PHI CARES
National Air Membership Program
A Service of PHI Air Medical

BEYOND THE CALL

AMBULANCE MEMBERSHIP PLAN COVERAGE

SEE IMPORTANT NOTICES ON PAGE 2 PRIOR TO PURCHASE.

AGREEMENT FOR MEMBERSHIP: This Air Ambulance Membership Plan Coverage Agreement ("Agreement") is entered into between PHI Inc., doing business as PHI Air Medical (referred to herein as "PHI Air Medical"), based at 801-D Airport Way, Modesto, CA 95354, and based at 10713 Airport Rd, Columbia, CA 95310, and doing business as Mercy Air Ambulance (referred to herein as "Mercy Air"), based at, 5900 Old Oregon Trail, Redding, CA 96002, and the signatory on the 2009-2010 PHI Air Medical / Mercy Air Membership Plan Application ("Application"). The Membership Office is located at 801-D Airport Way, Modesto, CA 95354.

By signing the Application, I agree, on behalf of myself and the residents of my household listed on the Application, to abide by the terms of PHI Air Medical / Mercy Air's 2009-2010 Ambulance Membership Plan (the "Plan"), as set forth in this Agreement. Coverage will begin the day after PHI Air Medical / Mercy Air receives my Application and payment, and will expire midnight on the last day of the month payment is received of the following year.

PERSONS COVERED: The Plan covers me and the household members listed in my Application, so long as they remain full-time residents of the specified household. New household members may be added, household members may be deleted or the household location may be changed by written notice to PHI Air Medical / Mercy Air, effective the day following receipt by PHI Air Medical / Mercy Air of such notice. All persons covered by the Plan shall be referred to herein as "Plan Members" or "Members." References to "I" or "me" and similar references shall be construed as including all Members.

CONDITIONS OF MEMBERSHIP: As a condition of obtaining the benefits of membership and Plan coverage, I must submit a complete, accurate Application and pay PHI Air Medical / Mercy Air a non-refundable membership fee in the amount specified in the Application. In the event of any change in the insurance coverage or status of any individual named in the Application, I agree to notify PHI Air Medical / Mercy Air within ten (10) days and, if the change results in the affected individual owing an additional membership fee, I agree to pay the additional amount upon receipt of an invoice from PHI Air Medical / Mercy Air.

PAYMENT FOR SERVICES: I understand that I am responsible for payment for any services provided to me by PHI Air Medical / Mercy Air, but that my membership in the Plan will assist me by discharging that part of my financial liability that is not covered by insurance for those PHI Air Medical / Mercy Air services specified in this Agreement. This benefit is subject to certain limitations specified in this Agreement. As a condition of receiving this benefit, I hereby assign to PHI Air Medical / Mercy Air all rights and benefits that I or the other Members in my household have under any and all medical, health, supplemental, worker's compensation, liability, auto or homeowner's insurance policies or plans, or from other third party payers or sources which provide coverage or would otherwise pay for air ambulance services covered by this Agreement. Such payment sources are collectively referred to in this Agreement as "Insurance." I authorize payment of all Insurance benefits or payments for ah- ambulance services covered by this Agreement to PHI Air Medical / Mercy Air.

I understand that PHI Air Medical / Mercy Air will, whenever it deems it feasible, file claims for and directly collect the benefits payable from Insurance, up to the amount of PHI Air Medical / Mercy Air's charges for its services. When requested by PHI Air Medical / Mercy Air, I agree to complete any forms and take any other reasonable action that may be necessary to collect such amounts. If I or anyone on my behalf receive any Insurance or other third party payments for air ambulance services provided by PHI Air Medical / Mercy Air, I will promptly turn over those payments to PHI Air Medical / Mercy Air. I agree to pay PHI Air Medical / Mercy Air for any services it provides that are not covered by this Plan.

