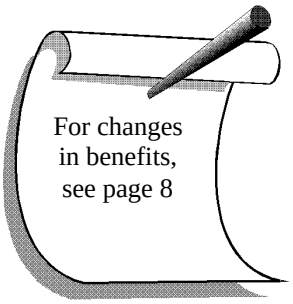
Mercy Health Plans/ Premier Health Plans

http://www.mercyhealthplans.com

2002

A Health Maintenance Organization with a point of service product



Serving: St. Louis Metro Area (Eastern Missouri Region), Columbia Metro Area (Central Missouri Region), Springfield Metro Area (Southwest Missouri Region), Laredo Metro Area (South Texas Region) and surrounding counties

Enrollment in this Plan is limited. You must live or work in our Geographic service area to enroll. See page 7 for requirements.

Enrollment codes for this Plan:

Missouri Regions	Texas Region
7M1 Self Only	HM1 Self Only
7M2 Self and Family	HM2 Self and Family

Authorized for distribution by the:

UNITED STATES
OFFICE OF PERSONNEL MANAGEMENT
RETIREMENT AND INSURANCE SERVICE
HTTP://WWW.OPM.GOV/INSURE

FEHB
Federal Employees Health Benefits Program

RI 73-756

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Introduction

Mercy Health Plans
425 South Woods Mill Road
Chesterfield, MO 63017

Premier Health Plans
One Corporate Centre, Suite 200
1949 East Sunshine
Springfield, MO 65804

Mercy Health Plans
5901 McPherson
Suites 1 & 2B
Laredo, TX 78041

This brochure describes the benefits of Mercy Health Plans/Premier Health Plans under our contract (CS 2834) with the Office of Personnel Management (OPM), as authorized by the Federal Employees Health Benefits law. This brochure is the official statement of benefits. No oral statement can modify or otherwise affect the benefits, limitations, and exclusions of this brochure.

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled for 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, 2002, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2002, and changes are summarized on page 8. Rates are shown at the end of this brochure.

Plain Language

Teams of Government and health plans' staff worked on all FEHB brochures to make them responsive, accessible, and understandable to the public. For instance,

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

If you have comments or suggestions about how to improve the structure of this brochure, let OPM know. Visit OPM's "Rate Us" feedback area at www.opm.gov/insure or e-mail OPM at fehbwebcomments@opm.gov. You may also write to OPM at the Office of Personnel Management, Office of Insurance Planning and Evaluation Division, 1900 E Street, NW Washington, DC 20415-3650.

Inspector General Advisory

Stop health care fraud!

Fraud increases the cost of health care for everyone. If you suspect that a physician, pharmacy, or hospital 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 Mercy Health Plans (Eastern and Central Missouri Regions) at 314-214-8196 or 1-800-327-0763; (Texas Region) at

956-723-7667 or 1-800-617-3433; or Premier Health Plans (Southwest Missouri Region) at 417-836-0402 or 1-800-836-0402 and explain the situation.

- If we do not resolve the issue, call or write

THE HEALTH CARE FRAUD HOTLINE
202/418-3300
The United States Office of Personnel Management
Office of the Inspector General Fraud Hotline
1900 E Street, NW, Room 6400
Washington, DC 20415

Penalties for Fraud

Anyone who falsifies a claim to obtain FEHB Program benefits can be prosecuted for fraud. Also, the Inspector General may investigate anyone who uses an ID card if the person tries to obtain services for someone who is not an eligible family member, or is no longer enrolled in the Plan and tries to obtain benefits. Your agency may also take administrative action against you.

Section 1. Facts about this HMO plan

This Plan is a health maintenance organization (HMO). We require you to see specific physicians, hospitals, and other providers that contract with us. These Plan providers coordinate your health care services.

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

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

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

We also have Point-of-Service (POS) benefits:

Our HMO offers Point-of-Service (POS) benefits. This means you can receive covered services from a participating provider without a required referral, or from a non-participating provider. These out-of-network benefits have higher out-of-pocket costs than our in-network benefits.

How we pay providers

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

Who provides my healthcare?

You are required to select a Primary Care Physician (PCP) from Mercy Health Plans/Premier Health Plans participating doctors in the Plan's service area. Your PCP will meet many of your health care needs and arrange for specialist care if the need arises.

Your Rights

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

If you want more information about us, call our Member Services department at:

Mercy Health Plans:	(Eastern and Central Missouri Regions) at 314-214-8196 or 1-800-327-0763
Mercy Health Plans:	(Texas Region) at 956-723-7667 or 1-800-617-3433
Premier Health Plans:	(Southwest Missouri Region) at 417-836-0402 or 1-800-836-0402

or write to:

Mercy Health Plans:	425 South Woods Mill Road, Chesterfield, MO 63017 (Eastern and Central Missouri Regions)
Mercy Health Plans:	5901 McPherson, Suites 1 & 2B, Laredo TX 78041 (Texas Region)
Premier Health Plans:	One Corporate Centre, Suite 200, 1949 East Sunshine, Springfield, MO 65804 (Southwest Missouri Region)

You may also contact us by fax at:

(Eastern and Central Missouri Region):	314-214-8102;
(Southwest Missouri Region):	417-836-0457 ; or
(Texas Region)	956-723-8246

Visit our website at www.mercyhealthplans.com.

Service Area

To enroll in this Plan, you must live in or work in our Service Area. This is where our providers practice. Our service area is:

MERCY HEALTH PLANS (Eastern and Central Missouri Regions) include these Missouri counties: Audrain, Boone, Callaway, Chariton, Cole, Cooper, Franklin, Gasconade, Howard, Iron, Jefferson, Lincoln, Linn, Macon, Madison, Maries, Miller, Moniteau, Monroe, Montgomery, Morgan, Osage, Pettis, Pike, Ralls, Randolph, Reynolds, Saline, St. Charles, St. Francois, St. Louis, St. Louis City, Warren and Washington. The Illinois counties are: Clinton, Jersey, Macoupin, Madison, Monroe, Randolph and St. Clair.

MERCY HEALTH PLANS (Texas Region) include these Texas counties: Duval, Jim Hogg, Webb and Zapata.

PREMIER HEALTH PLANS (Southwest Missouri Region) include these Missouri counties: Barry, Barton, Benton, Cedar, Christian, Crawford, Dade, Dallas, Dent, Douglas, Greene, Henry, Hickory, Howell, Jasper, Laclede, Lawrence, McDonald, Newton, Oregon, Ozark, Phelps, Polk, Pulaski, Shannon, St. Clair, Stone, Taney, Texas, Vernon, Webster and Wright.

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 or point-of-service benefits. We will not pay for any other health care services.

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. How we change for 2002

Do not rely on these change descriptions; this page 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.

Program-wide changes

- We changed the address for sending disputed claims to OPM. (Section 8)

Changes to this Plan

- We clarified the Preventive care, adult benefits by removing the entry for blood lead level testing for adults because it is a test more typically done for children. (Section 5(a))
- We changed speech therapy benefits by removing the requirement that services must be required to restore functional speech. (Section 5(a))
- We no longer limit total blood cholesterol tests to certain age groups. (Section 5(a))
- We now cover certain intestinal transplants. (Section 5(b))
- Your share of the non-Postal biweekly premium for **Missouri Regions** will increase by $10.31, which equals 39.8% for Self Only or $28.18, which equals 46.8% for Self and Family. Your share of the non-Postal biweekly premium for the **Texas Region** will increase by $3.53, which equals 12.5% for Self Only or $7.72, which equals 8.9% for Self and Family.
- We added Point of Service benefits to the Texas Region. (Section 5(i))

Section 3. How you get care

Identification cards

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

If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call us at:

Eastern and Central Missouri Regions:	314-214-8196 or 1-800-327-0763
Southwest Missouri Region:	417-836-0402 or 1-800-836-0402
Texas Region:	956-723-7667 or 1-800-617-3433

Where you get covered care

You get care from "Plan providers" and "Plan facilities". You will only pay copayments and/or coinsurance and you will not have to file claims. You can access health care from the point-of-service plan. These services are subject to a calendar year deductible, coinsurance copayments and balance billing. (Balance billing refers to the amount billed by a provider that exceeds the usual, customary and reasonable (UCR) charges allowed for payment by the Plan). Balanced-billed charges are your responsibility along with the annual deductible and coinsurance and do not apply to out-of-pocket maximums. You are responsible for verifying that the required prior approval is given by the Plan for certain procedures. Please contact Member Services for further details. If you use our point-of-service program, you can also get care from non-Plan providers, or from participating providers without a required referral, but it will cost you more.

- **Plan providers**

Plan providers are physicians and other health care professionals in our service area that we contract with to provide covered services to our members. We credential Plan providers according to national standards. Log on to http://www.mercyhealthplans.com and learn more about our physicians. The site features our Physician Directory, so you will be able to find the information you need on our large selection of doctors.

- **Plan facilities**

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

What you must do to get covered care

It depends on the type of care you need. First, you and each family member must choose a primary care physician. This decision is important since your primary care physician provides or arranges for most of your health care. You should ask yourself some questions before you choose your Primary Care Physician (PCP). What is the doctor's specialty? Does the PCP have a subspecialty, such as gastroenterology or pulmonology? Is the doctor's office close to your home, office or school? Are the doctor's office hours convenient for you? We suggest that you call the doctors you are considering so you can conduct your own interview. You will be one step ahead in ensuring your health and the health of your family.

- **Primary care**

Your primary care physician can be a family practitioner, general practitioner internist, or pediatrician. Your primary care physician will provide most of your health care, or give you a referral to see a specialist. Female Members have direct access to an Obstetrician or Gynecologist (OB/GYN).

Members in the Texas Region must select an OB/GYN, on or before open enrollment, to provide health care services within their scope of practice.

If you want to change primary care physicians or if your primary care physician leaves the Plan, call us. We will help you select a new one.

• Specialty care

Your primary care physician will refer you to a specialist for needed care. When you receive a referral from your primary care physician, you must return to the primary care physician after the consultation, unless your primary care physician authorized a certain number of visits without additional referrals. The primary care physician must provide or authorize all follow-up care. Do not go to the specialist for return visits unless your primary care physician gives you a referral. However, you may see an OB/GYN without a referral. You can access a non-participating OB/GYN under your POS benefit, except for well-woman visits.

When medically necessary, your PCP will arrange for referrals to a specialist. Your primary care physician and specialist will work together to coordinate your total care. If you access specialty care without an understanding of the number of visits and the amount of time approved for treatment, you may be responsible for the entire bill. Your PCP will arrange a standing referral to a specialist or specialists center (if necessary). Your PCP, the Chief Medical Officer and participating specialist will determine the need and parameters of a standing referral. A standing referral is based on a diagnosis of a life-threatening condition or disease; a degenerative and disabling condition or disease; ongoing care from a specialist or required specialized medical care over a prolonged period of time. Your PCP may request standing referrals.

Here are other things you should know about specialty care:

- If you need to see a specialist frequently because of a chronic, complex, or serious medical condition, your PCP 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 use our criteria when creating your treatment plan (the physician may have to get an authorization or approval beforehand).

- If you are seeing a specialist when you enroll in our Plan, talk to your primary care physician. Your primary care physician will decide what treatment you need. 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 or disabling condition and lose access to your specialist because we:

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

  - drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB 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 in the hospital when your enrollment in our Plan begins, call our customer service department immediately at

Eastern & Central Missouri Regions:	314-214-8196 or 1-800-327-0763
Southwest Missouri Region:	417-836-0402 or 1-800-836-0402
Texas Region:	956-723-7667 or 1-800-617-3433

If you are new to the FEHB Program, we will arrange for you to receive care.

