MercyCare Health Plans

www.mercycarehealthplans.com

Customer service (800) 895-2421

2015

A Health Maintenance Organization (high option) health plan

This plan's health coverage qualifies as minimum essential coverage and meets the minimum value standard for the benefits it provides. See page 3 for details.

Serving: Rock, Walworth, Jefferson and Green Counties

Enrollment in this plan is limited. You must live or work in our geographic service area to enroll. See page 13 for requirements.

Enrollment code for this Plan:

EY1 - High Option - Self Only
EY2 - High Option - Self and Family

IMPORTANT
- Rates: Back Cover
- Changes for 2015: Page 13
- Summary of benefits: Page 80

Authorized for distribution by the:

United States
Office of Personnel Management

Healthcare and Insurance
http://www.opm.gov/insure

Important Notice from MercyCare About

Our Prescription Drug Coverage and Medicare

OPM has determined that the MercyCare's prescription drug coverage is, on average, expected to pay out as much as the standard Medicare prescription drug coverage will pay for all plan participants and is considered Creditable Coverage. This means you do not need to enroll in Medicare Part D and pay extra for prescription drug coverage. If you decide to enroll in Medicare Part D later, you will not have to pay a penalty for late enrollment as long as you keep your FEHB coverage.

However, if you choose to enroll in Medicare Part D, you can keep your FEHB coverage and your FEHB plan will coordinate benefits with Medicare.

Remember: If you are an annuitant and you cancel your FEHB coverage, you may not re-enroll in the FEHB Program.

Please be advised

If you lose or drop your FEHB coverage and go 63 days or longer without prescription drug coverage that's at least as good as Medicare's prescription drug coverage, your monthly Medicare Part D premium will go up at least 1% per month for every month that you did not have that coverage. For example, if you go 19 months without Medicare Part D prescription drug coverage, your premium will always be at least 19 percent higher than what many other people pay. You will have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the next Annual Coordinated Election Period (October 15 through December 7) to enroll in Medicare Part D.

Medicare's Low Income Benefits

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information regarding this program is available through the Social Security Administration (SSA) online at www.socialsecurity.gov, or call the SSA at 1-800-772-1213 (TTY: 1-800-325-0778).

You can get more information about Medicare prescription drug plans and the coverage offered in your area from these places:

- Visit www.medicare.gov for personalized help.
- Call 1-800-MEDICARE (1-800-633-4227), (TTY:1-877-486-2048).

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Introduction

This brochure describes the benefits of MercyCare Health Plans under our contract CS-2926 with the United States Office of Personnel Management, as authorized by the Federal Employees Health Benefits law. Customer service may be reached at 1 (800) 895-2421 or through our website: www.mercycarehealthplans.com. The address for administrative offices is:

MercyCare Health Plans

P.O. Box 550

Janesville, WI 53547-0550

This brochure is the official statement of benefits. No oral statement can modify or otherwise affect the benefits, limitations, and exclusions of this brochure. It is your responsibility to be informed about your health benefits.

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled in Self and Family coverage, each eligible family member is also entitled to these benefits. You do not have a right to benefits that were available before January 1, 2015, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2015, and changes are summarized on page 80. Rates are shown at the end of this brochure.

Coverage under this plan qualifies as minimum essential coverage (MEC) and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at www.irs.gov/uac/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision for more information on the individual requirement for MEC.

The ACA establishes a minimum value for the standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). The health coverage of this plan does meet the minimum value standard for the benefits the plan provides.

Plain Language

All FEHB brochures are written in plain language to make them easy to understand. Here are some examples:

- Except for necessary technical terms, we use common words. For instance, "you" means the enrollee or family member, "we" means MercyCare Health Plan.
- We limit acronyms to ones you know. FEHB is the Federal Employees Health Benefits Program. OPM is the United States Office of Personnel Management. If we use others, we tell you what they mean.
- Our brochure and other FEHB plans' brochures have the same format and similar descriptions to help you compare plans.

Stop Health Care Fraud!

Fraud increases the cost of health care for everyone and increases your Federal Employees Health Benefits Program premium.

OPM's Office of the Inspector General investigates all allegations of fraud, waste, and abuse in the FEHB Program regardless of the agency that employs you or from which you retired.

Protect Yourself From Fraud – Here are some things that you can do to prevent fraud:

- Do not give your plan identification (ID) number over the telephone or to people you do not know, except for your health care providers, authorized health benefits plan, or OPM representative.
- Let only the appropriate medical professionals review your medical record or recommend services.
- Avoid using health care providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.

- Carefully review explanations of benefits (EOBs) that you receive from us.
- Periodically review your claim history for accuracy to ensure we have not been billed for services that you did not receive.

- Do not ask your doctor to make false entries on certificates, bills or records in order to get us to pay for an item or service.
- If you suspect that a provider has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:
  - Call the provider and ask for an explanation. There may be an error.
  - If the provider does not resolve the matter, call us at (800) 895-2421 and explain the situation.
  - If we do not resolve the issue:

CALL - THE HEALTH CARE FRAUD HOTLINE

877-499-7295

OR go to www.opm.gov/oig

You can also write to:

United States Office of Personnel Management

Office of the Inspector General Fraud Hotline

1900 E Street NW Room 6400

Washington, DC 20415-1100

- Do not maintain as a family member on your policy:
  - Your former spouse after a divorce decree or annulment is final (even if a court order stipulates otherwise); or
  - Your child age 26 or over (unless he/she was disabled and incapable of self support prior to age 26).
- If you have any questions about the eligibility of a dependent, check with your personnel office if you are employed, with your retirement office (such as OPM) if you are retired, or with the National Finance Center if you are enrolled under Temporary Continuation of Coverage.
- Fraud or intentional misrepresentation of material fact is prohibited under the Plan. You can be prosecuted for fraud and your agency may take action against you. Examples of fraud include, falsifying a claim to obtain FEHB benefits, trying to or obtaining services or coverage for yourself or for someone else who is not eligible for coverage, or enrolling in the Plan when you are no longer eligible.
- If your enrollment continues after you are no longer eligible for coverage (i.e., you have separated from Federal service) and premiums are not paid, you will be responsible for all benefits paid during the period in which premiums were not paid. You may be billed by your provider for services received. You may be prosecuted for fraud for knowingly using health insurance benefits for which you have not paid premiums. It is your responsibility to know when you or a family member are no longer eligible to use your health insurance coverage.

Preventing medical mistakes

An influential report from the Institute of Medicine estimates that up to 98,000 Americans die every year from medical mistakes in hospitals alone. That's about 3,230 preventable deaths in the FEHB Program a year. While death is the most tragic outcome, medical mistakes cause other problems such as permanent disabilities, extended hospital stays, longer recoveries, and even additional treatments. By asking questions, learning more and understanding your risks, you can improve the safety of your own health care, and that of your family members. Take these simple steps:

1. Ask questions if you have doubts or concerns.

- Ask questions and make sure you understand the answers.

- Choose a doctor with whom you feel comfortable talking.
- Take a relative or friend with you to help you ask questions and understand answers.

2. Keep and bring a list of all the medicines you take.

- Bring the actual medicines or give your doctor and pharmacist a list of all the medicines and dosage that you take, including non-prescription (over-the-counter) medicines and nutritional supplements.
- Tell your doctor and pharmacist about any drug, food, and other allergies you have, such as to latex.
- Ask about any risks or side effects of the medication and what to avoid while taking it. Be sure to write down what your doctor or pharmacist says.
- Make sure your medicine is what the doctor ordered. Ask the pharmacist about your medicine if it looks different than you expected.
- Read the label and patient package insert when you get your medicine, including all warnings and instructions.
- Know how to use your medicine. Especially note the times and conditions when your medicine should and should not be taken.
- Contact your doctor or pharmacist if you have any questions.

3. Get the results of any test or procedure.

- Ask when and how you will get the results of tests or procedures.
- Don't assume the results are fine if you do not get them when expected, be it in person, by phone, or by mail.
- Call your doctor and ask for your results.
- Ask what the results mean for your care.

4. Talk to your doctor about which hospital is best for your health needs.

- Ask your doctor about which hospital has the best care and results for your condition if you have more than one hospital to choose from to get the health care you need.
- Be sure you understand the instructions you get about follow-up care when you leave the hospital.

5. Make sure you understand what will happen if you need surgery.

- Make sure you, your doctor, and your surgeon all agree on exactly what will be done during the operation.
- Ask your doctor, "Who will manage my care when I am in the hospital?"
- Ask your surgeon:
  - "Exactly what will you be doing?"
  - "About how long will it take?"
  - "What will happen after surgery?"
  - "How can I expect to feel during recovery?"
- Tell the surgeon, anesthesiologist, and nurses about any allergies, bad reactions to anesthesia, and any medications or nutritional supplements you are taking.

Patient Safety Links

www.ahrq.gov/consumer. The Agency for Healthcare Research and Quality makes available a wide-ranging list of topics not only to inform consumers about patient safety but to help choose quality health care providers and improve the quality of care you receive.

www.npsf.orig. The National Patient Safety Foundation has information on how to ensure safer health care for you and your family.

www.talkaboutrx.org. The National Council on Patient Information and Education is dedicated to improving communication about the safe, appropriate use of medicines.

www.leapfroggroup.org The Leapfrog Group is active in promoting safe practices in hospital care.

www.ahqa.org The American Health Quality Association represents organizations and health care professionals working to improve patient safety.

Never Events

When you enter the hospital for treatment of one medical problem, you don't expect to leave with additional injuries, infections or other serious conditions that occur during the course of your stay. Although some of these complications may not be avoidable, too often patients suffer from injuries or illnesses that could have been prevented if the hospital had taken proper precautions.

We have a benefit payment policy that encourages hospitals to reduce the likelihood of hospital-acquired conditions such as certain infections, severe bedsores and fractures, and to reduce medical errors that should never happen. These conditions and errors are called "Never Events". When a Never Event occurs, neither your FEHB plan nor you will incur cost to correct the medical error.

You will not be billed for inpatient services related to treatment of specific hospital-acquired conditions or for inpatient services needed to correct Never Events, if you use MercyCare preferred providers. This policy helps to protect you from preventable medical errors and improve the quality of care you recieve.

FEHB Facts

Coverage information

No pre-existing condition limitation	We will not refuse to cover the treatment of a condition you had before you enrolled in this Plan solely because you had the condition before you enrolled.
Minimum essential coverage (MEC)	Coverage under this plan qualifies as minimum essential coverage (MEC) and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at www.irs.gov/uac/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision for more information on the individual requirement for MEC.
Minimum value standard	Our health coverage meets the minimum value standard of 60% established by the ACA. This means that we provide benefits to cover at least 60% of the total allowed costs of essential health benefits. The 60% standard is an actuarial value; your specific our-of-pocket costs are determined as explained in the brochure.
Where you can get information about enrolling in the FEHB Program	See www.opm.gov/insure/health for enrollment information as well as: • Information on the FEHB Program and plans available to you • A health plan comparison tool • A list of agencies that participate in Employee Express • A link to Employee Express • Information on and links to other electronic enrollment systems Also, your employing or retirement office can answer your questions, and give you a *Guide to Federal Employees Health Benefits Plans,* brochures for other plans, and other materials you need to make an informed decision about your FEHB coverage. These materials tell you: • When you may change your enrollment • How you can cover your family members • What happens when you transfer to another Federal agency, go on leave without pay, enter military service, or retire • When your enrollment ends • When the next Open Season for enrollment begins We don't determine who is eligible for coverage and, in most cases, cannot change your enrollment status without information from your employing or retirement office.
Types of coverage available for you and your family	Self Only coverage is for you alone. Self and Family coverage is for you, your spouse, and your dependent children under age 26, including any foster children authorized for coverage by your employing agency or retirement office. Under certain circumstances, you may also continue coverage for a disabled child 26 years of age or older who is incapable of self-support. If you have a Self Only enrollment, you may change to a Self and Family enrollment if you marry, give birth, or add a child to your family. You may change your enrollment 31 days before to 60 days after that event. The Self and Family enrollment begins on the first day of the pay period in which the child is born or becomes an eligible family member. When you change to Self and Family because you marry, the change is effective on the first day of the pay period that begins after your employing office receives your enrollment form; benefits will not be available to your spouse until you marry.

Your employing or retirement office will **not** notify you when a family member is no longer eligible to receive benefits, nor will we. Please tell us immediately of any changes in family member status, including your marriage, divorce, annulment, or when your child reaches age 26.

If you or one of your family members is enrolled in one FEHB plan, that person may not be enrolled in or covered as a family member by another FEHB plan.

If you have a qualifying life event (QLE) - such as a marriage, divorce, or the birth of a child - outside of the Federal Benefits Open Season, you may be eligible to enroll in the FEHB Program, change your enrollment, or cancel coverage. For a complete list of QLE's, visit the FEHB website at www.opm.gov/healthcare-insurance/life-events. If you need assistance, please contact your employing agency, Tribal Benefits Officer, personnel/payroll office, or retirement office.

Family member coverage

Family members covered under your Self and Family enrollment are your spouse (including a valid common law marriage) and children as described in the chart below.

Children	Coverage
Natural children, adopted children, and stepchildren	Natural, adopted children and stepchildren (including qualified children of same-sex domestic partners in certain states) are covered until their 26th birthday.
Foster children	Foster children are eligible for coverage until their 26th birthday if you provide documentation of your regular and substantial support of the child and sign a certification stating that your foster child meets all the requirements. Contact your human resources office or retirement system for additional information.
Children Incapable of self-support	Children who are incapable of self-support because of a mental or physical disability that began before age 26 are eligible to continue coverage. contact your human resources office or retirement system for additional information.
Married children	Married children (but **NOT** their spouse or their own children) are covered until their 26th birthday.
Children with or eligible for employer-provided health insurance	Children who are eligible for or have their own employer-provided health insurance are covered until their 26th birthday.

You can find additional information at www.opm.gov/insure.

Children's Equity Act

OPM has implemented the Federal Employees Health Benefits Children's Equity Act of 2000. This law mandates that you be enrolled for Self and Family coverage in the FEHB Program, if you are an employee subject to a court or administrative order requiring you to provide health benefits for your child(ren).

If this law applies to you, you must enroll for Self and Family coverage in a health plan that provides full benefits in the area where your children live or provide documentation to your employing office that you have obtained other health benefits coverage for your children. If you do not do so, your employing office will enroll you involuntarily as follows:

- If you have no FEHB coverage, your employing office will enroll you for Self and Family coverage in the Blue Cross and Blue Shield Service Benefit Plan's Basic Option;
- If you have a Self Only enrollment in a fee-for-service plan or in an HMO that serves the area where your children live, your employing office will change your enrollment to Self and Family in the same option of the same plan; or
- If you are enrolled in an HMO that does not serve the area where the children live, your employing office will change your enrollment to Self and Family in the Blue Cross and Blue Shield Service Benefit Plan's Basic Option.

