

MercyCare Health Plans

www.mercycarehealthplans.com

Customer Service - 800-895-2421



2020

A Health Maintenance Organization (High and Standard 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 9 for details. This plan is accredited. See page 13.

Serving: Rock, Walworth, Jefferson and Green Counties in Wisconsin and Boone and Winnebago Counties in Illinois.

Enrollment in this plan is limited. You must live or work in our geographic service area to enroll. See page 14 for requirements.

Enrollment codes for this Plan:

- EY1 - High Option - Self Only
- EY3 - High Option - Self Plus One
- EY2 - High Option - Self and Family

- EY4 - Standard Option - Self Only
- EY6 - Standard Option - Self Plus One
- EY6 Standard Option - Self and Family

IMPORTANT

- Rates: Back Cover
- Changes for 2020: Page 15
- Summary of Benefits: Page 93

"Special notice - A new Standard Option has been added for 2020"



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**Important Notice from MercyCare HMO, Inc. 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 800-772-1213 (TTY: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 800-MEDICARE 800-633-4227, TTY:877-486-2048.

Introduction

This brochure describes the benefits MercyCare HMO, Inc. 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 (800) 895-2421 or through our website: www.mercycarehealthplans.com. The address for MercyCare's administrative offices is:

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

This brochure is the official statement of benefits. No verbal 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 Plus One or 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, 2018, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2018, and changes are summarized on page 15. Rates are shown at the end of this brochure.

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 Plans.
- 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 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/our-inspector-general/hotline-to-report-fraud-waste-or-abuse/complaint-form/
The online reporting form is the desired method of reporting fraud in order to ensure accuracy, and a quicker response time.

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). A Carrier may request that an enrollee verify the eligibility of any or all family members listed as covered under the enrollee's FEHB enrollment.
- 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 (TCC).
- 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.

Discrimination is Against the Law

The MercyCare Health Plans complies with applicable Federal civil rights laws, to include both Title VII of the Civil Rights Act of 1964 and Section 1557 of the Affordable Care Act. Pursuant to Section 1557, MercyCare Health Plans does not discriminate, exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

If a carrier is a covered entity, its members may file a 1557 complaint with HHS Office of Civil Rights, OPM, or FEHB Program carriers. For purposes of filing a complaint with OPM, covered carriers should use the following:

You can also file a civil rights complaint with the Office of Personnel Management by mail at:

Office of Personnel Management
Healthcare and Insurance
Federal Employee Insurance Operations
Attention: Assistant Director, FEIO
1900 E Street NW, Suite 3400-S
Washington, D.C. 20415-3610

Preventing Medical Mistakes

Medical mistakes continue to be a significant cause of preventable deaths within the United States. 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. Medical mistakes and their consequences also add significantly to the overall cost of healthcare. Hospitals and healthcare providers are being held accountable for the quality of care and reduction in medical mistakes by their accrediting bodies. You can also improve the quality and safety of your own health care and that of your family members by learning more about and understanding your risks. 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 take notes, ask questions and understand answers.

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

- Bring the actual medication or give your doctor and pharmacist a list of all the medications and dosage that you take, including non-prescription (over-the-counter) medications 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 medication is what the doctor ordered. Ask the pharmacist about your medication if it looks different than you expected.
- Read the label and patient package insert when you get your medication, including all warnings and instructions.
- Know how to use your medication. Especially note the times and conditions when your medication should and should not be taken.
- Contact your doctor or pharmacist if you have any questions.
- Understand both the generic and brand names of your medication. This helps ensure you do not receive double dosing from taking both a generic and a brand. It also helps prevent you from taking a medication to which you are allergic.

3. Get the results of any test or procedure.

- Ask when and how you will get the results of tests or procedures. Will it be in person, by phone, mail, through the Plan or Provider's portal?

- Don't assume the results are fine if you do not get them when expected. Contact your healthcare provider and ask for your results.
- Ask what the results mean for your care.

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

- Ask your doctor about which hospital or clinic has the best care and results for your condition if you have more than one hospital or clinic 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 or clinic.

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

For more information on patient safety, please visit:

www.jointcommission.org/speakup.aspx. The Joint Commission's Speak Up™ patient safety program.

www.jointcommission.org/topics/patient_safety.aspx. The Joint Commission helps health care organizations to improve the quality and safety of the care they deliver.

www.ahrq.gov/patients-consumers/. 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.org. The National Patient Safety Foundation has information on how to ensure safer health care for you and your family.

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

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.

Preventable Healthcare Acquired Conditions ("Never Events")

When you enter the hospital for treatment of one medical problem, you do not 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, patients do suffer from injuries or illnesses that could have been prevented if doctors or the hospital had taken proper precautions. Errors in medical care that are clearly identifiable, preventable and serious in their consequences for patient's, can indicate a significant problem in the safety and credibility of a health care facility. These conditions and errors are sometimes called "Never Events" or "Serious Reportable Events."

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. When such an event occurs, neither you nor your FEHB plan will incur costs to correct the medical error.

FEHB Facts Coverage information

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. 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 out-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/healthcare-insurance 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 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 Plus One coverage is an enrollment that covers you and one eligible family member. Self and Family coverage is for you, and one eligible family member, or 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 Plus one or 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 Plus One or 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 Plus One or 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 are married. A carrier may request that an enrollee verify the eligibility of any or all family members listed as covered under the enrollee's FEHB enrollment.

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 are enrolled in one FEHB plan, you or they cannot be enrolled in or covered as a family member by another enrollee in 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. A Self Plus One enrollment covers you and your spouse, or one eligible family member as described in the chart below.

Children	Coverage
Natural children, adopted children, and stepchildren	Natural, adopted children and stepchildren 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.

Newborns of covered children are insured only for routine nursery care during the covered portion of the mother's maternity stay.

You can find additional information at www.opm.gov/healthcare-insurance.

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 Plus One or 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 in Self Plus One or 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 Plus One or Self and Family coverage, as appropriate, in the-lowest-cost nationwide plan option as determined by OPM.
- 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 Plus One or Self and Family, as appropriate, 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 Plus One or Self and Family, as appropriate, in the-lowest-cost nationwide plan option as determined by OPM.

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 does not 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 does not serve the area in which your children live as long as the court/administrative order is in effect. Similarly, you cannot change to Self Plus One if the court/administrative order identifies more than one child. 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 2020 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 2019 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 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.

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 information about your coverage choices. You can also visit OPM's website at www.opm.gov/healthcare-insurance/healthcare/plan-information/. A carrier may request that an enrollee verify the eligibility of any or all family members listed as covered under the enrollee's FEHB enrollment.

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, 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 of 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

If you leave Federal or Tribal service, your employing office will notify you of your right to convert. You must contact us in writing 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 contact us in writing 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. Your waiting period will not be imposed, and your coverage will not be limited due to pre-existing conditions. When you contact us, we will assist you in obtaining information about health benefits coverage inside or outside the Affordable Care Act's Health Insurance Marketplace in your state. For assistance in finding coverage, please contact us at 800-895-2421 or visit our website at www.mercycarehealthplans.com.

Health Insurance Marketplace

If you would like to purchase health insurance through the ACA'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). OPM requires that FEHB plans be accredited to validate that plan operations and/or care management meet nationally recognized standards. MercyCare HMO, Inc. holds the following accreditation's: National Committee for Quality Assurance. To learn more about this plan's accreditation(s), please visit the following websites: www.ncqa.org.

We require you to see specific physicians, hospitals, and other providers that contract with us. These Plan providers coordinate your health care services. We are solely responsible for the selection of these providers in your area. Contact us for a copy of our most recent provider directory.

HMO's 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& 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 and Standard Options

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 cost-sharing (copayments, coinsurance deductibles, and non-covered services and supplies).

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.

Deductible Information

The High Option has no deductible. The Calendar year deductible is \$500 per person, \$1,000 per Self Plus One enrollment, or \$1,000 per Self and Family enrollment for the Standard Option. Where the deductible applies to the words "after deductible" are added.

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 and responsibilities

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

You are entitled to a wide range of consumer protections and have specific responsibilities as a member of this plan. You can view the complete list of these rights and responsibilities by visiting our website, MercyCare Health Plans at www.mercycarehealthplans.com. You can also contact us to request that we mail a copy to you.

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 visit our website at www.mercycarehealthplans.com.

By law, you have the right to access your protected health information (PHI). For more information regarding access to PHI, visit our website MercyCare Health Plans at www.mercycarehealthplans.com to obtain our Notice of Privacy Practices. You can also contact us to request that we mail you a copy of that Notice.

Your medical and claims records are confidential

We will keep your medical and claims records confidential. Please note that we may disclose your medical and claims information (including our prescription drug utilization) to any of your treating physicians or dispensing pharmacies.

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 and Boone and Winnebago Counties in Illinois.

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 2020

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.

Changes to this plan

- A new Standard Option will be offered for the first time during the 2020 Open Season.

Changes to High Option only

- Your share of the non-Postal premium will increase for Self Only or increase for Self and Family or increase for Self Plus One. See page 94.