BENEFITS: Payment of the membership fee and compliance with the terms of this Agreement entitle Members to the following benefits within the Service Area as specified below:

a. Emergency air ambulance services: Members who receive medically necessary emergency air ambulance services from PHI Air Medical / Mercy Air shall pay nothing out of pocket, except as specified herein.

b. Inter-facility air ambulance services. Members who receive medically necessary inter-facility air ambulance services from PHI Air Medical / Mercy Air shall pay nothing out of pocket, except as specified herein.

LIMITATIONS and EXCLUSIONS: Membership benefits only extend to medically necessary rotary wing (helicopter) and fixed wing (airplane) air ambulance services provided by PHI Air Medical / Mercy Air provided in the Service Area as described below. No benefits are provided for ground ambulance services, even if provided as a means of facilitating air ambulance services.

Any ambulance service which is denied coverage by a Member's primary Insurance shall be deemed not to be medically necessary and shall not be covered by this Plan. Subject to the foregoing, in determining whether any emergency or inter-facility air ambulance service is "medically necessary,"

PHI Air Medical / Mercy Air reserves the right to require a certificate of medical necessity from a qualified physician in determining medical necessity. As a condition of receiving the full benefit of membership with respect to any ambulance service provided by PHI Air Medical / Mercy Air, the ambulance service must be covered by the Member's primary Insurance coverage. Some insurance programs require the insured person to obtain prior authorization before receiving ambulance services. Some plans require certain documentation from the insured within a specified time limit, or the plans deny or reduce coverage for ambulance services. Services outside the Service Area are or beyond the mileage limitations specified below are not covered. PHI Air Medical / Mercy Air shall apply the standards of the Medicare program. **Medi-Cal participants are not eligible for membership.**

SERVICE AREA: The Service Area for **Central California** covers only the Counties of: Alpine, Amador, Calaveras, Madera, Mariposa, Merced, San Joaquin, Stanislaus, and Tuolumne. The Service Area for **Northern California** covers only the Counties of: Shasta, Lassen, Modoc, Siskiyou, Del Norte, Humboldt, Mendocino, Tehama, Sierra, Butte, Trinity, Plumas, Glenn, Colusa and other counties in which PHI Air Medical / Mercy Air has a full time air ambulance base. Only the first 200 miles of helicopter transport are covered. Only the first 600 miles of airplane transport, which shall be deemed to be within the Service Area are covered.

TERMINATION AND RENEWAL OF COVERAGE: PHI Air Medical / Mercy Air may terminate this Agreement and the participation of any Membership the Plan for failure to comply with the terms of this Agreement. PHI Air Medical / Mercy Air reserves the right to discontinue its Ambulance Plan at any time upon notice to Members. In such event, PHI Air Medical / Mercy Air shall return a pro rata portion of the membership fee. PHI Air Medical / Mercy Air also reserves the right to unilaterally modify the terms of this Plan, including but not limited to the membership fee to be charged to Members who join or renew their membership after the effective date of such change. Subject to the foregoing, PHI Air Medical / Mercy Air shall renew membership on an annual basis upon completion by a Member of an Application or Renewal Application and payment of the specified Membership Fee. Renewal contracts may include changes in coverage.

NOTICES REQUIRED BY THE DEPARTMENT OF MANAGED HEALTH CARE:

(A) BEFORE YOU PURCHASE: If you are currently enrolled in a health maintenance organization (HMO) or other health insurance, the benefits provided by an Ambulance Plan may duplicate the benefits provided by your HMO or other health insurance. If you have a question regarding whether your HMO or other health insurance offers benefits for ambulance services, you should contact that other company directly.

(B) WARNING: This Ambulance Plan is not an insurance program. It will not compensate or reimburse another ambulance company that provides emergency transportation to you or your family. This may occur when the 911 Emergency System has independently determined that another company could provide more expeditious service or is next in the rotation to receive a call. This might also occur when this Ambulance Plan is unable to perform within a medically appropriate timeframe due to a mechanical or maintenance problem or being on another call.
YOU MUST SIGN OR INITIAL THIS STATEMENT IN THE APPLICATION.