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; or
- 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.

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.

Services requiring our prior approval

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

We call this review and approval process prior approval. Your physician must obtain prior approval for services such as:

- Certain medications
- All inpatient hospitalization
- All skilled nursing facility
- All rehabilitation facility
- Home Health Care, including DME
- Physical, Speech, and Occupational Therapy
- Any procedure that may be cosmetic
- Surgical procedures

It is the shared responsibility of both you and your PCP or specialist to assure that referrals are obtained, accurate and current. You are responsible for verifying the approved date range of the referral, number of visits and types of services that have been authorized. When you choose to receive services from a participating provider without a prior referral from your chosen primary care physician, the specialists will request that you be responsible for payment of the services. When this occurs, you may be responsible for the charges. A referral must be obtained prior to receiving certain services.

It is your responsibility to verify that the required prior approval has been given by the Plan for out-of-network services. If prior approval is not given, eligible charges will be subject to the non-compliance reduction and the amount of the reduction will not apply toward your out-of-pocket maximum or deductible.

Section 4. Your costs for covered services

You must share the cost of some services. You are responsible for:

- **Copayments**

A copayment is a fixed amount of money you pay to the provider, facility, pharmacy, etc., when you receive services.

Example: When you see your primary care physician you pay a copayment of $10 per office visit and when you go in the hospital, you pay $0 per admission.

- **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.

In **Missouri Regions**, you are required to pay a $500 deductible per member per calendar year and $1,000 deductible per family per calendar year for out-of-network benefits. Your cost is 30% coinsurance after the deductible. The out-of-pocket maximum per member is $3,500 (including the deductible) and $7,000 per family (including deductible). This deductible applies to POS benefits only.

In the **Texas Region**, you are required to pay a $1,000 deductible per member per calendar year and a $2,000 deductible per family per calendar year for out-of-network benefits. Your cost is 40% coinsurance after the deductible. There is an unlimited out-of-pocket maximum for members and their families in the Texas Region.

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.

And, if you change options in this Plan during the year, we will credit the amount of covered expenses already applied toward the deductible of your old option to any deductible of your new option.

- **Coinsurance**

Coinsurance is the percentage of our negotiated fee that you must pay for your care. Coinsurance doesn't begin until you meet your deductible.

Example: In our Plan, you pay 50% of our allowance for infertility services up to $5,000.

Your catastrophic protection out-of-pocket maximum for deductibles, coinsurance, and copayments

In Network

In **Missouri Regions**, after your copayments and/or coinsurance for in-network services total $1,100 per person or $3,300 per family enrollment in any calendar year, you do not have to pay any more for covered services. However, copayments or coinsurance for the following services do not count toward your out-of-pocket maximum, and you must continue to pay copayments or coinsurance for these services:

- *Chiropractic*
- *Infertility*
- *Outpatient Prescription Drugs*

In the **Texas Region**, after your copayments and/or coinsurance for in-network services total $1,000 per person or $2,000 per family enrollment in any calendar year, you do not have to pay any more for covered services.

Out of Network

In **Missouri Regions**, after your deductible, coinsurance and/or copayments for out-of-network services total $3,500 (including deductible) per person or $7,000 (including deductible) per family, you do not have to pay any more for covered services.

In the **Texas Region**, members and their families have unlimited out-of-pocket maximums.

Be sure to keep accurate records of your copayments or coinsurance since you are responsible for informing us when you reach the maximum.

Section 5. Benefits -- OVERVIEW

(See page 8 for how our benefits changed this year and see inside back cover for a benefits summary.)

NOTE: This benefits section is divided into subsections. Please read the important things you should keep in mind at the beginning of each subsection. Also read the General Exclusions in Section 6; they apply to the benefits in the following subsections. To obtain claims forms, claims filing advice, or more information about our benefits, contact us at:

Mercy Health Plans (Eastern and Central Missouri Regions): *(314) 214-8196 or 1-800-327-0763*
Mercy Health Plans (Texas Region): *(956) 723-7667 or 1-800-617-3433*
Premier Health Plans (Southwest Missouri Region): *(417) 836-0402 or 1-800-836-0402*

or at our website at www.mercyhealthplans.com.

(a) Medical services and supplies provided by physicians and other health care professionals 16-24

- Diagnostic and treatment services
- Lab, X-ray, and other diagnostic tests
- Preventive care, adult
- Preventive care, children
- Maternity care
- Family planning
- Infertility services
- Allergy care
- Treatment therapies
- Physical and occupational therapies
- Speech therapy
- Hearing services (testing, treatment, and supplies)
- Vision services (testing, treatment, and supplies)
- Foot care
- Orthopedic and prosthetic devices
- Durable medical equipment (DME)
- Home health services
- Chiropractic
- Alternative treatments
- Educational classes and programs

(b) Surgical and anesthesia services provided by physicians and other health care professionals 25-27

- Surgical procedures
- Reconstructive surgery
- Oral and maxillofacial surgery
- Organ/tissue transplants
- Anesthesia

(c) Services provided by a hospital or other facility, and ambulance services 28-29

- Inpatient hospital
- Outpatient hospital or ambulatory surgical center
- Extended care benefits/skilled nursing care facility benefits
- Hospice care
- Ambulance

(d) Emergency services/accidents 30-31

- Medical emergency
- Ambulance

(e) Mental health and substance abuse benefits 32-33

(f) Prescription drug benefits 34-36

(g) Special features 37

- *Flexible benefits option*
- *24 hour nurse line*
- *Services for deaf and hearing impaired*

(h) Dental benefits 38

(i) Point of service benefits 39-45

(j) Non-FEHB benefits available to Plan members 46

Summary of benefits ..... Inside Back Cover

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

IMPORTANT

Here are some important things to 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.
- *We have no calendar year deductible, however out-of-network benefits services are subject to a calendar year deductible.*
- 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.

IMPORTANT

Benefit Description	You pay
Diagnostic and treatment services	
Professional services of physicians · In physician's office	$10 per office visit to your primary care physician $10 per office visit to a specialist
Professional services of physicians · In an urgent care center · During a hospital stay · In a skilled nursing facility · Office medical consultations · Second surgical opinion	 $25 Copayment per visit Nothing Nothing $10 Copayment per office visit $10 Copayment per office visit
Not covered: · *Physical examinations that are not necessary for medical reasons, such as those required for obtaining or continuing employment or insurance, attending camp or travel*	*All charges.*

Lab, X-ray and other diagnostic tests	You Pay
Tests, such as: · Blood tests · Urinalysis · Non-routine pap tests · Pathology · X-rays · Non-routine Mammograms · Cat Scans/MRI · Ultrasound · Electrocardiogram and EEG	Nothing
Preventive care, adult	
Routine screenings, such as: · Hearing and vision screening · Blood pressure testing · Complete Blood Count (CBC) · Total Blood Cholesterol - once every three years · Colorectal Cancer screening, including _ Fecal occult blood test _ Sigmoidoscopy, screening - every five years starting at age 50	$10 per office visit
Prostate Specific Antigen (PSA test) – one annually for men age 40 and older	$10 per office visit
Routine pap test Note: The office visit is covered if pap test is received on the same day; see *Diagnostic and Treatment*, above.	$10 per office visit
Routine mammogram – covered for women age 35 and older, as follows: · From age 35 through 39, one during this five year period · At age 40 and older, one every calendar year	Nothing
Not covered: Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, or travel.	*All charges.*
Routine immunizations, limited to: · Tetanus-diphtheria (Td) booster – once every 10 years, ages 19 and over (except as provided for under Childhood immunizations) · Influenza/Pneumococcal vaccines, annually, age 65 and over	Nothing

Preventive care, children	You pay
· Childhood immunizations recommended by the American Academy of Pediatrics	Nothing
· Well-child care charges for routine examinations, immunizations and care (through age 22)	$10 per office visit
· Examinations, such as: _ Eye exams through age 17 to determine the need for vision correction. _ Ear exams through age 17 to determine the need for hearing correction _ Examinations done on the day of immunizations (through age 22)	
Maternity care	
Complete maternity (obstetrical) care, such as: · Prenatal care · Delivery · Postnatal care Note: Here are some things to keep in mind: · You do not need to precertify your normal delivery. · You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will extend your inpatient stay if medically necessary. · We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self and Family enrollment. · We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See Hospital benefits (Section 5c) and Surgery benefits (Section 5b).	One time $10 Copayment for all office visits associated with prenatal care during a single pregnancy.
Not covered: Routine sonograms to determine fetal age, size or sex	*All charges*
Family planning	
A broad range of voluntary family planning services, limited to: · Voluntary sterilization · Surgically implanted contraceptives (such as Norplant) · Injectable contraceptive drugs (such as Depo provera) · Intrauterine devices (IUDs) · Diaphragms NOTE: We cover oral contraceptives under the prescription drug benefit	$10 per office visit
Not covered: reversal of voluntary surgical sterilization, genetic counseling and voluntary abortions.	*All charges.*

Infertility services	You pay
Diagnosis and treatment of infertility, such as: · Artificial insemination _ intravaginal insemination (IVI) _ intracervical insemination (ICI) _ intrauterine insemination (IUI)	$10 per office visit for the diagnosis of infertility For treatment, you pay 50% of the first $5,000 of the usual, customary and reasonable (UCR) rate of approved charges, charges in excess of the UCR rate, and 100% of the charges for infertility services over $5,000.
Not covered: · *Assisted reproductive technology (ART) procedures, such as:* *_ in vitro fertilization* *_ embryo transfer, gamete GIFT and zygote ZIFT* *_ zygote transfer* · *Services and supplies related to excluded ART procedures* · *Cost of donor sperm* · *Cost of donor egg* · *Fees for preparation and storage of sperm and embryos* · *Infertility services after voluntary sterilization* · *Fertility drugs*	*All charges.*
Allergy care	
Testing and treatment Allergy injection	$10 per office visit Nothing
Allergy serum	Nothing
Not covered: provocative food testing and sublingual allergy desensitization	*All charges.*

Treatment therapies	You Pay
· Chemotherapy and radiation therapy Note: High dose chemotherapy in association with autologous bone marrow transplants are limited to those transplants listed under Organ/Tissue Transplants on page 27. · Respiratory and inhalation therapy · Dialysis – Hemodialysis and peritoneal dialysis · Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy · Growth hormone therapy (GHT) Note: Growth hormone is covered under the prescription drug benefit Note: – Before we cover GHT, there are certain guidelines to be performed and documented. There are separate guidelines for children and adults. We will ask you to submit information that establishes that the GHT is medically necessary for that child or adult. Ask us to authorize GHT before you begin treatment; otherwise, 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. See *Services requiring our prior approval* in Section 3.	$10 per office visit All other services covered at no additional charge.
Not covered: treatments that have no proven clinical benefit for your condition.	*All charges.*
Physical and occupational therapies	
· 60 visits per condition per calendar year for the services of each of the following: _ qualified physical therapists and _ occupational therapists. Note: We only cover therapy to restore bodily function when there has been a total or partial loss of bodily function due to illness or injury. · Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction is provided up to 36 visits per condition.	$10 per office visit $10 per outpatient visit Nothing per visit during covered inpatient admission
Not covered: · *long-term rehabilitative therapy* · *exercise programs* · *neuro-rehabilitation* · *work hardening programs or developmental educational therapy*	*All charges.*
Speech therapy	
60 visits per condition per calendar year	$10 Copayment