Section 3. How You Get Care

Identification cards	<p>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.</p> <p>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.</p>
Where you get covered care	<p>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.</p>
<ul style="list-style-type: none">• Plan providers	<p>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.</p> <p>We list Plan providers in the provider directory, which we update periodically. The list is also on our website at www.mercycarehealthplans.com.</p>
<ul style="list-style-type: none">• Plan facilities	<p>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.</p>
What you must do to get covered care	<p>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.</p>
<ul style="list-style-type: none">• Primary care	<p>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 and has 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.</p> <p>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.</p>
<ul style="list-style-type: none">• Specialty care	<p>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.</p> <p>Here are some other things you should know about specialty care:</p>

- 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*.

You must get prior approval for certain services. Failure to do so will result in a denial of services leaving you responsible for 100% of the charges for that service.

- **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 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 or not it is an urgent care claim by applying the judgment of a prudent layperson that 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 let you know what information we need to complete our review of the claim. You will then have up to 48 hours to provide the required 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 FEHB 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, we will make a decision within 24 hours after we receive the claim.

- **The Federal Flexible Spending Account Program- FSAFEDS**
 - Reimbursed you for eligible out-of-pocket health care expenses (such as copayments, deductibles, **physician prescribed** over-the-counter drugs and medications, vision and dental expenses and much more) for you and your tax dependents, including adult children (through the end of the calendar year in which they turn 26).
 - FSAFEDS offers paperless reimbursement for your HCFSA through a number of FEHS and FEDVIP plans. This means that when you or your provider files claims with your FEHB or FEDVIP plan, FSAFEDS will automatically reimburse your eligible out-of-pocket expenses based on the claim information it receives from your plan.

- **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, 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 Cost 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 A deductible is a fixed expense you must incur for certain covered services and supplies before we start paying benefits for them. Copayments do not count toward any deductible.

- The calendar year deductible is \$0 per person under High Option and \$500 per person under Standard Option. Under a Self Only enrollment, the deductible is considered satisfied and benefits are payable for you when your covered expenses applied to the calendar year deductible for your enrollment reach \$0 under High Option and \$500 under Standard Option. Under a Self Plus One enrollment, the deductible is considered satisfied and benefits are payable for you and one other eligible family member then the combined covered expenses applied to the calendar year deductible for your enrollment reach \$0 under High Option and \$1,000 under Standard Option. Under a Self and Family enrollment, the deductible is considered satisfied and benefits are payable for all family members when the combined covered expenses applied to the calendar year deductible for family members reach \$0 under High Option and \$1,000 under Standard Option.

Note: If you change plans during Open Season, you do not have to start a new deductible under your old plan between January 1 and the effective date of your new plan. If you change plans at another time during the year, you must begin a new deductible under your new plan.

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

For the High and Standard Option after your copayments and coinsurance total of \$7,350 for self only or \$14,700 for self plus one and self and family enrollment in any calendar year, you do not have to pay any more for covered services. ***The maximum annual limitation on cost sharing listed under Self Only of \$7,350 applies to each individual, regardless of whether the individual is enrolled in Self Only, Self Plus One, or Self and Family.***

Example Scenario: Your plan has a \$7,350 Self Only maximum out-of-pocket limit and a \$14,700 Self Plus One or Self and Family maximum out-of-pocket limit. If you or one of your eligible family members has out-of-pocket qualified medical expenses of \$7,350 more for the calendar year, any remaining qualified medical expenses for that individual will be covered fully by your health plan. With a Self and Family enrollment out-of-pocket maximum of \$14,700 a second family member, or an aggregate of other eligible family members, will continue to accrue out-of-pocket qualified medical expenses up to a maximum of \$7,350 for the calendar year before their qualified medical expenses will begin to be covered in full.

However, copayments and coinsurance, if applicable for the following services do not count toward your catastrophic protection out-of-pocket maximum, and you must continue to pay copayments and coinsurance for these services:

- Genetic counseling and testing
- Podiatry services
- Coinsurance for infertility treatment
- Expenses for services and supplies that exceed the stated maximum dollar or day limit
- Expenses from utilizing out-of-network providers

Be sure to keep accurate records of your copayments and coinsurance to ensure the plan's calculation of your out-of-pocket maximum is reflected accurately.

Carryover

If you changed to this Plan during open season from a plan with a catastrophic protection benefit and the effective date of the change was after January 1, any expenses that would have applied to that plan's catastrophic protection benefit during the prior year will be covered by your old plan if they are for care you received in January before your effective date of coverage in this Plan. If you have already met your old plan's catastrophic protection benefit level in full, it will continue to apply until the effective date of your coverage in this Plan. If you have not met this expense level in full, your old plan will first apply your covered out-of-pocket expenses until the prior year's catastrophic level is reached and then apply the catastrophic protection benefit to covered out-of-pocket expenses incurred from that point until the effective date of your coverage in this Plan. Your old plan will pay these covered expenses according to this year's benefits; benefit changes are effective January 1.

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 and Standard Option Benefits Overview

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

The High and Standard 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 primary care physician office visit copayment, inpatient/outpatient services covered at 100%, written referrals are not required when seeing a MercyCare Health Plan Provider.
- **Standard Option** - \$20 primary care physician office visit copayment, inpatient/outpatient services covered at 10% coinsurance after deductible, written referrals are not required when seeing a MercyCare Health Plan Provider.

MercyCare has been NCQA accredited since 1998 and Mercy Health System is a winner of the Malcolm Baldrige award and a Magnet® Recipient. 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 health 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.
- The High Option has no deductible. the Calendar year deductible is \$500 per person, \$1,000 per Self Plus One enrollment, or \$1,000 per Self and Family enrollment for the Standard Plan. Where the deductible applies the words "after deductible" are added.
- 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	
	High	Standard
Diagnostic and treatment services		
Professional services of physicians	\$10 copay per primary care physician visit	\$20 copay per primary care physician visit
• In physician’s office	\$20 copay per specialist visit	\$40 copay per specialist visit
Professional services of physicians	\$10 copay per primary care physician visit	\$20 copay per primary care physician visit
• In an urgent care center	\$20 copay per specialist visit	\$40 copay per specialist visit
• Office medical consultations	\$40 copay per urgent care visit	\$40 copay per urgent care visit
• Second surgical opinion		
• At home		
• Advanced care planning		
<i>Note:</i>		
<i>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.</i>		
• During a hospital stay	Nothing	10% coinsurance after deductible
• In a skilled nursing facility		
• Initial examination of a newborn child covered under a family enrollment		

Benefit Description	You Pay	
Diagnostic and treatment services (cont.)	High	Standard
Telehealth services <ul style="list-style-type: none"> • No benefit 	<i>All charges</i>	<i>All charges</i>
Lab, X-ray and other diagnostic tests	High	Standard
Tests, such as: <ul style="list-style-type: none"> • Blood tests • Urinalysis • Non-routine pap test • Pathology • X-rays • Non-routine mammograms • CAT Scans • Ultrasound • Electrocardiogram and EEG 	Nothing	10% coinsurance after deductible.
<ul style="list-style-type: none"> • *MRI • *Pet Scans <p>*Prior authorization required when ordered by a primary care physician</p>	Nothing	10% coinsurance after deductible.
Preventive care, adult	High	Standard
Screenings, such as: <ul style="list-style-type: none"> • Annual physicals • Depression • Diabetes • High blood pressure • HIV • Total blood cholesterol • Colorectal cancer screening <ul style="list-style-type: none"> - Fecal occult blood test - sigmoidoscopy screening- every five years starting at age 50 - colonoscopy screening <p>Individual counseling on prevention and reducing health risks.</p>	Nothing	Nothing

Preventive care, adult - continued on next page

Benefit Description	You Pay	
	High	Standard
<p>Preventive care, adult (cont.)</p> <p>Preventive Medications- Statins</p> <p>The USPSTF recommends that adults without a history of cardiovascular disease (CVD) (ie, symptomatic coronary artery disease or ischemic stroke) use a low- to moderate-dose statin (See Formulary for the list of drugs that are available with no member cost sharing) for the prevention of CVD events and mortality when all of the following criteria are met:</p> <ol style="list-style-type: none"> 1) they are aged 40 to 75 years; 2) they have 1 or more CVD risk factors (ie, dyslipidemia, diabetes, hypertension, or smoking); and 3) they have a calculated 10-year risk of a cardiovascular event of 10% or greater. <p>To meet ACA preventative care requirements that USPSTF Grade B recommendations are covered at no cost.</p>	Nothing	Nothing
<p>Well woman care; based on current recommendations such as:</p> <ul style="list-style-type: none"> • Cervical cancer screening (pap smear) • Human papillomavirus (HPV) testing • Chlamydia/gonorrhea screening • Gonorrhea prophylactic medication to protect newborns • Osteoporosis screening • Breast cancer screening • 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 • Perinatal depression: counseling and interventions <p>Routine mammogram – covered for women</p> <p>Adult immunizations endorsed by the Centers for Disease Control and Prevention (CDC): based on the Advisory Committee on Immunization Practices (ACIP) schedule.</p>	Nothing	Nothing

