Mercy Health Plans/ Premier Health Plans

http://www.mercyhealthplans.com

2003

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

Federal Employees Health Benefits Program

RI 73-756

UNITED STATES
OFFICE OF PERSONNEL MANAGEMENT
WASHINGTON, DC 20415-0001

OFFICE OF THE DIRECTOR

Dear Federal Employees Health Benefits Program Participant:

I am pleased to present this Federal Employees Health Benefits (FEHB) Program plan brochure for 2003. The brochure explains all the benefits this health plan offers to its enrollees. Since benefits can vary from year to year, you should review your plan's brochure every Open Season. Fundamentally, I believe that FEHB participants are wise enough to determine the care options best suited for themselves and their families.

In keeping with the President's health care agenda, we remain committed to providing FEHB members with affordable, quality health care choices. Our strategy to maintain quality and cost this year rested on four initiatives. First, I met with FEHB carriers and challenged them to contain costs, maintain quality, and keep the FEHB Program a model of consumer choice and on the cutting edge of employer-provided health benefits. I asked the plans for their best ideas to help hold down premiums and promote quality. And, I encouraged them to explore all reasonable options to constrain premium increases while maintaining a benefits program that is highly valued by our employees and retirees, as well as attractive to prospective Federal employees. Second, I met with our own FEHB negotiating team here at OPM and I challenged them to conduct tough negotiations on your behalf. Third, OPM initiated a comprehensive outside audit to review the potential costs of federal and state mandates over the past decade, so that this agency is better prepared to tell you, the Congress and others the true cost of mandated services. Fourth, we have maintained a respectful and full engagement with the OPM Inspector General (IG) and have supported all of his efforts to investigate fraud and waste within the FEHB and other programs. Positive relations with the IG are essential and I am proud of our strong relationship.

The FEHB Program is market-driven. The health care marketplace has experienced significant increases in health care cost trends in recent years. Despite its size, the FEHB Program is not immune to such market forces. We have worked with this plan and all the other plans in the Program to provide health plan choices that maintain competitive benefit packages and yet keep health care affordable.

Now, it is your turn. We believe if you review this health plan brochure and the FEHB Guide you will have what you need to make an informed decision on health care for you and your family. We suggest you also visit our web site at www.opm.gov/insure.

Sincerely,

Kay Coles James
Director

Notice of the Office of Personnel Management's

Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

By law, the Office of Personnel Management (OPM), which administers the Federal Employees Health Benefits (FEHB) Program, is required to protect the privacy of your personal medical information. OPM is also required to give you this notice to tell you how OPM may use and give out ("disclose") your personal medical information held by OPM.

OPM **will** use and give out your personal medical information:

- To you or someone who has the legal right to act for you (your personal representative),
- To the Secretary of the Department of Health and Human Services, if necessary, to make sure your privacy is protected,
- To law enforcement officials when investigating and/or prosecuting alleged or civil or criminal actions, and
- Where required by law.

OPM **has the right** to use and give out your personal medical information to administer the FEHB Program. For example:

- To communicate with your FEHB health plan when you or someone you have authorized to act on your behalf asks for our assistance regarding a benefit or customer service issue.
- To review, make a decision, or litigate your disputed claim.
- For OPM and the General Accounting Office when conducting audits.

OPM **may** use or give out your personal medical information for the following purposes under limited circumstances:

- For Government healthcare oversight activities (such as fraud and abuse investigations),
- For research studies that meet all privacy law requirements (such as for medical research or education), and
- To avoid a serious and imminent threat to health or safety.

By law, OPM must have your written permission (an "authorization") to use or give out your personal medical information for any purpose that is not set out in this notice. You may take back ("revoke") your written permission at any time, except if OPM has already acted based on your permission.

By law, you **have the right** to:

- See and get a copy of your personal medical information held by OPM.
- Amend any of your personal medical information created by OPM if you believe that it is wrong or if information is missing, and OPM agrees. If OPM disagrees, you may have a statement of your disagreement added to your personal medical information.
- Get a listing of those getting your personal medical information from OPM in the past 6 years. The listing will not cover your personal medical information that was given to you or your personal representative, any information that you authorized OPM to release, or that was given out for law enforcement purposes or to pay for your health care or a disputed claim.
- Ask OPM to communicate with you in a different manner or at a different place (for example, by sending materials to a P.O. Box instead of your home address)

For more information on exercising your rights set out in this notice, look at www.opm.gov/insure on the web. You may also call 202-606-0191 and ask for OPM's FEHB Program privacy official for this purpose.