Speech Therapy continued on next page

Speech therapy *(Continued)*	**You Pay**
Not covered: Therapies that are not considered as medically necessary by the Plan.	*All charges*
Hearing services (testing, treatment, and supplies)	
· First hearing aid and testing only when necessitated by accidental injury · Hearing testing for children through age 17 (see *Preventive care, children*)	$10 per office visit
Not covered: · *all other hearing testing* · *hearing aids, testing and examinations for them*	*All charges.*
Vision services (testing, treatment, and supplies)	
Diagnosis and treatment of diseases of eye, annual eye refractions (to provide a written lens prescription for eyeglasses or contact lenses) may be obtained from Plan providers	$10 per office visit
· One pair of eyeglasses or contact lenses to correct an impairment directly caused by accidental ocular injury or intraocular surgery (such as for cataracts)	$10 per office visit
Not covered: · *Eyeglasses or contact lenses and, after age 17, examinations for them* · *Eye exercises and orthoptics* · *Radial keratotomy and other refractive surgery*	*All charges.*
Foot care	
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes. See orthopedic and prosthetic devices for information on podiatric shoe inserts.	$10 per office visit
Not covered: · *Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above* · *Treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery)*	*All charges.*

Orthopedic and prosthetic devices	You Pay
· Artificial limbs and eyes; stump hose · Externally worn breast prostheses and surgical bras, including necessary replacements, following a mastectomy · Internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, and surgically implanted breast implant following mastectomy. Note: See 5(b) for coverage of the surgery to insert the device. · Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome.	20% Coinsurance
Not covered: · *orthopedic and corrective shoes* · *arch supports* · *foot orthotics (except those authorized by the Plan)* · *heel pads and heel cups* · *lumbosacral supports* · *corsets, elastic stockings, support hose, and other supportive devices* · *prosthetic replacements provided less than 3 years after the last one we covered* · *electrical continence aids, anal or urethral* · *implants for cosmetic or psychologic reasons* · *other dental appliances* · *replacement of cataract lenses necessary after cataract surgery* · *remote control devices* · *devices employing robotics* · *all mechanical organs* · *investigational or obsolete devices and supplies* · *computer assisted devices*	*All charges.*
Durable medical equipment (DME)	
Rental or purchase, at our option, including repair and adjustment, of durable medical equipment prescribed by your Plan physician, such as oxygen and dialysis equipment. Under this benefit, we also cover: · casts, splints, surgical supplies and appliance, catheters and ilesotomy supplies; · wheelchairs or hospital-type bed; · purchase of a truss, brace or support; · oxygen and the equipment necessary for its administration; · mechanical equipment required for the treatment of a chronic or acute respiratory illness or failure, such as asthmatic equipment; and · ambulatory dialysis.	Nothing

Durable Medical Equipment continued on next page

Durable medical equipment (DME) *(Continued)*	**You pay**
Note: Call us at: (Eastern and Central Missouri Regions): 314-214-8196 or 1-800-327-0763 (Southwest Missouri Region): 417-836-0402 or 1-800-836-0402 (Texas Region): 956-723-7667 or 1-800-617-3433 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.	
Not covered: · *augmentative communication devices (i.e., computer assisted speech devices, speech teaching machines, telephones, TDD equipment, etc.)* · *automated travel devices (i.e., motor scooters, etc.)* · *chair lifts and other transfer devices* · *devices that are primarily non-medical in nature or used primarily for comfort (i.e., foam pads, maternity belts, heating pads, etc.)* · *elevators* · *equipment designed to alter the environment (i.e., air filters, humidifiers, dehumidifiers, air conditioners, lighting, etc.)* · *exercise equipment* · *hygienic items (i.e., shower chairs, raised toilet seats, sauna baths, incontinence supplies, etc.)* · *massage devices* · *overhead tables* · *whirlpools, whirlpool pumps, hot tubs, and related items* · *telephone alert systems* · *motorized wheel chairs*	*All charges.*
Home health services	
· Home health care 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.	Nothing
Not covered: · *Services primarily for hygiene, feeding, exercising, moving the patient, homemaking, companionship or giving oral medication.* · *Nursing care requested by, or for the convenience of, the patient or the patient's family.* · *Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative.* · *Private duty nursing or nursing assistants.*	*All charges.*

Chiropractic	You Pay
· Manipulation of the spine and extremities	$10 per office visit
· Adjunctive procedures such as ultrasound, electrical muscle stimulation, vibratory therapy, and cold pack application	Referrals required for Eastern and Central MO regions and Texas Region
Not covered: · *Services for examination and/or treatment of strictly non-neuromusculoskeletal disorders*	*All charges*
Alternative treatments	
Acupuncture – by a doctor of medicine or osteopathy for: anesthesia, pain relief	$10 per office visit
Not covered: · *Biofeedback* · *Birth Coaches (other prenatal/parenting education classes)* · *Homeopathy* · *Hypnotherapy* · *Massage Therapy* · *Naturopathic services (i.e., herbal therapy, etc.)*	*All charges.*
Educational classes and programs	
Coverage is limited to:	
· Smoking Cessation- Up to $100 for one smoking cessation program per member per lifetime, including all related expenses such as drugs. **(Smoking Cessation programs not available in the Texas Region)**	$25 copayment per program per year
· Diabetes self-management	Consistent with type of services required.

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

IMPORTANT

Here are some important things to 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.
- *We have no calendar year deductible, however health care services from the point of service plan are subject to a calendar year deductible.*
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by a physician or other health care professional for your surgical care. Look in Section 5(c) for charges associated with the facility (i.e. hospital, surgical center, etc.).
- **YOU MUST OBTAIN AUTHORIZATION BEFORE ANY SERVICE IS RENDERED OUT-OF-NETWORK.** Please refer to the precertification information in Section 5(i).

IMPORTANT

Benefit Description	You pay
Surgical procedures	
A comprehensive range of services, such as: · Operative procedures · Treatment of fractures, including casting · Normal pre- and post-operative care by the surgeon · Correction of amblyopia and strabismus · Endoscopy procedures · Biopsy procedures · Removal of tumors and cysts · Correction of congenital anomalies (see reconstructive surgery) · Surgical treatment of morbid obesity -- a condition in which an individual weighs 100 pounds or 100% over his or her normal weight according to current underwriting standards; eligible members must be age 18 or over · Insertion of internal prosthetic devices. See 5(a) – Orthopedic and prosthetic devices for device coverage information. · Voluntary sterilization · Treatment of burns Note: Generally, we pay for internal prostheses (devices) according to where the procedure is done. For example, we pay Hospital benefits for a pacemaker and Surgery benefits for insertion of the pacemaker.	$10 per office visit; nothing for hospital visits
Not covered: · *Reversal of voluntary sterilization* · *Routine treatment of conditions of the foot; see Foot care.*	*All charges.*

Reconstructive surgery	You Pay
· Surgery to correct a functional defect · Surgery to correct a condition caused by injury or illness if: _ the condition produced a major effect on the member's appearance and _ the condition can reasonably be expected to be corrected by such surgery · Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birth marks; webbed fingers; and webbed toes. · All stages of breast reconstruction surgery following a mastectomy, such as: _ surgery to produce a symmetrical appearance on the other breast; _ treatment of any physical complications, such as lymphedemas; _ breast prostheses and surgical bras and replacements (see Prosthetic devices) 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.	$10 per office visit
Not covered: · *Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury* · *Surgeries related to sex transformation* · *Removal of tattoo* · *Hair transplant for baldness, lipectomy (operation for removal of adipose tissue (fat) from the abdomen or other part of the body)- unless required by a sickness condition.* · *Augmentation of mammoplasty (operation for augmentation of the breasts) for cosmetic reasons.*	*All charges*
Oral and maxillofacial surgery	
Oral surgical procedures, limited to: · Reduction of fractures of the jaws or facial bones; · Surgical correction of cleft lip, cleft palate or severe functional malocclusion; · Removal of stones from salivary ducts; · Excision of leukoplakia or malignancies; · Excision of cysts and incision of abscesses when done as independent procedures; and · Other surgical procedures that do not involve the teeth or their supporting structures.	$10 per office visit

Oral and maxillofacial surgery continued on next page

Oral and maxillofacial surgery *(Continued)*	**You Pay**
Not covered: · *Enabling procedures for implants, as well as placement, maintenance, restoration, and removal of dental implants.* · *Oral implants and transplants* · *Any prosthetic superstructure fabricated upon a dental implant is also excluded.* · *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)*	*All charges.*
Organ/tissue transplants	
Limited to: · Cornea · Heart · Heart/lung · Kidney · Kidney/Pancreas · Liver · Lung: Single –Double · Pancreas · Allogeneic (donor) bone marrow transplants · Autologous bone marrow transplants (autologous stem cell and peripheral stem cell support) for the following conditions: acute lymphocytic or non-lymphocytic leukemia; advanced Hodgkin's lymphoma; advanced non-Hodgkin's lymphoma; advanced neuroblastoma; breast cancer; multiple myeloma; epithelial ovarian cancer; and testicular, mediastinal, retroperitoneal and ovarian germ cell tumors · Intestinal transplants (small intestine) and the small intestine with the liver or small intestine with multiple organs such as the liver, stomach, and pancreas Limited Benefits - Treatment for breast cancer, multiple myeloma, and epithelial ovarian cancer may be provided in an NCI- or NIH-approved clinical trial at a Plan-designated center of excellence and if approved by the Plan's medical director in accordance with the Plan's protocols. Payments are limited to the allowed amount at a participating transplant facility. Note: We cover related medical and hospital expenses of the donor when we cover the recipient.	Nothing
Not covered: · *Donor screening tests and donor search expenses, except those performed for the actual donor* · *Implants of artificial organs* · *Transplants not listed as covered*	*All charges*
Anesthesia	
Professional services provided in – · Office · Hospital (inpatient) · Hospital outpatient department · Skilled nursing facility · Ambulatory surgery center	 $10 per office visit Nothing Nothing Nothing Nothing

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

IMPORTANT

Here are some important things to remember 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 and you must be hospitalized in a Plan facility.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by the facility (i.e., hospital or surgical center) or ambulance service for your surgery or care. Any costs associated with the professional charge (i.e., physicians, etc.) are covered in Sections 5(a) or (b).
- **YOU MUST OBTAIN AUTHORIZATION BEFORE ANY SERVICE IS RENDERED OUT-OF-NETWORK.** Please refer to the precertification information in Section 5(i).