As long as the court/administrative order is in effect, and you have at least one child identified in the order who is still eligible under the FEHB Program, you cannot cancel your enrollment, change to Self Only, or change to a plan that doesn't serve the area in which your children live, unless you provide documentation that you have other coverage for the children. If the court/administrative order is still in effect when you retire, and you have at least one child still eligible for FEHB coverage, you must continue your FEHB coverage into retirement (if eligible) and cannot cancel your coverage, change to Self Only, or change to a plan that doesn't serve the area in which your children live as long as the court/administrative order is in effect. Contact your employing office for further information.

When benefits and premiums start

The benefits in this brochure are effective January 1. If you joined this Plan during Open Season, your coverage begins on the first day of your first pay period that starts on or after January 1. **If you changed plans or plan options during Open Season and you receive care between January 1 and the effective date of coverage under your new plan or option, your claims will be paid according to the 2015 benefits of your old plan or option**. However, if your old plan left the FEHB Program at the end of the year, you are covered under that plan's 2014 benefits until the effective date of your coverage with your new plan. Annuitants' coverage and premiums begin on January 1. If you joined at any other time during the year, your employing office will tell you the effective date of coverage.

If your enrollment continues after you are no longer eligible for coverage, (i.e. you have separated from Federal service) and premiums are not paid, you will be responsible for all benefits paid during the period in which premiums were not paid. You may be billed for services received directly from your provider. You may be prosecuted for fraud for knowlingly using health insurance benefits for which you have not paid premiums. It is your responsibility to know when you or a family member are no longer eligible to use your health insurance coverage.

When you retire

When you retire, you can usually stay in the FEHB Program. Generally, you must have been enrolled in the FEHB Program for the last five years of your Federal service. If you do not meet this requirement, you may be eligible for other forms of coverage, such as Temporary Continuation of Coverage (TCC).

When you lose benefits

When FEHB coverage ends

You will receive an additional 31 days of coverage, for no additional premium, when:

- Your enrollment ends, unless you cancel your enrollment, or
- You are a family member no longer eligible for coverage.

Any person covered under the 31 day extension of coverage who is confined in a hospital or other institution for care or treatment on the 31st day of the temporary extension is entitled to continuation of the benefits of the Plan during the continuance of the confinement but not beyond the 60th day after the end of the 31 day temporary extension.

You may be eligible for spouse equity coverage or Temporary Continuation of Coverage (TCC), or a conversion policy (a non-FEHB individual policy.)

Upon divorce

If you are divorced from a Federal employee or annuitant, you may not continue to get benefits under your former spouse's enrollment. This is the case even when the court has ordered your former spouse to provide health coverage to you. However, you may be eligible for your own FEHB coverage under either the spouse equity law or Temporary Continuation of Coverage (TCC). If you are recently divorced or are anticipating a divorce, contact your ex-spouse's employing or retirement office to get RI 70-5, the *Guide To Federal Employees Health Benefits Plans for Temporary Continuation of Coverage and Former Spouse Enrollees,* or other information about your coverage choices. You can also download the guide from OPM's website, www.opm.gov/healthcare-insurance/healthcare/plan-information/guides.

Temporary Continuation of Coverage (TCC)

If you leave Federal service, Tribal employment or if you lose coverage because you no longer qualify as a family member, you may be eligible for Temporary Continuation of Coverage (TCC). The Affordable Care Act (ACA) did not eliminate TCC or change the TCC rules. For example, you can receive TCC if you are not able to continue your FEHB enrollment after you retire, if you lose your Federal or Tribal job, if you are a covered dependent child and you turn age 26, regardless of marital status, etc. You may not elect TCC if you are fired from your Federal or Tribal job due to gross misconduct.

Enrolling in TCC. Get the RI 79-27, which describes TCC, and the RI 70-5, the *Guide to Federal Employees Health Benefits Plans for Temporary Continuation of Coverage and Former Spouse Enrollees,* from your employing or retirement office or from www.opm.gov/healthcare-insurance. It explains what you have to do to enroll.

Alternatively, you can buy coverage through the Health Insurance Marketplace where, depending on your income, you could be eligible for a new kind fo tax credit that lowers your monthly premiums. Visit www.HealthCare.gov to compare plans and see what your premium, deductible, and out of pocket costs would be before you make a decision to enroll. Finally, if you qualify for coverage under another group health plan (such as your spouse's plan), you may be able to enroll in that plan, as long as you apply within 30 days of losing FEHBP coverage.

Converting to individual coverage

You may convert to a non-FEHB individual policy if:

- Your coverage under TCC or the spouse equity law ends (If you canceled your coverage or did not pay your premium, you cannot convert);
- You decided not to receive coverage under TCC or the spouse equity law; or
- You are not eligible for coverage under TCC or the spouse equity law.

If you leave Federal or Tribal service, your employing office will notify you of your right to convert. You must apply in writing to us within 31 days after you receive this notice. However, if you are a family member who is losing coverage, the employing or retirement office will **not** notify you. You must apply in writing to us within 31 days after you are no longer eligible for coverage.

Your benefits and rates will differ from those under the FEHB Program; however, you will not have to answer questions about your health, and we will not impose a waiting period or limit your coverage due to pre-existing conditions.

Health Insurance Marketplace

If you would like to purchase health insurance through the Affordable Care Act's Health Insurance Marketplace, please visit www.HealthCare.gov. This is a website provided by the U.S. Department of Health and Human Services that provides up-to-date information on the Marketplace.

Section 1. How this plan works

This Plan is a health maintenance organization (HMO). We require you to see specific physicians, hospitals, and other providers that contract with us. These Plan providers coordinate your health care services. The Plan is solely responsible for the selection of these providers in your area. Contact the Plan for a copy of their most recent provider directory.

HMOs emphasize preventive care such as routine office visits, physical exams, well-baby care, and immunizations, in addition to treatment for illness and injury. Our providers follow generally accepted medical practice when prescribing any course of treatment.

When you receive services from Plan providers, you will not have to submit claim forms or pay bills. You pay only the copayments, coinsurance, and deductibles described in this brochure. When you receive emergency services from non-Plan providers, you may have to submit claim forms.

You should join an HMO because you prefer the plan's benefits, not because a particular provider is available. You cannot change plans because a provider leaves our Plan. We cannot guarantee that any one physician, hospital, or other provider will be available and/or remain under contract with us.

General features of our High Option

We have Open Access benefits

Our HMO offers Open Access benefits. This means you can receive covered services from a participating provider without a required referral from your primary care physician or by another participating provider in the network.

How we pay providers

We contract with individual physicians, medical groups, and hospitals to provide the benefits in this brochure. These Plan providers accept a negotiated payment from us, and you will only be responsible for your copayments or coinsurance.

Preventive care services

Preventive care services are generally covered with no cost sharing and are not subject to copayments, deductibles or annual limits when received from a network provider. First dollar coverage may be limited to a maximum dollar amount each year.

Catastrophic protection

We protect you against catastrophic out-of-pocket expenses for coinsurance you pay for covered services. Your annual out-of-pocket expenses for covered services, cannot exceed $5,000 for Self Only enrollment, or $10,000 family coverage.

Health education resources and accounts management tools

Please refer to our website, www.mercycarehealthplans.com, for information on education and resources. There are tools and education resources under case management, utilization and pricing, clinical practice guidelines and behavioral health.

Your rights

OPM requires that all FEHB plans provide certain information to their FEHB members. You may get information about us, our networks, and our providers. OPM's FEHB website (www.opm.gov/healthcare-insurance) lists the specific types of information that we must make available to you. Some of the required information is listed below.

- MercyCare has been in existence since 1994
- MercyCare is a for profit HMO

If you want more information about us, call (800) 895-2421, or write to MercyCare Health Plans, Attention Customer Service, PO Box 550, Janesville, WI, 53547-0550. You may also contact us by fax at (608) 741-5238 or visit our website at www.mercycarehealthplans.com.

Service Area

To enroll in this Plan, you must live in or work in our service area. This is where our providers practice. Our service area is: Rock, Walworth, Jefferson and Green counties in Wisconsin.

Ordinarily, you must get your care from providers who contract with us. If you receive care outside our service area, we will pay only for emergency care benefits. We will not pay for any other health care services out of our service area unless the services have prior plan approval.

If you or a covered family member move outside of our service area, you can enroll in another plan. If your dependents live out of the area (for example, if your child goes to college in another state), you should consider enrolling in a fee-for-service plan or an HMO that has agreements with affiliates in other areas. If you or a family member move, you do not have to wait until Open Season to change plans. Contact your employing or retirement office.

Section 2. Changes for 2015

Do not rely only on these change descriptions; this Section is not an official statement of benefits. For that, go to Section 5 Benefits. Also, we edited and clarified language throughout the brochure; any language change not shown here is a clarification that does not change benefits.

- Your share of the non-Postal premium will increase for Self Only or increase for Self and Family. See page 82.
- The wellness benefit that was available in 2014 will no longer be offered in 2015.
- Your prescription drug benefit has changed for 2015. See page 54 for details.
  - Tier 1 Generics - $20 copay
  - Tier 2 Preferred Brands - $40 copay
  - Tier 3 Expanded Brands and Selected Generics - $60 copay

Section 3. How you get care

Identification cards

We will send you an identification (ID) card when you enroll. You should carry your ID card with you at all times. You must show it whenever you receive services from a Plan provider, or fill a prescription at a Plan pharmacy. Until you receive your ID card, use your copy of the Health Benefits Election Form, SF-2809, your health benefits enrollment confirmation (for annuitants), or your electronic enrollment system (such as Employee Express) confirmation letter.

If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call us at (800) 895-2421 or write to us at P. O. Box 550, Janesville, WI 53547-0550. You may also request replacement cards through a link on our website: www.mercycarehealthplans.com.

Where you get covered care

You get care from "Plan providers" and "Plan facilities." You will only pay copayments, and/ or coinsurance. Your primary care physician is responsible for your care. You can visit any participating provider without a referral, but your primary care physician is available to assist you in finding the appropriate participating care.

- **Plan providers**

Plan providers are physicians and other health care professionals in our service area that we contract with to provide covered services to our members. We credential Plan providers according to NCQA standards.

We list Plan providers in the provider directory, which we update periodically. The list is also on our website at www.mercycarehealthplans.com.

- **Plan facilities**

Plan facilities are hospitals and other facilities in our service area that we contract with to provide covered services to our members. We list these in the provider directory, which we update periodically. The list is also on our website at www.mercycarehealthplans.com.

What you must do to get covered care

It depends on the type of care you need. First, you and each family member must choose a primary care physician. This decision is important since your primary care physician provides or arranges for most of your health care. A member's primary care physician evaluates a member's total health care needs, provides personal medical care in one or more medical fields and is in charge of coordinating other health services and referring the member to other providers of health care when appropriate. Each family member may choose a different primary care physician.

- **Primary care**

You may choose one of the following as your primary care physician: Family Medicine (FM) is a medical specialty devoted to comprehensive health care to people of all ages. An Internal Medicine physician focuses on the diagnosis and medical treatment of adults. A physician who specializes in internal medicine is referred to as an internist. A minimum of seven years of medical school and postgraduate training are focused on learning the prevention, diagnosis, and treatment of diseases of adults. A Pediatrician is a physician that deals with the care of infants and children and the treatment of their diseases. Your primary care physician will provide most of your health care, or give you a referral to see a specialist.

If you want to change primary care physicians or if your primary care physician leaves the Plan, call us at (800) 895-2421. We will help you select a new one. You may also change your primary care physician on our website at www.mercycarehealthplans.com.

- **Specialty care**

Your primary care physician will refer you to a specialist for needed care. MercyCare does not require members to have a referral when accessing participating specialists. However, some specialists may require a written referral from your primary care physician.

Here are some other things you should know about specialty care:

- If you need to see a specialist frequently because of a chronic, complex, or serious medical condition, your primary care physician will develop a treatment plan that allows you to see your specialist for a certain number of visits without additional referrals.

Your primary care physician will create your treatment plan. The physician may have to get an authorization or approval from us beforehand. If you are seeing a specialist when you enroll in our Plan, talk to your primary care physician. If he or she decides to refer you to a specialist, ask if you can see your current specialist.

If your current specialist does not participate with us, you must receive treatment from a specialist who does. Generally, we will not pay for you to see a specialist who does not participate with our Plan.

- If you are seeing a specialist and your specialist leaves the Plan, call your primary care physician, who will arrange for you to see another specialist. You may receive services from your current specialist until we can make arrangements for you to see someone else.
- If you have a chronic and disabling condition and lose access to your specialist because we:

- terminate our contract with your specialist for other than cause;

-drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB program plan; or

-reduce our service area and you enroll in another FEHB plan.

You may be able to continue seeing your specialist for up to 90 days after you receive notice of the change. Contact us, or if we drop out of the Program, contact your new plan.

If you are in the second or third trimester of pregnancy and you lose access to your specialist based on the above circumstances, you can continue to see your specialist until the end of your postpartum care, even if it is beyond the 90 days.

- **Hospital care**

Your Plan primary care physician or specialist will make necessary hospital arrangements and supervise your care. This includes admission to a skilled nursing or other type of facility.

If you are hospitalized when your enrollment begins

We pay for covered services from the effective date of your enrollment. However, if you are in the hospital when your enrollment in our Plan begins, call our Customer Service Department immediately at (800) 895-2421. If you are new to the FEHB Program, we will arrange for you to receive care and provide benefits for your covered services while you are in the hospital beginning on the effective date of your coverage.

If you changed from another FEHB plan to us, your former plan will pay for the hospital stay until:

- you are discharged, not merely moved to an alternative care center;
- the day your benefits from your former plan run out; or
- the 92nd day after you become a member of this Plan, whichever happens first.

These provisions apply only to the benefits of the hospitalized person. If your plan terminates participation in the FEHB Program in whole or in part, or if OPM orders an enrollment change, this continuation of coverage provision does not apply. In such cases, the hospitalized family member's benefits under the new plan begin on the effective date of enrollment.

You need prior Plan approval for certain services

Since your primary care physician arranges most referrals to specialists and inpatient hospitalization, the pre-service claim approval process only applies to care shown under *Other services.*

- **Inpatient hospital admission**

Precertification is the process by which - prior to your inpatient hospital admission - we evaluate the medical necessity of your proposed stay and the number of days required to treat your condition.

- **Other services**

Your primary care physician has authority to refer you for most services. For certain services, however, your physician must obtain prior approval from us. Before giving approval, we consider if the service is covered, medically necessary, and follows generally accepted medical practice. You must obtain prior authorization for:

- 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
- Psychological disorder and chemical dependency (see Section 5e)
- Reproductive services, inpatient
- Surgical services, inpatient, outpatient, and at a freestanding surgical facility
- Skilled nursing facility services
- Temporomandibular disorders (TMJ)
- Transplants

- **How to request precertification for an admission or get prior authorization for Other services**

First, your physician, your hospital, you, or your representative, must call us at (800) 895-2421 before admission or services requiring prior authorization are rendered.

Next, provide the following information:

- enrollee's name and Plan identification number;
- patient's name, birth date, identification number and phone number;
- reason for hospitalization, proposed treatment or surgery;
- name and phone number of admitting physician;
- name of hospital or facility; and
- number of days requested for hospital stay.

