification of the Claim, date of service, Health Care Provider, Claim amount (if applicable), and a statement describing denial codes with their meanings and the standards used. Upon request, diagnosis/treatment codes with their meanings and the standards used are also available;
d) An explanation of the Plan's external review processes (and how to initiate an external review) and a statement of your right, if any, to bring a civil action under Section 502(a) of ERISA following a final denial on internal appeal;
e) In certain situations, a statement in non-English language(s) that written notice of Claim denials and certain other benefit information may be available (upon request) in such non-English language(s);
f) In certain situations, a statement in non-English language(s) that indicates how to access the language services provided by the Plan;
g) The right to request, free of charge, reasonable access to and copies of all documents, records and other information relevant to the Claim for benefits;
h) Any internal rule, guideline, protocol or other similar criterion relied on in the determination, or a statement that a copy of such rule, guideline, protocol or other similar criterion will be provided free of charge on request;
i) An explanation of the scientific or clinical judgment relied on in the determination, or a statement that such explanation will be provided free of charge upon request;
j) A description of the standard that was used in denying the Claim and a discussion of the decision; and
k) Contact information for the Department of Insurance complaint division is stated in the Department of Insurance section of the certificate. .
l) The right to file an external review if the internal appeal has been delayed by the Plan, 30 days for concurrent or prospective, and 60 days for retrospective.
m) The right to file for external review if an expedited internal appeal has been delayed by the Plan 48 hours.
m) The provider and member each have the right to appeal one time each for the adverse benefit determination.

If the Plan's decision is to continue to deny or partially deny your provision of or payment for a health care service or course of treatment or you do not receive timely decision or the Plan waives the exhaustion requirement of its internal appeals process, you may be able to request an external review of your Claim by an independent review organization not associated with the Plan, who will review the denial and issue a final decision. You can file an external review You can request an external review regardless of the status of a

provider appeal. Your external review rights are described in the INDEPENDENT EXTERNAL REVIEW section below.

Expedited I Appeals:
If your situation meets the definition of an expedited clinical appeal, you may be entitled to an appeal on an expedited basis. An expedited clinical appeal is an appeal of a clinically urgent nature related to health care services, including but not limited to, procedures or treatments ordered by a Health Care Provider, as well as continued hospitalization. Before authorization of benefits for an ongoing course of treatment is terminated or reduced, MercyCare will provide you with notice at least 24 hours before the previous benefits authorization ends and an opportunity to appeal. For the ongoing course of treatment, coverage will continue during the appeal process.
Upon receipt of an expedited pre-service or concurrent clinical appeal, the Plan will notify the party filing the appeal, as soon as possible, but in no event more than 24 hours after submission of the appeal, of all the information needed to review the appeal. The Plan will render a decision on the appeal within 24 hours after it receives the requested information, but in no event more than 48 hours after the appeal has been received by the Plan.

DEPARTMENT OF INSURANCE
If an appeal is not resolved to your satisfaction, you may appeal the Plan's decision to the Illinois Department of Insurance by filing a complaint with the Department. The Illinois Department of Insurance will notify the Plan of the appeal. The Plan will have 21 days to respond to the Illinois Department of Insurance for the complaint regarding administrative issues.

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

The Illinois Department of Insurance can be contacted at:

Illinois Department of Insurance
Office of Consumer Health Insurance
320 W. Washington Street
Springfield, IL 62767-0001
1–877-527-9431 (toll free)
FAX (217) 558-2083
Email: Consumer_complaints@ins.state.il.us
https://mc.insurance.illinois.gov/messagecenter.nsf

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

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

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

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

Illinois Department of Insurance
Office of Consumer Health Insurance
External Review Unit
320 W. Washington Street
Springfield, IL 62767-0001
1–877-850-4740 (toll free)
FAX (217)557-8495
Email: Doi.externalreview@illinois.gov
https://mc.insurance.illinois.gov/messagecenter.nsf

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

a) **Preliminary Review**. Within five business days of receipt of the request from the Director, the Plan will complete a preliminary review of your request to determine whether:
   - You were a covered person at the time health care service was requested or provided; The service that is the subject of the Adverse Determination or the Final Adverse Determination is a Covered Service under this benefit program, but the Plan has determined that the health care service is not covered;
   - You have exhausted the Plan's internal appeal process, unless you are not required to exhaust the Plan's internal appeal process pursuant to the Illinois Health Carrier External Review Act; and
   - You have provided all the information and forms required to process an external review.