IMPORTANT

Benefit Description	You pay
Inpatient hospital	
Room and board, such as · ward, semiprivate, or intensive care accommodations; · general nursing care; and · meals and special diets. NOTE: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.	Nothing
Other hospital services and supplies, such as: · Operating, recovery, maternity, and other treatment rooms · Prescribed drugs and medicines · Diagnostic laboratory tests and X-rays · Administration of blood and blood products · Blood or blood plasma, if not donated or replaced · Dressings, splints, casts, and sterile tray services · Medical supplies and equipment, including oxygen · Anesthetics, including nurse anesthetist services · Take-home items · Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home	Nothing
Not covered: · *Custodial care (see definition under Extended care benefits)* · *Non-covered facilities, such as nursing homes, schools* · *Personal comfort items, such as telephone, television, barber services, guest meals and beds* · *Private nursing care*	*All charges*

Outpatient hospital or ambulatory surgical center	You Pay
· Operating, recovery, and other treatment rooms · Prescribed drugs and medicines · Diagnostic laboratory tests, X-rays, and pathology services · Administration of blood, blood plasma, and other biologicals · Blood and blood plasma, if not donated or replaced · Pre-surgical testing · Dressings, casts, and sterile tray services · Medical supplies, including oxygen · Anesthetics and anesthesia service NOTE: – We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. We do not cover the dental procedures	Nothing
Not covered: blood and blood derivatives not replaced by the member	*All charges*
Extended care benefits/skilled nursing care facility benefits	
Skilled Nursing Facility (SNF): Medically Necessary room and board, services and supplies, including medications provided under the direction of a Participating Physician in a Participating Skilled Nursing Facility for the care and treatment of an Injury or Illness which would otherwise require inpatient confinement in a Hospital. Coverage for up to a maximum of one-hundred twenty (120) days per calendar year.	Nothing
Not covered: Custodial care, which is care designed to assist with activities of daily living such as bathing, exercising, moving a patient, cooking, cleaning, etc. and involves non-medical personnel. For an institutionalized individual, custodial care includes room and board, non-skilled care, or such other care that is provided to an individual who cannot reasonably be expected to live outside an institution. Rest care, respite care, and home care provided by a family member (including a spouse, sibling, child, or parent of the member) is also considered custodial care.	*All charges*
Hospice care	
Services provided either on an inpatient or an outpatient basis, based on approved acceptable medical practices, when approved in advance by the Plan's Chief Medical Officer or designee. This benefit is available once per lifetime for terminally ill person with a life expectancy of less than six months.	Nothing
Not covered: Independent nursing, homemaker services, services received out-of-network.	*All charges*
Ambulance	
· Local professional ambulance service when medically appropriate	Nothing

Section 5 (d). Emergency services/accidents

IMPORTANT

Here are some important things to keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure.
- We have no calendar year deductible
- 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.

IMPORTANT

What is a medical emergency?

A medical emergency is the sudden and unexpected onset of a condition or an injury that you believe endangers your life or could result in serious injury or disability, and requires immediate medical or surgical care. Some problems are emergencies because, if not treated promptly, they might become more serious; examples include deep cuts and broken bones. Others are emergencies because they are potentially life-threatening, such as heart attacks, strokes, poisonings, gunshot wounds, or sudden inability to breathe. There are many other acute conditions that we may determine are medical emergencies – what they all have in common is the need for quick action.

What to do in case of emergency:

Emergencies within our service area: If you are in an emergent or urgent situation, if possible call your Plan physician immediately. If the emergency is so urgent that failure to get immediate medical attention could be life threatening or cause serious harm, go immediately to the nearest emergency facility. Once an urgent or life-threatening situation has been brought under control, you will need to call your Plan physician as soon as reasonably possible, so that any continued care can be arranged and authorized. If you do not report emergency treatment, as soon as reasonably possible thereafter, care may not be covered.

If you need to be hospitalized in a non-Plan facility, the Plan must be notified on the first working day following your admission, unless it is not reasonably possible to notify the Plan within that time. If you are hospitalized in non-Plan facilities and a Plan doctor believes care can be better provided in a Plan hospital, you will be transferred when medically feasible with any ambulance charges covered in full.

Benefits are available for care from non-Plan providers in a medical emergency only if delay in reaching a Plan provider would result in death, disability or significant jeopardy to your condition. To be covered by this Plan, any follow-up care recommended by non-Plan providers must be approved by the Plan or provided by Plan providers.

Emergencies outside our service area: If you require health care services, present your I.D. card to the physician or hospital caring for you and identify yourself as a Mercy Health Plans member. If you need to be hospitalized, call Member Services as soon as possible. Member Services will notify your Plan physician and arrange to have your medical records shared with the attending physician. Arrangements will be made for you to be transferred to the care of a Plan doctor and hospital when it is medically appropriate. Your Plan physician will coordinate all follow-up care upon return to the area.

If follow-up care is required outside the area, you must contact your Plan physician to receive authorization for the continued care. To be covered by this Plan, any follow-up care recommended by non-Plan providers must be approved by the Plan or provided by Plan providers. The Plan pays reasonable charges for emergency services to the extent the services would have been covered if received from Plan providers.

Benefit Description	You pay
Emergency within our service area	
· Emergency care at a doctor's office	$10 per office visit
· Emergency care at an urgent care center	$25 per office visit
· Emergency care as an outpatient or inpatient at a hospital, including doctors' services	$50 per visit, except Copayment charge will be waived if you are admitted to an observation, outpatient surgery, outpatient procedure, or inpatient care setting.
Not covered: Elective care or non-emergency care	*All charges*
Emergency outside our service area	
· Emergency care at a doctor's office · Emergency care at an urgent care center · Emergency care as an outpatient or inpatient at a hospital, including doctors' services	$50 per visit, except Copayment charge will be waived if you are admitted to an observation, outpatient surgery, outpatient procedure, or inpatient care setting.
Not covered: · *Elective care or non-emergency care* · *Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area*	*All charges*
Ambulance	
Professional ambulance service when medically appropriate. See 5(c) for non-emergency service.	Nothing
Not covered: · *air ambulance (unless Medically necessary)* · *air ambulance transportation out of a foreign country is not covered under any circumstances*	*All charges*

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

IMPORTANT

When you get our approval for services and follow a treatment plan we approve, cost-sharing and limitations for Plan mental health and substance abuse benefits will be no greater than for similar benefits for other illnesses and conditions.

Here are some important things to keep in mind about these benefits:

- All benefits are subject to the definitions, limitations, and exclusions in this brochure.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- **YOU MUST GET PREAUTHORIZATION OF THESE SERVICES.** See the instructions after the benefits description below.

IMPORTANT

Benefit Description	You pay
Mental health and substance abuse benefits	
All diagnostic and treatment services recommended by a Plan provider and contained in a treatment plan that we approve. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure. Note: Plan benefits are payable only when we determine the care is clinically appropriate to treat your condition and only when you receive the care as part of a treatment plan that we approve.	Your cost sharing responsibilities are no greater than for other illnesses or conditions.
· Professional services, including individual or group therapy by providers such as psychiatrists, psychologists, or clinical social workers · Medication management	$10 per visit
· Diagnostic tests	Nothing
· Services provided by a hospital or other facility · Services in approved alternative care settings such as partial hospitalization, half-way house, residential treatment, full-day hospitalization, facility based intensive outpatient treatment	Nothing

Mental health and substance abuse benefits continued on next page

Mental health and substance abuse benefits *(Continued)*	**You pay**
Not covered: Services we have not approved. *Note: 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 one clinically appropriate treatment plan in favor of another.*	*All charges*

Preauthorization

To be eligible to receive these benefits you must obtain a treatment plan and follow all of the following authorization processes:

You must obtain services from Participating Providers and authorized in advance by the Plan by calling the Mental Health and Substance Abuse Member Assistance Hotline (MH/SA Hotline) for assistance.

(Eastern and Central Missouri): (314) 729-4600 or 1-800-413-8008
(Southwest Missouri): (417) 836-0402 or 1-800-836-0402
(Texas): (956) 723-7667 or 1-800-617-3433

Limitation

We may limit your benefits if you do not obtain a treatment plan.

Section 5 (f). Prescription drug benefits

IMPORTANT

Here are some important things to keep in mind about these benefits:

- 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.
- There are a handful of medications that require prior authorizations. Your Plan physician has a listing of the specific drugs.
- 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.

IMPORTANT

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

- **Who can write your prescription.** *A licensed physician must write the prescription.*
- **Where you can obtain them.** *You must fill your prescription at a Plan pharmacy, except in the case of a medical emergency. You have access to over 15,000 pharmacies nationwide. Also, you are covered under the mail service pharmacy benefit. This benefit allows you to obtain covered maintenance prescriptions used to treat chronic or long-term health conditions (high blood pressure or diabetes) through the Walgreen's Healthcare Plus mail service pharmacy.*
- **We use a formulary.** *Prescription drugs prescribed by a Plan or referral doctor and obtained at a Plan pharmacy will be dispensed for up to a thirty (30) day supply at a Plan Pharmacy. Drugs are prescribed by Plan doctors and dispensed in accordance with the Plan's drug formulary. A "formulary" is a list of drugs approved for use by your physician in connection with specific conditions. You pay a copayment of $7 in the case of a generic drug, $12 in the case of a brand drug and $25 for Non-formulary approved drugs dispensed in accordance with the formulary. We cover non-formulary drugs prescribed by a Plan doctor.*

  If your physician believes a name brand product is necessary or there is no generic available, your physician may prescribe a name brand drug from a formulary list. This list of name brand drugs is a preferred list of drugs that we selected to meet patient needs at a lower cost. To order a prescription drug brochure, call Mercy Health Plans
  (Eastern and Central Missouri Regions): 314-214-8196 or 1-800-327-0763
  (Southwest Missouri Region) 417-836-0402 or 1-800-836-0402
  (Texas Region): 956-723-7667 or 1-800-617-3433

- **These are the dispensing limitations.** *Prescription drugs will be dispensed for up to a thirty-(30) day supply. If you choose to receive the brand drug (with the approval of your physician), you will be responsible for the appropriate copayment plus the cost difference between the "brand" name and the "generic" name drug. Prescriptions filled through the Walgreen's Healthcare Plus mail service pharmacy, is limited up to a ninety-(90) day supply. If an order is placed more than two weeks before the refill date, the order may be returned unfilled with a request to resubmit them at a later date.*

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

Covered Prescription drug benefits continued on next page

- **Why use generic drugs?** *Generic drugs offer a safe and economic way to meet your prescription drug needs. The generic name of a drug is its chemical name; the name brand is the name under which the manufacturer advertises and sells a drug. Under federal law, generic and name brand drugs must meet the same standards for safety, purity, strength, and effectiveness. A generic prescription costs you – and us – less than a name brand prescription.*

- **When you have to file a claim.** *If you use a participating pharmacy you will not have to file a claim. However, if you receive emergency services out-of-network and purchase prescriptions, you must contact member services for reimbursement.*

Benefit Description	You pay
Covered medications and supplies	
We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy or through our mail order program: · Disposable needles and syringes needed to inject covered prescribed medication · Diabetic supplies, including insulin syringes needles, glucose test tablets and test tape, Benedict's solution or equivalent, glucose monitors and acetone test tablets · Drugs and medicines that by Federal law of the United States require a physician's prescription for their purchase, except those listed as *Not covered*. · Drugs for sexual dysfunction (see Section 3 - *Services requiring our prior approval*) · Insulin; a copay charge applies to each vial · Contraceptive drugs and devices You are entitled to receive prescription drugs included on the formulary at the time a prescription written is actually filled by a participating pharmacy. You will pay a Copayment of $7 for generic drugs, $12 Copayment for brand drugs and $25 Copayment for non-formulary approved drugs. If a brand drug is dispensed when a generic alternative is available and your physician has not specified Dispense as Written (DAW) for the name brand drug, you pay the appropriate Copayment plus the difference in cost of the brand drug and the generic drug.	$7 Copayment for generic drugs on Formulary $12 Copayment for brand drugs on Formulary $25 Copayment for Non-formulary approved drugs 2 Copayments for a 90-day supply for mail-order

Covered medications and supplies continued on next page

Covered medications and supplies	
Not covered: · *Drugs available without a prescription or for which there is a nonprescription equivalent available* · *Prescriptions dispensed by other than a Plan pharmacy, except in the case of a medical emergency* · *Drugs obtained at a non-Plan pharmacy, except for out-of-area emergencies* · *Vitamins and nutritional substances that can be purchased without a prescription* · *Medical supplies such as dressing and antiseptics* · *Drugs and supplies for cosmetic purposes* · *Drugs to enhance athletic performance* · *Appetite suppressants and other drugs taken for the purpose of weight loss* · *Drugs which have not been approved by the FDA* · *Fertility drugs*	*All Charges*

Section 5 (g). Special features

Feature	Description
Flexible benefits option	Under the flexible benefits option, we determine the most effective way to provide services. · We may identify medically appropriate alternatives to traditional care and coordinate other benefits as a less costly alternative benefit. · Alternative benefits are subject to our ongoing review. · By approving an alternative benefit, we cannot guarantee you will get it in the future. · The decision to offer an alternative benefit is solely ours, and we may withdraw it at any time and resume regular contract benefits. · Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process.
24 hour nurse line **(not available in Texas)**	For any of your health concerns, 24 hours a day, 7 days a week, you may call: (Eastern and Central Missouri): 800-811-1187; or (Southwest Missouri): (417) 888-8888 or 800-909-TEAM (8326) and talk with a registered nurse who will discuss treatment options and answer your health questions.
Services for deaf and hearing impaired	Mercy Health Plans/Premier Health Plans offers a TDD Line: · Mercy Health Plans (Eastern and Central Missouri Region) at 314-214-8299 or 800-698-4807 · Mercy Health Plans (Texas Region) at 877-206-7903 · Premier Health Plans (Southwest Missouri Region) at 417-837-0249 or 800-446-1468

Section 5 (h). Dental benefits

IMPORTANT

Here are some important things to 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 dentists must provide or arrange your care.
- We have no calendar year deductible.
- We cover hospitalization for dental procedures only when a nondental 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.
- 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.