- **Non-urgent care claims**

For non-urgent care claims, we will then tell the physician and/or hospital the number of approved inpatient days, or the care that we approve for other services that must have prior authorization. We will make our decision within 15 days of receipt of the pre-service claim. If matters beyond our control require an extension of time, we may take up to an additional 15 days for review and we will notify you of the need for an extension of time before the end of the original 15 day period. Our notice will include the circumstances underlying the request for the extension and the date when a decision is expected.

If we need an extension because we have not received necessary information from you, our notice will describe the specific information required and we will allow you up to 60 days from the receipt of the notice to provide the information.

- **Urgent care claims**

If you have an urgent care claim (i.e., when waiting for the regular time limit for your medical care or treatment could seriously jeopardize your life, health, or ability to regain maximum function, or in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without this care or treatment), we will expedite our review and notify you of our decision within 72 hours. If you request that we review your claim as an urgent care claim, we will review the documentation you provided and decide whether it is an urgent care claim by applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine.

If you fail to provide sufficient information, we will contact you within 24 hours after we receive the claim to provide notice of the specific information we need to complete our review of the claim. We will allow you up to 48 hours from the receipt of this notice to provide the necessary information. We will make our decision on the claim within 48 hours of (1) the time we received the additional information or (2) to end of the time frame, whichever is earlier.

We may provide our decision orally within these time frames, but we will follow up with written or electronic notification within three days of the oral notification.

You may request that your urgent care claim on appeal be reviewed simultaneously by us and OPM. Please let us know that you would like a simultaneous review of your urgent care claim by OPM either in writing at the time you appeal our initial decision, or by calling us at (800) 895-2421. You may also call OPM's Health Insurance 3 at (202) 606-0737 between 8 a.m and 5 p.m. Eastern Time to ask for the simultaneous review. We will cooperate with OPM so they can quickly review your claim on appeal. In addition, if you did not indicate that your claim was a claim for urgent care, call us at (800) 895-2421. If it is determined your claim is an urgent care claim, we will expedite our review (if we have not yet responded to your claim).

- Concurrent care claims

A concurrent care claim involves care provided over a period of time or over a number of treatments. We will treat any reduction or termination of our pre-approved course of treatment before the end of the approved period of time or number of treatments as an appealable decision. This does not include reduction or termination due to benefit changes or if your enrollment ends. If we believe a reduction or termination is warranted we will allow you sufficient time to appeal and obtain a decision from us before the reduction or termination takes effect.

If you request an extension of an ongoing course of treatment at least 24 hours prior to the expiration of the approved time period and this is also an urgent care claim, then we will make a decision within 24 hours after we receive the claim.

- **Emergency inpatient admission**

If you have an emergency admission due to a condition that you reasonably believe puts your life in danger or could cause serious damage to bodily function, you, your representative, the physician, or the hospital must telephone us within two business days following the day of the emergency admission, even if you have been discharged from the hospital.

- **Maternity care**

If you are using a participating provider, your treating physician (primary care or obstetrician) will make the necessary arrangements.

- **If your treatment needs to be extended**

If you request an extension of an ongoing course of treatment at least 24 hours prior to the expiration of the approved time period and this is also an urgent care claim, then we will make a decision within 24 hours after we receive the claim.

What happens when you do not follow the precertification rules when using non-network facilities

If pre-certification is not obtained for services from a non network facility MercyCare will not cover any claims associated with those services and will deny all related services as member liability.

Circumstances beyond our control

Under certain extraordinary circumstances, such as natural disasters, we may have to delay your services or we may be unable to provide them. In that case, we will make all reasonable efforts to provide you with the necessary care.

If you disagree with our pre-service claim decision

If you have a **pre-service claim** and you do not agree with our decision regarding precertification of an inpatient admission or prior approval of other services, you may request a review in accord with the procedures detailed below.

If you have already received the service, supply, or treatment, then you have a **post-service claim** and must follow the entire disputed claim process detailed in Section 8.

- **To reconsider a non-urgent care claim**

Within 6 months of our initial decision, you may ask us in writing to reconsider our initial decision. Follow Step 1 of the disputed claims process detailed in Section 8 of this brochure.

In the case of a pre-service claim and subject to a request for additional information, we have 30 days from the date we receive your written request for reconsideration to

1. Precertify your hospital stay or, if applicable, arrange for the health care provider to give you the care or grant your request for prior approval for a service, drug, or supply; or
2. Ask you or your provider for more information

You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days.

If we do not receive the information within 60 days we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.

3. Write to you and maintain our denial

- **To reconsider an urgent care claim**

In the case of an appeal of a pre-service urgent care claim, within 6 months of our initial decision, you may ask us in writing to reconsider our initial decision. Follow Step 1 of the disputed claims process detailed in Section 8 of this brochure.

Unless we request additional information, we will notify you of our decision within 72 hours after receipt of your reconsideration request. We will expedite the review process, which allows oral or written requests for appeals and the exchange of information by telephone, electronic mail, facsimile, or other expeditious methods.

- **To file an appeal with OPM**

After we reconsider your **pre-service claim**, if you do not agree with our decision, you may ask OPM to review it by following Step 3 of the disputed claims process detailed in Section 8 of this brochure.

Section 4. Your costs for covered services

This is what you will pay out-of-pocket for covered care:

Cost-sharing	Cost-sharing is the general term used to refer to your out-of-pocket costs (e.g., deductible, coinsurance, and copayments) for the covered care you receive.
Copayments	A copayment is a fixed amount of money you pay to the provider, facility, pharmacy, etc., when you receive certain services. Example: When you see your primary care physician, you pay a copayment of $10 per office visit.
Deductible	We do not have a deductible.
Coinsurance	Coinsurance is the percentage of our allowance that you must pay for your care. Example: In our Plan, you pay 50% of our allowance for diagnosis and treatment of infertility services and 25% of our allowance for durable medical equipment.
Differences between our Plan allowance and the bill	1. Contractual reduction - difference between the billed amount and the allowed amount per contract with providers. You are not responsible for this amount. 2. Usual and Customary - difference between the billed amount and the maximum amount payable based upon the average charge for the same service provided. You may be responsible for this amount.
Your catastrophic protection out-of-pocket maximum	After your (copayments and coinsurance) total $5,000 for self only or $10,000 per family enrollment in any calendar year, you do not have to pay any more coinsurance for covered services.
Carryover	This plan does not have a carryover provision.
When Government Facilities Bill Us	Facilities of the Department of Veterans Affairs, the Department of Defense, and the Indian Health Services are entitled to seek reimbursement from us for certain services and supplies they provide to you or a family member. They may not seek more than their governing laws allow. You may be responsible to pay for certain services and charges. Contact the government facility directly for more information.

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High Option Benefits Overview

This Plan offers a High Option. The benefit package is described in Section 5.

The High Option Section 5 is divided into subsections. Please read *Important things you should keep in mind* at the beginning of the subsections. Also read the general exclusions in Section 6; they apply to the benefits in the following subsections. To obtain claim forms, claims filing advice, or more information about High Option benefits, contact us at (800) 895-2421 or on our website at www.mercycarehealthplans.com.

- **High Option** - $10 office visit copayment, inpatient/outpatient services covered at 100%, written referrals are not required when seeing a MercyCare Health Plan Provider.

MercyCare has been NCQA accredited since 1998 and is a winner of the Malcolm Baldrige award. We offer quality care close to home.

It is important that you stay informed and educated about your health care benefit information. Our Customer Service specialists are ready to assist you regarding any aspect of your heath care benefit needs. Customer Service can be reached by calling (800) 895-2421, Monday through Friday between 8:30 a.m. and 5:00 p.m. Our goal is to make sure you receive the information or help you need and to provide this service courteously and with respect to our members.

Section 5(a). Medical services and supplies provided by physicians and other health care professionals

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- A facility copay applies to services that appear in this section but are performed in an ambulatory surgical center or the outpatient department of a hospital
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also, read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The services listed below are for the charges billed by a physician or other health care professional for your surgical care. See Section 5 (c) for charges associated with the facility (i.e. hospital, surgical center, etc.).

Benefit Description	You Pay
Diagnostic and treatment services	**High Option**
Professional services of physicians • In physician's office	$10 per office visit
Professional services of physicians • In an urgent care center • Office medical consultations • Second surgical opinion • At home	$10 per office visit
• During a hospital stay • In a skilled nursing facility • Initial examination of a newborn child covered under a family enrollment	Nothing
Not covered *Any services and/or supplies given primarily at the request of, for the protection of, or to meet the requirements of, a party other than the member when such services and/or supplies are not otherwise medically necessary or appropriate, unless the services and/or supplies are state-mandated. Excluded services and supplies include physical exams, disease immunizations, services and supplies for employment (including travel for employment), licensing, marriage, adoption, insurance, camp, school, sports, and travel.*	*All charges*

Benefit Description	You Pay
Lab, X-ray and other diagnostic tests	**High Option**
Tests, such as: • Blood tests • Urinalysis • Non-routine Pap test • Pathology • X-rays • Non-routine mammograms • CAT Scans • Ultrasound • Electrocardiogram and EEG	Nothing
• *MRI • *Pet Scans *Prior authorization required when ordered by a primary care physician	Nothing
Preventive care, adult	**High Option**

Routine screenings, such as:
• Annual physicals
• Total blood cholesterol
• Colorectal cancer screening, including
  • Fecal occult blood test
  • Sigmoidoscopy screening - every five years starting at age 50
  • Colonosocopy screening
	Nothing

Routine Prostate Specific Antigen (PSA) test – one annually for men age 40 and older	Nothing
Well woman care; including but not limited to: • Routine Pap test • Human papillomavirus testing for women age 30 and up once every three years • Annual counseling for sexually transmitted infections • Annual counseling and screening for human immune-deficiency virus • Contraceptive methods and counseling • Screening and counseling for interpersonal and domestic violence	Nothing
Routine mammogram – covered for women age 35 and older, as follows: • From age 35 through 39, one during this five year period • From age 40 through 64, one every calendar year	Nothing

Preventive care, adult - continued on next page

Benefit Description	You Pay
Preventive care, adult (cont.)	**High Option**
• At age 65 and older, one every two consecutive calendar years	Nothing
Adult routine immunizations endorsed by the Centers for Disease Control and Prevention (CDC).	Nothing
Note: A complete list of preventive care services recommended under the U.S. Preventive Services Task Force is available online at http://www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm.	
Not covered: *Any services and/or supplies given primarily at the request of, for the protection of, or to meet the requirements of, a party other than the member when such services and/or supplies are not otherwise medically necessary or appropriate, unless the services and/or supplies are state-mandated. Excluded services and supplies include physical exams, disease immunizations, services and supplies for employment (including travel for employment), licensing, marriage, adoption, insurance, camp, school, sports, and travel.*	*All charges*
Preventive care, children	**High Option**
• Childhood immunizations recommended by the American Academy of Pediatrics	Nothing
• Well-child care charges for routine examinations, immunizations and care (up to age 22). • Examinations such as: - Eye exams through age 17 to determine the need for vision correction - Hearing exams through age 17 to determine the need for hearing correction - Examinations done on the day of immunizations (through age 17)	Nothing
Note: A complete list of preventive care services recommended under the U.S. Preventive Services Task Force (USPSTF) is available online at http://www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm and HHS at www.healthcare.gov/prevention.	

Benefit Description	You Pay
Maternity care	**High Option**
• Pregnancy benefits include coverage for inpatient hospital care and pre- and post-natal care received from a participating provider. • Screening for gestational diabetes for pregnant women between 24-28 weeks gestation or first prenatal visit for women at high risk.	Nothing
Breastfeeding support, supplies and counseling for each birth.	Nothing
Note: Here are some things to keep in mind: • You do not need to precertify your normal delivery; see page 31 for other circumstances, such as extended stays for you or your baby. • You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will cover an extended stay if medically necessary. • We pay hospitalization and surgeon services for non-maternity care the same as for illness and injury.	
Not covered: • Elective abortions • Treatment, services or supplies required as the result of a written or unwritten agreement for the benefit of a party other than the member, or as a volunteer for such as a party. • Maternity services received out of the service area in the last 30 days of pregnancy without the 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.	*All charges*
Family planning	**High Option**
Contraceptive counseling on an annual basis at no cost sharing.	Nothing
A range of voluntary family planning services, limited to: • Voluntary sterilization (See Surgical procedures Section 5 (b)) • Surgically implanted contraceptives • Injectable contraceptive drugs (such as Depo provera) • Intrauterine devices (IUDs) • Diaphragms	$10 per office visit

Family planning - continued on next page

Benefit Description	You Pay
Family planning (cont.)	**High Option**
Note: We cover oral contraceptives under the prescription drug benefit.	$10 per office visit
Not covered: • *Reversal of voluntary surgical sterilization* • *Genetic counseling, except as defined on page 51, Genetic Testing and Counseling*	*All charges*
Infertility services	**High Option**
Diagnosis and treatment of infertility, such as: • Intravaginal insemination (IVI) • Intracervical insemination (ICI) • Intrauterine insemination (IUI)	50% coinsurance
Not covered: • *Assisted Reproductive Technology (ART) procedures, such as but not limited to:* - *In Vitro Fertilization* - *Embryo Transfer, Gamete Intra-Fallopian Transfer (GIFT) and Zygote Intra-Fallopian transfer (ZIFT)* • *Services and supplies related to ART procedures* • *Cost of donor sperm* • *Cost of donor egg* • *Infertility services which are not for the treatment of illness or injury (i.e. treatment needed to achieve pregnancy). The diagnosis of infertility alone does not constitute an illness.* • *Storage and collection fees for sperm and ovum* • *Reversal of voluntarily induced sterilization* • *Revision of scarring caused by implantable birth control devices* • *Treatment, services or supplies required as the result of a written or unwritten agreement for the benefit of a party other than the member, or as a volunteer for such a party.* • *Fertility drugs*	*All charges*
Allergy care	**High Option**
• Testing and treatment, including materials • Allergy injections	$10 per office visit
• Allergy serum	Nothing
Not covered: • *Sublingual (under the tongue) allergy testing and/or treatment*	*All charges*

Benefit Description	You Pay
Treatment therapies	**High Option**
• Chemotherapy and radiation therapy Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under Organ/Tissue Transplants on page 34. • Respiratory and inhalation therapy • Dialysis – hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy. Prior authorization required. • Applied Behavior Analysis (ABA) Therapy for autism Spectrum Disorder • Growth hormone therapy (GHT) Note: Growth hormone is covered under the prescription drug benefit. See your pharmacy benefit description. Note: We only cover GHT when we preauthorize the treatment. We will ask you to submit information that establishes that the GHT is medically necessary. Ask us to authorize GHT before you begin treatment. We will only cover GHT services and related services and supplies that we determine are medically necessary. See Other services under You need prior Plan approval for certain services on page 12.	$10 per office visit
Physical, occupational and speech therapies	**High Option**
Therapy visits are allowed for a combined 60 visits per condition (physical, occupational, and speech therapy or habilitative services) on an outpatient basis if a significant improvement can be expected within two months for each of the following: • Qualified Network Physical Therapists • Network Occupational Therapists • Network Speech Therapists Occupational therapy is limited to services that assist the member to achieve and maintain self care and improved function in activities of daily living.	20% coinsurance
Not covered: • *Maintenance or long-term rehabilitative 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* • *Exercise programs* • *Massage therapist*	*All charges*