Preventive care, adult - continued on next page

Benefit Description	You Pay	
	High	Standard
<p>Preventive care, adult (cont.)</p> <p>Note: Any procedure, injection, diagnostic service, laboratory, or x-ray service done in conjunction with a routine examination and is not included in the preventive listings of services will be subject to the applicable member copayments, coinsurance, and deductible.</p> <p>Note: A complete list of preventive care services recommended under the U.S. Preventive Services Task Force is available online at www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm.</p> <p>HHS: www.healthcare.gov/preventive-care-benefits/</p> <p>CDC: www.cdc.gov/vaccines/schedules/index.html</p> <p>Women's preventive services: www.healthcare.gov/preventive-care-women/</p> <p>For additional information: healthfinder.gov/myhealthfinder/default.aspx</p> <p>Note: For a complete list of the American Academy of Pediatrics Bright Futures Guidelines go to brightfutures.aap.org/Pages/default.aspx</p>		
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, athletic exams, or travel.</i> • <i>Immunizations, boosters, and medications for travel or work-related exposure.</i> 	<i>All charges</i>	<i>All charges</i>
<p>Preventive care, children</p> <p>Well-child: Well-child visits examinations, and immunizations as described in the Bright Future Guidelines provided by the American Academy of Pediatrics</p> <p>Note: Any procedure, injection, diagnostic service, laboratory, or x-ray service done in conjunction with a routine examination and is not included in the preventive listings of services will be subject to the applicable member copayments, coinsurance, and deductible.</p>	Nothing	Nothing

Preventive care, children - continued on next page

Benefit Description	You Pay	
Preventive care, children (cont.)	High	Standard
<p>Note: A complete list of preventive care services recommended under the U.S. Preventive Services Task Force (USPSTF) is available online at www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/ and HHS at www.healthcare.gov/preventive-care-benefits/, CDC: www.cdc.gov/vaccines/schedules/index.html</p> <p>For additional information:</p> <p>healthfinder.gov/myhealthfinder/default.aspx</p> <p>Note: For a complete list of the American Academy of Pediatrics Bright Futures Guidelines go to brightfutures.aap.org/Pages/default.aspx</p>	Nothing	Nothing
Maternity care	High	Standard
<ul style="list-style-type: none"> • 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. • Delivery • Postnatal care 	Nothing	<p>Nothing for routine parental care or the first postpartum care visit; \$40 per office visit for all postpartum care visits thereafter</p> <p>10% coinsurance after deductible for inpatient hospital professional delivery services</p>
Breastfeeding support, supplies and counseling for each birth.	Nothing	Nothing
<p>Note: Here are some things to keep in mind:</p> <ul style="list-style-type: none"> • You do not need to precertify your vaginal delivery; see page 50 for other circumstances, such as extended stays for you or your baby. • You may remain in the hospital up to 48 hours after a vaginal 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. • Hospital services are covered under Section 5(c) and Surgical benefits Section 5(b) 		

Maternity care - continued on next page

Benefit Description	You Pay	
	High	Standard
Maternity care (cont.)		
<ul style="list-style-type: none"> We cover routine nursery care of the newbornchild during the covered portion of the mother’s maternity We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self Plus One or Self and Family enrollment. Surgical benefits, not maternity benefits, apply to circumcision. <p>Note: When a newborn requires definitive treatment during or after the mother’s confinement, the newborn is considered a patient in his or her own right. If the newborn is eligible for coverage, regular medical or surgical benefits apply rather than maternity benefits.</p>		
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> Elective abortions 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. 	<i>All charges</i>	<i>All charges</i>
Family planning	High	Standard
Contraceptive counseling on an annual basis at no cost sharing.	Nothing	Nothing
<p>A range of voluntary family planning services, limited to:</p> <ul style="list-style-type: none"> Voluntary sterilization (See Surgical procedures Section 5 (b)) Surgically implanted contraceptives Injectable contraceptive drugs (such as Depo Provera) Intrauterine devices (IUDs) Diaphragms <p>Note: We cover oral contraceptives under the prescription drug benefit.</p>	\$20 per office visit	\$40 per office visit
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <i>Reversal of voluntary surgical sterilization</i> <i>Genetic testing and counseling, except as defined on page 74, Genetic Testing and Counseling</i> 	<i>All charges</i>	<i>All charges</i>

Benefit Description	You Pay	
	High	Standard
Infertility services		
Diagnosis and treatment of infertility, such as: <ul style="list-style-type: none"> • Intravaginal insemination (IVI) • Intracervical insemination (ICI) • Intrauterine insemination (IUI) 	50% coinsurance	50% coinsurance
<i>Not covered:</i> <i>Assisted Reproductive Technology (ART) procedures, such as but not limited to:</i> <ul style="list-style-type: none"> • Artificial insemination (AI) • <i>In Vitro Fertilization (IVF)</i> • <i>Embryo Transfer, Gamete Intra-Fallopian Transfer (GIFT) and Zygote Intra-Fallopian transfer (ZIFT)</i> • <i>Services and supplies related to ART procedures</i> • <i>Cost of donor sperm</i> • <i>Cost of donor egg</i> • <i>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.</i> • <i>Storage and collection fees for sperm and ovum</i> • <i>Reversal of voluntarily induced sterilization</i> • <i>Revision of scarring caused by implantable birth control devices</i> • <i>Fertility drugs</i> 	<i>All charges</i>	<i>All charges</i>
Allergy care	High	Standard
<ul style="list-style-type: none"> • Testing and treatment, including materials • Allergy injections 	\$20 per office visit	\$40 per office visit
<ul style="list-style-type: none"> • Allergy serum 	Nothing	Nothing
<i>Not covered:</i> <ul style="list-style-type: none"> • <i>Sublingual (under the tongue) allergy testing and/or treatment</i> 	<i>All charges</i>	<i>All charges</i>

Benefit Description	You Pay	
	High	Standard
<p>Treatment therapies</p> <ul style="list-style-type: none"> • Chemotherapy and radiation therapy <p>Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under Organ/Tissue Transplants on page 46.</p> <ul style="list-style-type: none"> • Respiratory and inhalation therapy • Cardiac rehabilitation following qualifying event/condition is provided for up to 36 sessions. Please also see the top of page 35. (Cardiac Rehabilitation) • 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 • 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. <p>- Covered Services:</p> <ul style="list-style-type: none"> • 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: <ul style="list-style-type: none"> - 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 <p>- Coverage Provisions:</p>	<p>\$20 per office visit</p>	<p>\$40 per office visit (Consult and or evaluation.</p> <p>10% coinsurance after deductible.</p>

Treatment therapies - continued on next page

Benefit Description	You Pay	
Treatment therapies (cont.)	High	Standard
<ul style="list-style-type: none"> To be covered, intensive-level services must: <p>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</p> <ul style="list-style-type: none"> To be covered, nonintensive-level service must: <p>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</p> <ul style="list-style-type: none"> Growth hormone therapy (GHT) <p>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 17.</p>	<p>\$20 per office visit</p>	<p>\$40 per office visit (Consult and or evaluation. 10% coinsurance after deductible.</p>
<p>Not covered:</p> <ul style="list-style-type: none"> Any services that do not have prior authorization from the Plan Custodial or respite care Animal-based therapy, including hippotherapy Auditory integration training Chelation therapy Cranial sacral therapy Hyperbaric oxygen therapy Special diets or supplements 	<p><i>All charges</i></p>	<p><i>All charges</i></p>

Benefit Description	You Pay	
Treatment therapies (cont.)	High	Standard
<p>Not covered:</p> <ul style="list-style-type: none"> • 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 	<i>All charges</i>	<i>All charges</i>
Physical and occupational therapies	High	Standard
<p>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:</p> <ul style="list-style-type: none"> • Qualified Network Physical Therapists • Network Occupational Therapists • Network Speech Therapists <p>Note: We only cover therapy when a physician:</p> <ul style="list-style-type: none"> • orders the care • identifies the specific professional skills the patient requires and the medical necessity for skilled services; and • indicates the length of time the services are needed. <p>Occupational therapy is limited to services that assist the member to achieve and maintain self care and improved function in activities of daily living.</p>	20% coinsurance	10% coinsurance after deductible

Physical and occupational therapies - continued on next page

Benefit Description	You Pay	
	High	Standard
Physical and occupational therapies (cont.) <i>Not covered:</i> <ul style="list-style-type: none"> • <i>Exercise programs</i> • <i>Massage therapist</i> • <i>Behavioral or vocational counseling, including evaluation and treatment and work hardening programs</i> • <i>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</i> • <i>Speech and hearing screening examinations are limited to routine or preventive screening tests performed by a participating provider for determining the need for correction</i> 	<i>All charges</i>	<i>All charges</i>
Speech therapy 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: Network Speech Therapists	20% coinsurance	10% coinsurance after deductible

Speech therapy - continued on next page

Benefit Description	You Pay	
Speech therapy (cont.)	High	Standard
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • 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 	<p><i>All charges</i></p>	<p><i>All charges</i></p>
Cardiac rehabilitation	High	Standard
<p>Cardiac Rehabilitation is covered when obtained through a participating provider, when medically necessary and with prior authorization by the Plan.</p> <p>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:</p> <ul style="list-style-type: none"> - a heart attack - coronary bypass surgery - onset of angina pectoris - heart valve surgery - onset of decubital angina - percutaneous transitional angioplasty - cardiac transplant <p>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.</p>	<p>Nothing</p>	<p>10% coinsurance after deductible</p>
<p><i>Not covered:</i></p> <p><i>Phase 3 Cardiac Rehabilitation programs</i></p>	<p><i>All charges</i></p>	<p><i>All charges</i></p>