IMPORTANT

Accidental injury benefit	You pay
We cover restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth. Orthodontic braces are not covered. The need for these services must result from an accidental injury. All services in connection with this benefit must be provided within six (6) months from the date of the Accidental Injury.	20% *Copayment.*

Dental benefits

We have provided for dental care at affordable prices for you and your eligible dependent(s) through CAREington dental network. A list of participating dentists is provided with the provider directory. Following are significant points of the program:

- No claim forms to file. You pay only the copay shown in the schedule of benefits at the time of service.
- To receive significant savings from a participating dentist, merely show your CAREington membership card at each visit and you will receive the discount.
- CAREington only contracts with dentists who meet their credentialing criteria and must continue to meet the high standards of quality established.

Not covered:

- *dental implants*

Section 5 (i). Point of service benefits

IMPORTANT	Here are some important things to keep in mind about these benefits:	IMPORTANT
	· All benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.	

Facts about this Plan's POS option

At your option, you may choose to obtain benefits covered by this Plan from non-Plan doctors and hospitals whenever you need care, except for the benefits listed below under "What is not covered." Benefits not covered under Point of Service must either be received from or arranged by Plan doctors to be covered. When you obtain covered non-emergency medical treatment from a Plan doctor without a referral from a Plan doctor, you are subject to the deductibles, coinsurance and maximum benefit stated below.

What is covered

Benefits Subject to UCR limits, precertification required for certain procedures.		
	Missouri Regions	**Texas Region**
PLAN MAXIMUMS		
Medical Benefit Maximum Per Member (While Covered)	$2,500,000	Unlimited
Calendar Year Deductible-Member (Family)	$500 (2 x Member)	$1,000 (2 x Member)
Calendar Year Out-of-Pocket Maximum-Member (Family)	$3,500 Includes Deductible (2 x Member)	Unlimited
MEDICAL SERVICES		
Services and Supplies	30% Coinsurance After Deductible	40% Coinsurance After Deductible
Surgery performed in a Physician's Office	30% Coinsurance After Deductible	40% Coinsurance After Deductible
Allergy Services - Office Visits - Injections/Treatment - Allergy serum	 30% Coinsurance After Deductible 30% Coinsurance After Deductible 30% Coinsurance After Deductible	 40% Coinsurance After Deductible 40% Coinsurance After Deductible 40% Coinsurance After Deductible
Lab and X-ray	30% Coinsurance After Deductible	40% Coinsurance After Deductible
Maternity (includes prenatal, delivery, and postnatal care)	30% Coinsurance After Deductible	40% Coinsurance After Deductible
INPATIENT HOSPITAL SERVICES	30% Coinsurance After Deductible	40% Coinsurance After Deductible
OUTPATIENT SERVICES		
Emergency Care	$50 Copayment per visit, except Copayment charge will be waived when inpatient admission for the same condition occurs within 24 hours	$50 Copayment per visit, except Copayment charge will be waived when inpatient admission for the same condition occurs within 24 hours
Non-Emergency Services - Outpatient Surgery - Diagnostic Tests	 30% Coinsurance After Deductible 30% Coinsurance After Deductible	 40% Coinsurance After Deductible 40% Coinsurance After Deductible
Urgent Care	$25 Copayment per visit	$25 Copayment per visit

Benefits Subject to UCR limits, precertification required for certain procedures.		
	Missouri Regions	**Texas Region**
Outpatient Rehabilitative Therapy Services: Physical and Occupational Speech	30% Coinsurance After Deductible (Max. of up to 60 visits per condition per calendar year)	40% Coinsurance After Deductible (Max. of up to 60 visits per condition per calendar year)
MISCELLANEOUS COVERED SERVICES Home Health Agency Services (includes intravenous fluids and medications)	30% Coinsurance After Deductible	40% Coinsurance After Deductible
Skilled Nursing Facility Services	30% Coinsurance After Deductible (Max. of up to 120 days per calendar year)	40% Coinsurance After Deductible (Max. of up to 120 days per calendar year)
Ambulance	30% Coinsurance After Deductible	40% Coinsurance After Deductible
Prosthetic Equipment	30% Coinsurance After Deductible	40% Coinsurance After Deductible
Chemotherapy, radiation therapy and inhalation therapy	Covered In-Mercy Network Only	40% Coinsurance After Deductible
Dialysis services	Covered In-Mercy Network Only	40% Coinsurance After Deductible
Durable Medical Equipment and Supplies	30% Coinsurance After Deductible	40% Coinsurance After Deductible
Diabetes Services	30% Coinsurance After Deductible	40% Coinsurance After Deductible
Transplant Services	Covered In-Mercy Network Only	40% Coinsurance After Deductible
Family Planning Services	Covered In-Mercy Network Only	40% Coinsurance After Deductible
Infertility Services	Covered In-Mercy Network Only	40% Coinsurance After Deductible
Accidental Dental	30% Coinsurance After Deductible	40% Coinsurance After Deductible
Hospice Services	Covered In-Mercy Network Only	40% Coinsurance After Deductible
Alcoholism/Chemical Dependency - Inpatient - Outpatient	 Covered In-Mercy Network Only Covered In-Mercy Network Only	 40% Coinsurance After Deductible 40% Coinsurance After Deductible
Mental Health - Inpatient - Outpatient	 Covered In-Mercy Network Only Covered In-Mercy Network Only	 40% Coinsurance After Deductible 40% Coinsurance After Deductible
Routine Immunizations	Covered In-Mercy Network Only	40% Coinsurance After Deductible
Preventive care, including well-baby/child care and periodic check-ups	Covered In-Mercy Network Only	40% Coinsurance After Deductible
Mammography	Covered In-Mercy Network Only	40% Coinsurance After Deductible
Outpatient Prescription Drug - Generic - Brand Name - Mail-Order	 Covered in PCS Network Only Covered in PCS Network Only Covered in PCS Network Only	 Covered in PCS Network Only Covered in PCS Network Only Covered in PCS Network Only

When a Member seeks services from a Non-Participating Provider and/or fails to follow pre-established guidelines, reimbursement for HMO Covered Services will be made for "Covered Services". The Member will be required to share a larger part of the "Eligible Charges" by satisfying the annual up front Deductible and paying the required coinsurance. Preventive care or "well care" is not covered **(Missouri Members only)**, along with other benefit limitations described herein. Finally, when health care is received from a Non-Participating Provider, the Member will be responsible for submitting a completed claim form along with an itemized bill.

"Covered Services" means only the medical care, services and supplies rendered under the following conditions: (a) prescribed by a Physician for the therapeutic treatment of injury, illness or pregnancy; (b) deemed Medically Necessary and appropriate in type, level, setting, and length of service by the Plan; (c) rendered in accordance with generally accepted medical practice and professionally recognized standards; (d) not considered to be experimental, investigational, or which are performed for research purposes.

"Eligible Charges or Eligible Expenses" means the usual, customary and reasonable (UCR) Rate for Covered Services rendered by a Provider reduced by any Non-compliance Reduction.

In order to receive certain benefits, Members are required to comply with the specific pre-certification requirements described in connection with the Utilization Management Program as outlined. The Member is responsible for making sure the Plan is contacted

before services are rendered. Failure to comply with the requirement of the Utilization Management Program described will result in a reduction in the Benefits Payable.

Services do not need to be obtained within the service area to be eligible for coverage under POS.

Pre-certification

For pre-certification of services call:
(Eastern and Central Missouri): (314) 214-8196 or 1-800-327-0763
(Southwest Missouri): (417) 836-0402 or 1-800-836-0402
(Texas): (956) 723-7667 or 1-800-617-3433

You must obtain authorization before any service is rendered. It is your responsibility to verify that the required pre-certifications have been given by the Plan for coverage. This is called pre-certification. If pre-certification is not given, or you fail to comply with the requirements, eligible charges will be subject to the Non-compliance reduction. Non-compliance reduction means the charges considered for payment are reduced as a result of your failure to comply with the pre-certification. These eligible charges will not be used to meet a deductible or out-of-pocket maximum.

In the **Missouri Regions**, Services Subject to Pre-Certification Review and Non-compliance Reduction

1. Inpatient Hospitalization.	50% Reduction in Eligible Charges.
2. Outpatient surgical procedures.	50% Reduction in Eligible Charges (the Reduction applies to both the facility and the professional charges).
3. Health Services provided during Confinement.	50% Reduction in Eligible Charges (the Reduction applies to both facility and professional charges).
4. Home health care.	50% Reduction in Eligible Charges.
5. MRI, RAST tests and CAT scans.	50% Reduction in Eligible Charges.
6. Prosthetics.	100% Reduction in Eligible Charges; No Benefit Payable.
7. Durable Medical Equipment.	100% Reduction in Eligible Charges; No Benefit Payable.
8. Physical Therapy, Occupational Therapy and Speech Therapy.	100% Reduction in Eligible Charges; No Benefit Payable.

Note: It is the Member's responsibility to verify that the required certification has been given by the Plan. If certification is not given, or the Member fails to comply with the requirements stated in this Section, Eligible Charges will be subject to the Non-compliance Reduction and the amount of the reduction will not apply toward the Member's Out-of-Pocket Maximum or Deductible.

Also, you are required to notify the Plan three (3) days in advance of any hospital admission for a non-emergency. If it is impossible to notify the Plan, you must obtain pre-certification review as soon as reasonably practical prior to the provisions of the service and in no event less than one (1) business day prior to the service. If you fail to comply with the pre-certification requirements, there is a 50% reduction of eligible charges for non-compliance.

Care rendered in connection with a Pregnancy will be treated as an exception to the three (3) day prior notice requirement. The Pre-certification Review requirement will be treated as satisfied if proper notice is given by the Member no later than the fifth month of Pregnancy and the Member notifies the Plan within one (1) business day after admission to the Hospital for delivery.