Physical, occupational and speech therapies - continued on next page

Benefit Description	You Pay
Physical, occupational and speech therapies (cont.)	**High Option**
• *Behavioral or vocational counseling, including evaluation and treatment and work hardening programs* • *Any form of therapy or treatment for learning or developmental disabilities, including: hearing therapy for a learning disability and communication delay; therapy for perceptual disorders, mental retardation and related conditions; evaluation and therapy for behavior disorders; special evaluation and treatment of multiple handicaps, hyperactivity, or sensory deficit and motor dysfunction; developmental and neuro-education testing or treatment; and other special therapy, except as specifically listed in this Brochure* • *Speech and hearing screening examinations are limited to routine or preventive screening tests performed by a participating provider for determining the need for correction*	*All charges*
Cardiac rehabilitation	**High Option**
Cardiac Rehabilitation is covered when obtained through a participating provider, when medically necessary and with prior authorization by the Plan. Phase II cardiac rehabilitation is limited to 36 visits and must be prior authorized by the plan. It must be provided in an outpatient department of a hospital, in a medical center, or in a clinic program. This benefit applies only to member with a recent history of: - a heart attack - coronary bypass surgery - onset of angina pectoris - heart valve surgery - onset of decubital angina - percutaneous transitional angioplasty - cardiac transplant 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.	Nothing
Not covered: *Phase 3 Cardiac Rehabiliation programs*	*All charges*

Benefit Description	You Pay
Hearing services (testing, treatment, and supplies)	**High Option**
• Hearing aids, hearing exams and hearing aid procedures are covered when obtained through a participating provider, and with prior authorization from the Plan • The reconditioning and repair of existing aids is covered when considered medically necessary • Hearing testing for children through age 17, as shown in Preventive care, children	$10 per office visit
New hearing aids are covered once per ear in a 36-month period.	All costs over $1,000
Cochlear implants and hearing aids are covered for children under the age of 18 with prior authorization from the Plan. Implantable bone conduction hearing aid, also called bone-anchored hearing aid (Baha) is covered for patients with conductive hearing losses (unilateral or bilateral), or mixed hearing losses, if the patient has a bone conduction pur tone average up to 45 dBHL and a speech discrimination score better than 60% (in the indicated ear) who additionally has any one or more of the following conditions: 1. Congenital or surgically induced malformations of the external ear canal and/or middle ear (example: etresia) 2. Tumors of the external ear canal and/or tympanic cavity 3. Severe chronic external otitis or otitis media 4. Ostosclerosis in those who are not suitable candidates for stapedectomy 5. Dermatitis of the external ear canal, including reactions from ear molds used for typical air conduction hearing aids 6. Other conditions in which an air conduction hearing aid is contraindicated (example: relapsing polychondritis) Implantable bone conduction hearing aid, also called bone-anchored hearing aid (Baha) is covered for the treatment of unilateral sensorineural hearing loss (single sided deafness) when there is a normal hearing in the opposite ear (defined as a 20 dBHL air conduction pur tone average. **The procedure and related services to implant a bone conduction hearing aid are covered as medical/surgical benefits; the device itself (bone anchored aid) is covered under the hearing aid benefit portion of your Plan.**	Nothing

Hearing services (testing, treatment, and supplies) - continued on next page

Benefit Description	You Pay
Hearing services (testing, treatment, and supplies) (cont.)	**High Option**
Not covered: • *Hearing aids if more than one per ear in any 36-month period* • *Cochlear implants for members age 18 and older* • *Coverage for services in excess of the limits stated in your brochure*	*All charges*
Vision services (testing, treatment, and supplies)	**High Option**
Covered Services: • Medical eye examinations provided as part of the treatment for pathological conditions when rendered by or at the direction of a participating physician • Routine or preventive eye examinations are covered when rendered by a participating ophthalmologist or optometrist • Initial eyeglasses or contact lenses are covered after cataract surgery if purchased from a participating provider Note: See *Preventive care, children* for eye exams for children	$10 per office visit
Not covered: • *Eyeglasses or contact lenses, except as shown above* • *Eye exercises and orthoptics* • *Radial keratotomy and other refractive surgery*	*All charges*
Foot care	**High Option**
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes.	$10 per office visit
Not covered: • *Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above* • *Treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery)*	*All charges*

Benefit Description	You Pay
Prosthetic devices	**High Option**
• Artificial limbs and eyes; stump hose • Externally worn breast prostheses and surgical bras, including necessary replacements following a mastectomy • Internal prosthetic devices, such as artificial joints, pacemakers, and surgically implanted breast implant following mastectomy Note: Internal prosthetic devices are paid as hospital benefits; see Section 5(c) for payment information. Insertion of the device is paid as a surgery; see Section 5(b) for coverage of the surgery to insert the device. • Replacement of natural or artificial limbs and eyes no longer functional due to physiological change or malfunction beyond repair, if medically necessary • Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome	25% of the charge per purchase or rental
Not covered: • 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.	*All charges*
Durable medical equipment (DME)	**High Option**
• Durable medical equipment is defined as: a) able to withstand repeated use b) primarily and customarily used to serve a medical purpose c) not generally useful except for the treatment of a bodily injury or sickness d) is appropriate for use in the home e) provides therapeutic benefits or enables the patient to perform certain tasks that he or she would be unable to perform or otherwise undertake due to certain covered medical conditions or illnesses 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. • Durable medical equipment (DME) is covered only: a) with prior authorization by the Plan and when	25% of charge per purchase or rental

Durable medical equipment (DME) - continued on next page

Benefit Description	You Pay
Durable medical equipment (DME) (cont.)	**High Option**
b) determined to be medically necessary c) purchased at a participating DME provider or other provider authorized by the Plan d) ordered or prescribed by a participating provider, or a non-participating provider with an active referral authorized by the Plan e) not generally available over the counter (OTC) • Orthotics are covered for acute conditions only • Foot orthotics are covered only when all the preceding conditions are met and the following conditions are met: a) are a prescription orthotic b) the member has a documented diagnosis of diabetes with neuropathy or peripheral vascular disease • Orthopedic shoes that are an integral part of a covered brace • Home monitoring equipment for the treatment of diabetes, infant apnea, or premature labor • Compression stockings, when ordered by a participating provider, are limited by compression weight (greater than 30 mmhg) and to two pairs per contract year • Injectable medication given in an office or outpatient setting • Rental of cervical and/or lumbar traction devices is limited to a three month rental • Mechanical Devices used to treat sleep apnea require a three month rental to establish that there is a regular and consistent use, and a medical benefit prior to purchase • Audible prescription reading devices • Speech generating devices We cover rental or purchase of durable medical equipment, at our option, including repair and adjustment. Rental costs are covered only up to the purchase price of the item.	25% of charge per purchase or rental
Not covered: • *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*	*All charges*

Durable medical equipment (DME) - continued on next page

Benefit Description	You Pay
Durable medical equipment (DME) (cont.)	**High Option**
• *Replacement of supplies without prior authorization from the Plan* • *Replacement for damaged, lost or stolen items* • *Repairs and replacement of durable medical equipment without prior authorization from the Plan* • *Physician equipment, home testing and monitoring equipment, including but not limited to blood pressure equipment, stethoscopes, otoscopes, equipment that tests for blood levels other than glucose, oxygen level monitoring equipment and equipment that may monitor other types of measures or values* • *Exercise or Physical fitness equipment (examples: treadmills, exercise bikes, bicycles, foam roller, etc.)* • *Equipment models or devices which have features over and above those which are medically necessary for the member. Coverage is limited to the standard model as determined by the Plan.* • *Any food, liquid or nutritional supplements including those prescribed by a physician* • *Motorized vehicles, or power operated vehicles, including but not limited to motorized scooters, except for motorized wheel chair when medically necessary*	*All charges*

Durable medical equipment (DME) - continued on next page

Benefit Description	You Pay
Durable medical equipment (DME) (cont.)	**High Option**
• *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; lambs 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*	*All charges*
Home health services	**High Option**
Home health care benefits are covered with prior authorization, when the attending physician certifies that: • Confinement in a hospital or skilled facility would be necessary if home care were not provided • The home health care services are provided and coordinated by a state licensed or Medicare certified home health agency or certified rehabilitation agency • A significant improvement can be expected within two months Home health care means one or more of the following: • The evaluation of the need for home care when approved or requested by the attending physician	No charge

Home health services - continued on next page

Benefit Description	You Pay
Home health services (cont.)	**High Option**
• 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. • Home health aide services that are medically necessary as part of the home care plan must consist solely of caring for the patient. A registered nurse or medical social worker must supervise the care. • Physical, respiratory, occupational and speech therapy • Medical supplies, drugs and medicines prescribed by a physician, and lab services by or from a hospital. These services are covered to the same extent such items would be covered under the policy if you were confined to a hospital • Nutritional counseling under the supervision of a registered or certified dietitian if considered medically necessary as part of the home care plan	No charge
Not covered: • *Nursing care requested by, or for the convenience of, the patient or the patient's family* • *Home care primarily for personal assistance that does not include a medical component and is not diagnostic,therapeutic, or rehabilitative* • *Custodial care*	*All charges*
Chiropractic	**High Option**
• Manipulation of the spine and extremities • Adjunctive procedures such as ultrasound, electrical muscle stimulation, vibratory therapy, and cold pack application	$10 per office visit
Not covered: *Maintenance and long term therapies*	*All charges*
Alternative treatments	**High Option**
Acupuncture - services performed by a certified or licensed participating acupuncturist are covered without a referral. • Services are limited to 12 visits per year • Services are not covered by non-participating providers • Services are not covered by non-certified or non-licensed providers Biofeedback is covered only for the treatment of headaches, spastic torticollis, urinary incontinence, and post traumatic stress disorder.	$10 per office visit

Alternative treatments - continued on next page

Benefit Description	You Pay
Alternative treatments (cont.)	**High Option**
• Benefit limitations will be determined based on the provider of service • Biofeedback services must have prior authorization from the Plan	$10 per office visit
Not covered: *Naturopathic services* *Hypnotherapy*	*All charges*
Educational classes and programs	**High Option**
Coverage is provided for: • MercyCare covers a variety of smoking cessation drugs and compensates primary care offices for tobacco counseling. The health plan also refers members to American Lung Association online resources • Diabetes self management • Childhood obesity education	Nothing

Section 5(b). Surgical and anesthesia services provided by physicians and other health care professionals

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also, read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The services listed below are for the charges billed by a physician or other health care professional for your surgical care. See Section 5(c) for charges associated with the facility (i.e. hospital, surgical center, etc.).
- **YOUR PHYSICIAN MUST GET PRECERTIFICATION FOR SOME SURGICAL PROCEDURES.** Please refer to the precertification information shown in Section 3.

Benefit Description	You Pay
Surgical procedures	**High Option**
A comprehensive range of services, such as: • Operative procedures • Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedures • Biopsy procedures • Removal of tumors and cysts • Correction of congenital anomalies (see Reconstructive surgery) • Bariatric surgery for the treatment of morbid obesity for a person over the age of 18, which has persisted for at least 5 years is covered with prior authorization. If, - a laboratory assessment has been performed - there is a confirmed failure of a multifaceted weight loss program, including consultation with a dietician - and, there is a confirmed behavioral health consultation • Insertion of internal prosthetic devices with prior authorization. See 5(a)-*Orthopedic and prosthetic devices* for device coverage information • Voluntary sterilization (e.g., tubal ligation, vasectomy) • Treatment of burns	No charge
Not covered:	*All charges*

Surgical procedures - continued on next page

Benefit Description	You Pay
Surgical procedures (cont.)	**High Option**
• *Reversal of voluntary sterilization* • *Services of a standby surgeon, except during angioplasty or other high risk procedures when we determine standbys are medically necessary* • *Routine treatment of conditions of the foot; see Foot care*	*All charges*
Reconstructive surgery	**High Option**
• Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: - the condition produced a major effect on the member's appearance and - the condition can reasonably be expected to be corrected by such surgery • Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birth marks; and webbed fingers and toes. • All stages of breast reconstruction surgery following a mastectomy, such as: - Surgery to produce a symmetrical appearance of breasts - treatment of any physical complications, such as lymphedemas - breast prostheses; and surgical bras and replacements (see *Prosthetic devices* for coverage) Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.	No charge
Not covered: • *Plastic or Cosmetic Surgery which is not medically necessary for the correction of a functional defect caused by a bodily injury or sickness. Psychological reasons do not represent a medical/ surgical necessity.* • *Surgeries related to sex transformation or sexual dysfunction*	*All charges*

Benefit Description	You Pay
Oral and maxillofacial surgery	**High Option**
Oral surgical procedures, limited to: • Reduction of fractures of the jaws or facial bones • Surgical correction of cleft lip, cleft palate or severe functional malocclusion • Removal of stones from salivary ducts • Excision of leukoplakia or malignancies • Excision of cysts and incision of abscesses when done as independent procedures • Other surgical procedures that do not involve the teeth or their supporting structures Temporomandibular Disorders 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: • you have prior authorization from the plan for all temporomandibular related evaluation and other services, and for the facilities where services are performed • the condition is caused by a congenital, developmental or acquired deformity, sickness or bodily injury • under the accepted standards of the profession of the health care provider rendering the service, the procedure or device is reasonable and appropriate for the diagnosis or treatment of this condition • the purpose of the procedure or device is to control or eliminate infection, pain, disease or dysfunction This includes coverage for prescribed intra-oral splint therapy devices. Benefit maximum for TMJ is $1250.00 per year.	$10 per office visit
Not covered: • *Oral implants and transplants* • *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)* • *Cosmetic or elective orthodontic care, periodontic care or general dental care* • *Any treatment or supply for bruxism* • *Charges that exceed $1250.00 for the treatment of TMJ*	*All charges*

Benefit Description	You Pay
Organ/tissue transplants	**High Option**
These **solid organ transplants** are covered. These solid organ transplants are subject to medical necessity and experimental/investigational review by the Plan. See Other services under You need prior Plan approval for certain services on page 16. Solid organ transplants are limited to: • Cornea • Heart • Heart/lung • Intestinal transplants - Isolated Small intestine • Isolated small intestine transplant considered only for patients who cannot be maintained on long term total parenteral nutrition and who are experiencing one or more specific complications are currently considered as candidates for intestinal transplantation. - Isolated Small intestine with liver - Isolated Small intestine with multiple organs, such as the liver, stomach, and pancreas • Kidney • Liver • Lung: single/bilateral/lobar • Pancreas • Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis - This procedure may be an option for patients undergoing total removal of their pancreas and have not yet developed diabetes from destruction of the pancreas and islets, nor have they had other pancreatic surgeries.	Nothing
These **tandem blood or marrow stem cell transplants for covered transplants** are subject to medical necessity review by the Plan. Refer to *Other services* in Section 3 for prior authorization procedures. • Autologous tandem transplants for: - Al Amyloidosis - Multiple myeloma (de novo and treated) - Recurrent germ cell tumors (including testicular cancer)	Nothing