If you believe OPM has violated your privacy rights set out in this notice, you may file a complaint with OPM at the following address:

Privacy Complaints
Office of Personnel Management
P.O. Box 707
Washington, DC 20004-0707

Filing a complaint will not affect your benefits under the FEHB Program. You also may file a complaint with the Secretary of the Department of Health and Human Services.

By law, OPM is required to follow the terms in this privacy notice. OPM has the right to change the way your personal medical information is used and given out. If OPM makes any changes, you will get a new notice by mail within 60 days of the change. The privacy practices listed in this notice will be effective April 14, 2003.

Table of Contents

Introduction

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. The addresses for Mercy Health Plans/Premier Health Plans administrative offices are:

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

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled in Self and Family coverage, each eligible family member is also entitled to these benefits. You do not have a right to benefits that were available before January 1, 2003, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2003, and changes are summarized on page 8. Rates are shown at the end of this brochure.

Plain Language

All FEHB brochures are written in plain language 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.

Stop Health Care Fraud!

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

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

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

- Be wary of giving your plan identification (ID) number over the telephone or to people you do not know, except to your doctor, other provider, or authorized plan or OPM representative.
- Let only the appropriate medical professionals review your medical record or recommend services.
- Avoid using health care providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.
- Carefully review explanations of benefits (EOBs) that you receive from us.
- Do not ask your doctor to make false entries on certificates, bills or records in order to get us to pay for an item or service.

- If you suspect that a provider has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:
    - Call the provider and ask for an explanation. There may be an error.
    - If the provider does not resolve the matter, call 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 -- THE HEALTH CARE FRAUD HOTLINE
202-418-3300

OR WRITE TO:
The United States Office of Personnel Management
Office of the Inspector General Fraud Hotline
1900 E Street, NW, Room 6400
Washington, DC 20415

- Do not maintain as a family member on your policy:
    - your former spouse after a divorce decree or annulment is final (even if a court order stipulates otherwise); or
    - your child over age 22 (unless he/she is disabled and incapable of self support).
- If you have any questions about the eligibility of a dependent, check with your personnel office if you are employed or with OPM if you are retired.
- You can be prosecuted for fraud and your agency may take action against you if you falsify a claim to obtain FEHB benefits or try to obtain services for someone who is not a eligible family member or who is no longer enrolled in the Plan.

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. The Plan is solely responsible for the selection of these providers in your area. Contact the Plan for a copy of their most recent provider directory.

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

When you receive services from Plan providers, you will not have to submit claim forms or pay bills. You 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.

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 out of our service area unless the services have prior plan approval.

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

Section 2. How we change for 2003

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

- A Notice of the Office of Personnel Management's Privacy Practices is included.
- A section of the Children's Equity Act describes when an employee is required to maintain Self and Family coverage.
- Program information on TRICARE and CHAMPVA explains how annuitants or former spouses may suspend their FEHB Program enrollment.
- Program information on Medicare is revised.
- By law, the DoD/FEHB Demonstration project ends on December 31, 2002.

Changes to this Plan

- Your share of the non-Postal premium will increase by 79.3% for Self Only or 76% for Self and Family for the (7M) Missouri Regions.
- Your share of the non-Postal premium will increase by 104% for Self Only or 96.9% for Self and Family for the (HM) Texas Region.
- Copays for Specialist office visits have changed in the Missouri Regions only. When you visit a Network Specialist your copay will be increased from $10 per visit to $20 per visit.