In the **Texas Region**, precertification is required for the following services:

· Inpatient confinement, including inpatient confinement for maternity care; and
· Maternity Care
· Transplant Services

The Member or the Member's designated representative must notify MERCY HEALTH PLANS (MHP) to precertify the admission, maternity care or transplant, as the case may be, prior to receiving any of the services or supplies associated with that admission, maternity care, or transplant.

To initiate the precertification process, call MHP at the telephone number listed on the Member's identification card. This call must be made as follows:

· For a non-emergency inpatient confinement, the call must be made at least seven (7) days prior to any planned admission into a Hospital.
· For an inpatient confinement due to a Medical Emergency, the call must be made within two (2) working days after the time of the admission or as soon thereafter as reasonably possible; and
· For maternity care, the call must be made within twenty-four (24) hours after the birth or as soon thereafter as possible.

The Member may request a review of the Precertification decision pursuant to the MHP grievance procedure as described in this brouchure.

FAILURE TO PRECERTIFY WILL RESULT IN A 50% REDUCTION OF POS BENEFITS.

The additional percentage or dollar amount of the UCR, which a Member may pay as a penalty for failure to obtain precertification under this section is not a covered expense, and will not be applied to the Deductible or the maximum out-of-pocket limit, if any.

Deductible

"Deductible" means the amount of Eligible Charges payable by each member before benefits are payable. No Benefit is payable for any part of Eligible Charges used to meet a Deductible.

In the **Missouri Regions**, you will pay a $500 deductible per member per calendar year and $1,000 deductible per family per calendar year.

In the **Texas Region**, you will pay a $1,000 deductible per member per calendar year and $2,000 deductible per family per calendar year.

Coinsurance

"Coinsurance" means the Member's share of the cost of Eligible Charges stated as a percentage up to the Out-of-Pocket Maximum.

In the **Missouri Regions**, members are responsible for 30% coinsurance after the deductible.

The out-of-pocket maximum per member is $3,500 (including the deductible) and $7,000 per family (including deductible). The lifetime maximum benefit is $2,500,000 per member. The member's out-of-pocket expenses under POS do not qualify for the Plan's in-Plan out-of-pocket maximum.

In the **Texas Region**, members and their families have unlimited out-of-pocket maximums, as well as an unlimited lifetime maximum benefit. The member's out-of-pocket expenses under POS do not qualify for the Plan's in-Plan out-of-pocket maximum.

Members are responsible for a 40% coinsurance after the deductible.

When you use a non-participating provider and fail to follow pre-established guidelines, reimbursement for covered services, you are responsible for sharing a larger part of the cost for the services. The benefit when a non-participating hospital is used is shown in the POS outline of benefits. The Plan will pay a participating hospital in full even though the POS benefit (and non-Plan doctor) are being used. The hospital charge, sometimes called facility charge, does not cover any charges for doctor's services.

True emergency care is always payable as an in-Plan benefit.

Charges by a Provider in excess of the UCR Rate will not be covered by MHP and will not be counted toward your Deductible or maximum out-of-pocket limit, if any.

Maximum benefit

The maximum limit is $2,500,000 lifetime maximum per member in **Missouri Regions**.
In the **Texas Region**, members have unlimited lifetime maximums.

Hospital/extended care

In the **Missouri Regions**, members are responsible for 30% coinsurance after the deductible.

In the **Texas Region**, members are responsible for a 40% coinsurance after the deductible.

Emergency benefits

You will pay a $50 Copayment per visit for service and supplies, except the Copayment charge will be waived when inpatient admission for the same condition occurs within twenty-four (24) hours.

What is not covered

The following are not covered under the POS benefit in the **Missouri Regions**:

- Well-child care and immunizations
- Eye and ear examinations to determine the need for vision and hearing correction
- Alcoholism and drug abuse services, including but not limited to diagnosis and medical treatment and services.
- Prescription drugs other than drugs provided by a hospital to a member as an inpatient
- Chiropractic services
- Hemodialysis and dialysis services
- Services for treatment of mental or nervous disorders.
- Non-symptomatic mammography services
- Promotion of conception including, but not limited to, treatment of impotency or infertility, in vitro fertilization, embryo transplantation, reproductive therapy, artificial insemination, or reversal of voluntarily induced sterility.
- Smoking cessation services
- Any organ transplant surgery or procedures, including services rendered on behalf of an organ recipient or an organ donor.
- Charges in excess of the Eligible Charge for the service provided as determined by MHP, or any charges which exceed a calendar year maximum, or other benefit maximum.
- Any types of services, supplies or treatment not specifically provided for herein.

The following are not covered under the POS benefit in the **Texas Region:**

- HMO benefits received
- Hospice care
- Outpatient prescription drugs
- Hearing aids, including fitting
- If a Member is admitted to a Hospital on a Friday or Saturday and such admission is not Medically Necessary, hospital charges incurred on the day of admission and on the following day, if a Saturday, are not covered.
- Services provided by the Member's spouse, parent, child, grandparent, brother, sister or parent-in-law
- Reversal of surgical sterilization
- Sterilization procedures
- Chiropractic services

How to obtain benefits

A. **In Missouri:** If a charge is made to a Member for any expenses which are covered under this POS benefit, written proof of such charge must be furnished to the Plan within thirty-one (31) days of actual payment of the charge by the Member, within thirty-one (31) days of notice of such charge to the Member, or, at the latest, within twelve (12) months after the performance of the service. Failure of the Member to timely furnish such proof of claim to the Plan will result in denial of the Member's claim for reimbursement. Proof of claim includes, but is not limited to, receipt of a duly completed claimant's statement, attending Physician's Statement, itemized provider bills, medical records, and, if applicable, an accident report. Proof of claim includes, but is not limited to, receipt of a duly completed claimant's statement, attending Physician's Statement, itemized provider bills, medical records, and, if applicable, an accident report. A claim form can be obtained from your employer or from the Plan. Submit your claim form along with proof of claim to Mercy Health Plans/Premier Health Plans, P.O. Box 4568, Springfield, Missouri 65808-4568.

In Texas:

1) Within twenty (20) days after the Member receives Covered Services, or as soon as reasonably possible, the Member or someone on the Member's behalf, must notify the Plan in writing of their claim.
2) Within fifteen (15) days after the Plan receives the Member's written notice of claim., the Plan must:
    a) acknowledge receipt of the claim;
    b) begin any investigation of the claim;
    c) specify the information the Member must provide to file proof of loss. (The Plan can request additional information during the investigation, if necessary); and
    d) send the Member any forms the Plan require for filing proof of loss. If the Plan does not send the forms within this time period, the Member can file proof of loss by giving the Plan a letter describing the occurrence, the nature and extent of the claim. The Member must give the Plan this letter within the time period for filing proof of loss.
3) Within ninety (90) days after the Member receive Covered services, the Member must send the Plan written proof of claim. If it is not reasonably possible to give the Plan written proof of claim in the time required, the Plan will not reduce or deny the claim for being late if the proof is filed as soon as reasonably possible, unless the Member is not legally capable, the required proof must always be given to the Plan no later than one year from the date otherwise required.
4) Within fifteen (15) business days after the Plan receives all the information required to secure final proof of claim, the Plan must:
    a) give the Member written notice that their claim or part of their claim has been accepted and pay benefits within five (5) business days after the Plan notify the Member of acceptance; or
    b) give the Member written notice that their claim has been rejected and the reason(s) for the rejection; or
    c) give the Member written notice if the Plan need more time to make their decisions and the reasons the Plan need additional time. However, the Plan must notify the Member of their final decision within forty-five (45) days.
5. If payment of the claim or part of the claim requires the performance of an act by the Member, the Plan will pay within five (5) business days after the date the act was performed by the Member.

B. Failure to Furnish Proof of Claim

Failure to furnish proof within the required time established in paragraph A of this Section shall not invalidate or reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is provided as soon as reasonably possible.

C. If a claim is denied, a Subscriber may obtain a review of the denial through the disputed claims process in Section 8.

D. Payment of Claim

In Missouri: All benefits are payable to the Subscriber unless benefits are assigned. If any such benefits remain unpaid at the Subscriber's death, or if the Subscriber is, or its administrator's opinion, incapable of giving a legally binding receipt for payment of any benefit, or its administrator may, at its option, pay such benefit to any one or more of the Subscriber's relatives as follows: spouse, mother, father, child or children, brother(s), or sister(s) or any other relative of blood or marriage. Any payment so made will constitute a complete discharge of obligations to the extent of such payment under this benefit.

In Texas:

Benefits will be paid to the Member or to the Provider if a valid assignment has been made by the Member. Any benefits that are unpaid to the Member at their death will be paid either to the beneficiary or their estate, if no beneficiary is named. If benefits are payable to the Member, or the estate of the Member or to a beneficiary who cannot execute a valid release, the Plan may pay benefits up to $1,000 to someone related to the Member or a beneficiary by blood or marriage whom the Plan deem to be equitably entitled to such benefits. The Plan will be discharged to their extent of any such payments made by the Plan in good faith.

Benefits paid on behalf of a covered dependent child may be paid to a person who is not the Subscriber, if an order issued by a court of competent jurisdiction in this or any other state names such person the managing conservator of the child. To be entitled to receive benefits, a managing conservator of a child must submit to the Plan with the claim form, written notice that such person is the managing conservator of the child on whose behalf that claim is made and submit a certified copy of a court order establishing the person as managing conservator. This will not apply in the case of any unpaid medical bill for which a valid assignment of benefits has been exercised or to claims submitted by the Subscriber where the Subscriber has paid any portion of a medical bill that would be covered under the terms of this POS Rider.

When services are paid for or rendered by the Texas Department of Human Services on behalf of the Subscriber or a covered dependent, payment for the services will be made directly to the Texas Department of Human Services. In the case of a covered dependent child, when services are paid or rendered by the Texas Department of Human Services on behalf of such covered dependent child, payment for the services will be made directly to the Texas Department of Human Services if:

1) The parent who is a Subscriber is:
   a) a possessory conservator of the child under an order issued by a court in Texas; or
   b) is not entitled to possession of or access to the child and is required by court order or court-approved agreement to pay child support;
2) The Texas Department of Human Services is paying benefits on behalf of the child under Chapter 31 or Chapter 32, Human Resources Code; and The Plan is notified through an attachment to the claim for insurance benefits when the claim is first submitted to the Plan that the benefits must be paid directly to the Texas Department of Human Services.

Section 5 (j). Non-FEHB benefits available to Plan members

The benefits on this page 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 out-of-pocket maximums

Wellness Programs

The following wellness programs are available at the Plan's participating hospitals. Program fees may apply. Members are encouraged to contact the participating hospital nearest you for more information.

- Health Screenings
- Fitness and Weight Management
- Health Education
- Support/Therapy Groups
- Parenting Classes
- Birth/Baby Care Programs
- Children's Health Programs
- Senior Programs

Section 6. General exclusions – things we don't cover

The exclusions in this section apply to all benefits. **Although we may list a specific service as a benefit, we will not cover it unless your Plan doctor determines it is medically necessary to prevent, diagnose, or treat your illness, disease, injury, or condition** and we agree, as discussed under *What Services Require Our Prior Approval* on page 11**.**

We do not cover the following:

- Care by non-Plan providers except for authorized referrals or emergencies (see Emergency Benefits);
- Educational Services;
- Expenses you incurred while you were not enrolled in this Plan;
- Experimental or investigational procedures, treatments, drugs or devices;
- Services provided by a first degree relative;
- Services provided in connection with the reversal of an elective sterilization procedure.
- Services provided in connection with treatment or surgery to change gender or restore sexual function;
- Services, drugs, or supplies not required according to accepted standards of medical, dental, or psychiatric practice;
- Services, drugs, or supplies related to abortions, except when the life of the mother would be endangered if the fetus were carried to term or when the pregnancy is the result of an act of rape or incest;
- Services, drugs, or supplies related to sex transformations;
- Services, drugs, or supplies that are not medically necessary;
- Services, drugs, or supplies you receive from a provider or facility barred from the FEHB Program; or
- Services, drugs, or supplies you receive while you are not enrolled in this Plan.