(C) COMPLAINTS: For complaints regarding this Ambulance Plan, or if you have questions regarding the Plan, first attempt to call PHI Air Medical / Mercy Air at 1.888.IFLYPHI (888.435.9744). If PHI Air Medical / Mercy Air fails to resolve the complaint to your satisfaction, contact the Department of Managed Health Care at 1-800-400-0815. The Department's website is http://www.dmhc.ca.gov. You may obtain complaint forms and instructions online.

(D) OPERATING UNDER CONDITIONAL EXEMPTION: This Ambulance Plan is operating pursuant to an exemption from the Knox-Keene Health Care Service Plan Act of 1975 (Health and Safety Code section 1340 ct scq.).

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BEYOND THE CALL

MERCY AIR
A Service of PHI Air Medical

AIR AMBULANCE APPLICATION

GROUP NAME: _____

☐ NEW

☐ RENEWAL

SEE IMPORTANT NOTICES ON PAGE 2 PRIOR TO PURCHASE

MAIL THIS FORM AND PAYMENT TO: PHI CARES 801-D AIRPORT WAY, MODESTO, CA 95354

Mailing Address_____City_____State_____Zip _____
Physical Address _____City_____State_____Zip _____
County of Residence_____Phone ( )_____
EMAIL(optional)_____

HEAD OF HOUSEHOLD **LIST ANYONE ELSE IN YOUR HOUSEHOLD THAT YOU WOULD LIKE INCLUDED**

First_____MI___Last_____Date of Birth_____

Insurance (Circle one) Yes **No**

OTHER MEMBER

First_____MI___Last_____Date of Birth_____

Insurance (Circle one) Yes **No**

OTHER MEMBER

First_____MI___Last_____Date of Birth_____

Insurance (Circle one) Yes **No**

OTHER MEMBER

First_____MI___Last_____Date of Birth_____

Insurance (Circle one) Yes **No**

PLEASE ATTACH OTHER PAGES TO INCLUDE ADDITIONAL MEMBERS OF YOUR HOUSEHOLD

MEMBERSHIP ANNUAL FEES

Plan Types*	Indiviudal or Household Annual Fees	Group Annual Fees
With Health Insurance	$50.00	Call for Details
With No Health Insurance	$100.00	Call for Details

***Households with mixed insurance coverage majority will make determination.**

(See below for example.)

i.e. Three with insurance / Two without = $50 **Three without insurance / Two with = $100.00**

METHOD OF PAYMENT: VISA____ MASTERCARD___DISCOVER ___CVN(3 digit code)_____

CREDIT CARD NUMBER: _____ EXPIRATION DATE_____

CHECK_____MONEY ORDER_____ Amount Paid $_____

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SIGN OR INITIAL HERE_____

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All membership applicants 19 years or older must sign below

I hereby apply for membership in the PHI Cares* Membership program. I have reviewed the PHI Cares* Membership Plan Coverage Agreement and agree to abide by the terms thereof. I request payment of authorized Medicare or other insurance benefits to me or on my behalf to PHI Cares* for any ambulance services and supplies furnished to me by PHI Cares*. I authorize any holder of medical information about me or minors within my household to release that information to the Centers for Medicare and Medicaid Services, other providers, their agents and carriers, or PHI Cares*, in order to determine benefits payable on my behalf, now and in the future. This agreement and authorization is executed on my own behalf and on behalf of other members of my household, if they are minors or otherwise unable to sign. In the event of any change in the insurance coverage or status specified on this application, I agree to notify PHI Cares* within ten (10) days and, if the change results in the affected member(s) owing an additional membership fee, I agree to pay the additional amount upon receipt of an invoice from PHI Cares* specifying the additional amount due. Failure to notify PHI Cares* of any such change or to pay any additional amount due within thirty days of the invoice date shall result in the automatic termination of this Agreement without any notice to the affected member. By signing this application for Membership, I agree to all conditions of the "PHI Cares Air Ambulance Plan Coverage Agreement" as stated in said contract.

X_____ Date_____
SIGNATURE OF HEAD OF HOUSEHOLD

X_____ Date_____
SIGNATURE

X_____ Date_____
SIGNATURE

X_____ Date_____
SIGNATURE