  For example:

  Missouri Region
  $10 per visit to your primary care physician
  $20 per visit to a specialist

  Texas Region
  $10 per visit to your primary care physician
  $10 per visit to a specialist

- The copay for Emergency Room has increased in the Missouri Regions only. The copay has increased from $50 to $75.
- In the Missouri Regions only, we increased the pharmacy/mail-order generic, formulary brand drugs and non-formulary approved drugs copays to $10/$20/$35 and $20/$40/$70 respectively.
- We increased the In-Network catastrophic protection out-of-pocket maximum for the Missouri Regions only. The In-Network catastrophic protection out-of-pocket maximum has been increased from $1,100 per person or $3,300 per family to $2,200 per person or $6,600 per family. Once this catastrophic protection out-of-pocket maximum has been met, benefits will be at 100%.
- Members covered by Mercy Health Plans' PCP Select product in the Eastern Missouri Region will no longer need a Plan assigned referral number from a Primary Care Physician (PCP) to an in-network Specialist. However, members who receive care in the Alton MultiSpecialist Group will continue to need the Plan assigned referral number for PCP referrals to specialists (see Section 3).

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

Or write to us at:

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

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. If you are enrolled in the PCP Select product, you should select a PCP. 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 (if needed). 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**

Members covered by Mercy Health Plans' PCP Select product in the Eastern Missouri Region should choose a participating PCP. Once your PCP determines you have a medical condition, which requires specialty consultation, your PCP will provide you with the information needed to see a participating provider. No additional Mercy Health Plans' generated referral number is required. However, the Alton MultiSpecialist Group is an exception to the PCP Select Product. If you receive care within the Alton MulitSpecialist Group, you are still required to select a PCP and obtain Plan approval and the required Plan generated referral number for PCP referrals to a specialist.

Members with Mercy/Premier Health Plans in our Central and Southwest Missouri Regions and Texas Regions are required to select a PCP. Once the PCP determines that the individual requires specialty care, a referral number is obtained from our (or Mercy/Premier Health Plans' designee's/delegate's) utilization management department. This referral number must be obtained in advance of services in order for benefits to be considered.

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.

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).

Here are other things you should know about specialty care for all Regions:

- 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
- Surgical procedures
- Hospice care, inpatient or outpatient

It is the shared responsibility of both you and your PCP or specialist to assure that referrals are obtained, accurate and current. If a referral is required, 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. If required, 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. See Section 5(i).

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. This deductible applies to Point of Service (POS) benefits only. The catastrophic protection out-of-pocket maximum per member is $3,500 (including the deductible) and $7,000 per family (including deductible). Please refer to Section 5(i) for additional information.

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. This deductible applies to POS benefits only. 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. Please refer to Section 5(i) for additional information.

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 $2,200 per person or $6,600 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 catastrophic protection 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 page 71 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*
Premier Health Plans (Southwest Missouri Region): *(417) 836-0402 or 1-800-836-0402*
Mercy Health Plans (Texas Region): *(956) 723-7667 or 1-800-617-3433*

or at our website at www.mercyhealthplans.com.

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 in-network calendar year deductible.
- Be sure to read Section 4, *Your costs for covered services,* or valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- **Your physician must get pre-authorization for some in-network services and supplies. Please see Section 3.**
- **POS out-of-network services are subject to a calendar year deductible. You must get preauthorization before any service is rendered out-of-network. POS benefits and services are limited. Please see Sections 3 & 5(i) for details.**

IMPORTANT

Benefit Description	You pay
Diagnostic and treatment services	
Professional services of physicians • In physician's office	**Missouri Region** $10 per visit to your primary care physician $20 per visit to a specialist **Texas Region** $10 per visit to your primary care physician $10 per 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 per visit Nothing Nothing For office medical consultations and second surgical opinion, copays are the following: **Missouri Region** $10 per visit to your primary care physician $20 per visit to a specialist **Texas Region** $10 per visit to your primary care physician $10 per visit to a specialist
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	
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	**Missouri Region** $10 per visit to your primary care physician $20 per visit to a specialist **Texas Region** $10 per visit to your primary care physician $10 per visit to a specialist
Routine Prostate Specific Antigen (PSA) test – one annually for men age 40 and older	**Missouri Region** $10 per visit to your primary care physician $20 per visit to a specialist **Texas Region** $10 per visit to your primary care physician $10 per visit to a specialist
Routine pap test Note: The office visit is covered if pap test is received on the same day; see *Diagnosis and Treatment*, above.	**Missouri Region** $10 per visit to your primary care physician $20 per visit to a specialist **Texas Region** $10 per visit to your primary care physician $10 per visit to a specialist