Organ/tissue transplants - continued on next page

Benefit Description	You Pay
Organ/tissue transplants (cont.)	**High Option**
Blood or marrow stem cell transplants limited to the stages of the following dignoses. For the diagnoses listed below, the medical necessity limitation is considered satisfied if the patient meets the staging description. • Allogeneic transplants for - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Acute myeloid leukemia - Advanced Myeloproliferative disorders (MPDs) - Amyloidosis - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Hemoglobinopathy - Marrow failure and related disorders (i.e., Fanconi's, PNH, Pure Red Cell Aplasia) - Myelodysplasia/Myelodysplastic syndromes - Paroxysmal Nocturnal Hemoglobinuria - Phagocytic/Hemophagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome) - Severe combined immunodeficiency - Severe or very severe aplastic anemia • Autologous transplants for: - Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Amyloidosis - Multiple myeloma - Neuroblastoma - Testicular, Mediastinal, Retroperitonial, and ovarian germ cell tumors	Nothing
Mini-transplants performed in a clinical trial setting (non-myeloablative, reduced intensity conditioning or RIC) for members with a diagnosis listed below are subject to medical necessity review by the Plan.	Nothing

Organ/tissue transplants - continued on next page

Benefit Description	You Pay
Organ/tissue transplants (cont.)	**High Option**
Refer to *Other services* in section 3 for prior authorization procedures: • Allogeneic transplants for: - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Acute myeloid leukemia - Advanced Myeloproliferative Disorders (MPDs) - Amyloidosis - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Hemoglobinopathy - Marrow failure and related disorders (i.e. Fanconi's, PNH, Pure red Cell Aplasia) - Myelodysplasia/Myelodysplastic syndromes - Paroxysmal Nocturnal Hemoglobinuria - severe combined immunodeficiency - Severe or very severe aplastic anemia • Autologous transplants for: Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - - - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Amyloidosis - Neuroblastoma These blood or marrow stem cell transplants are covered only in a National Cancer Institute or National Institutes of health **approved clinical trial** or a Plan- designated center of excellence and if approved by the Plan's medical dirtector in accorcance with the Plan's protocols.	Nothing

Organ/tissue transplants - continued on next page

Benefit Description	You Pay
Organ/tissue transplants (cont.)	**High Option**
If you are a participant in a clinical trial, the Plan will provide benefits for related routine care that is medically necessary (such as doctors visits, lab tests, x- rays, and scans,and hospitalization related to treating the patients condition) if it is not provided by the clinical trials. We encourage you to contact the Plan to discuss specific services if you participate in a clinical trial. • Autologous Transplants for - Advanced Childhood kidney cancers - Advanced Ewing sarcoma - Childhood rhabdomyosarco - Epithelial Ovarian Cancer - Mantle Cell (Non-Hodgkin lymphoma)	Nothing
Note: We cover related medical and hospital expenses of the donor when we cover the recipient. We cover donor testing for the actual solid organ donor or up to four bone marrow/stem cell transplant donors in addition to the testing of the family members.	Nothing
Not covered: • *Donor screening tests and donor search expenses, except those as shown above* • *Implants of artificial organs* • *Transplants not listed as covered*	*All charges*
Anesthesia	**High Option**
Professional services provided in – • Hospital (inpatient)	Nothing
Professional services provided in – • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Office	Nothing

Section 5(c). Services provided by a hospital or other facility, and ambulance services

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works. Also, read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by the facility (i.e., hospital or surgical center) or ambulance service for your surgery or care. Any costs associated with the professional charge (i. e., physicians, etc.) are in Sections 5(a) or (b).
- **YOUR PHYSICIAN MUST GET PRECERTIFICATION FOR HOSPITAL STAYS.**

Benefit Description	You Pay
Inpatient hospital	**High Option**
Room and board, such as: • Ward, semiprivate, or intensive care accommodations • General nursing care • Meals and special diets Note: If you want a private room when it is not medically necessary, you pay the additional charge above semiprivate room rate.	Nothing
Other hospital services and supplies, such as: • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and X-rays • Blood or blood plasma • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Inpatient dental procedures, as follows: - limited hospitalization benefit for certain procedures is covered when a Plan doctor determines there is a need for hospitalization for reasons totally unrelated to the dental procedure - the plan will cover the hospitalization, but not the cost of professional dental services - Conditions for which hospitalization would be covered include hemophilia and heart disease. The need for anesthesia by itself, is not a condition.	Nothing
Not covered:	*All charges*

Inpatient hospital - continued on next page

Benefit Description	You Pay
Inpatient hospital (cont.)	**High Option**
• *Custodial care; see definition* • *Non-covered facilities, such as nursing homes or schools* • *Personal comfort items, such as telephone, television, barber services, guest meals and beds* • *Private nursing care* • *The cost of the professional dental services*	*All charges*
Outpatient hospital or ambulatory surgical center	**High Option**
• Operating, recovery, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests, X-rays , and pathology services • Administration of blood, blood plasma, and other biologicals • Blood and blood plasma • Pre-surgical testing • Dressings , casts , and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service Note: – We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. We do not cover the dental procedures.	Nothing
Extended care benefits/Skilled nursing care facility benefits	**High Option**
Skilled nursing facility (SNF): Charges for daily room and board and general nursing services provided during a skilled nursing facility confinement up to 120 days of confinement per benefit year are covered if you entered the facility within 24 hours after discharge from a covered hospital confinement for continued treatment of the same condition. Confinement in a swing bed in a hospital is considered the same as a skilled nursing facility. Coverage is provided for physical therapy, occupational therapy, speech therapy, and durable medical equipment if medically necessary and provided by a participating provider. Your primary care physician must certify that your skilled nursing facility confinement is medically necessary for care or treatment of the bodily injury or sickness that caused the hospital confinement.	Nothing

Extended care benefits/Skilled nursing care facility benefits - continued on next page

Benefit Description	You Pay
Extended care benefits/Skilled nursing care facility benefits (cont.)	**High Option**
Skilled nursing facility services require prior authorization from the Plan and the Plan must consider the services to be at a skilled level of care and medically necessary.	Nothing
Not Covered: • *Custodial care* • *Skilled nursing facility days in excess of 120 days of confinement per benefit year*	*All charges*
Extended care benefit: Prior authorization is required	Nothing
Not Covered: *Custodial Care*	*All charges*
Hospice care	**High Option**
Hospice Care services are covered with prior authorization from the Plan and if a member's life expectancy is six months or less, and the care is available on an intermittent basis with on-call services available on a 24-hour basis. It includes services provided in order to ease pain and make the member as comfortable as possible. Hospice care must be provided through a licensed hospice care provider approved by the Plan.	Nothing
Not covered: • *Independent nursing, homemaker services.* • *Hospice room and board expenses*	*All charges*
Ambulance	**High Option**
• Local professional ground and air ambulance service when medically appropriate	Nothing

Section 5(d). Emergency services/accidents

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost sharing works. Also, read Section 9 about coordinating benefits with other coverage, including with Medicare.

What is a medical emergency?

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

Other acute conditions are emergencies when these four elements exist:

1. They require immediate medical care for bodily injury or sickness.

2. Symptoms are unexpected and severe enough to cause a person to seek medical help right away.

3. Immediate care is secured.

4. Diagnosis or the symptoms themselves show that immediate care was required.

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

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

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

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

To be covered, non-emergency or follow-up care must be provided by a participating provider. Follow up care and non-emergency care for all members is covered at 50% of usual and customary fees if medically necessary and prior authorized. This benefit is available if you are temporarily out of the service area.

URGENT CARE

Urgent care is care for a bodily injury or illness that you need sooner than a routine doctor's visit. Examples of urgent care situations are broken bones, sprains, non-severe bleeding, minor cuts and burns, and drug reactions.

In the Service Area:

To be covered, urgent care must be received from a participating provider or at a participating urgent care center.

Outside the Service Area:

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

Benefit Description	You Pay
Emergency Services In or Outside Our Service Area	**High Option**
Emergency care at a doctor's office	$10 per office visit
Emergency care an an urgent care center	$10 per office visit
Emergency care as an outpatient at a hospital, including doctors' service	$75 per visit
Note: We waive the emergency room copay if you are admitted to the hospital. In addition to the emergency room copay, emergency treatment provided by a non-participating providers may be subject to usual and customary charges.	
Not covered: • *Emergency doctor office visits and urgent care visits at non-Plan providers within the service area* • *Elective care or non-emergency care and follow-up care recommended by non-Plan providers that has not been approved by the plan or provided by Plan providers* • *Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area* • *Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area*	*All charges*
Ambulance	**High Option**
Professional ambulance service when medically appropriate. Note: See 5(c) for non-emergency service.	Nothing

Section 5(e). Mental health and substance abuse benefits

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also, read Section 9 about coordinating benefits with other coverage, including with Medicare.
- **YOU MUST GET PREAUTHORIZATION OF THESE SERVICES.** Benefits are payable only when we determine the care is clinically appropriate to treat your condition and only when you receive the care as part of a treatment plan that we approve. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure. To be eligible to receive full benefits, you must follow the preauthorization process and get Plan approval of your treatment plan:
  - You may receive up to ten (10) clinic visits without prior authorization. To be eligible to receive more than 10 clinic visits you must obtain a treatment plan that is reviewed for prior authorization by the Plan.
  - Inpatient and alternative care settings require prior authorization by the Plan.
- We will provide medical criteria or reasons for treatment plan denials to enrollees, members or providers upon request or as otherwise required.

Benefit Description	You Pay
Professional services	**High Option**
When part of a treatment plan we approve, we cover professional services by licensed professional mental health and substance abuse practitioners when acting within the scope of their license, such as psychiatrists, psychologists, clinical social workers, licensed professional counselors, or marriage and family therapists. Diagnosis and treatment of psychiatric conditions, mental illness, or mental disorders. Services include: • Diagnostic evaluation • Crisis intervention and stabilization for acute episodes • Medication evaluation and management (pharmacotherapy) • Psychological and neuropsychological testing necessary to determine the appropriate psychiatric treatment • Treatment and counseling (including individual or group therapy visits) • Diagnosis and treatment of alcoholism and drug abuse, including detoxification, treatment and counseling • Professional charges for intensive outpatient treatment in a provider's office or other professional setting	$10 per office visit

Professional services - continued on next page

Benefit Description	You Pay
Professional services (cont.)	**High Option**
• Electroconvulsive therapy	$10 per office visit
Diagnostics	**High Option**
• Outpatient diagnostic tests provided and billed by a licensed mental health and substance abuse practitioner • Outpatient diagnostic tests provided and billed by a laboratory, hospital or other covered facility • Inpatient diagnostic tests provided and billed by a hospital or other covered facility	Nothing
Inpatient hospital or other covered facility	**High Option**
Inpatient services provided and billed by a hospital or other covered facility • Room and board, such as semi-private or intensive accommodations, general nursing care, meals and special diets, and other hospital services	Nothing
Outpatient hospital or other covered facility	**High Option**
Outpatient services provided and billed by a hospital or other covered facility • Services in approved treatment programs, such as partial hospitalization, half-way house, residential treatment, full-day hospitalization, or facility-based intensive outpatient treatment	Nothing
Not covered	**High Option**
Services that are not part of a preauthorized approved treatment plan	*All charges*

Preauthorization

- You may receive benefits up to ten (10) clinic visits without prior authorization. To be eligible to receive more than 10 clinic visits you must obtain a treatment plan that is reviewed for prior authorization by the Plan.
- Inpatient and alternative care settings require prior authorization

Limitation

- We may limit your benefit if you do not obtain a treatment plan

Section 5(f). Prescription drug benefits

Important things you should keep in mind about this benefit:

- We cover prescribed drugs and medications, as described in the chart beginning on the next page.
- All benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Members must make sure their physicians obtian prior approval/ authorizations for certain prescription drugs and supplies before coverage applies. Prior approval/ authorizations must be renewed periodically.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost sharing works. Also, read Section 9 about coordinating benefits with other coverage, including with Medicare.

There are important features you should be aware of. These include:

Who can write your prescription. A licensed physician or dentist, and in states allowing it, licensed or certified Physician Assistant, Nurse Practitioner and Psychologist must presecribe your medication.

Where you can obtain them. You may fill the prescription at any network pharmacy.

We use a formulary. MercyCare Health Plans (MCHP) maintains a drug formulary as a guide for providers to prescribe medications. The MercyCare Pharmacy and Therapeutic Committee (P&T) is a group of physicians and pharmacists that endorse the agents listed in the formulary based on product selection criteria. The MercyCare P&T Committee consists of physicians and participating pharmacists whose primary purpose is to recommend policies in the evaluation selection and therapeutic use of medications. The P&T Committee meets quarterly to determine formulary status of new to market existing drugs. Updates are communicated to the MercyCare Health Plans participating providers through physician newsletters and our website: www.mercycarehealthplans.com.

The MercyCare P&T Committee will consider all FDA approved drugs for inclusion on the formulary, except those drugs in therapeutic classes excluded from coverage by MercyCare. The evaluation includes a literature review and expert opinion may be sought. Formal reviews are prepared which typically address the following information:

- Safety
- Efficacy
- Comparative studies
- Approved indications
- Adverse Effects
- Contraindications/Warnings/Precautions
- Pharmacokinetics
- Patient administration/Compliance considerations
- Medical outcome and pharmacoeconomic studies
- Cost

When a new drug is considered for formulary inclusion an attempt will be made to examine the drug relative to similar drugs currently on formulary. In addition, entire therapeutic classes are periodically reviewed. The class review process may result in deletion of one or more drugs in a particular therapeutic class, in an effort to continually promote the most clinically useful and cost-effective agents.

There may be occasions when an unlisted drug is desired for medical management of a specific patient. In those infrequent instances, the unlisted medication may be requested through the Drug Exception process

These are the dispensing limitations. The maximum quantity of medication you may receive in a single prescription is a supply sufficient for 30 days or 100 units whichever is less, according to the physician's instructions. You may receive up to a 90-day supply if prescribed by your physician; but you will be required to pay three (3) copays at the time of purchase.

To promote safe and appropriate cost effective use of specific classes of medications, dispensing limits are in place for some medications. For example, bulk items such as inhalers, creams, ointments, and eye drugs are limited to one (1) container per copay.

A generic equivalent will be dispensed if it is available, unless your physician specifically requires a name brand. If you receive a name brand drug when a Federally-approved generic drug is available, and your physician has not specified Dispense as Written for the name brand drug, you have to pay the difference in cost between the name brand drug and the generic.

Why use generic drugs? By choosing generic equivalents instead of brand name medication, you may lower your prescription drug costs. Not only will you usually pay less out of pocket today, you may have a positive impact on future health care costs. According to the U.S. Food and Drug Administration (FDA), these are some important facts to know about generic drugs:

- Generic drugs are safe and effective
- Generic drugs meet the same rigid standards set by the FDA as brand name drugs
- Generic drugs can be significantly less expensive than brand name drugs
- A generic equivalent is available for approximately half of the brand name drugs prescribed in the United States today

Generics should be considered first before using branded drugs in the class where appropriate. Generic drugs are widely recognized as effective medications with the same clinical results as brand name drugs but at a lower cost. Generic drugs cost substantially less than the equivalent brand name drug thus reducing the member's copayment or coinsurance.