Section 7. Filing a claim for covered services

When you see Plan physicians, receive services at Plan hospitals and facilities, or obtain your prescription drugs at Plan pharmacies, you will not have to file claims. Just present your identification card and pay your copayment, coinsurance, or deductible.

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

Medical, Hospital and Drug benefits

In most cases, providers and facilities file claims for you. Physicians must file on the form HCFA-1500, Health Insurance Claim Form. Facilities will file on the UB-92 form. For claims questions and assistance, call us at

(Eastern and Central Missouri Regions):	314-214-8196 or 1-800-327-0763
(Southwest Missouri Region):	417-836-0402 or 1-800-836-0402
(Texas Region):	956-723-7667 or 1-800-617-3433

. When you must file a claim – such as for out-of-area care – submit it on the HCFA-1500 or a claim form that includes the information shown below. Bills and receipts should be itemized and show:

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

Submit your claims to: Mercy Health Plans/Premier Health Plans
P.O. Box 4568
Springfield, MO 65808-4568

Deadline for filing your claim

Send us all of 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.

When we need more information

Please reply promptly when we ask for additional information. We may delay processing or deny your claim if you do not respond.

Section 8. The disputed claims process

Follow this Federal Employees Health Benefits Program disputed claims process if you disagree with our decision on your claim or request for services, drugs, or supplies – including a request for preauthorization:

Step	Description
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: Mercy Health Plans, 425 South Woods Mill Road, Chesterfield, MO 63017 (Eastern and Central MO) Mercy Health Plans, 5901 McPherson, Suites 1 & 2B, Laredo TX 78041 (Texas) Premier Health Plans, One Corporate Centre, Suite 200, 1949 East Sunshine, Springfield, MO 65804 (Southwest MO) (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.
2	We have 30 days from the date we receive your request to: (a) Pay the claim (or arrange for the health care provider to give you the care); or (b) Write to you and maintain our denial – go to step 4; or (c) Ask you or your provider for more information. If we ask your provider, we will send you a copy of our request—go to step 3.
3	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.
4	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: Office of Personnel Management, Office of Insurance Programs, Contracts Division 2, 1900 E Street, NW, Washington, DC 20415-3620.

The disputed claims process, continued on next page

The Disputed Claims process (Continued)

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.

Note: If you want OPM to review different claims, 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.

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

5 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. OPM will send you a final decision within 60 days. There are no other administrative appeals.

6 If you do not agree with OPM's decision, your only recourse is to sue. 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 sue 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

(a) We haven't responded yet to your initial request for care or preauthorization/prior approval, then call us at:

(Eastern and Central Missouri Regions):	314-214-8196 or 1-800-327-0763
(Southwest Missouri Region):	417-836-0402 or 1-800-836-0402
(Texas Region):	956-723-7667 or 1-800-617-3433

and we will expedite our review; or

(b) We denied your initial request for care or preauthorization/prior approval, then:

- If we expedite our review and maintain our denial, we will inform OPM so that they can give your - claim expedited treatment too, or
- You can call OPM's Health Benefits Contracts Division 2 at 202/606-3818 between 8 a.m. and 5 p.m. eastern time.

Section 9. Coordinating benefits with other coverage

When you have other health coverage

You must tell us if you are covered or a family member is covered under another group 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' guidelines.

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.

· **What is Medicare?**

Medicare is a Health Insurance Program for:

- People 65 years of age and 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 two 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. (Someone who was a Federal employee on January 1, 1983 or since automatically qualifies). Otherwise, if you are age 65 or older, you may be able to buy it. Contact 1-800-MEDICARE for more information.
- Part B (Medical Insurance). Most people pay monthly for Part B. Generally, Part B premiums are withheld from your monthly Social Security check or your retirement check.

If you are eligible for Medicare, you may have choices in how you get your health care. Medicare+ Choice is the term used to describe the various health plan choices available to Medicare beneficiaries. The information in the next few pages shows how we coordinate benefits with Medicare, depending on the type of Medicare managed care plan you have.

· **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. Some things are not covered under Original Medicare, like prescription drugs.

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. Your care must continue to be authorized by your Plan PCP. We will not waive any of our copayments, coinsurance, or deductibles.

(Primary payer chart begins on next page.)

The following chart illustrates whether the **Original Medicare Plan** or this Plan should be the primary payer 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.

Primary Payer Chart		
A. When either you -- or your covered spouse -- are age 65 or over and …	**Then the primary payer is…**	
	Original Medicare	**This Plan**
1) Are an active employee with the Federal government (including when you or a family member are eligible for Medicare solely because of a disability),		✓
2) Are an annuitant,	✓	
3) Are a reemployed annuitant with the Federal government when… a) The position is excluded from FEHB, or	✓	
b) The position is not excluded from FEHB (Ask your employing office which of these applies to you.)		✓
4) 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),	✓	
5) Are enrolled in Part B only, regardless of your employment status,	✓ (for Part B services)	✓ (for other services)
6) Are a former Federal employee receiving Workers' Compensation and the Office of Workers' Compensation Programs has determined that you are unable to return to duty,	✓ (except for claims related to Workers' Compensation.)	
B. When you -- or a covered family member -- have Medicare based on end stage renal disease (ESRD) and…		
1) Are within the first 30 months of eligibility to receive Part A benefits solely because of ESRD,		✓
2) Have completed the 30-month ESRD coordination period and are still eligible for Medicare due to ESRD,	✓	
3) Become eligible for Medicare due to ESRD after Medicare became primary for you under another provision,	✓	
C. When you or a covered family member have FEHB and…		
1) Are eligible for Medicare based on disability, and a) Are an annuitant, or	✓	
b) Are an active employee, or		✓
c) Are a former spouse of an annuitant, or	✓	
d) Are a former spouse of an active employee		✓

Claims process when you have the Original Medicare Plan - You probably will never have to file a claim form when you have both our Plan and the Original Medicare Plan.

- When we are the primary payer, we process the claim first.
- When Original Medicare is the primary payer, Medicare processes your claim first. In most cases, your claims will be coordinated automatically and we will pay the balance of covered charges. You will not need to do anything. To find out if you need to do something about filing your claims, call us at 314-214-8196 or 1-800-327-0763; (Texas Region) at 956-723-7667 or 1-800-617-3433; or Premier Health Plans (Southwest Missouri Region) at 417-836-0402 or 1-800-836-0402 or visit our website at www.mercyhealthplans.com.

We do not waive any costs when you have Medicare.

- **Medicare managed care plan**

If you are eligible for Medicare, you may choose to enroll in and get your Medicare benefits from another type of Medicare+Choice plan - a Medicare managed care plan. These are health care choices (like HMOs) in some areas of the country. In most Medicare managed care plans, you can only go to doctors, specialists, or hospitals that are part of the plan. Medicare managed care plans provide all the benefits that Original Medicare covers. Some cover extras, like prescription drugs. To learn more about enrolling in a Medicare managed care plan, contact Medicare at 1-800-MEDICARE (1-800-633-4227) or at www.medicare.gov.

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

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

Suspended FEHB coverage to enroll in a Medicare managed care plan: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in a Medicare managed care plan, eliminating your FEHB premium. (OPM does not contribute to your Medicare managed care 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 managed care plan's service area.

- **If you do not enroll in Medicare Part A or B**

If you do not have one or both Parts of Medicare, you can still be covered under the FEHB Program. We will not require you to enroll in Medicare Part B and , if you can't get premium-free Part A, we will not ask you to enroll in it.

TRICARE

TRICARE is the health care program for eligible dependents of military persons, and retirees of the military. TRICARE includes the CHAMPUS program. If both TRICARE and this Plan cover you, we pay first. See your TRICARE Health Benefits Advisor if you have questions about TRICARE coverage.

Workers' Compensation

We do not cover services that:

· you 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. You must use our Providers.

Medicaid

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

When other Government agencies are responsible for your care

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

When others are responsible for injuries

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

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

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.

Coinsurance

Coinsurance is the percentage of our allowance that you must pay for your care. See page 13.

Copayment

A copayment is a fixed amount of money you pay when you receive covered services. See page 13.

Covered services

Care we provide benefits for, as described in this brochure.

Custodial care

Assistance with activities of daily living (bathing, dressing, eating, etc.).

Deductible

A deductible is a fixed amount of covered expenses you must incur for certain covered services and supplies before we start paying benefits for those services.

Experimental or Investigational service

Services determined by the Plan to not be generally accepted by health care professional as effective in treating the illness for which their use is proposed. These services are said not be proven scientifically to effectively treat the condition prescribed.

Group health coverage

Any plan on an insured or uninsured basis which provides medical or dental benefits or services: (a) group coverage, (b) services plan contracts, (c) coverage under any trustee plans, welfare plans or employee benefit organization plans, or (d) benefits under Medicare.

Medical necessity

Health care services and supplies that are ordered by a Plan physician and found to be medically appropriate and necessary to meet basic health needs.

Plan allowance

The Plan's determination of charges for medical care, services and supplies that do not exceed the fees and prices generally approved for cases of comparable nature and severity at the time and place. The Plan will use the following guidelines for determining usual, customary and reasonable (UCR):

a. The usual fee frequently charged by the provider for a service or supply;
b. The widely accepted rate of fees charges in the same area by the health professionals of like training and experience; and
c. Unusual circumstances or complication requiring additional time skill and experience in connection with the provided services or supply.

Us/We

Us and we refer to Mercy Health Plans/Premier Health Plans.

You

You refers to the enrollee and each covered family member.

Section 11. FEHB facts

No pre-existing condition limitation

We will not refuse to cover the treatment of a condition that you had before you enrolled in this Plan solely because you had the condition before you enrolled.

Where you can get information about enrolling in the FEHB Program

See www.opm.gov/insure. Also, your employing or retirement office can answer your questions, and give you *a Guide to Federal Employees Health Benefits Plans,* brochures for other plans, and other materials you need to make an informed decision about:

- 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; and
- When the next open season for enrollment begins.

We don't determine who is eligible for coverage and, in most cases, cannot change your enrollment status without information from your employing or retirement office.

Types of coverage available for you and your family

Self Only coverage is for you alone. Self and Family coverage is for you, your spouse, and your unmarried dependent children under age 22, including any foster children or stepchildren your employing or retirement office authorizes coverage for. Under certain circumstances, you may also continue coverage for a disabled child 22 years of age or older who is incapable of self-support.

If you have a Self Only enrollment, you may change to a Self and Family enrollment if you marry, give birth, or add a child to your family. You may change your enrollment 31 days before to 60 days after that event. The Self and Family enrollment begins on the first day of the pay period in which the child is born or becomes an eligible family member. When you change to Self and Family because you marry, the change is effective on the first day of the pay period that begins after your employing office receives your enrollment form; benefits will not be available to your spouse until you marry.

Your employing or retirement office will **not** notify you when a family member is no longer eligible to receive health benefits, nor will we. Please tell us immediately when you add or remove family members from your coverage for any reason, including divorce, or when your child under age 22 marries or turns 22.

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

When benefits and premiums start

The benefits in this brochure are effective on 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. 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.