Preventive care, adult -- continued on next page

Preventive care, adult *(continued)*	**You pay**
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
Routine immunizations, limited to: • Tetanus-diphtheria (Td) booster – once every 10 years, ages 19 and over (except as provided for under Childhood immunizations) • Influenza vaccine, annually • Pneumococcal vaccine, age 65 and over	Nothing
Not covered: Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, or travel.	*All charges.*
Preventive care, children	
• Childhood immunizations recommended by the American Academy of Pediatrics	Nothing

• Well-child care charges for routine examinations, immunizations and care (to age 22)
• 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 (to age 22)
	Missouri Region
	$10 per visit to your primary care physician
	$20 per visit to a specialist
	
	Texas Region
	$10 per visit to your primary care physician
	$10 per visit to a specialist

Maternity care	You pay
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. Circumcision is covered under surgical benefits. • We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See Hospital benefits (Section 5c) and Surgery benefits (Section 5b).	**Missouri Region** One time $20 Copayment for all office visits associated with prenatal care during a single pregnancy. **Texas Region** 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 range of voluntary family planning services, limited to: • Voluntary sterilization (See Surgical procedures Section 5 (b)) • 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.	**Missouri Region** $10 per visit to your primary care physician $20 per visit to a specialist **Texas Region** $10 per visit to your primary care physician $10 per visit to a specialist
Not covered: Reversal of voluntary surgical sterilization and genetic counseling.	*All charges.*

Infertility services	You pay

Diagnosis and treatment of infertility, such as:
• Artificial insemination:
  • *intravaginal insemination (IVI)*
  • *intracervical insemination (ICI)*
  • *intrauterine insemination (IUI)*
	Missouri Region
	$10 per visit to your primary care physician for the diagnosis of infertility
	$20 per visit to a specialist for the diagnosis of infertility
	
	Texas Region
	$10 per visit to your primary care physician for the diagnosis of infertility.
	$10 per visit to a specialist for the diagnosis of infertility.
	For treatment, you pay 50% of the first $5,000 of the usual, customary and reasonable (UCR) rate of Plan allowance, charges in excess of the UCR rate, and 100% of the charges for infertility services over $5,000. (Missouri and Texas Regions.)

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*
• *Fertility drugs*
• *Infertility services after voluntary sterilization*
	All charges.

Allergy care	
Testing and treatment	**Missouri Region** $10 per visit to your primary care physician $20 per visit to a specialist **Texas Region** $10 per visit to your primary care physician $10 per visit to a specialist
Allergy injection	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 30. • 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.	**Missouri Region** $20 per office visit $20 per outpatient visit **Texas Region** $10 per office visit $10 per outpatient 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 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 for up to 36 visits per condition.	**Missouri Region** $20 per office visit $20 per outpatient visit **Texas Region** $10 per office visit $10 per outpatient visit Nothing per visit during covered inpatient admission.

Physical and occupational therapies – continued on next page

Physical and occupational therapies *(Continued)*	**You Pay**
Not covered: • *long-term rehabilitative therapy* • *exercise programs* • *neuro-rehabilitation* • *work hardening programs or developmental educational therapy*	*All charges.*
Speech therapy	
60 visits per calendar year	**Missouri Region** $20 per office visit $20 per outpatient visit **Texas Region** $10 per office visit $10 per outpatient visit
Not covered: • *Therapies that are not considered 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*)	**Missouri Region** $10 per visit to your primary care physician $20 per visit to a specialist **Texas Region** $10 per visit to your primary care physician $10 per visit to a specialist
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. • One pair of eyeglasses or contact lenses to correct an impairment directly caused by accidental ocular injury or intraocular surgery (such as for cataracts).	**Missouri Region** $10 per visit to your primary care physician $20 per visit to a specialist **Texas Region** $10 per visit to your primary care physician $10 per visit to a specialist