In approving a generic drug product, the FDA requires many rigorous tests and procedures to assure that the generic drugs is interchangeable with the brand name drug under all approved indications and conditions of use. In addition to tests performed prior to market entry, the FDA regularly assesses the quality of products in the marketplace and thoroughly researches and evaluates reports of alleged drug product in equivalence. To date there are no documented examples of generic product manufactured to meet approved specifications that could not be used interchangeably with the corresponding brand name drug. Because patients may pay closer attention to their symptoms when the substitution of one drug product for another occurs, an increase in symptoms may be reported at that time, and anecdotal reports of decreased efficacy or increased toxicity may result. Upon investigation by the FDA, no problems attributed to substitution of one approved drug product for another has occurred.

When you do have to file a claim. When you fill a prescription, present your pharmacy coverage card and the pharmacy will electronically submit your prescription claims. If the pharmacy is unable to electronically submit your prescription claim, you may submit an itemized receipt to us for reimbursement for all covered prescription drugs. Send receipt to MercyCare Health Plans, PO Box 550, Janesville WI 53547-0550, Attn: Customer Service.

Benefits Description	You Pay
Covered medications and supplies	**High Option**
We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy or through our mail order program: • Drugs and medicines that by Federal law of the United States require a physician's prescription for their purchase, except those listed as *Not covered.* • Insulin • Diabetic supplies, limited to: - Disposable needles and syringes for the administration of covered medications	Tier 1 Generics - $20 copay Tier 2 Preferred Brands - $40 copay Tier 3 Expanded Brands and Selected Generics - $60 copay Note: If there is no generic equivalent available, you will still have to pay the brand name copay.

Covered medications and supplies - continued on next page

Benefits Description	You Pay
Covered medications and supplies (cont.)	**High Option**
• Drugs for sexual dysfunction • Growth Hormone Therapy (GHT) - Must be prior authorized prior to treatment, and - Requires documentation submitted that establishes the medical necessity • If you do not request authorization prior to treatment, we will only cover GHT services from the date you submit the information. If you do not ask or if we determine GHT is not medically necessary, we will not cover the GHT or related services and supplies.	Tier 1 Generics - $20 copay Tier 2 Preferred Brands - $40 copay Tier 3 Expanded Brands and Selected Generics - $60 copay Note: If there is no generic equivalent available, you will still have to pay the brand name copay.
Mail Order Prescription Drug Benefit	At MercyCare's mail order pharmacy, members receive a three (3) month supply of prescriptions at a two (2) month copay.
Women's contraceptive drugs and devices NOTE: The "morning after pill" is considered a preventative service under contraceptives and is an over-the-counter (OTC) emergency contraceptive drug, when prescribed by a physician and purchased at a network pharmacy.	Nothing
Not covered: • *Drugs and supplies for cosmetic purposes* • *Nonprescription medicines* • *Drugs to enhance athletic performance* • *Fertility drugs* • *Drugs obtained at a non-plan pharmacy; except for out-of-area emergencies* • *Vitamins, nutrients and food supplements even if a physician prescribes or administers them (with the exception of Vitamin D, which ACA requires coverage for adults 65 and older).* • *Replacement of any lost, stolen or destroyed medication* • *A specialty medication that is not obtained from the designated specialty pharmacy* Note: Over-the-counter and prescription drugs approved by the FDA to treat tobacco dependence are covered under the Tobacco cessation benefit. See page 30.	*All charges*

Section 5(g). Dental benefits

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also, read Section 9 about coordinating benefits with other coverage, including with Medicare.
- Note: We cover hospitalization for dental procedures only when a non-dental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient. We do not cover the dental procedure. See Section 5 (c) for inpatient hospital benefits.
- If you are enrolled in a Federal Employees Dental/Vision Insurance Program (FEDVIP) Dental Plan, your FEHB Plan will be First/Primary payor of any Benefit payments and your FEDVIP Plan is secondary to your FEHB Plan. See Section 9 Coordinating benefits with other coverage.

	You Pay
Accidental injury benefit	**High Option**
Treatment with prior authorization from the Plan for 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 • the bodily injury is not caused by chewing or biting • the treatment begins within 90 days of the bodily injury and within a maximum of 180 days from the date of injury to complete treatment	$10 per office visit
Dental benefit	**High Option**
With required prior authorization, inpatient hospital and free-standing surgical facility services and anesthetics provided in conjunction with dental care in a hospital or free-standing surgical facility, if the member: • is under age 5 • 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 • has a medical condition that requires hospital confinement or general anesthesia for dental care Also covered: • Oral surgery with prior authorization from the Plan for gum or bone tumors and cysts • Surgical removal of impacted wisdom teeth (third molars)	Nothing

Dental benefit - continued on next page

	You Pay
Dental benefit (cont.)	**High Option**
Not covered: • *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 brochure. These exclusions include, but are not limited to:* - *dental implants* - *shortening of the mandible or maxillae* - *correction of malocclusion* - *treatment for any jaw joint problems, other than temporomandibular disorders including craniomaxillary, carniomandibular disorder, or other conditions of the joint linking the jaw bone and skull* - *hospital costs for any of these services except as specifically described in the brochure* - *any treatment for bruxism-including splint devices* • *Oral surgery except as specifically described in this brochure* • *All periodontic procedures*	*All charges*

Section 5(h). Special features

Special feature	Description
Flexible benefits option	Under the flexible benefits option, we determine the most effective way to provide services. • We may identify medically appropriate alternatives to regular contract benefits as a less costly alternative. If we identify a less costly alternative, we will ask you to sign an alternative benefits agreement that will include all of the following terms in addition to other terms as necessary. Until you sign and return the agreement, regular contract benefits will continue. • Alternative benefits will be made available for a limited time period and are subject to our ongoing review. You must cooperate with the review process. • By approving an alternative benefit, we do not guarantee you will get it in the future. • The decision to offer an alternative benefit is solely ours, and except as expressly provided in the agreement, we may withdraw it at any time and resume regular contract benefits. • If you sign the agreement, we will provide the agreed-upon alternative benefits for the state time period (unless circumstances change). You may request an extension of the time period, but regular contract benefits will resume if we do not approve your request. • Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process. However, if at the time we make a decision regarding alternative benefits, we also decide that regular contract benefits are not payable, then you may dispute our regular contract benefits under the OPM disputed claim process (see Section 8).
Case Management	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.
Travel benefit/services overseas	Life threatening emergencies are covered anywhere in the world, however providers outside the United States may not accept insurance payments and may require you to provide payment. Reimbursement for covered benefits can be arranged when you return to the service area.
Metabolic Syndrome Pilot Project	Pilot project for members with metabolic syndrome in order to provide guidance and promote therapeutic lifestyle changes in coordination with the Mercy Healthy Image Plus Program (HIP). This project applies to all members that have been referred to HIP with metabolic syndrome for assessment and possible enrollment into this pilot project. This pilot project is being implemented because the Healthy Image Plus Program is not a covered benefit. Members who have been clinically diagnosed with metabolic syndrome are provided dietary and exercise counseling for up to 16 weeks and are not eligible for re-enrollment in the program.
Autism	Autism Spectrum Disorder Treatment means treatment for members who have a primary verified diagnosis of autism spectrum disorder when made by a provider skilled in testing and in the use of empirically validated tools specific for autism spectrum disorders. MercyCare reserves the right to require a second opinion in establishing the diagnosis of autism. **Covered Services:** • Diagnostic testing and evaluation by a provider approved by the Plan • Intensive-level services for up to four (4) cumulative years for members between the age of 2 and 9 years

	• Nonintensive-level services that are provided: - after the completion of intensive-level services treatment - to a member who has not and will not receive intensive-level services, but for whom nonintensive-level services will improve the member's condition • Nonintensive-level services that include direct or consultative services when provided by qualified providers, qualified supervising providers, qualified professionals, qualified paraprofessionals or qualified therapists **Coverage Provisions:** • To be covered, intensive-level services must: - Have prior authorization from the Plan - be provided by one of these participating providers: qualified provider, qualified supervising provider, qualified professional, qualified paraprofessional or qualified therapist - be deemed to be evidence-based and efficacious - be part of the member's treatment plan that was subject to prior authorization - be provided when the parent or guardian is present the majority of the time • To be covered, nonintensive-level service must: - Have prior authorization from the Plan - be provided by one of these participating providers: qualified provider, qualified supervising provider, qualified professional, qualified paraprofessional or qualified therapist - be deemed to be evidence-based and efficacious *Non-covered services:* • *Any services that do not have prior authorization from the Plan* • *Custodial or respite care* • *Travel time for qualified providers, supervising providers, professionals therapists, or paraprofessionals* • *Animal-based therapy, including hippotherapy* • *Auditory integration training* • *Chelation therapy* • *Child care fees* • *Cranial sacral therapy* • *Hyperbaric oxygen therapy* • *Special diets or supplements* • *Treatment provided by parent(s) or legal guardian(s)* • *Autism therapy, treatment or services provided to a member who is residing in an residential treatment center, inpatient treatment or day treatment facility* • *The cost for the facility or location when treatment, therapy or services are provided outside a member's home*
Biofeedback	**Covered Services:** • Biofeedback is covered only for treatment of headaches, spastic torticollis, urinary incontinence, and post traumatic stress disorder • Benefit limitations will be determined based on the provider of services • Biofeedback services must have prior authorization from the Plan

Special feature	Description
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 • the test is medically necessary • 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 • 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 benefits to the Plan member*
Stay Healthy Program	**Covered Services:** • Health education or physical fitness programs are covered up to $100.00 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*

Non-FEHB benefits available to Plan members

The benefits in this section are not part of the FEHB contract or premium, and you cannot file an FEHB disputed claim about them. Fees you pay for these services do not count toward FEHB deductibles or catastrophic protection out-of-pocket maximums. These programs and materials are the responsibility of the Plan, and all appeals must follow their guidelines. For additional information contact the Plan, at (800) 895-2421 or visit their website at www.mercycarehealthplans.com.

24 hour nurse line - MercyCare Health Line is available to refer you to Mercy physicians, clinics, and services. They also provide information pertaining to Mercy's community education classes, support groups, and upcoming health screenings. For information about these services, contact them at 608-758-5770 or 888-756-6060.

Services for deaf and hearing impaired - If you have questions or need assistance, TTY users may call 800-947-3529 for assistance.

MyChart - Mychart is available to those patients who have a Mercy Health System family practice, internal medicine or pediatric primary care provider. Visit their website at www.mercyhealthsystem.org.

Section 6. General exclusions- services, drugs and supplies we do not cover

The exclusions in this section apply to all benefits. There may be other exclusions and limitations listed in Section 5 of this brochure. **Although we may list a specific service as a benefit, we will not cover it unless it is medically necessary to prevent, diagnose, or treat your illness, disease, injury, or condition. For more information on obtaining prior approval for specific services, such as transplants, see Section 3** ***When you need prior Plan approval for certain services.***

We do not cover the following:

- Care by non-plan providers except for authorized referrals or emergencies (see *Emergency services/accidents).*
- Services, drugs, or supplies you receive while you are not enrolled in this Plan.
- Services, drugs, or supplies not medically necessary.
- Services, drugs, or supplies not required according to accepted standards of medical, dental, or psychiatric practice.
- Experimental or investigational procedures, treatment, drugs or devices (see specifics regarding transplants).
- Services, drugs, or supplies related to abortions, except when the life of the mother would be endangered if the fetus were carried to term, or when the pregnancy is the result of an act of rape or incest.
- Services, drugs, or supplies related to sex transformations.
- Services, drugs, or supplies you receive from a provider or facility barred from the FEHB Program.
- Services, drugs, or supplies you receive without charge while in active military service.

Section 7. Filing a claim for covered services

This Section primarily deals with post-service claims (claims for services, drugs or supplies you have already received). See Section 3 for information on pre-service claims procedures (services, drugs or supplies requiring prior Plan approval), including urgent care claims procedures. When you see Plan physicians, receive services at Plan hospitals and facilities, or obtain your prescription drugs at Plan pharmacies, you will not have to file claims. Just present your identification card and pay your copayment, coinsurance, or deductible.

You will only need to file a claim when you receive emergency services from non-plan providers. Sometimes these providers bill us directly. Check with the provider.

If you need to file the claim, here is the process:

Medical and hospital benefits

In most cases, providers and facilities file claims for you. Physicians must file on the form CMS-1500, Health Insurance Claim Form. Your facility will file on the UB-04 form. For claims questions and assistance, call us at (800) 895-2421 or at our website at http://www.mercycarehealthplans.com.

When you must file a claim - such as for services you received outside the Plan's service area - submit it on the CMS-1500 or a claim form that includes the information shown below. Bills and receipts should be itemized and show:

- Covered member's name, date of birth, address, phone number and ID number
- Name and address of the physician or facility that provided the service or supply
- Dates you received the services or supplies
- Diagnosis
- Type of each service or supply
- The charge for each service or supply
- A copy of the explanation of benefits, payments, or denial from any primary payor - such as the Medicare Summary Notice (MSN)
- Receipts, if you paid for your services

Note: Canceled checks, cash register receipts, or balance due statements are not acceptable substitutes for itemized bills.

Submit your claims to: MercyCare Health Plans
P.O. Box 550
Janesville, WI 53547-0550

Prescription drugs

Submit your claims to: MercyCare Health Plans
P.O. Box 550
Janesville, WI 53547-0550

Other supplies or services

Submit your claims to: MercyCare Health Plans
P.O. Box 550
Janesville, WI 53547-0550

Deadline for filing your claim

Send us all the documents for your claim as soon as possible. You must submit the claim by December 31 of the year after the year you received the service, unless timely filing was prevented by administrative operations of Government or legal incapacity, provided the claim was submitted as soon as reasonably possible.

Post-service claims procedures

We will notify you of our decision within 30 days after we receive your post-service claim. If matters beyond our control require an extension of time, we may take up to an additional 15 days for review and we will notify you before the expiration of the original 30-day period. Our notice will include the circumstances underlying the request for the extension and the date when a decision is expected.

If we need an extension because we have not received necessary information from you, our notice will describe the specific information required and we will allow you up to 60 days from the receipt of the notice to provide the information.

If you do not agree with our initial decision, you may ask us to review it by following the disputed claims process detailed in Section 8 of this brochure.

Authorized Representative

You may designate an authorized representative to act on your behalf for filing a claim or to appeal claims decisions to us. For urgent care claims, we will permit a health care professional with knowledge of your medical condition to act as your authorized representative without your express consent. For the purposes of this section, we are also referring to your authorized representative when we refer to you.

Notice Requirements

If you live in a county where at least 10 percent of the population is literate only in a non-English language (as determined by the Secretary of Health and Human Services), we will provide language assistance in that non- English language. You can request a copy of your Explanation of Benefits (EOB) statement, related correspondence, oral language services (such as telephone customer assistance), and help with filing claims and appeals (including external reviews) in the applicable non- English language. The English versions of your EOBs and related correspondence will include information in the non -English language about how to access language services in that non -English language.

Any notice of an adverse benefit determination or correspondence from us confirming an adverse benefit determination will include information sufficient to identify the claim involved (including the date of service, the health care provider, and the claim amount, if applicable), and a statement describing the availability, upon request, of the diagnosis and procedure codes.