Your medical and claims records are confidential

We will keep your medical and claims information confidential. Only the following will have access to it:

- OPM, this Plan, and subcontractors when they administer this contract;
- This Plan and appropriate third parties, such as other insurance plans and the Office of Workers' Compensation Programs (OWCP), when coordinating benefit payments and subrogating claims;
- Law enforcement officials when investigating and/or prosecuting alleged civil or criminal actions;
- OPM and the General Accounting Office when conducting audits;
- Individuals involved in bona fide medical research or education that does not disclose your identity; or
- OPM, when reviewing a disputed claim or defending litigation about a claim.

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.

You may be eligible for spouse equity coverage or Temporary Continuation of Coverage.

• Spouse equity coverage

If you are divorced from a Federal employee or annuitant, you may not continue to get benefits under your former spouse's enrollment. But, you may be eligible for your own FEHB coverage under the spouse equity law. If you are recently divorced or are anticipating a divorce, contact your ex-spouse's employing or retirement office to get RI 70-5, the *Guide to Federal Employees Health Benefits Plans for Temporary Continuation of Coverage and Former Spouse Enrollees*, or other information about your coverage choices.

_ Temporary continuation of coverage (TCC)

If you leave Federal service, or if you lose coverage because you no longer qualify as a family member, you may be eligible for Temporary Continuation of Coverage (TCC). For example, you can receive TCC if you are not able to continue your FEHB enrollment after you retire, if you lose your job, if you are a covered dependent child and you turn 22 or marry, etc.

You may not elect TCC if you are fired from your Federal job due to gross misconduct.

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

•Converting to individual coverage

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

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

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

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

Getting a Certificate of Group Health Plan Coverage

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a Federal law that offers limited Federal protections for health coverage availability and continuity to people who lose employer group coverage. If you leave the FEHB Program, we will give you a Certificate of Group Health Plan Coverage that indicates how long you have been enrolled with us. You can use this certificate when getting health insurance or other health care coverage. Your new plan must reduce or eliminate waiting periods, limitations, or exclusions for health related conditions based on the information in the certificate, as long as you enroll within 63 days of losing coverage under this Plan. If you have been enrolled with us for less than 12 months, but were previously enrolled in other FEHB plans, you may also request a certificate from those plans.

For more information, get OPM pamphlet RI 79-27, Temporary Continuation of Coverage (TCC) under the FEHB Program. See also the FEHB web site (www.opm.gov/insure/health); refer to the "TCC and HIPAA" frequently asked question. These highlight HIPAA rules, such as the requirement that Federal employees must exhaust any TCC eligibility as one condition for guaranteed access to individual health coverage under HIPAA, and have information about Federal and State agencies you can contact for more information.

Long Term Care Insurance Is Coming Later in 2002

- Many FEHB enrollees think that their health plan and/or Medicare will cover their long-term care needs. Unfortunately, they are *WRONG*!
- How are YOU planning to pay for the future custodial or chronic care you may need?
- You should consider buying long-term care insurance.

The Office of Personnel Management (OPM) will sponsor a high-quality long term care insurance program effective in October 2002. As part of its educational effort, OPM asks you to consider these questions:

What is long term care (LTC) insurance?

- It's insurance to help pay for long term care services you may need if you can't take care of yourself because of an extended illness or injury, or an age-related disease such as Alzheimer's.
- LTC insurance can provide broad, flexible benefits for nursing home care, care in an assisted living facility, care in your home, adult day care, hospice care, and more. *LTC insurance can supplement care provided by family members, reducing the burden you place on them.*

I'm healthy. I won't need long term care. Or, will I?

- Welcome to the club!
- 76% of Americans believe they will never need long term care, but the facts are that about half of them will. And it's not just the old folks. About 40% of people needing long term care are under age 65. They may need chronic care due to a serious accident, a stroke, or developing multiple sclerosis, etc.
- We hope you will never need long term care, but everyone should have a plan just in case. *Many people now consider long term care insurance to be vital to their financial and retirement planing.*

Is long term care expensive?

- Yes, it can be very expensive. A year in a nursing home can exceed $50,000. Home care for only three 8- hour shifts a week can exceed $20,000 a year. And that's before inflation!
- Long term care can easily exhaust your savings. *Long term care insurance can protect your savings.*

But won't my FEHB plan, Medicare or Medicaid cover my long term care?

- Not FEHB. Look at the "*Not covered*" blocks in sections 5(a) and 5(c) of your FEHB brochure. Health plans don't cover custodial care or a stay in an assisted living facility or a continuing need for a home health aide to help you get in and out of bed and with other activities of daily living. Limited stays in skilled nursing facilities can be covered in some circumstances.
- Medicare only covers skilled nursing home care (the highest level of nursing care) after a hospitalization for those who are blind, age 65 or older or fully disabled. It also has a 100 day limit.
- Medicaid covers long term care for those who meet their state's poverty guidelines, but has restrictions on covered services and where they can be received. *Long term care insurance can provide choices of care and preserve your independence.*

When will I get more information on how to apply for this new insurance coverage?

- Employees will get more information from their agencies during the LTC open enrollment period in the late summer/early fall of 2002.
- Retirees will receive information at home.

How can I find out more about the program NOW?

- Our toll-free teleservice center will begin in mid-2002. In the meantime, you can learn more about the program on our web site at www.opm.gov/insure/ltc.

Department of Defense/FEHB Demonstration Project

What is it?

The Department of Defense/FEHB Demonstration Project allows some active and retired uniformed service members and their dependents to enroll in the FEHB Program. The demonstration will last for three years and began with the 1999 open season for the year 2000. Open season enrollments will be effective January 1, 2002. DoD and OPM have set up some special procedures to implement the Demonstration Project, noted below. Otherwise, the provisions described in this brochure apply.

Who is eligible

DoD determines who is eligible to enroll in the FEHB Program. Generally, you may enroll if:

- You are an active or retired uniformed service member and are eligible for Medicare;
- You are a dependent of an active or retired uniformed service member and are eligible for Medicare;
- You are a qualified former spouse of an active or retired uniformed service member and you have not remarried; or
- You are a survivor dependent of a deceased active or retired uniformed service member; and
- You live in one of the geographic demonstration areas.

If you are eligible to enroll in a plan under the regular Federal Employees Health Benefits Program, you are not eligible to enroll under the DoD/FEHBP Demonstration Project.

The demonstration areas

- Dover AFB, DE
- Fort Knox, KY
- Dallas, TX
- New Orleans, LA
- Adair County, IA
- Commonwealth of Puerto Rico
- Greensboro/Winston Salem/High Point, NC
- Humboldt County, CA area
- Naval Hospital, Camp Pendleton, CA
- Coffee County, GA area

When you can join

You may enroll under the FEHB/DoD Demonstration Project during the 2001 open season, November 12, 2001, through December 10, 2001. Your coverage will begin January 1, 2002. DoD has set-up an Information Processing Center (IPC) in Iowa to provide you with information about how to enroll. IPC staff will verify your eligibility and provide you with FEHB Program information, plan brochures, enrollment instructions and forms. The toll-free phone number for the IPC is 1-877/DOD-FEHB (1-877/363-3342).

You may select coverage for yourself (Self Only) or for you and your family (Self and Family) during open season. Your coverage will begin January 1, 2002. If you become eligible for the DoD/FEHB Demonstration Project outside of open season, contact the IPC to find out how to enroll and when your coverage will begin.

DoD has a web site devoted to the Demonstration Project. You can view information such as their Marketing/Beneficiary Education Plan, Frequently Asked Questions, demonstration area locations and zip code lists at www.tricare.osd.mil/fehbp. You can also view information about the demonstration project, including "The 2002 Guide to Federal Employees Health Benefits Plans Participating in the DoD/FEHB Demonstration Project," on the OPM web site at www.opm.gov.

Temporary Continuation Of Coverage (TCC)

See Section 11, FEHB Facts; it explains temporary continuation of coverage (TCC). Under this DoD/FEHB Demonstration Project the **only** individual eligible for TCC is one who ceases to be eligible as a "member of family" under your self and family

enrollment. This occurs when a child turns 22, for example, or if you divorce and your spouse does not qualify to enroll as an unremarried former spouse under title 10, United States Code. For these individuals, TCC begins the day after their enrollment in the DoD/FEHB Demonstration Project ends. TCC enrollment terminates after 36 months or the end of the Demonstration Project, whichever occurs first. You, your child, or another person must notify the IPC when a family member loses eligibility for coverage under the DoD/FEHB Demonstration Project.

TCC is not available if you move out of a DoD/FEHB Demonstration Project area, you cancel your coverage, or your coverage is terminated for any reason. TCC is not available when the demonstration project ends.

Other features

The 31-day extension of coverage and right to convert do not apply to the DoD/FEHB Demonstration Project.

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Do not rely on this page; it is for your convenience and may not show all pages where the terms appear.

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Summary of benefits for the Mercy Health Plans/Premier Health Plans - 2002

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

Benefits	You Pay	Page
Medical services provided by physicians: · Diagnostic and treatment services provided in the office.....	Office visit copay: $10 primary care; $10 specialist	16
Services provided by a hospital: · Inpatient ..... · Outpatient	 Nothing Nothing	 28 29
Emergency benefits: · In-area ..... · Out-of-area.....	$50 Copayment per visit, except Copayment charge will be waived when inpatient admission for the same condition occurs within 24 hours	31
Mental health and substance abuse treatment.....	Regular benefits	32
Prescription drugs.....	$7/$12/$25 Copayment	34
Dental Care.....	Discounted fee schedule	38
Vision Care.....	$10 per office visit; one pair of eyeglasses or contact lenses to correct an impairment directly caused by accidental ocular injury or intraocular surgery (such as cataracts)	21
Special features: · Flexible benefits option · 24 hour nurse line (not available in Texas) · Services for deaf and hearing impaired		37
Point of Service benefits -- Yes		39
Protection against catastrophic costs (your out-of-pocket maximum).....	Nothing after $1,100/Self Only or $3,300/Family (Missouri Regions) or $1,000/Self Only or $2,000/Family (Texas Region) enrollment per year. Some costs do not count toward this protection	13

2002 Rate Information for
Mercy Health Plans/Premier Health Plans

Non-Postal rates apply to most non-Postal enrollees. If you are in a special enrollment category, refer to the FEHB Guide for that category or contact the agency that maintains your health benefits enrollment.

Postal rates apply to career Postal Service employees. Most employees should refer to the FEHB Guide for United States Postal Service Employees, RI 70-2. Different postal rates apply and special FEHB guides are published for Postal Service Nurses, see RI 70-2B; and for Postal Service Inspectors and Office of Inspector General (OIG) employees (see RI 70-2IN).

Postal rates do not apply to non-career postal employees, postal retirees or associate members of any postal employee organization. Such persons not subject to postal rates must refer to the applicable FEHB Guide.

		Non-Postal Premium				Postal Premium	
		Biweekly		Monthly		Biweekly	
Type of Enrollment	Code	Gov't Share	Your Share	Gov't Share	Your Share	USPS Share	Your Share
Missouri Regions (see page 7 for service area)							
Self Only	7M1	$97.86	$36.22	$212.03	$78.48	$115.52	$18.56
Self and Family	7M2	$223.41	$88.44	$484.06	$191.62	$263.75	$48.10
Texas Region (see page 7 for service area)							
Self Only	HM1	$95.32	$31.77	$206.52	$68.84	$112.79	$14.30
Self and Family	HM2	$223.41	$94.32	$484.06	$204.36	$263.75	$53.98