Vision Services (testing, treatment, and supplies) – continued on next page

Vision services (testing, treatment, and supplies) *(Continued)*	**You pay**
Not covered: • *Eye glasses and contact lenses, except as described on page 22* • *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.	**Missouri Region** $10 per visit to your primary care physician $20 per visit to a specialist **Texas Region** $10 per visit to your primary care physician $10 per visit to a specialist
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	
• 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

Orthopedic and prosthetic devices – continued on next page

Orthopedic and prosthetic devices *(Continued)*	**You pay**
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* • *prosthetic devices to restore sexual function (i.e. penile implants)*	*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; • ambulatory dialysis; • crutches; • walkers; • blood glucose monitors; and • insulin pumps. 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.	Nothing

Durable medical equipment (DME) – continued on next page

Durable medical equipment (DME) *(Continued)*	**You pay**
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 • Adjunctive procedures such as ultrasound, electrical muscle stimulation, vibratory therapy, and cold pack application.	**Missouri Region** $20 per office visit **Texas Region** $10 per office visit Referrals are required for Central Missouri Region 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	**Missouri Region** $10 per visit to your primary care physician $20 per visit to a specialist **Texas Region** $10 per visit to your primary care physician $10 per visit to a specialist
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.)** • Diabetes self-management	$25 copayment per program per year. Will vary with the 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.
- 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.).
- **Your physician must get pre-authorization for some in-network services. Please see Section 3.**
- **POS out-of-network services are subject to a calendar year deductible. You must get preauthorization before any service is rendered out-of-network. POS benefits and services are limited. Please see Sections 3 & 5(i) for details.**

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 (e.g., Tubal ligation, Vasectomy) • 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.	**Missouri Region** $10 per visit if performed in a primary care physician's office $20 per visit if performed in a specialist's office Nothing for inpatient or outpatient surgery **Texas Region** $10 per visit if performed in a primary care physician's office $10 per visit if performed in a specialist's office Nothing for inpatient or outpatient surgery
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.
	Missouri Region
	$10 per visit if performed in a primary care physician's office
	$20 per visit if performed in a specialist's office
	Nothing for inpatient or outpatient surgery
	
	Texas Region
	$10 per visit if performed in a primary care physician's office
	$10 per visit if performed in a specialist's office
	Nothing for inpatient or outpatient surgery

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	You Pay
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.	**Missouri Region** $10 per visit if performed in a primary care physician's office $20 per visit if performed in a specialist's office Nothing for inpatient or outpatient surgery **Texas Region** $10 per visit if performed in a primary care physician's office $10 per visit if performed in specialist's office Nothing for inpatient or outpatient surgery
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	You pay
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	You pay
Professional services provided in –	
• Office	**Missouri Region** $20 per office visit **Texas Region** $10 per office visit
• Hospital (inpatient)	Nothing
• Hospital outpatient department	Nothing
• Skilled nursing facility	Nothing
• Ambulatory surgery center	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.
- We have no in-network 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 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).
- **Your physician must get pre-authorization for all hospital stays and some in-network services. Please see Section 3.**
- **POS out-of-network services are subject to a calendar year deductible. You must get preauthorization before any service is rendered out-of-network. POS benefits and services are limited. Please see Sections 3 & 5(i) for details.**

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* • *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	You pay
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 and are payable only when we determine they are medically necessary.
- 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 or Premier 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	**Missouri Region** $10 per visit to your primary care physician $20 per visit to a specialist **Texas Region** $10 per visit to your primary care physician $10 per visit to a specialist
• Emergency care at an urgent care center	$25 per office visit
• Emergency care as an outpatient or inpatient at a hospital, including doctors' services	**Missouri Region** $75 per visit, except Copayment will be waived if you are admitted to an observation, outpatient surgery, outpatient procedure, or inpatient care setting. **Texas Region** $50 per visit, except Copayment 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	**Missouri Region** $10 per visit to your primary care physician $20 per visit to a specialist **Texas Region** $10 per visit to your primary care physician $10 per visit to a specialist
• Emergency care at an urgent care center	$25 per visit, except Copayment will be waived if you are admitted to an observation, outpatient surgery, outpatient procedure, or inpatient care setting.