Benefit Description	You Pay	
	High	Standard
<p>Hearing services (testing, treatment, and supplies)</p> <ul style="list-style-type: none"> For treatment related to illness or injury, including evaluation and diagnostic hearing test performed by an M.D., D.O., or audiologist. <p>Note: For routine hearing screening performed during a child's preventive care visit, see section 59(a) Preventive care, children.</p> <ul style="list-style-type: none"> 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 	\$20 per office visit	\$40 per office visit
New hearing aids are covered once per ear in a 36-month period.	All costs over \$1,000	All cost over \$1,000
<p>Cochlear implants and hearing aids are covered for children under the age of 18 with prior authorization from the Plan.</p> <p>Implantable bone conduction hearing aid, also called bone-anchored hearing aid (BAHA) is covered for patients with conductive hearing losses (unilateral or bilateral), or mixed hearing losses, if the patient has a bone conduction pure tone average up to 45 dBHL and a speech discrimination score better than 60% (in the indicated ear) who additionally has any one or more of the following conditions:</p> <ol style="list-style-type: none"> 1. Congenital or surgically induced malformations of the external ear canal and/or middle ear (example: atresia) 2. Tumors of the external ear canal and/or tympanic cavity 3. Severe chronic external otitis or otitis media 4. Osteosclerosis 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) 	Nothing	10% coinsurance after deductible

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

Benefit Description	You Pay	
	High	Standard
Hearing services (testing, treatment, and supplies) (cont.)		
<p>Implantable bone anchored 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.</p> <p>The procedure and related services to implant a bone conduction hearing aid are covered as medical/surgical benefits; the device itself (bone anchored hearing aid) is covered under the hearing aid benefit portion of your Plan.</p>	Nothing	10% coinsurance after deductible
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Hearing aids if more than one per ear in any 36-month period</i> • <i>Cochlear implants for members age 18 and older</i> • <i>Coverage for services in excess of the limits stated in your brochure</i> • <i>Hearing services that are not shown as covered</i> 	<i>All charges</i>	<i>All charges</i>
Vision services (testing, treatment, and supplies)	High	Standard
<p>Covered Services:</p> <ul style="list-style-type: none"> • 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 • One pair of eyeglasses or contact lenses to correct an impairment directly caused by accidental ocular injury or intraocular surgery (such as for cataracts) <p>Note: See <i>Preventive care, children</i> for eye exams for children</p>	\$20 per office visit	\$40 per office visit

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

Benefit Description	You Pay	
Vision services (testing, treatment, and supplies) (cont.)	High	Standard
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Eyeglasses or contact lenses, except as shown above</i> • <i>Eye exercises and orthoptics</i> • <i>Radial keratotomy and other refractive surgery</i> 	<i>All charges</i>	<i>All charges</i>
Foot care	High	Standard
<p>Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes.</p>	\$20 per office visit	\$40 per office visit
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>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</i> • <i>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)</i> 	<i>All charges</i>	<i>All charges</i>
Orthopedic and Prosthetic devices	High	Standard
<ul style="list-style-type: none"> • Artificial limbs and eyes • Prosthetic sleeve or sock • 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 <p>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.</p> <ul style="list-style-type: none"> • 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 	10% of the charge per purchase or rental	10% coinsurance after deductible

Orthopedic and Prosthetic devices - continued on next page

Benefit Description	You Pay	
Orthopedic and Prosthetic devices (cont.)	High	Standard
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Prosthetic replacements provided according to CMS guidelines.</i> • <i>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.</i> • <i>Durable medical equipment required for athletic performance and/or participation</i> • <i>Garments and/or other equipment and supplies that are not medically necessary to treat a covered bodily injury or sickness</i> • <i>Replacement of supplies without prior authorization from the Plan</i> • <i>Replacement for damaged, lost or stolen items</i> • <i>Repairs and replacement of durable medical equipment without prior authorization from the Plan</i> • <i>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</i> • <i>Exercise or Physical fitness equipment (examples: treadmills, exercise bikes, bicycles, foam roller, etc.)</i> • <i>Any food, liquid or nutritional supplements including those prescribed by a physician</i> 	<p><i>All charges</i></p>	<p><i>All charges</i></p>
Durable medical equipment (DME)	High	Standard
<p>We cover rental or purchase of durable medical equipment, at our option, including repair and adjustment rental cost are covered only up to the purchase price of the item. Covered items include:</p> <ul style="list-style-type: none"> • Oxygen • Dialysis equipment • Hospitalbeds • Wheelchairs • Crutches • Walkers • Audible prescription reading devices 	<p>10% of charge per purchase or rental</p>	<p>10% coinsurance after deductible</p>

Durable medical equipment (DME) - continued on next page

Benefit Description	You Pay	
Durable medical equipment (DME) (cont.)	High	Standard
<ul style="list-style-type: none"> • Speech generating devices • Blood glucose monitors • Insulin pumps <p>Note: Call us at 800-895-2421 as soon as your Plan physician prescribes this equipment. We will arrange with a health care provider to rent or sell you durable medical equipment at discounted rates and will tell you more about this service when you call.</p> <ul style="list-style-type: none"> • Durable medical equipment is defined as: <ul style="list-style-type: none"> 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 <p>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.</p> <ul style="list-style-type: none"> • Durable medical equipment (DME) is covered only: <ul style="list-style-type: none"> a) with prior authorization by the Plan and when 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: 	<p>10% of charge per purchase or rental</p>	<p>10% coinsurance after deductible</p>

Durable medical equipment (DME) - continued on next page

Benefit Description	You Pay	
	High	Standard
<p>Durable medical equipment (DME) (cont.)</p> <ul style="list-style-type: none"> 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 	<p>10% of charge per purchase or rental</p>	<p>10% coinsurance after deductible</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Durable medical equipment required for athletic performance and/or participation</i> • <i>Garments and/or other equipment and supplies that are not medically necessary to treat a covered bodily injury or sickness</i> • <i>Replacement of supplies without prior authorization from the Plan</i> • <i>Replacement for damaged, lost or stolen items</i> • <i>Repairs and replacement of durable medical equipment without prior authorization from the Plan</i> • <i>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</i> 	<p><i>All charges</i></p>	<p><i>All charges</i></p>

Durable medical equipment (DME) - continued on next page

Benefit Description	You Pay	
Durable medical equipment (DME) (cont.)	High	Standard
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Exercise or Physical fitness equipment (examples: treadmills, exercise bikes, bicycles, foam roller, etc.)</i> • <i>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.</i> 	<i>All charges</i>	<i>All charges</i>

Durable medical equipment (DME) - continued on next page

Benefit Description	You Pay	
Durable medical equipment (DME) (cont.)	High	Standard
<ul style="list-style-type: none"> Any food, liquid or nutritional supplements including those prescribed by a physician Motorized vehicles, or power operated vehicles, including but not limited to motorized scooters, except for motorized wheel chair when medically necessary Durable medical equipment for comfort, personal hygiene, and convenience items including but not limited to: air conditioners; air cleaners, purifiers, humidifiers, or dehumidifiers; alternative communication devices; self-help devices not medical in nature; automobile modifications or lifts; baskets for wheelchairs and walkers; bath benches, or chairs; bath systems or lifts; car seats; cervical pillows; dressing sticks or aids; diapers; disposable gloves; disposable undergarments; eating utensils; 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 	<p>All charges</p>	<p>All charges</p>

Benefit Description	You Pay	
Home health services	High	Standard
<ul style="list-style-type: none"> • Home healthcare ordered by a Plan physician and provided by a registered nurse (R.N.), licensed practical nurse (L.P.N.), licensed vocational nurse (L.V.N.), or home health aide. • Services include oxygen therapy, intravenous therapy and medications. <p>Home health care benefits are covered with prior authorization, when the attending physician certifies that:</p> <ul style="list-style-type: none"> • 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 <p>Home health care means one or more of the following:</p> <ul style="list-style-type: none"> • The evaluation of the need for home care when approved or requested by the attending physician • Home nursing care that is provided from time to time or on a part-time basis. It must be provided or supervised by a registered nurse. • 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 	<p>Nothing</p>	<p>10% coinsurance after deductible</p>

Home health services - continued on next page

Benefit Description	You Pay	
Home health services (cont.)	High	Standard
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Nursing care requested by, or for the convenience of, the patient or the patient's family</i> • <i>Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative</i> • <i>Custodial care</i> 	<i>All charges</i>	<i>All charges</i>
Chiropractic	High	Standard
<ul style="list-style-type: none"> • Manipulation of the spine and extremities • Adjunctive procedures such as ultrasound, electrical muscle stimulation, vibratory therapy, and cold pack application 	\$20 per office visit	\$40 per office visit
<p><i>Not covered:</i></p> <p><i>Maintenance and long term therapies</i></p>	<i>All charges</i>	<i>All charges</i>
Alternative treatments	High	Standard
<p>Acupuncture - services performed by a certified or licensed participating acupuncturist are covered without a referral.</p> <ul style="list-style-type: none"> • anesthesia • pain relief • biofeedback • Services are limited to 12 visits per year <p>Biofeedback is covered only for the treatment of headaches, spastic torticollis, urinary incontinence, and post traumatic stress disorder.</p> <ul style="list-style-type: none"> • Benefit limitations will be determined based on the provider of service • Biofeedback services must have prior authorization from the Plan 	\$20 per office visit	\$40 per office visit
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Naturopathic services</i> • <i>Hypnotherapy</i> • <i>Services are not covered by non-participating providers</i> • <i>Services are not covered by non-certified or non-licensed providers</i> 	<i>All charges</i>	<i>All charges</i>

Benefit Description	You Pay	
Educational classes and programs	High	Standard
<p>Coverage is provided for:</p> <ul style="list-style-type: none"> • MercyCare covers a variety of smoking cessation drugs and compensates primary care offices for tobacco cessation/E-cigarettes counseling, over-the-counter (OTC) and prescription drugs approved by the FDA to treat tobacco dependence. The health plan also refers members to American Lung Association online resources • Diabetes self management • Childhood obesity education 	Nothing	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.
- The High Option has no deductible. The calendar year deductible is \$500 per person, \$1,000 per Self Plus One enrollment, or \$1,000 per Self and Family enrollment for the Standard Option. where the deductible applies the words "after deductible" are added.
- 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 to be sure which services require precertification and identify which surgeries require precertification.