For appeals relating to a determination based on treatment being experimental or investigational, the Plan will complete a preliminary review to determine whether the requested service or treatment that is the subject of

the Adverse Determination or Final Adverse Determination is a Covered Service, except for the Plan's determination that the service or treatment is experimental or investigational for a particular medical condition and is not explicitly listed as an excluded benefit. In addition, your Health Care Provider has certified that one of the following situations is applicable:

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

- In addition,

a) Your Health Care provider has certified in writing that the health care service or treatment is likely to be more beneficial to you, in the opinion of your Health Care Provider, than any available standard health care services or treatments; or

b) **Y**our Health Care Provider, who is a licensed, board certified or board eligible physician qualified to practice in the area of medicine appropriate to treat your condition has certified in writing that scientifically valid studies using accepted protocols demonstrate that the health care service or treatment requested is likely to be more beneficial to you than any available standard health care services or treatments.

c) **Notification**. Within one business day after completion of the preliminary review, the Plan shall notify the Director, you and your authorized representative, if applicable, in writing whether the request is complete and eligible for an external review. If the request is not complete or not eligible for an external review, the Director, you and your authorized representative shall be notified by the Plan in writing of what materials are required to make the request complete or the reason for its ineligibility. The Plan's determination that the external review request is ineligible for review may be addressed with the Director by filing a complaint with the Director. The Director may determine that a request is eligible for external review and require that it be referred for external review. In making such determination, the Director's decision shall be in accordance with the terms of your benefit program (unless such terms are inconsistent with applicable laws) and shall be subject to all applicable laws.

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

Within five business days after the date of receipt of the notice provided by the Director of assignment of an IRO, the Plan shall provide to the assigned IRO the documents and any information considered in making the Adverse Determination or Final Adverse Determination. In addition, you or your authorized representative may, within five business days following the date of receipt of the notice of assignment of an IRO, submit in writing to the assigned IRO additional information that the IRO shall consider when conducting the external review. The IRO is not required to, but may, accept and consider additional information submitted after five business days. If the Plan or its designated utilization review organization does not provide the documents and information within five business days, the IRO may end the external review and make a decision to reverse the Adverse Determination or Final Adverse Determination. A failure by the Plan or designated utilization review organization to provide the documents and information to the IRO within five business days shall not delay the conduct of the external review. Within one business day after making the decision to end the external review, the IRO shall notify the Plan, you and, if applicable, your authorized representative, of its decision to reverse the determination.

If you or your authorized representative submitted additional information to the IRO, the IRO shall forward the additional information to the Plan within one business day of receipt from you or your authorized representative. Upon receipt of such information, the Plan may reconsider the Adverse Determination or Final Adverse Determination.
Such reconsideration shall not delay the external review. The Plan may end the external review and make a decision to reverse the Adverse Determination or Final Adverse Determination. Within one business day after making the decision to end the external review, the Plan shall notify the Director, the IRO, you, and if applicable, your authorized representative of its decision to reverse the determination.

e) **IRO's Decision**. In addition to the documents and information provided by the Plan and you, or if applicable, your authorized representative, the IRO shall also consider the following information if available and appropriate:
- Your pertinent medical records;
- Your health care Provider's recommendation;
- Consulting reports from appropriate health care Providers and other documents submitted to the Plan or its designated utilization review organization, you, your authorized representative or your treating Provider;
- The terms of coverage under the benefit program;
- The most appropriate practice guidelines, which shall include applicable evidence–based standards and may include any other practice guidelines developed by the federal government, national or professional medical societies, boards and associations;
- Any applicable clinical review criteria developed and used by the Plan or its designated utilization review organization; and
- The opinion of the IRO's clinical reviewer or reviewers after consideration of the items described above.

Within one business day after the receipt of notice of assignment to conduct an external review with respect to a denial of coverage based on a determination that the health care service or treatment recommended or requested is experimental or investigational, the IRO will select one or more clinical reviewers, as it determines is appropriate, to conduct the external review, which clinical reviewers must meet the minimum qualifications set forth in the Illinois Health Carrier External Review Act, and neither you, your authorized representative, if applicable, nor the Plan will choose or control the choice of the physicians or other health care professionals to be selected to conduct the external review. Each clinical reviewer will provide a written opinion to the IRO within 20 days after being selected by the IRO to conduct the external review on whether the recommended or requested health care service or treatment should be covered.

The IRO will make a decision within 20 days after the date it receives the opinion of each clinical reviewer, which will be determined by the recommendation of a majority of the clinical reviewers. Within five days after the date of receipt of the necessary information, but in no event more than 45 days after the date of receipt of request for an external review, the IRO will render its decision to uphold or reverse the Adverse Determination or Final Adverse Determination and will notify the Director, the Plan, you and your authorized representative, if applicable, of its decision.