Emergency outside our service area – continued on next page

Emergency outside our service area *(Continued)*	**You pay**
• Emergency care as an outpatient or inpatient at a hospital including doctor's services	**Missouri Region** $75 per visit, except Copayment will be waived if you are admitted to an observation, outpatient surgery, outpatient procedure, or inpatient care setting. **Texas Region** $50 per visit, except Copayment 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:

- Please remember that all benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- We have no in-network calendar year deductible.
- A deductible applies to out-of-network Mental Health and Substance Abuse benefits only in the Texas Region Point of Service (POS) plan. There are no POS benefits in the Missouri Regions. Please refer to Section 5(i) for details.
- **YOU MUST GET PREAUTHORIZATION OF THESE SERVICES.** See the instruction 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	**Missouri Region** $10 per visit to your primary care physician $20 per visit to a specialist **Texas Region** $10 per visit to your primary care physician $10 per visit to a specialist
• 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

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):	1-800-413-8008

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 (such as 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. 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 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

  You may also view the formulary by visiting our website at www.mercyhealthplans.com.

- **These are the dispensing limitations.** Prescription drugs will be dispensed for up to a thirty-(30) day supply. Prescriptions filled through the Walgreen's Healthcare Plus mail service pharmacy, is limited up to a ninety-(90) day supply. If a mail 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 (DAW) 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.

Prescription Drug Benefits – continued on next page

Prescription Drug Benefits *(Continued)*

- **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: • 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*. • 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 for sexual dysfunction (see Section 3 - *Services requiring our prior approval*) • Insulin; a copay charge applies to each vial • Contraceptive drugs and devices **Missouri Region** 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 $10 for generic drugs, $20 Copayment for brand drugs and $35 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. **Texas Region** 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.	**Missouri Region** $10 Copayment for generic drugs on Formulary $20 Copayment for brand drugs on Formulary $35 Copayment for Non-formulary approved drugs 2 Copayments for a 90-day supply for mail-order **Texas Region** $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 *(continued)*	**You pay**
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 Regions) 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 in-network 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; See Section 5 (c) for inpatient hospital benefits. 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.
- **POS out-of-network services are subject to a calendar year deductible. You must get preauthorization before any service is rendered out-of-network. POS benefits and services are limited. Please see Sections 3 & 5(i) for details.**

IMPORTANT

Accidental injury benefit	You pay
We cover restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth. 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 CAREington 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.
- You can contact CAREington at (800) 290-0523 or www.careington.com.

Not covered:

- *Dental implants*
- *Orthodontic braces*

Section 5 (i). Point of service (POS) benefits

IMPORTANT

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 and are payable only when we determine they are medically necessary.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost sharing works.
- POS out-of-network services are subject to a calendar year deductible. You must get preauthorization before any service is rendered out-of-network. POS benefits and services are limited. Please see Sections 3 & 5(i) for details.

IMPORTANT

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 all services and supplies.

	Missouri Regions	Texas Region
PLAN MAXIMUMS		
Medical Benefit Maximum Per Person (While Covered)	$2,500,000	Unlimited
Calendar Year Deductible-Person	$500	$1,000
(Family)	$1,000	$2,000
Calendar Year Out-of-Pocket Maximum-Family	$3,500 per Person --Includes Deductible $7,000	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	30% Coinsurance After Deductible	40% Coinsurance After Deductible
- Injections/Treatment	30% Coinsurance After Deductible	40% Coinsurance After Deductible
- Allergy serum	30% 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	$75 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		

Benefits Subject to UCR limits, precertification required for all services and supplies.		
	Missouri Regions	**Texas Region**
- Outpatient Surgery - Outpatient Hospital Procedures	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
Outpatient Rehabilitative Therapy Services: Physical and Occupational Speech	30% Coinsurance After Deductible (Max. of up to 60 visits per calendar year)	40% Coinsurance After Deductible (Max. of up to 60 visits 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 you seek services from a Non-Plan Provider and/or fail to follow pre-established guidelines, reimbursement for HMO Covered Services will be made for "Covered Services". You will be required to share a larger part of the "Eligible Charges" by satisfying the annual 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-Plan Provider, you 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, you are required to comply with the specific pre-certification requirements described in connection with the Utilization Management Program as outlined. You are 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 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

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.
9. Orthotics	100% Reduction in Eligible Charges; No Benefit Payable.
10. Skilled Nursing	100% Reduction in Eligible Charges; No Benefit Payable.
11. Inpatient Rehabilitation	50% Reduction in Eligible Charges.