Benefit Description	You Pay	
	High	Standard
Surgical procedures		
<p>A comprehensive range of services, such as:</p> <ul style="list-style-type: none"> • 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, <ul style="list-style-type: none"> - 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 	Nothing	10% coinsurance after deductible.

Surgical procedures - continued on next page

Benefit Description	You Pay	
	High	Standard
Surgical procedures (cont.)		
<ul style="list-style-type: none"> • Insertion of internal prosthetic devices with prior authorization. See 5(a)-<i>Orthopedic and prosthetic devices</i> for device coverage information • Voluntary sterilization (e.g., tubal ligation, vasectomy) • Treatment of burns 	Nothing	10% coinsurance after deductible.
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Reversal of voluntary sterilization</i> • <i>Services of a standby surgeon, except during angioplasty or other high risk procedures when we determine standbys are medically necessary</i> • <i>Routine treatment of conditions of the foot; (see Foot care)</i> 	<i>All charges</i>	<i>All charges</i>
Reconstructive surgery		
<ul style="list-style-type: none"> • Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: <ul style="list-style-type: none"> - 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: <ul style="list-style-type: none"> - Surgery to produce a symmetrical appearance of breasts - treatment of any physical complications, such as lymphedemas - breast prostheses; and surgical bras and replacements (see <i>Prosthetic devices</i> for coverage) <p>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.</p>	Nothing	10% coinsurance after deductible

Reconstructive surgery - continued on next page

Benefit Description	You Pay	
Reconstructive surgery (cont.)	High	Standard
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>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.</i> • <i>Surgeries related to sexual dysfunction</i> 	<i>All charges</i>	<i>All charges</i>
Oral and maxillofacial surgery	High	Standard
<p>Oral surgical procedures, limited to:</p> <ul style="list-style-type: none"> • 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 <p>Temporomandibular Disorders</p> <p>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:</p> <ul style="list-style-type: none"> • 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 <p>This includes coverage for prescribed intra-oral splint therapy devices.</p> <p>Benefit maximum for TMJ is \$1,250.00 per year.</p>	\$20 per office visit	<p>\$40 per office visit (Surgery consult and or evaluation)</p> <p>10% coinsurance after deductible</p>

Oral and maxillofacial surgery - continued on next page

Benefit Description	You Pay	
Oral and maxillofacial surgery (cont.)	High	Standard
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • 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 \$1,250.00 for the treatment of TMJ 	<p><i>All charges</i></p>	<p><i>All charges</i></p>
Organ/tissue transplants	High	Standard
<p>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 17. Solid organ transplants are limited to:</p> <ul style="list-style-type: none"> • Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis <ul style="list-style-type: none"> - 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. • Cornea • Heart • Heart/lung • Intestinal transplants <ul style="list-style-type: none"> - Isolated small intestine <ul style="list-style-type: none"> • 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. - Small intestine with liver - Small intestine with multiple organs, such as the liver, stomach, and pancreas • Kidney 	<p>Nothing</p>	<p>10% coinsurance after deductible</p>

Organ/tissue transplants - continued on next page

Benefit Description	You Pay	
Organ/tissue transplants (cont.)	High	Standard
<ul style="list-style-type: none"> • Kidney-pancreas • Liver • Lung: single/bilateral/lobar • Pancreas <p>These tandem blood or marrow stem cell transplants for covered transplants are subject to medical necessity review by the Plan. Refer to <i>Other services</i> in Section 3 for prior authorization procedures.</p> <ul style="list-style-type: none"> • Autologous tandem transplants for: <ul style="list-style-type: none"> - Al Amyloidosis - Multiple myeloma (de novo and treated) - Recurrent germ cell tumors (including testicular cancer) <p>Blood or marrow stem cell transplants</p> <p>The plan extends coverage for the diagnoses as indicated below.</p> <ul style="list-style-type: none"> • Allogeneic transplants for <ul style="list-style-type: none"> - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Acute Myeloid Leukemia - Advanced Hodgkin’s lymphoma with recurrence (relapsed) - Advanced Myeloproliferative Disorders (MPDs) - Advanced non-Hodgkin’s lymphoma with recurrence (relapsed) - Amyloidosis - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Hemoglobinopathy - Marrow failure and related disorders (i.e., Fanconi's, Paroxysmal Nocturnal Hemoglobinuria, 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: 	<p>Nothing</p>	<p>10% coinsurance after deductible</p>

Organ/tissue transplants - continued on next page

Benefit Description	You Pay	
Organ/tissue transplants (cont.)	High	Standard
<ul style="list-style-type: none"> - Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Amyloidosis - Breast Cancer - Epithelial ovarian cancer - Multiple myeloma - Neuroblastoma - Testicular, Mediastinal, Retroperitoneal, and ovarian germ cell tumors <p>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.</p> <p>Refer to <i>Other services</i> in section 3 for prior authorization procedures:</p> <ul style="list-style-type: none"> • Allogeneic transplants for: <ul style="list-style-type: none"> - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Acute myeloid leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced Myeloproliferative Disorders (MPDs) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - 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: 	<p>Nothing</p>	<p>10% coinsurance after deductible</p>

Organ/tissue transplants - continued on next page

Benefit Description	You Pay	
Organ/tissue transplants (cont.)	High	Standard
<ul style="list-style-type: none"> - 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 <p>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 director in accordance with the Plan's protocols.</p> <p>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. Section 9 has additional information on cost related to clinical trials. We encourage you to contact the Plan to discuss specific services if you participate in a clinical trial.</p> <ul style="list-style-type: none"> • Autologous Transplants for <ul style="list-style-type: none"> - Advanced childhood kidney cancers - Advanced Ewing sarcoma - Aggressive non-Hodgkin's lymphoma - Breast Cancer - Childhood rhabdomyosarco - Epithelial Ovarian Cancer - Mantle Cell (Non-Hodgkin lymphoma) <p>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.</p>	Nothing	10% coinsurance after deductible
National Transplant Program (NTP)		
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Donor screening tests and donor search expenses, except those as shown above • Implants of artificial organs 	<i>All charges</i>	<i>All charges</i>

Organ/tissue transplants - continued on next page

Benefit Description	You Pay	
Organ/tissue transplants (cont.)	High	Standard
<ul style="list-style-type: none"> • <i>Transplants not listed as covered</i> 	<i>All charges</i>	<i>All charges</i>
Anesthesia	High	Standard
Professional services provided in – <ul style="list-style-type: none"> • Hospital (inpatient) 	Nothing	10% coinsurance after deductible
Professional services provided in – <ul style="list-style-type: none"> • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Office 	Nothing	10% coinsurance after deductible

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 High Option has no deductible. The calendar year deductible is \$500 per person, \$1,000 per Self Plus One enrollment, or \$1,000 per Self and Family enrollment for the Standard Option. Where the deductible applies the words "after deductible" are added.
- 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.** Please refer to Section 3 to be sure which services require precertification.