The written notice will include:

a) A general description of the reason for the request for external review;
b) The date the IRO received the assignment from the Director;
c) The time period during which the external review was conducted;
d) References to the evidence or documentation including the evidence–based standards, considered in reaching its decision or, in the case of external reviews of experimental or investigational services or treatments, the written opinion of each clinical reviewer as to whether the recommended or requested health care service or treatment should be covered and the rationale for the reviewer's recommendation;
e) The date of its decisions;
f) The principal reason or reasons for its decision, including what applicable, if any, evidence–based standards that were a basis for its decision; and
g) The rationale for its decision.

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

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

Expedited External Review:

If you have a medical condition where the timeframe for completion of (a) an expedited internal review of an appeal involving an Adverse Determination;(b) a Final Adverse Determination; or, (c) a standard external review as described above, would seriously jeopardize your life or health or your ability to regain maximum function, then you or your authorized representative may file a request for an expedited external review by an IRO not associated with the Plan. In addition, if a Final Adverse Determination concerns an admission, availability of care, continued stay or health care service for which you received emergency services, but have not been discharged from a facility, then you or your authorized representative may request an expedited external review. You or your authorized representative may file the request immediately after a receipt of notice of a Final Adverse Determination if the Plan fails to provide a decision on a request for an expedited internal appeal within 48 hours.

You may also request an expedited external review if a Final Adverse Determination concerns a denial of coverage based on the determination that the treatment or service in question is considered experimental or investigational and your health care Provider certifies in

writing that the treatment or service would be significantly less effective if not started promptly. Expedited external review will not be provided for retrospective adverse or final adverse determinations. Your request for an expedited independent external review may be submitted to the Director either orally (by calling 877-850-4740) or in writing as set forth above for requests for standard external review.

Notification. Upon receipt of a request for an expedited external review, the Director shall immediately send a copy of the request to the Plan. The Plan shall immediately notify the Director, you and your authorized representative, if applicable, whether the expedited request is complete and eligible for an expedited external review. The Plan's determination that the external review request is ineligible for review may be addressed with the Director by filing a complaint with the Director. The Director may determine that a request is eligible for expedited external review and require that it be referred for an expedited external review. In making such determination, the Director's decision shall be in accordance with the terms of the benefit program (unless such terms are inconsistent with applicable law) and shall be subject to all applicable laws.

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

Upon receipt from the Director of the name of the IRO assigned to conduct the external review, the Plan or its designated utilization review organization shall immediately, (but in no case more than 24 hours after receiving such notice) provide to the assigned IRO the documents and any information considered in making the Adverse Determination or Final Adverse Determination. In addition, you or your authorized representative may submit additional information in writing to the assigned IRO. If the Plan or its designated utilization review organization does not provide the documents and information within 24 hours, the IRO may end the external review and make a decision to reverse the Adverse Determination or Final Adverse Determination. Within one business day after making the decision to end the external review, the IRO shall notify the Director, the Plan, you and, if applicable, your authorized representative, of its decision to reverse the determination.
As expeditiously as your medical condition or circumstances requires (but in no event more than 72 hours after the date of receipt of the request for an expedited external review), the assigned IRO will render a decision whether or not to uphold or reverse the Adverse Determination or Final Adverse Determination and will notify the Director, the Plan, you and, if applicable, your authorized representative. If the initial notice regarding its determination was not in writing, within 48 hours after the date of providing such notice, the assigned IRO shall provide written confirmation of the decision to you, the Director, the Plan and, if applicable, your authorized representative, including all the information outlined under the standard process above.

If the external review was a review of experimental or investigational treatments, each clinical reviewer shall provide an opinion orally or in writing to the assigned IRO as expeditiously as your medical condition or circumstances requires, but in no event less than five calendar days after being selected. Within 48 hours after the date it receives the opinion of each clinical reviewer, the IRO will make a decision and provide notice of the decision either orally or in writing to the Director, the Plan, you and your authorized representative, if applicable.

If the IRO's initial notice regarding its determination was not in writing, within 48 hours after the date of providing such notice, the assigned IRO shall provide written confirmation of the decision to you, the Director, the Plan and, if applicable, your authorized representative.
The assigned IRO is not bound by any decisions or conclusions reached during the Plan's utilization review process or the Plan's internal appeal process. Upon receipt of a notice of a decision reversing the Adverse Determination or Final Adverse Determination, the Plan shall immediately approve the coverage that was the subject of the determination.