Note: It is your responsibility to verify that the required certification has been given by the Plan. If certification is not given, or you fail 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 your 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 not possible 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 you notify us no later than the fifth month of Pregnancy and you notify us 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

You or your designated representative must notify the Plan 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 us at the telephone number listed on your 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.

You may request a review of the Precertification decision as described in this brochure. (See Section 8, The Disputed Claims Process)

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

The additional percentage or dollar amount of the UCR, which would be payable 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 you or your family 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 person per calendar year and $1,000 deductible per family per calendar year.

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

Coinsurance

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

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

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

In the **Texas Region**, you and your family have unlimited out-of-pocket maximums, as well as an unlimited lifetime maximum benefit. Your out-of-pocket expenses under POS do not qualify for the Plan's in-Plan out-of-pocket maximum.

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

When you use a non-participating provider and fail to follow pre-certified guidelines, 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 us 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 person in **Missouri Regions**.
In the **Texas Region**, you have unlimited lifetime maximums.

Hospital/extended care

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

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

Emergency benefits

Missouri Regions: You will pay a $75 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.

Texas Region: 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 us, 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 for the same service
- 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 your spouse, parent, child, grandparent, brother, sister or parent-in-law
- Reversal of surgical sterilization
- Sterilization procedures
- Chiropractic services

How to obtain benefits

- Please see Section 7, Filing a Claim for Covered Services.
- If a claim is denied, you may obtain a review of the denial through the disputed claims process in Section 8.

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 catastrophic protection 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 12**.**

We do not cover the following:

- Care by non-Plan providers except for authorized referrals or emergencies for in-network plan benefits (see Emergency Benefits);
- Educational Services;
- Experimental or investigational procedures, treatments, drugs or devices;
- Services provided by a first degree relative;
- Devices provided in connection with treatment to restore sexual function (i.e. penile implants);
- 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 gender 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;
- Services, drugs, or supplies you receive while you are not enrolled in this Plan; or
- Service, drugs, or supplies you receive without charge while in active military service.

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. You will also need to file a claim when you receive covered out-of-network services under the POS benefits plan. 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 services you receive outside of the Plan's service area – 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 more than one claim, you must clearly identify which documents apply to which claim.

Note: You are the only person who has a right to file a disputed claim with OPM. Parties acting as your representative, such as medical providers, must include a copy of your specific written consent with the review request.

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.

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):	957-723-7667 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 may 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 or a covered family member have coverage 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.

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 claim will be coordinated automatically and we will then provide secondary benefits for covered charges. You will not need to do anything.

  To find out if you need to do something to file your claim, call us at:

  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

  or visit our website at www.mercyhealthplans.com.

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

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.

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		

- **Medicare managed care plan** If you are eligible for Medicare, you may choose to enroll in and get your Medicare benefits from 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 our Medicare managed care plan: You may enroll in our Medicare managed care plan and also remain enrolled in our FEHB plan. In this case, we do not waive cost-sharing for your FEHB coverage.

  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 and CHAMPVA

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

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

generally you may do so only at the next Open Season unless you involuntarily lose coverage under the program.

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.

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

When other Government agencies are responsible for 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.). Custodial care that lasts 90 days or more is sometimes known as Long Term Care.

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 your FEHB coverage. These materials tell you:

- When you may change your enrollment;
- How you can cover your family members;
- What happens when you transfer to another Federal agency, go on leave without pay, enter military service, or retire;
- When your enrollment ends; 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.

Children's Equity Act

OPM has implemented the Federal Employees Health Benefits Children's Equity Act of 2000. This law mandates that you be enrolled for Self and Family coverage in the Federal Employees Health Benefits (FEHB)

Program, if you are an employee subject to a court or administrative order requiring you to provide health benefits for your child(ren).

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

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

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

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.