Section 8. The disputed claims process

You may be able to appeal directly to the Office of Personnel Management (OPM) if we do not follow required claims processes. For more information about situations to which you are entitled to immediately appeal to OPM, including additional requirements not listed in Sections 3, 7 and 8 of this brochure, please visit www.mercycarehealthplans.com.

Please follow this Federal Employees Health Benefits Program disputed claims process if you disagree with our decision on your post-service claim (a claim where services, drugs or supplies have already been provided). In Section 3 *If you disagree with our pre-service claim decision*, we describe the process you need to follow if you have a claim for services, referral, drugs or supplies that must have prior Plan approval, such as inpatient hospital admissions.

To help you prepare your appeal, you may arrange with us to review and copy, free of charge, all relevant materials and Plan documents under our control relating to your claim, including those that involve any expert review(s) of your claim. To make your request, please contact our Customer Service Department by writing: MercyCare Health Plans, P.O. Box 550, Janesville, WI 53547-0550 or calling (800) 895-2421.

Our reconsideration will take into account all comments, documents, records, and other information submitted by you relating to the claim, considered in the initial benefit determination.

When our initial decision is based (in whole or in part) on a medical judgement (i.e., medical necessity, experimental/ investigational). we will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgement and who was not involved in making the initial decision.

Our reconsideration decision will not afford deference to the initial decision and will be conducted by a plan representative who is neither the individual who made the initial decision that is the subject of the reconsideration, nor the subordinate of that individual.

We will not make our decisions regarding hiring, compensation, termination, promotion or other similar matters with respect to any individual (such as claims adjudicator or medical expert) based upon the likelihood that the individual will support the denial of benefits.

1 Ask us in writing to reconsider our initial decision. You must:

a) Write to us within 6 months from the date of our decision; and

b Send your request to us at: MercyCare Health Plans, P.O. Box 550 Janesville WI 53547-0550; and

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

d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms.

e) Include your email address (optional for member), if you would like to receive our decision via email. Please note that giving us your email, we may be able to provide our decision more quickly.

We will provide you, free of charge and in a timely manner, with any new or additional evidence considered, relied upon, or generated by us or at our direction in connection with your claim and any new rationale for our claim decision. We will provide you with this information sufficiently in advance of the date that we are required to provide you with our reconsideration decision to allow you a reasonable opportunity to respond to us before that date. However, our failure to provide you with new evidence or rationale in sufficient time to allow you to timely respond shall not invalidate our decision on reconsideration. You may respond to that new evidence or rationale at the OPM review stage described in step 4.

2 In the case of a post-service claim, we have 30 days from the date we receive your request to:

a) Pay the claim or

b) Write to you and maintain our denial or

c) Ask you or your provider for more information.

You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days.

If we do not receive the information within 60 days we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.

If you do not agree with our decision, you may ask OPM to review it.

3

You must write to OPM within:

- 90 days after the date of our letter upholding our initial decision; or
- 120 days after you first wrote to us -- if we did not answer that request in some way within 30 days; or
- 120 days after we asked for additional information.

Write to OPM at: United States Office of Personnel Management, Healthcare and Insurance, Federal Employee Insurance Operations, Health Insurance 3, 1900 E Street, NW, Washington, DC 20415-3630.

Send OPM the following information:

- A statement about why you believe our decision was wrong, based on specific benefit provisions in this brochure;
- Copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms;
- Copies of all letters you sent to us about the claim;
- Copies of all letters we sent to you about the claim; and
- Your daytime phone number and the best time to call.
- Your email address, if you would like to receive OPM's decision via email. Please note by providing your email address, you may receive OPM's decision more quickly.

Note: If you want OPM to review more than one claim, you must clearly identify which documents apply to which claim.

Note: You are the only person who has a right to file a disputed claim with OPM. Parties acting as your representative, such as medical providers, must include a copy of your specific written consent with the review request. However, for urgent care claims, a health care professional with knowledge of your medical condition may act as your authorized representative without your express consent.

Note: The above deadlines may be extended if you show that you were unable to meet the deadline because of reasons beyond your control.

4

OPM will review your disputed claim request and will use the information it collects from you and us to decide whether our decision is correct.

If you do not agree with OPM's decision, your only recourse is to file a lawsuit. If you decide to sue, you must file the suit against OPM in Federal court by December 31 of the third year after the year in which you received the disputed services, drugs, or supplies or from the year in which you were denied precertification or prior approval. This is the only deadline that may not be extended.

OPM may disclose the information it collects during the review process to support their disputed claim decision. This information will become part of the court record.

You may not file a lawsuit until you have completed the disputed claims process. Further, Federal law governs your lawsuit, benefits, and payment of benefits. The Federal court will base it review on the record that was before OPM when OPM decided to uphold or overturn our decision. You may recover only the amount of benefits in dispute.

Note: **If you have a serious or life threatening condition** (one that may cause permanent loss of bodily functions or death if not treated as soon as possible), and you did not indicate that your claim wa a claim for urgent care, then call us at (800) 895-2421. We will expedite our review (if we have not yet responded to your claim); or we will inform OPM so they can quickly review your claim on appeal. You may call OPM's Health Insurance 3 At 202-606-0737 between 8 a.m. and 5 p.m. Eastern Time.

Please remember that we do not make decisions about plan eligibility issues. For example, we do not determine whether you or a dependent is covered under this plan. You must raise eligibility issues with your Agency personnel/ payroll office if you are an employee, your retirement system if you are an annuitant or the Office of Workers' Compensation Programs if you are receiving Workers' Compensation benefits.

Section 9. Coordinating benefits with Medicare and other coverage

When you have other health coverage

You must tell us if you or a covered family member have coverage under any other health plan or have automobile insurance that pays health care expenses without regard to fault. This is called "double coverage."

When you have double coverage, one plan normally pays its benefits in full as the primary payer and the other plan pays a reduced benefit as the secondary payer. We, like other insurers, determine which coverage is primary according to the National Association of Insurance Commissioners'(NAIC) guidelines. For more information on NAIC rules regarding the coordination of benefits, visit the NAIC website at http://www.NAIC.org

When we are the primary payer, we will pay the benefits described in this brochure.

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

- **TRICARE and CHAMPVA**

TRICARE is the health care program for eligible dependents of military persons, and retirees of the military. TRICARE includes the CHAMPUS program. CHAMPVA provides health coverage to disabled Veterans and their eligible dependents. If TRICARE or CHAMPVA and this Plan cover you, we pay first. See your TRICARE or CHAMPVA Health Benefits Advisor if you have questions about these programs.

Suspended FEHB coverage to enroll in TRICARE or CHAMPVA: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in one of these programs, eliminating your FEHB premium. (OPM does not contribute to any applicable plan premiums.) For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage under TRICARE or CHAMPVA.

- **Workers' Compensation**

We do not cover services that:

- You (or a covered family member) need because of a workplace-related illness or injury that the Office of Workers' Compensation Programs (OWCP) or a similar Federal or State agency determines they must provide; or
- OWCP or a similar agency pays for through a third-party injury settlement or other similar proceeding that is based on a claim you filed under OWCP or similar laws.

Once OWCP or similar agency pays its maximum benefits for your treatment, we will cover your care.

- **Medicaid**

When you have this Plan and Medicaid, we pay first.

Suspended FEHB coverage to enroll in Medicaid or a similar State-sponsored program of medical assistance: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in one of these State programs, eliminating your FEHB premium. For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage under the State Program.

When other Government agencies are responsible for you care

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

When others are responsible for injuries

When you receive money to compensate you for medical or hospital care for injuries or illness caused by another person, you must reimburse us for any expenses we paid. However, we will cover the cost of treatment that exceeds the amount you received in the settlement.

If you do not seek damages, you must agree to let us try. This is called subrogation. If you need more information, contact us for our subrogation procedures.

When you have Federal Employees Dental and Vision Insurance Plan (FEDVIP) coverage

Some FEHB plans already cover some dental and vision services. When you are covered by more than one vision/dental plan, coverage provided under your FEHB plan remains as your primary coverage. FEDVIP coverage pays secondary to that coverage. When you enroll in a dental and/or vision plan on BENEFEDS.com, you will be asked to provide information on your FEHB plan so that your plans can coordinate benefits. Providing your FEHB information may reduce your out-of-pocket cost.

Clinical trials

An approved clinical trail includes a phase I, phase II, phase III or a 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 either Federally funded; conducted under an investigational new drug application reviewed by the Food and Drug Administration; or is a drug trial that is exempt from the requirement of an investigational new drug application.

If you are a participant in a clinical trial, this health plan will provide related care as follows, if it is not provided by the clinical trial:

- Routine care costs - costs for routine services such as doctor visits, lab tests, x-rays and scans, and hospitalizations related to treating the patient's condition, whether the patient is in a clinical trial or is receiving standard therapy.
- Extra care costs - costs related to taking part in a clinical trial such as additional tests that a patient may need as part of the trial, but not as part of the patient's routine care.
- Research costs - costs related to conducting the clinical trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes. These costs are generally covered by the clinical trials. This plan does not cover these costs.

When you have Medicare

- **What is Medicare?**

Medicare is a Health Insurance Program for:

- People 65 years of age or older
- Some people with disabilities under 65 years of age
- People with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant)

Medicare has four parts:

- Part A (Hospital Insurance). Most people do not have to pay for Part A. If you or your spouse worked for at least 10 years in Medicare-covered employment, you should be able to qualify for premium-free Part A insurance. (If you were a Federal employee at any time both before and during January 1983, you will receive credit for your Federal employment before January 1983.) Otherwise, if you are age 65 or older, you may be able to buy it. Contact 1-800-MEDICARE for more information.
- Part B (Medical Insurance). Most people pay monthly for Part B. Generally, Part B premiums are withheld from your monthly Social Security check or your retirement check.
- Part C (Medicare Advantage). You can enroll in a Medicare Advantage plan to get your Medicare benefits. We do not offer a Medicare Advantage plan. Please review the information on coordinating benefits with Medicare Advantage plans on the next page.

- Part D (Medicare prescription drug coverage). There is a monthly premium for Part D coverage. Before enrolling in Medicare Part D, please review the important disclosure notice from us about the FEHB prescription drug coverage and Medicare. The notice is on the first inside page of this brochure. For people with limited income and resources, extra help in paying for a Medicare prescription drug plan is available. For more information about this extra help, visit the Social Security Administration online at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY: 1-800-325-0778).

- **Should I enroll in Medicare?**

The decision to enroll in Medicare is yours. We encourage you to apply for Medicare benefits 3 months before you turn age 65. It's easy. Just call the Social Security Administration toll-free number 1-800-772-1213 to set up an appointment to apply. If you do not apply for one or more Parts of Medicare, you can still be covered under the FEHB Program.

If you can get premium-free Part A coverage, we advise you to enroll in it. Most Federal employees and annuitants are entitled to Medicare Part A at age 65 **without cost**. When you don't have to pay premiums for Medicare Part A, it makes good sense to obtain the coverage. It can reduce your out-of-pocket expenses as well as costs to the FEHB, which can help keep FEHB premiums down.

Everyone is charged a premium for Medicare Part B coverage. The Social Security Administration can provide you with premium and benefit information. Review the information and decide if it makes sense for you to buy the Medicare Part B coverage. If you do not sign up for Medicare Part B when you are first eligible, you may be charged a Medicare Part B late enrollment penalty of a 10% increase in premium for every 12 months you are not enrolled. If you didn't take Part B at age 65 because you were covered under FEHB as an active employee (or you were covered under your spouse's group health insurance plan and he/she was an active employee), you may sign up for Part B (generally without an increased premium) within 8 months from the time you or your spouse stop working or are no longer covered by the group plan. You also can sign up at any time while you are covered by the group plan.

If you are eligible for Medicare, you may have choices in how you get your health care. Medicare Advantage is the term used to describe the various private health plan choices available to Medicare beneficiaries. The information in the next few pages shows how we coordinate benefits with Medicare, depending on whether you are in the Original Medicare Plan or a private Medicare Advantage plan.

- **The Original Medicare Plan (Part A or Part B)**

The Original Medicare Plan (Original Medicare) is available everywhere in the United States. It is the way everyone used to get Medicare benefits and is the way most people get their Medicare Part A and Part B benefits now. You may go to any doctor, specialist, or hospital that accepts Medicare. The Original Medicare Plan pays its share and you pay your share.

All physicians and other providers are required by law to file claims directly to Medicare for members with Medicare Part B, when Medicare is primary. This is true whether or not they accept Medicare.

When you are enrolled in Original Medicare along with this Plan, you still need to follow the rules in this brochure for us to cover your care.

Claims process when you have the Original Medicare Plan – You will probably not need to file a claim form when you have both our Plan and the Original Medicare Plan.

When we are the primary payer, we process the claim first.

When Original Medicare is the primary payer, Medicare processes your claim first. In most cases, your claim will be coordinated automatically and we will then provide secondary benefits for covered charges. You will not need to do anything. To find out if you need to do something to file your claim, call us at (800) 895-2421 or see our website at www.mercycarehealthplans.com

We do not waive any costs if the Original Medicare Plan is your primary payer.

- **Tell us about your Medicare coverage**

You must tell us if you or a covered family member has Medicare coverage, and let us obtain information about services denied or paid under Medicare if we ask. You must also tell us about other coverage you or your covered family members may have, as this coverage may affect the primary/secondary status of this Plan and Medicare.

- **Medicare Advantage (Part C)**

If you are eligible for Medicare, you may choose to enroll in and get your Medicare benefits from a Medicare Advantage plan. These are private health care choices (like HMOs and regional PPOs) in some areas of the country. To learn more about Medicare Advantage plans, contact Medicare at 1-800-MEDICARE (1-800-633-4227) or at www.medicare.gov.

If you enroll in a Medicare Advantage plan, the following options are available to you:

This Plan and another plan's Medicare Advantage plan: You may enroll in another plan's Medicare Advantage plan and also remain enrolled in our FEHB plan. We will still provide benefits when your Medicare Advantage plan is primary, even out of the Medicare Advantage plan's network and/or service area (if you use our Plan providers). However, we will not waive any of our copayments, coinsurance, or deductibles. If you enroll in a Medicare Advantage plan, tell us. We will need to know whether you are in the Original Medicare Plan or in a Medicare Advantage plan so we can correctly coordinate benefits with Medicare.

Suspended FEHB coverage to enroll in a Medicare Advantage plan: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in a Medicare Advantage plan, eliminating your FEHB premium. (OPM does not contribute to your Medicare Advantage plan premium.) For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage or move out of the Medicare Advantage plan's service area.

- **Medicare prescription drug coverage (Part D)**

When we are the primary payer, we process the claim first. If you enroll in Medicare Part D and we are the secondary payer, we will review claims for your prescription drug costs that are not covered by Medicare Part D and consider them for payment under the FEHB plan.