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

GLOSSARY

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

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

ACUTE
Acute means an illness or injury that is of rapid onset with an expected short-term duration.

APPROVED CLINICAL TRIAL
Approved Clinical Trial means 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 one of the following:

1. A federally funded or approved trial,
2. A clinical trial conducted under an FDA investigational new drug application, or
3. A drug trial that is exempt from the requirement of an FDA investigational new drug application.

BEHAVIOR HEALTH PRACTITIONER
Behavioral Health Practitioner means a Physician or professional Provider who is duly licensed to render services for the treatment of Mental Illness, Serious Mental Illness or Substance Use Disorder Treatment.

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

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

CHANGE OF STATUS FORM
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 the Group.

CHIROPRACTOR
Chiropractor means a duly licensed chiropractor.

CHRONIC
Chronic means an illness or condition that is of long duration and show little change, or a slow progression, of the symptoms or condition. Treatment is supportive in nature and not curative.

CIVIL UNION
Civil Union means a legal relationship between two persons, of either the same or opposite sex, established pursuant to or as otherwise recognized by the Illinois Religious Freedom Protection and Civil Union Act.

CLAIM
Claim means a demand for payment due in exchange for health care services rendered.

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

COINSURANCE
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) residential treatment center, 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.

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

CONTRACT YEAR
Contract Year means the 12-month period beginning on the effective date of the Group's Policy.

COPAYMENT
Copayment means the Member's portion that You are required to pay for certain Covered Services provided under this Policy.

COVERED SERVICE
Covered Service means a service or supply specified in this Certificate 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 provider, You have reached the maximum level of recovery. If You are institutionalized, custodial care also includes room and board, nursing care, or other care when, in the opinion of a provider, medical or surgical treatment cannot reasonably be expected to enable You to live outside an institution. Custodial care also includes rest cures, respite care, and home care provided by family Members.

DEDUCTIBLE
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.

DEPENDENT COVERAGE
Dependent Coverage means coverage for Your eligible spouse and/or dependents under this Certificate.

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

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

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

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

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

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

EMERGENCY
Emergency means a medical condition manifesting itself by Acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part.

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

EMPLOYEE COVERAGE
Employee Coverage means that Your application for coverage was only for yourself.

ENROLLMENT FORM
Enrollment Form means the form completed by a potential Member requesting coverage from MercyCare and listing all dependents to be covered on the effective date of coverage.

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:

1. Requires the approval by the appropriate federal or other governmental agency that has not been granted at the time it is used; or
2. 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:

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

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

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

FAMILY COVERAGE
Family Coverage means coverage for you and your eligible spouse and/or dependents under this Certificate.

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.

GRIEVANCE
Grievance means any dissatisfaction that You have with MercyCare or with a provider of service that has been expressed in writing by You or on Your behalf. See the Complaint Procedures section in this Certificate for more information.

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

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

HABILITATIVE SERVICES
Habilitative services means health care services that help a person keep, learn, or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

HEALTH CARE PROVIDER
Health Care Provider means any health care facility (for example, a Hospital or Skilled Nursing Facility) or person (for example, a Physician or Dentist) duly licensed to render Covered Services to you.

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

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

Hospital does not mean an institution that is chiefly:

1. A place for treatment of Substance Use Disorder
2. A nursing home; or
3. A federal hospital.

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

IDENTIFICATION CARD
Identification Card means the card that MercyCare issues to You that indicates Your eligibility to receive Covered Services.

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.

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
Health care services or supplies needed to prevent, diagnose or treat an illness, injury, condition, disease or its symptoms and that meet accepted standards of medicine.

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 and his/her dependents who have been enrolled and are entitled to benefits under the Policy.

MENTAL ILLNESS
Mental Illness means those illnesses classified as mental disorders in the edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association which is current as of the date services are rendered to a patient. Reference Serious Mental Illness definition.

MERCYCARE
MercyCare means MercyCare HMO, Inc.

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

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

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

OPTOMETRIST
Optometrist means a duly licensed optometrist.

OUT-OF-POCKET EXPENSES
Out-of-pocket Expenses means the portion of covered charges for which the Member is responsible because of applicable Coinsurance and/or Deductible provisions, or non-covered charges.

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

PHYSICIAN

Physician means a physician duly licensed to practice medicine in all of its branches.

PHYSICIAN CHANGE FORM
Physician Change Form refers to the form available through MercyCare's Customer Service Department that enables a Member to change his or her selection of Primary Care Physician. Refer to the provision entitled Primary Care Physician (PCP) in the Obtaining Services section of this Certificate for more information.

PLAN
Plan means the group health Plan offered by MercyCare HMO, Inc. as described in this Certificate.