Benefit Description	You Pay	
	High	Standard
<p>Inpatient hospital</p> <p>Room and board, such as:</p> <ul style="list-style-type: none"> • Ward, semiprivate, or intensive care accommodations • General nursing care • Meals and special diets <p>Note: If you want a private room when it is not medically necessary, you pay the additional charge above semiprivate room rate.</p>	Nothing	10% coinsurance after deductible
<p>Other hospital services and supplies, such as:</p> <ul style="list-style-type: none"> • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medications • 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: <ul style="list-style-type: none"> - 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 	Nothing	10% coinsurance after deductible

Inpatient hospital - continued on next page

Benefit Description	You Pay	
Inpatient hospital (cont.)	High	Standard
<ul style="list-style-type: none"> - Conditions for which hospitalization would be covered include hemophilia and heart disease. The need for anesthesia by itself, is not a condition. 	Nothing	10% coinsurance after deductible
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Custodial care; see definition</i> • <i>Non-covered facilities, such as nursing homes or schools</i> • <i>Personal comfort items, such as telephone, television, barber services, guest meals and beds</i> • <i>Private nursing care</i> • <i>The cost of the professional dental services</i> 	<i>All charges</i>	<i>All charges</i>
Outpatient hospital or ambulatory surgical center	High	Standard
<ul style="list-style-type: none"> • Operating, recovery, and other treatment rooms • Prescribed drugs and medications • 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 <p>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.</p>	Nothing	10% coinsurance after deductible
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Blood</i> • <i>Blood derivatives not replaced by the member</i> 	<i>All charges</i>	<i>All charges</i>

Benefit Description	You Pay	
	High	Standard
<p>Extended care benefits/Skilled nursing care facility benefits</p> <p>Skilled nursing facility (SNF):</p> <p>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.</p> <p>Coverage is provided for physical therapy, occupational therapy, speech therapy, and durable medical equipment if medically necessary and provided by a participating provider.</p> <p>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.</p> <p>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.</p> <p>Extended care benefit: Prior authorization is required.</p>	Nothing	10% coinsurance after deductible
<p><i>Not Covered:</i></p> <ul style="list-style-type: none"> • <i>Custodial care</i> • <i>Skilled nursing facility days in excess of 120 days of confinement per benefit year</i> 	<i>All charges</i>	<i>All charges</i>
<p>Hospice care</p> <p>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.</p> <p>Hospice care must be provided through a licensed hospice care provider approved by the Plan.</p>	Nothing	10% coinsurance after deductible
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Independent nursing, homemaker services.</i> 	<i>All charges</i>	<i>All charges</i>

Hospice care - continued on next page

High and Standard Option

Benefit Description	You Pay	
Hospice care (cont.)	High	Standard
<ul style="list-style-type: none"> <i>Hospice room and board expenses</i> 	<i>All charges</i>	<i>All charges</i>
End of life care	High	Standard
No benefit	<i>All charges</i>	<i>All charges</i>
Ambulance	High	Standard
<ul style="list-style-type: none"> Local professional ground and air ambulance service when medically appropriate 	Nothing	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.
- The High Option has no deductible. The calendar year deductible is \$500 per person, \$1,000 per Self Plus One enrollment, or \$1,000 per Self and Family enrollment for the Standard Option. where the deductible applies the words "after deductible" are added.

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	
	High	Standard
Emergency Services In or Outside Our Service Area		
Emergency care at a doctor's office	\$10 per office visit copay primary care physician/\$20 per office visit copay specialist	\$20 per office visit copay primary care physician/ \$40 per office visit copay specialist
Emergency care an an urgent care center		
Emergency care as an outpatient at a hospital, including doctors' service	\$40 per urgent care visit \$75 per emergency room visit	\$40 per urgent care visit \$150 per emergency room 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.		
<i>Not covered:</i>	<i>All charges</i>	<i>All charges</i>
<ul style="list-style-type: none"> • <i>Urgent care visits at non-Plan providers within the service area</i> • <i>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</i> • <i>Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area</i> • <i>Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area</i> 		
Ambulance	High	Standard
Professional ambulance service when medically appropriate.	Nothing	Nothing
Note: See 5(c) for non-emergency service.		

Section 5(e). Mental Health and Substance Use Disorder 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.
- The High Option has no deductible. The calendar year deductible is \$500 per person, \$1,000 per Self Plus One enrollment, or \$1,000 per Self and Family enrollment for the Standard Option. where the deductible applies the words "after deductible" are added.
- Hospital stays, outpatient hospital services, and alternative care settings require prior authorization by the plan.
- Outpatient clinic visits with a mental health or substance misuse treatment practitioner do not need prior authorization.
- Please refer to the section below for out-of-pocket costs for services.
- We will provide medical review criteria or reasons for treatment plan denials to enrollees, members or providers upon request or as otherwise required.
- OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide on clinically appropriate treatment plan in favor of another.

Benefit Description	You Pay	
	High	Standard
<p>Professional services</p> <p>We cover professional services by licensed professional mental health and substance use disorder treatment practitioners when acting within the scope of their license, such as psychiatrists, psychologists, clinical social workers, licensed professional counselors, or marriage and family therapists.</p> <p>Diagnosis and treatment of psychiatric conditions, mental illness, or mental disorders. Services include:</p> <ul style="list-style-type: none"> • 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 use, including detoxification, treatment and counseling 	<p>\$10 per office visit copay for primary care physician or specialist</p>	<p>\$20 per office visit copay for primary care physician or specialist</p>

Professional services - continued on next page

High and Standard Option

Benefit Description	You Pay	
Professional services (cont.)	High	Standard
<ul style="list-style-type: none"> • Professional charges for intensive outpatient treatment in a provider's office or other professional setting • Electroconvulsive therapy 	\$10 per office visit copay for primary care physician or specialist	\$20 per office visit copay for primary care physician or specialist
Diagnostics	High	Standard
<ul style="list-style-type: none"> • Outpatient diagnostic tests provided and billed by a licensed mental health and substance use disorder treatment 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	10% coinsurance after deductible
Inpatient hospital or other covered facility	High	Standard
<p>Inpatient services provided and billed by a hospital or other covered facility</p> <ul style="list-style-type: none"> • Room and board, such as semi-private or intensive accommodations, general nursing care, meals and special diets, and other hospital services 	Nothing	10% coinsurance after deductible
Outpatient hospital or other covered facility	High	Standard
<p>Outpatient services provided and billed by a hospital or other covered facility</p> <ul style="list-style-type: none"> • Services in approved treatment programs, such as partial hospitalization, half-way house, residential treatment, full-day hospitalization, or facility-based intensive outpatient treatment 	Nothing	10% coinsurance after deductible
<p>Not covered:</p> <ul style="list-style-type: none"> • Behavioral or vocational counseling, including evaluation and treatment and work hardening programs. 	<i>All charges</i>	<i>All charges</i>

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.
- The High Option has no deductible. The calendar year deductible is \$500 per person, \$1,000 per Self Plus One enrollment, or \$1,000 per Self and Family enrollment for the Standard Option. Where the deductible applies the words "after deductible" are added.
- Members must make sure their prescribers obtain prior approval/ authorizations for certain prescription drugs and supplies before coverage applies. Prior approval/ authorizations must be renewed periodically.
- Federal law prevents the pharmacy from accepting unused medications.
- 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/certified providers with prescriptive authority prescribing within their scope of practice must prescribe 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 is a group of physicians and pharmacists that endorse the agents listed in the formulary based on product selection criteria. The MercyCare Pharmacy and Therapeutic Committee consists of physicians and participating pharmacists whose primary purpose is to recommend policies in the evaluation selection and therapeutic use of medications. The Pharmacy and Therapeutic 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 Pharmacy and Therapeutic 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, unless you use MercyCare's mail order pharmacy. See Mail Order Prescription Drug Benefit for details.

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.

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 for reimbursement for all covered prescription drugs.

Benefits Description	You Pay	
Covered medications and supplies	High	Standard
<p>We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy or through our mail order program:</p> <ul style="list-style-type: none"> • Drugs and medicines that by Federal law of the United States require a physician's prescription for their purchase, except those listed as <i>Not covered</i>. • Insulin • Diabetic supplies, limited to: <ul style="list-style-type: none"> - -Disposable needles and syringes for the administration of covered medications • Growth Hormone Therapy (GHT) <ul style="list-style-type: none"> - Must be prior authorized prior to treatment, and - Requires documentation submitted that establishes the medical necessity <ul style="list-style-type: none"> • 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. • Drugs for sexual dysfunction 	<p>Tier 1 Generics - \$20 copay</p> <p>Tier 2 Preferred Brands and Select Generics - \$40 copay</p> <p>Tier 3 Non-preferred Brands and Non-preferred Generics - \$80 copay</p> <p>Tier 4 Specialty drugs - \$250 copay</p> <p>Note: If there is no generic equivalent available, you will still have to pay the brand name copay.</p>	<p>Tier 1 Generics - \$20 copay</p> <p>Tier 2 Preferred Brands and Select Generics - \$75 copay</p> <p>Tier 3 Non-preferred Brands and Non-preferred Generics - \$150 copay</p> <p>Tier 4 Specialty drugs - \$250 copay</p> <p>Note: If there is no generic equivalent available, you will still have to pay the brand name copay.</p>
<p>Mail Order Prescription Drug Benefit</p> <p>NOTE: Specialty drugs are not available through mail order.</p>	<p>At MercyCare's mail order pharmacy, members receive a three (3) month supply of prescriptions at a two (2) month copay.</p>	<p>At MercyCare's mail order pharmacy, members receive a three (3) month supply of prescriptions at a two (2) month copay.</p>
<p>Women's contraceptive drugs and devices</p> <p>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.</p>	<p>Nothing</p>	<p>Nothing</p>
Preventive care medications	High	Standard
<p>Medications to promote better health as recommended by ACA.</p> <p>The following drugs and supplements are covered without cost-share, even if over-the-counter, are prescribed by a health care professional and filled at a network pharmacy.</p>	<p>Nothing</p>	<p>Nothing</p>