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. This is the case even when the court has ordered your former spouse to supply health coverage to you. But, you may be eligible for your own FEHB

coverage under the spouse equity law or Temporary Continuation of Coverage (TCC). If you are recently divorced or are anticipating a divorce, contact your ex-spouse's employing or retirement office to get RI 70-5, the *Guide to Federal Employees Health Benefits Plans for Temporary Continuation of Coverage and Former Spouse Enrollees*, or other information about your coverage choices. You can also download the guide from OPM's website, www.opm.gov/insure.

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 Still Available!

Open Season for Long Term Care Insurance

- You can protect yourself against the high cost of long term care by applying for insurance in the Federal Long Term Care Insurance Program.
- Open Season to apply for long term care insurance through LTC Partners ends on December 31, 2002.
- If you're a Federal employee, you and your spouse need only answer a few questions about your health during Open Season.
- If you apply during the Open Season, your premiums are based on your age as of July 1, 2002. After Open Season, your premiums are based on your age at the time LTC Partners receives your application.

FEHB Doesn't Cover It

- Neither FEHB plans nor Medicare cover the cost of long term care. Also called "custodial care", long term care helps you perform the activities of daily living such as bathing or dressing yourself. It can also provide help you may need due to a severe cognitive impairment such as Alzheimer's disease.

You Can Also Apply Later, But…

- Employees and their spouses can still apply for coverage after the Federal Long Term Care Insurance Program Open Season ends, but they will have to answer more health-related questions.
- For annuitants and other qualified relatives, the number of health-related questions that you need to answer is the same during and after the Open Season.

You Must Act to Receive an Application

- Unlike other benefit programs, YOU have to take action – you won't receive an application automatically. You must request one through the toll-free number or website listed below.
- Open Season ends December 31, 2002 – act NOW so you won't miss the abbreviated underwriting available to employees and their spouses, and the July 1 "age freeze"!

Find Out More – Contact LTC Partners by calling **1-800-LTC-FEDS (1-800-582-3337) (TDD for the hearing impaired: 1-800-843-3557)** or visiting www.ltcfeds.com to get more information and to request an application.

Index

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

NOTES:

NOTES:

NOTES:

Summary of benefits for the Mercy Health Plans/Premier Health Plans - 2003

- **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.....	**Missouri Region** $10 per visit to your primary care physician $20 per visit to a specialist **Texas Region** $10 per visit to your primary care physician $10 per visit to a specialist	16
Services provided by a hospital: • Inpatient..... • Outpatient.....	 Nothing Nothing	 32 33
Emergency benefits: • In-area..... • Out-of-area	**Missouri Region** $75 Copayment per visit, except Copayment charge will be waived when inpatient admission for the same condition occurs within 24 hours **Texas Region** $50 Copayment per visit, except Copayment charge will be waived when inpatient admission for the same condition occurs within 24 hours	36
Mental health and substance abuse treatment.....	Regular cost-sharing	38

Benefits	You Pay	Page
Prescription drugs	**Missouri Region** $10/$20/$35 Copayment **Texas Region** $7/$12/$25 Copayment	40
Dental Care	Discounted fee schedule	44
Vision Care	One pair of eyeglasses or contact lenses to correct an impairment directly caused by accidental ocular injury or intraocular surgery (such as cataracts) **Missouri Region** $10 per visit to your primary care physician $20 per visit to a specialist **Texas Region** $10 per visit to your primary care physician $10 per visit to a specialist	22
Special features: • Flexible benefits option • 24 hour nurse line (not available in Texas) • Services for deaf and hearing impaired		43
Point of Service benefits -- Yes		45
Protection against catastrophic costs (your catastrophic protection out-of-pocket maximum)	Nothing after $2,200/Self Only or $6,600/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

2003 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 a special FEHB guide is published 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 who are not career postal employees. 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	$109.30	$64.94	$236.82	$140.70	$129.03	$45.21
Self and Family	7M2	$249.62	$155.67	$540.84	$337.29	$294.70	$110.59
Texas Region (see page 7 for service area)							
Self Only	HM1	$109.30	$64.81	$236.82	$140.42	$129.03	$45.08
Self and Family	HM2	$249.62	$185.67	$540.84	$402.29	$294.70	$140.59