Medicare always makes the final determination as to whether they are the primary payor. The following chart illustrates whether Medicare or this Plan should be the primary payor for you according to your employment status and other factors determined by Medicare. It is critical that you tell us if you or a covered family member has Medicare coverage so we can administer these requirements correctly. **(Having coverage under more than two health plans may change the order of benefits determined on this chart.)**

Primary Payor Chart		
A. When you - or your covered spouse - are age 65 or over and have Medicare and you...	**The primary payor for the individual with Medicare is...**	
	Medicare	**This Plan**
1) Have FEHB coverage on your own as an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through your spouse who is an annuitant	✓	
3) Have FEHB through your spouse who is an active employee		✓
4) Are a reemployed annuitant with the Federal government and your position is excluded from the FEHB (your employing office will know if this is the case) and you are not covered under FEHB through your spouse under #3 above	✓	
5) Are a reemployed annuitant with the Federal government and your position is not excluded from the FEHB (your employing office will know if this is the case) and...		
• You have FEHB coverage on your own or through your spouse who is also an active employee		✓
• You have FEHB coverage through your spouse who is an annuitant	✓	
6) Are a Federal judge who retired under title 28, U.S.C., or a Tax Court judge who retired under Section 7447 of title 26, U.S.C. (or if your covered spouse is this type of judge) and you are not covered under FEHB through your spouse under #3 above	✓	
7) Are enrolled in Part B only, regardless of your employment status	✓ for Part B services	✓ for other services
8) Are a Federal employee receiving Workers' Compensation disability benefits for six months or more	✓*	
B. When you or a covered family member...		
1) Have Medicare solely based on end stage renal disease (ESRD) and...		
• It is within the first 30 months of eligibility for or entitlement to Medicare due to ESRD **(30-month coordination period)**		✓
• It is beyond the 30-month coordination period and you or a family member are still entitled to Medicare due to ESRD	✓	
2) Become eligible for Medicare due to ESRD while already a Medicare beneficiary and...		
• This Plan was the primary payor before eligibility due to ESRD **(for 30 month coordination period)**		✓
• Medicare was the primary payor before eligibility due to ESRD	✓	
3) Have Temporary Continuation of Coverage (TCC) and...		
• Medicare based on age and disability	✓	
• Medicare based on ESRD **(for the 30 month coordination period)**		✓
• Medicare based on ESRD **(after the 30 month coordination period)**	✓	
C. When either you or a covered family member are eligible for Medicare solely due to disability and you...		
1) Have FEHB coverage on your own as an active employee or through a family member who is an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through a family member who is an annuitant	✓	
D. When you are covered under the FEHB Spouse Equity provision as a former spouse	✓	

*Workers' Compensation is primary for claims related to your condition under Workers' Compensation.

Section 10. Definitions of terms we use in this brochure

Calendar year

January 1 through December 31 of the same year. For new enrollees, the calendar year begins on the effective date of their enrollment and ends on December 31 of the same year.

Clinical trials cost categories

An approved clinical trial includes 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 either Federally funded; conducted under an investigational new drug application reviewed by the Food and Drug Administration; or is a drug trial that is exempt from the requirement of an investigational new drug application.

- Routine care costs- costs for routine services such as doctor visits, lab tests, x-rays and scans, and hospitalizations related to treating the patient's cancer, whether the patient is in a clinical trial or is recieiving standard therapy
- Extra care costs- costs related to taking part in a clinical trial such as additional tests that a patient may need as part of the trial, but not as part of the patient's routine care
- Research costs- costs related to conducting the clinical trial such asresearch physician and nurse time, analysis of results, and clinical tests performed only for research purposes. These costs are generally covered by the clinical trials. This plan does not cover these costs.

Coinsurance

Coinsurance is the percentage of our allowance that you must pay for your care. You may also be responsible for additional amounts. See page 21.

Copayment

A copayment is a fixed amount of money you pay when you receive covered services. See page 21.

Cost-sharing

Cost-sharing is the general term used to refer to your out-of-pocket costs (e.g., deductible, coinsurance, and copayments) for the covered care you receive.

Covered services

Services or supplies specified in this Brochure for which benefits will be provided.

Custodial Care

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

Experimental or investigational service

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

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

b) Is not yet recognized as acceptable medical practice to treat that bodily injury or sickness, as determined by MercyCare for a member's bodily injury or sickness.

The criteria that MercyCare uses for determining whether a service, treatment, procedure, facility, equipment, drug, device or supply is considered to be experimental or investigative include whether:

a) It is commonly performed or used on a widespread geographic basis.

b) It is generally accepted to treat that bodily injury or sickness by the medical profession in the United States.

c) Its failure rate or side effects are unacceptable.

d) The member has exhausted more conventional methods of treating the bodily injury or sickness.

e) It is recognized for reimbursement by Medicare, Medicaid and other insurers and self-funded plans.

Health care professional A physician or other health care professional licensed, accredited, or certified to perform specified health services consistent with state law.

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

1.Consistent with the symptom(s) or diagnosis and treatment of the member's bodily injury or sickness;

2.Appropriate under the standards of acceptable medical practice to treat that bodily injury or sickness;

3.Not solely for the convenience of the member, physician, hospital or other provider of health care;

4.The most appropriate service, treatment, procedure, equipment, drug, device or supply which can be safely provided to the member;

5.The most economical manner of accomplishing the desired end result.

Plan allowance Plan allowance is the amount we use to determine our payment and your coinsurance for covered services.

We determine our Plan allowance as follows: Covered charges will be paid based on the contract agreement between MercyCare and the plan provider (subject to any coinsurance and copay provisions in this brochure). If there is a difference between our contracted amount and the amount that the provider bills us, you will not be responsible for that amount.

In the case of non-contracted providers of emergency services, the Plan allowance means the Usual and Customary charge. You may be responsible for the difference between the billed amount and the Usual and Customary charge.

Post-service claims Any claims that are not pre-service claims. In other words, post-service claims are those claims where treatment has been performed and the claims have been sent to us in order to apply for benefits.

Pre-service claims Those claims (1) that require precertification, prior approval, or a referral and (2) where failure to obtain precertification, prior approval, or a referral results in a reduction of benefits.

Urgent care claims A claim for medical care or treatment is an urgent care claim if waiting for the regular time limit for non-urgent care claims could have one of the following impacts:

- Waiting could seriously jeopardize your life or health;
- Waiting could seriously jeopardize your ability to regain maximum function; or
- In the opinion of a physician with knowledge of your medical condition, waiting would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

	Urgent care claims usually involve Pre-service claims not Post-service claims We will judge whether a claim is an urgent care claim by applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine. If you believe your claim qualifies as an urgent care claim, please contact our Customer Service Department at (800)895-2421. You may also prove that your claim is an urgent care claim by providing evidence that a physician with knowledge of your medical condition has determined that your claim involves urgent care.
Us/We	Us and We refer to MercyCare Health Plans.
Usual and Customary Charge	The dollar amount for a treatment, service, or supply provided by a health care provider that is reasonable, as determined by the Plan, when taking into consideration among other factors, determined by MercyCare, amounts charged by health care providers for similar treatment, services, and supplies when provided in the same geographic area under similar or comparable circumstances.
You	You refers to the enrollee and each covered family member.

Section 11. Other Federal Programs

Important information about three Federal programs that complement the FEHB Program

Please note, the following programs are not part of your FEHB benefits. They are separate Federal programs that complement your FEHB benefits and can potentially reduce your annual out-of- pocket expenses. These programs are offered independent of the FEHB program and require you to enroll separately with no Government contribution.

First, the **Federal Flexible Spending Account Program**, also known as FSAFEDS, lets you set aside pre-tax money from your salary to reimburse you for eligible dependent care and/or health care expenses. You pay less in taxes so you can save money. The result can be a discount of 20% to more than 40% on services/products you routinely pay for out-of-pocket.

Second, the **Federal Employees Dental and Vision Insurance Program (FEDVIP)**, provides comprehensive dental and vision insurance at competitive group rates. There are several plans from which to choose. Under **FEDVIP** you may choose self only, self plus one, or self and family coverage for yourself and any eligible dependents.

Third, the **Federal Long Term Care Insurance Program (FLTCIP)** helps cover long term care costs, which are not covered under the FEHB Program.

The Federal Flexible Spending Account Program – *FSAFEDS*

What is an FSA?

It is an account where you contribute money from you salary **BEFORE** taxes are withheld, then incur eligible expenses and get reimbursed. You pay less in taxes so you save money. **Annuitants are not eligible to enroll.**

There are three types of FSAs offered by FSAFEDS. Each type has a minimum annual election of $100. The maximum annual election for a health care flexible spending account (HCFSA) or a limited expense health care spending account (LEX HCFSA) is $2,500 per person. The maximum annual election for a dependent care flexible spending account (DCFSA) is $5,000 per household.

- **Health Care FSA (HCFSA)** - Reimburses you for eligible out-of-pocket health care expenses (such as copayments, deductibles, prescriptions, **physician prescribed** over the counted drugs and medication, vision and dental expense, and much more) for you and your tax dependents, including adult children (through the end of the calender year in which they turn 26).

FSAFEDS offers paperless reimbursement for your HCFSA through a number of FEHB and FEDVIP plans. This means that when you or your provider files claims with your FEHB and FEDVIP plan, FSAFEDS will automatically reimburse your eligible out-of-pocket expenses based on the claim information it receives from your plan.

- **Limited Expense health Care FSA (LEX HCFSA) -** Designed for employees enrolled in or covered by a High Deductible Health Plan with a Health Savings Account. Eligible expenses are limited to out-of-pocket dental and vision care expenses for you and you tax dependents including adult children (through the end of the calendar year which they turn 26).
- **Dependent Care FSA (DCFSA) -** Reimburses you for eligible **non-medical** day care expenses for your children underage 13 and/or for any person you claim as a dependent on your Federal Tax return who is mentally or physically incapable of self-care. You (and your spouse if married) must be working, looking for work (income must be earned during the year), or attending school full-time to be eligible for a DCFSA.

- If you are new or a newly eligible employee you have 60 days from your hire date to enroll in an HCFSA or LEX HCFSA and/or DCFSA, but you must enroll before October 1. If you are hired or become eligible on or after October 1, you must wait and enroll during the Federal Benefits Open Season held each fall.

Where can I get more information about FSAFEDS?

Visit **www.FSAFEDS.com** or call an FSAFEDS Benefits Counselor toll-free at 1-877-FSAFEDS (1-877-372-3337), Monday through Friday, 9 a.m. until 9 p.m., Eastern Time. TTY: 1-800-952-0450.

The Federal Empolyees Dental and Vision Insurance Program – *FEDVIP*

Important Information

The Federal Employees Dental and Vision Insurance Program (FEDVIP) is separate and different from the FEHB Program, and was established by the Federal Employee Dental and Visions Benefits Enhancement Act of 2004. **The Program provides comprehensive dental and vision insurance at competitive group rates with no pre-existing condition limitations for enrollment.**

FEDVIP is available to eligible Federal and Postal Service employees, retirees, and their eligible family members on an enrollee-pay-all basis. Employee premiums are withheld from salary on a pre-tax basis.

Dental Insurance

All dental plans provide a comprehensive range of services, including:

- Class A (Basic) services, which include oral examinations, prophylaxis, diagnostic evaluations, sealants and x-rays.
- Class B (Intermediate) services, which include restorative procedures such as fillings, prefabricated stainless steel crowns, periodontal scaling, tooth extractions, and denture adjustments.
- Class C (Major) services, which include endodontic services such as root canals, periodontal services such as gingivectomy, major restorative services such as crowns, oral surgery, bridges and prosthodontic services such as complete dentures.
- Class D (Orthodontic) services with up to a 12-month waiting period. Most FEDVIP dental plans cover adult orthodontia. Review your FEDVIP dental plan's brochure for information on this benefit.

Vision Insurance

All vision plans provide comprehensive eye examinations and a coverage for lenses, frames and contact lenses. Other benefits such as discounts on LASIK surgery may also be available.

Additional Information

You can find a comparison of the plans available and their premiums on the OPM website at www.opm.gov/dental and www.opm.gov/vision. These sites also provide links to each plan's website, where you can view detailed information about benefits and preferred providers.

How do I enroll?

You enroll on the Internet at www.BENEFEDS.com. For those without access to a computer, call 1-877-888-3337, (TTY: 1-877-889-5680).

The Federal Long Term Care Insurance Program – *FLTCIP*

It's important protection

The Federal Long Term Care Insurance Program (FLTCIP) can help pay for the potentially high cost of long term care services, which are not covered by FEHB plans. Long term care is help you receive to perform activities of daily living - such as bathing or dressing yourself - or supervision you receive because of a severe cognitive impairment such as Alzheimer's disease. For example, long term care can be received in your home from a home health aide, in a nursing home, in an assisted living facility or in adult day care. To qualify for coverage under the FLTCIP, you must apply and pass a medical screening (called underwriting). Federal and U.S. Postal Service employees and annuitants, active and retired members of the uniformed services, and qualified relatives are eligible to apply. Certain medical conditions, or combination of conditions, will prevent some people from being approved for coverage. You must apply to know if you will be approved for enrollment. For more information, call 1-800-LTC-FEDS (1-800-582-3337), (TTY: 1-800-843-355), or visit www.ltcfeds.com.

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Summary of benefits for the High Option of MercyCare Health Plans - 2015

- **Do not rely on this chart alone.** All benefits are provided in full unless indicated and are subject to the definitions , limitations, and exclusions in this brochure. On this page we summarize specific expenses we cover; for more detail, look inside.
- If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.
- We only cover services provided or arranged by Plan physicians, except in emergencies.

High Option Benefits	You pay	Page
Medical services provided by physicians:		
• Diagnostic and treatment services provided in the office	Office visit copay: $10 primary care; $10 specialist	24
• Preventive care services, such as routine screenings and annual physicals	Nothing	25
Services provided by a hospital:		
• **Inpatient**	Nothing	46
• **Outpatient**	Nothing	47
Emergency benefits:		
• **In-area**	$75 per emergency room visit	50
• **Out-of-area**	$75 per emergency room visit	50
Mental health and substance abuse treatment:	$10 copay per visit	51
Prescription drugs:		
• Retail pharmacy	Tier 1 - $20 generic co-pay Tier 2 - $40 preferred brand co-pay Tier 3 - $60 expanded brands and select generics	55
• Mail order	At mail order pharmacies, a 90-day supply for 2 copays.	55
Dental care:	Accidental injury benefit only. $10 office visit copay.	56
Vision care:	One refraction annually; $10 per office visit copay.	32
Special features		58
Protection against catastrophic costs (out-of-pocket maximum)**:**	Nothing after $5,000 individual and $10,000 family.	11
Tobacco Cessation:		38

	MercyCare covers a variety of smoking cessation drugs and compensates primary care offices for tobacco counseling. The health plan also refers members to American Lung Association online resources.	
Alternative treatments:	• Acupuncture - 12 visits per year; $10 visit copay • Biofeedback - $10 per visit copay	37
Physical, Occupational, Speech therapies:	Combined 60 visits per condition; 20% coinsurance.	29
Durable Medical Equipment and Prosthetic Devices:	25% coinsurance for purchase or rental	33

2015 Rate Information

For 2015 health premium information, please see:
http://www.opm.gov/healthcare-insurance/indian-tribes/health-insurance/#url=Premiums or contact your tribe's Human Resources department.