Preventive care medications - continued on next page

Benefits Description	You Pay	
Preventive care medications (cont.)	High	Standard
<ul style="list-style-type: none"> • Aspirin (81mg) for men age-45-79 and women age 55-79 and women of child bearing age • Folic acid supplements for women of childbearing age 400 & 800 mcg • Liquid iron supplements for children age 6 months-1 year • Vitamin D supplements (prescription strength) (400 & 1000 units) for members 65 or older • Fluoride tablets, solution (not toothpaste, rinses) for children age 0-6 <p>Note: To receive this benefit a prescription from a doctor must be presented to pharmacy.</p> <p>Preventive Medications- Statins</p> <p>The USPSTF recommends that adults without a history of cardiovascular disease (CVD) (ie, symptomatic coronary artery disease or ischemic stroke) use a low- to moderate-dose statin (See Formulary for the list of drugs that are available with no member cost sharing) for the prevention of CVD events and mortality when all of the following criteria are met:</p> <ol style="list-style-type: none"> 1) they are aged 40 to 75 years; 2) they have 1 or more CVD risk factors (ie, dyslipidemia, diabetes, hypertension, or smoking); and 3) they have a calculated 10-year risk of a cardiovascular event of 10% or greater. <p>To meet ACA preventive care requirements that USPSTF Grade B recommendations are covered at no cost.</p> <p>For current recommendations go to www.uspreventiveservicestaskforce.org/BrowseRec/Index/browse-recommendations</p>	<p>Nothing</p>	<p>Nothing</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Drugs and supplies for cosmetic purposes</i> • <i>Nonprescription medicines-except as noted in this section</i> • <i>Drugs to enhance athletic performance</i> • <i>Fertility drugs</i> • <i>Drugs obtained at a non-plan pharmacy; except for out-of-area emergencies</i> 	<p><i>All charges</i></p>	<p><i>All charges</i></p>

Benefits Description	You Pay	
Preventive care medications (cont.)	High	Standard
<ul style="list-style-type: none"> • <i>Vitamins, nutrients and food supplements not listed as a covered benefit even if a physician prescribes or administers them (with the exception of Vitamin D, which ACA requires coverage for adults 65 and older).</i> • <i>Replacement of any lost, stolen or destroyed medication</i> • <i>A specialty medication that is not obtained from the designated specialty pharmacy</i> <p>Note: Over-the-counter and prescription drugs approved by the FDA to treat tobacco dependence are covered under the Tobacco cessation/E-cigarettes benefit. See page 48.</p>	<p><i>All charges</i></p>	<p><i>All charges</i></p>

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.
- 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.
- The High Option has no deductible. The calendar year deductible is \$500 per person, \$1,000 per Self Plus One enrollment, or \$1,000 per Self and Family enrollment for the Standard Option. Where the deductible applies the words "after deductible" are added.
- 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.
- 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 unless it is described below. See Section 5 (c) for inpatient hospital benefits.

Benefits Description	You Pay	
	High	Standard
Accidental injury benefit		
Treatment with prior authorization from the Plan for bodily injury to permanent, sound and natural teeth and bone, but only if: <ul style="list-style-type: none"> • 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 	\$20 per office visit	10% coinsurance after deductible
Dental benefit		
With required prior authorization, inpatient hospital and free-standing surgical facility services and anesthetics provided in conjunction with dental care <u>in a hospital or free-standing surgical facility</u> , if the member: <ul style="list-style-type: none"> • 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 	Nothing	10% coinsurance after deductible

Dental benefit - continued on next page

Benefits Description	You Pay	
Dental benefit (cont.)	High	Standard
<ul style="list-style-type: none"> • has a medical condition that requires hospital confinement or general anesthesia for dental care <p>Also covered:</p> <ul style="list-style-type: none"> • Oral surgery with prior authorization from the Plan for gum or bone tumors and cysts • Surgical removal of impacted wisdom teeth (third molars) 	Nothing	10% coinsurance after deductible
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Oral surgery performed solely for the fitting of dentures or the restoration or correction of teeth.</i> • <i>All services performed by a dentist or orthodontist, except those specifically listed in this brochure. These exclusions include, but are not limited to:</i> <ul style="list-style-type: none"> - <i>dental implants</i> - <i>shortening of the mandible or maxillae</i> - <i>correction of malocclusion</i> - <i>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</i> - <i>hospital costs for any of these services except as specifically described in the brochure</i> - <i>any treatment for bruxism-including splint devices</i> • <i>Oral surgery except as specifically described in this brochure</i> • <i>All periodontic procedures</i> 	<i>All charges</i>	All charges

Section 5(h). Wellness and Other Special Features

Special feature	Description
<p>Flexible benefits option</p>	<p>Under the flexible benefits option, we determine the most effective way to provide services.</p> <ul style="list-style-type: none"> • 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).
<p>Case Management</p>	<p>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.</p>
<p>Travel benefit/services overseas</p>	<p>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.</p>
<p>Metabolic Syndrome Pilot Project</p>	<p>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.</p>
<p>Autism</p>	<p>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.</p> <p>Covered Services:</p> <ul style="list-style-type: none"> • 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

	<ul style="list-style-type: none"> • Nonintensive-level services that are provided: <ul style="list-style-type: none"> - 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 <p>Coverage Provisions:</p> <ul style="list-style-type: none"> • To be covered, intensive-level services must: <ul style="list-style-type: none"> - 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: <ul style="list-style-type: none"> - 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 <p><i>Non-covered services:</i></p> <ul style="list-style-type: none"> • <i>Any services that do not have prior authorization from the Plan</i> • <i>Custodial or respite care</i> • <i>Travel time for qualified providers, supervising providers, professionals therapists, or paraprofessionals</i> • <i>Animal-based therapy, including hippotherapy</i> • <i>Auditory integration training</i> • <i>Chelation therapy</i> • <i>Child care fees</i> • <i>Cranial sacral therapy</i> • <i>Hyperbaric oxygen therapy</i> • <i>Special diets or supplements</i> • <i>Treatment provided by parent(s) or legal guardian(s)</i> • <i>Autism therapy, treatment or services provided to a member who is residing in an residential treatment center, inpatient treatment or day treatment facility</i> • <i>The cost for the facility or location when treatment, therapy or services are provided outside a member's home</i>
<p>Biofeedback</p>	<p>Covered Services:</p> <ul style="list-style-type: none"> • 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
<p>Genetic Testing and Counseling</p>	<p>Covered Services:</p> <p>With prior authorization from the Plan, genetic testing is covered when:</p> <ul style="list-style-type: none"> • the test is not considered experimental or investigational • the test is medically necessary • the results will affect the course of medically necessary treatment <p>With prior authorization from the Plan, genetic counseling is covered when:</p> <ul style="list-style-type: none"> • it is associated with a covered and approved test • it is for the purpose of determining if a specific genetic test is appropriate <p>Non-covered services:</p> <ul style="list-style-type: none"> • <i>Direct-to-consumer genetic testing</i> • <i>Paternity testing</i> • <i>Fetal sex determination</i> • <i>Genetic testing of a non-plan member</i> • <i>Genetic counseling that is associated with non-covered genetic tests</i> • <i>Genetic testing when the results do not provide direct medical benefits to the Plan member</i>
<p>Mercyhealth Weight Management Program (MHWMP)</p>	<p>Limited benefit available in order to provide guidance and promote therapeutic lifestyle changes and develop weight management skills. This is for members that have been diagnosed with obesity or morbid obesity.</p> <p>The program aligns with existing copays and coinsurance benefits as follows:</p> <ul style="list-style-type: none"> • Dietitian: \$20 copay • Psychologist (Health): \$20 copay • Physiologist (Excercise Therapy): 20% coinsurance

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 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 providers, 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. Providers 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 provider 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 all claims for medical, prescription and other supplies or services 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 appeal directly to the Office of Personnel Management (OPM) if we do not follow required claims processes. For more information or to make an inquiry 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 call your plan's customer service representative at the phone number found on your enrollment card, plan brochure, or plan website.

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 will not take into account the initial decision. The review will not be conducted by the same person, or his/her subordinate, who made the initial decision.

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.

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

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, FEHB 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 its 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 FEHB 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

Our right to pursue and receive subrogation and reimbursement recoveries is a condition of, and a limitation on, the nature of benefits or benefit payments and on the provision of benefits under our coverage.

If you have received benefits or benefit payments as a result of an injury or illness and you or your representative, heirs, administrator's, successors, or assignees receive payment from any party that may be liable, a third party's insurance policy's, your own policy's, or a worker's compensation program or policy, you must reimburse us out of that payment. Our right of reimbursement extends to any payment received by settlement, judgment, or otherwise.

We are entitled to reimbursement to the extent of the benefits we have paid or provided in connection with your injury or illness. However, we will cover the cost of treatment that exceeds the amount of the payment you received.

Reimbursement to us out of the payment shall take first priority (before any of the rights of any other parties are honored) and is not impacted by how the judgment, settlement, or other recovery is characterized, designated, or apportioned. Our right of reimbursement is not subject to reduction based on attorney fees or costs under the "common fund" doctrine and is fully enforceable regardless of whether you are "made whole" or fully compensated for the full amount of damages claimed.

We may, at our option, choose to exercise our right of subrogation and pursue a recovery from any liable party as successor to your rights.

If you do pursue a claim or case related to your injury or illness, you must promptly notify us and cooperate with our reimbursement or subrogation efforts.

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 or by phone at 1-877-888-3337, (TTY 1-877-889-5680), 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 trial 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.
- 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 800-772-1213 TTY: 1-800-325-0778.