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

POLICYHOLDER
Policyholder means the Group.

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) a Physician who spends a majority of clinical time engaged in general practice or in the practice of internal medicine, pediatrics, gynecology, obstetrics, psychiatry or family practice, or b) a Chiropractor, and who you have selected to be primarily responsible for assessing, treating or coordinating your health care needs.

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:

1. Provides entry into MercyCare's health care system.
2. Evaluates a Member's total health care needs.
3. Provides personal medical care in one or more medical fields.
4. 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 MercyCare's approval before You receive a service or supply. Any Prior Authorization requirement is stated in this Certificate or in the Schedule of Benefits.

PROVIDER NETWORK
Provider Network means a group of providers contracted with the Plan to provide services for Members within a specific geographic location.

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 Illinois, or other applicable jurisdiction to provide Covered Services.
c) Nurses licensed by the State of Illinois 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.

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

QUALIFIED TREATMENT FACILITY
Qualified Treatment Facility means a facility, institution, or clinic duly licensed to provide Mental Health or

GLOSSARY

Substance Use Disorder treatment; primarily established for that purpose; and operating within the scope of its license.

REFERRAL
Referral means a written request for a service or treatment from a Participating provider.

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

RESIDENTIAL TREATMENT CENTER
A facility setting offering a defined course of therapeutic intervention and special programming in a controlled environment which also offers a degree of security, supervision, structure and is licensed by the appropriate state and local authority to provide such service. It does not include half-way houses, supervised living, group homes, boarding houses or other facilities that provide primarily a supportive environment and address long-term social needs, even if counseling is provided in such facilities. Patients are medically monitored with 24 hour medical availability and 24 hour onsite nursing service for patients with Mental Illness and/or Substance Use Disorders. The Plan requires that any Mental Illness and/or Substance Use Disorder Residential Treatment Center must be licensed in the state where it is located, or accredited by a national organization that is recognized by the Plan as set forth in its current credentialing policy, and otherwise meets all other credentialing requirements set forth in such policy.

ROUTINE OR PREVENTIVE
Routine or Preventive 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.

SERIOUS MENTAL ILLNESS
Serious Mental Illness means the following psychiatric illnesses as defined in the most current edition of the Diagnostic and Statistical Manual (DSM) published by the American Psychiatric Association:

1. Schizophrenia;
2. Paranoid and other psychotic disorders;
3. Bipolar disorders (hypomanic, manic, depressive, and mixed);
4. Major depressive disorders (single episode or recurrent);
5. Schizoaffective disorders (bipolar or depressive);
6. Pervasive developmental disorders;
7. Obsessive-compulsive disorders;
8. Depression in childhood and adolescence; and
9. Panic disorder;
10. Post-traumatic stress disorders (acute, chronic, or with delayed onset); and
11. Anorexia nervosa and bulimia nervosa..

SERVICE AREA
Service Area means the geographical area in which MercyCare is authorized to offer a health Plan.

SICKNESS
Sickness means any condition or disease that causes loss of, or affects, normal body function other than those resulting from Bodily Injury.

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

SOUND AND NATURAL TEETH
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.

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

SUBSTANCE USE DISORDER
Substance Use Disorder means the following mental disorders as defined in the most current edition of the Diagnostic and Statistical Manual (DSM) published by the American Psychiatric Association: (1) substance abuse disorders; (2) substance dependence disorders; and (3) substance induced disorders. All medical

necessity determinations for substance use disorders will be made in accordance with the most current edition of the American Society of Addiction Medicine Patient Placement Criteria

TOBACCO USE CESSATION PROGRAM

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

TOBACCO USER

Tobacco User means a person who is permitted under state and federal law to legally use tobacco, with tobacco use (other than religious or ceremonial use of tobacco), occurring on average four or more times per week that last occurred within the past six months (or such other meaning required or permitted by applicable law). Tobacco includes, but is not limited to, cigarettes, cigars, pipe tobacco, smokeless tobacco, snuff, etc. For additional information, please call the number on the back of your identification card or visit our website at www.mercycarehealthplans.com.

TOTALLY DISABLED

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

The condition of being totally disabled will be determined based upon the medical opinion of 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 means 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.

WE

We means MercyCare HMO, Inc.

WOMAN'S PRINCIPLE HEALTH CARE PROVIDER (WPHCP)

Woman's Principal Health Care Provider (WPHCP) means a physician licensed to practice medicine in all of its branches, specializing in obstetrics or gynecology or specializing in family practice.

YOU/YOUR

You/Your means any Member enrolled in the Plan

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