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 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. We do not waive co-pays, deductibles or coinsurance. 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

Please review the following table it illustrates your cost share if you are enrolled in Medicare Part B. Medicare will be primary for all Medicare eligible services. Members must use providers who accept Medicare's assignment

Benefit Description	High Option You pay Without Medicare	High Option You pay with Medicare Part B
Deductible	\$0	\$0
Out of Pocket Maximum	\$7,350 self only / \$14,700 self plus one and self plus family	\$7,350 self only/\$14,700 self plus one and self plus family
Part B Premium Reimbursement Offered	N/A	Up to \$120
Primary Care Physician	\$10 copay per visit	\$10 copay per visit
Specialist	\$20 copay per visit	\$20 copay per visit
Inpatient Hospital	None	None
Outpatient Hospital	None	None
Incentives offered	N/A	N/A

Benefit Description	Standard Option You pay Without Medicare	Standard Option You pay with Medicare Part B
Deductible	\$0	\$0
Out of Pocket Maximum	\$7,350 self only / \$14,700 self plus one and self plus family	\$7,350 self only/\$14,700 self plus one and self plus family
Part B Premium Reimbursement Offered	N/A	Up to \$120
Primary Care Physician	\$20 copay per visit	\$20 copay per visit
Specialist	\$40 copay per visit	\$40 copay per visit
Inpatient Hospital	10% coinsurance after deductible	10% coinsurance after deductible
Outpatient Hospital	10% coinsurance after deductible	10% coinsurance after deductible
Incentives offered	N/A	N/A

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 800-772-1213, TTY 1-800-325-0778 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 did not 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.

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	<p>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.</p> <ul style="list-style-type: none">• 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 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.
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 19.
Copayment	A copayment is a fixed amount of money you pay when you receive covered services. See page 22.
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	<p>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:</p> <ol style="list-style-type: none">a) Requires the approval by the appropriate federal or other governmental agency that has not been granted at the time it is used; orb) 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. <p>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:</p> <ol style="list-style-type: none">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.

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 determine whether or not 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 MercyCare's 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.

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.

Reimbursement

A carrier's pursuit of a recovery if a covered individual has suffered an illness or injury and has received, in connection with that illness or injury, a payment from any party that may be liable, any applicable insurance policy, or a worker's compensation program or insurance policy, and the terms of the carrier's health benefits plan require the covered individual, as a result of such payment, to reimburse the carrier out of the payment to the extent of the benefits initially paid or provided. The right of reimbursement is cumulative with and not exclusive of the right of subrogation.

Subrogation

A carrier's pursuit of a recovery from any party that may be liable, any applicable insurance policy, or a workers' compensation program or insurance policy, as successor to the rights of a covered individual who suffered an illness or injury and has obtained benefits from that carrier's health benefits plan.

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Summary of Benefits for the High Option of MercyCare Health Plans - 2020

- **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. You can obtain a copy of our summary of Benefits and Coverage as required by the Affordable Care Act at <https://mercycahealthplans.com/office-personnel-management/>.
- 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.
- There is no annual deductible for the High Option for this Plan.

High Option Benefits	You pay	Page
Medical services provided by physicians:		
<ul style="list-style-type: none"> • Diagnostic and treatment services provided in the office 	Office visit copay: \$10 primary care; \$20 specialist	25
Services provided by a hospital:		
<ul style="list-style-type: none"> • Inpatient/Outpatient 	Nothing	55
Emergency benefits:		
<ul style="list-style-type: none"> • In-area/Out-of-area 	\$75 per emergency room visit	60
Mental health and substance use disorder treatment:	\$20 copay per visit	61
Prescription drugs:		
<ul style="list-style-type: none"> • Retail pharmacy 	Tier 1 - Generics - \$20 copay Tier 2 - Preferred Brands and Select Generics - \$40 copay Tier 3 - Non-preferred Brands and Non-preferred Generics - \$80 copay Tier 4- Specialty drugs - \$250 copay	64
<ul style="list-style-type: none"> • Mail order 	Tiers 1-3, a 90-day supply is available for 2 copays at mail order pharmacies. Tier 4 Specialty drugs are not eligible for mail order.	64
Dental care:	Accidental injury benefit, \$20 office visit copay.	68
Vision care:	\$20 per office visit copay.	38
Protection against catastrophic costs (out-of-pocket maximum):	\$7,350 Self Only/\$14,700 Self Plus One and Self and Family	22

Summary of Benefits for the Standard Option of MercyCare Health Plans - 2020

- **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. You can obtain a copy of our summary of Benefits and Coverage as required by the Affordable Care Act at <https://mercycahealthplans.com/office-personnel-management/>.
- 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.
- The annual deductible for the Standard Option is \$500 Self Only and \$1,000 Self Plus One and Self and Family enrollment.

Standard Option Benefits	You Pay	Page
Medical services provided by physicians:		
<ul style="list-style-type: none"> • Diagnostic and treatment services provided in the office 	Office visit copay: \$20 primary care, \$40 specialist	25
Services provided by a hospital:		
<ul style="list-style-type: none"> • Inpatient/Outpatient 	10% coinsurance after deductible	55
Emergency benefits:		
<ul style="list-style-type: none"> • In-area/Out-of-area 	\$150 per emergency room visit	60
Mental health and substance use disorder treatment:	\$20 copay per visit	61
Prescription drugs:		
Retail pharmacy	Tier 1 - Generics- \$20 copay Tier 2 - Preferred Brands and Select Generics - \$75 copay Tier 3 - Non-preferred Brands and Non-preferred Generics - \$150 copay Tier 4 - Specialty drugs - \$250 copay	64
<ul style="list-style-type: none"> • Mail order 	Tiers 1-3, a 90-day supply is available for 2 copays at mail order pharmacies. Tier 4 Specialty drugs are not eligible for mail order.	64
Dental care:	Accidental injury benefit, 10% coinsurance after deductible.	68
Vision Care:	\$40 office visit copay	38
Protection against Catastrophic cost (out-of-pocket maximum):	Nothing after \$7,350 individual and \$14,7000 family.	22

2020 Rate Information for MercyCare Health Plans

To compare your FEHB health plan options please go to www.opm.gov/fehcompare.

Non-Postal rates apply to most non-Postal employees. If you are in a special enrollment category, contact the agency that maintains your health benefits enrollment.

Postal rates apply to certain United States Postal Service employees as follows.

- **Postal Category 1 rates** apply to career bargaining unit employees who are represented by the following agreements: APWU, IT/AS, NALC, NPMHU, and NRLCA.
- If you are a career bargaining unit employee represented by the agreement with NPPN, you will find your premium rates on <https://liteblue.usps.gov/fehb>.
- **Postal Category 2 rates** apply to career bargaining unit employees who are represented by the following agreement: PPOA

Non-Postal rates apply to all career non-bargaining unit Postal Service employees. Postal Rates do not apply to non-career Postal employees, Postal retirees, and associate members of any Postal employee organization who are not career Postal Employees.

If you are a Postal Service employee and have questions or require assistance, please contact:

USPS Human Resources Shared Service Center: 877-477-3273, option 5, Federal Relay Services 800-877-8339

Premiums for Tribal employees are shown under the monthly non-Postal column. The amount shown under employee contribution is the maximum you will pay. Your Tribal employer may choose to contribute a higher portion of your premium. Please contact your Tribal Benefits Officer for exact rates.

Type of Enrollment	Enrollment Code	Non-Postal Premium				Postal Premium	
		Biweekly		Monthly		Biweekly	
		Gov't Share	Your Share	Gov't Share	Your Share	Category 1 Your Share	Category 2 Your Share

Illinois/Boone and Winnebago Counties

High Option Self Only	EY1	\$235.77	\$126.96	\$510.84	\$275.08	\$123.68	\$113.86
High Option Self Plus One	EY3	\$504.12	\$275.78	\$1,092.26	\$597.52	\$268.78	\$247.77
High Option Self and Family	EY2	\$546.47	\$400.14	\$1,184.02	\$866.97	\$392.55	\$369.79
Standard Option Self Only	EY4	\$211.01	\$70.34	\$457.19	\$152.40	\$67.52	\$58.38
Standard Option Self Plus One	EY6	\$453.70	\$151.23	\$983.01	\$327.67	\$145.18	\$125.52
Standard Option Self and Family	EY5	\$546.47	\$187.77	\$1,184.02	\$406.83	\$180.18	\$157.42

Type of Enrollment	Enrollment Code	Non-Postal Premium				Postal Premium	
		Biweekly		Monthly		Biweekly	
		Gov't Share	Your Share	Gov't Share	Your Share	Category 1 Your Share	Category 2 Your Share

Wisconsin/Rock, Walworth, Jefferson and Green counties

High Option Self Only	EY1	\$235.77	\$126.96	\$510.84	\$275.08	\$123.68	\$113.86
High Option Self Plus One	EY3	\$504.12	\$275.78	\$1,092.26	\$597.52	\$268.78	\$247.77
High Option Self and Family	EY2	\$546.47	\$400.14	\$1,184.02	\$866.97	\$392.55	\$369.79
Standard Option Self Only	EY4	\$211.01	\$70.34	\$457.19	\$152.40	\$67.52	\$58.38
Standard Option Self Plus One	EY6	\$453.70	\$151.23	\$983.01	\$327.67	\$145.18	\$125.52
Standard Option Self and Family	EY5	\$546.47	\$187.77	\$1,184.02	\$406.83	\$180.18	\$157.42