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# MEDICAL BENEFITS SCHEDULE

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|  | | **MERCY PROVIDERS** | | **ALL OTHER PROVIDERS** |
| Note: The maximums listed below are the total for Participating and Non-Participating Provider expenses. For example, if a maximum of 60 days is listed twice under a service, the Calendar Year maximum is 60 days total which may be split between Participating and Non-Participating Providers. | | | | |
| **DEDUCTIBLE, PER CALENDAR YEAR** | | | | |
| Per Covered Person  Per Family Unit | | $1,000.00  $2,000.00 | | N/A  N/A |
| The Calendar Year Deductible is waived for the following Covered Charges:  -Preventive Care (as listed) -Physician Visits (as listed) | | | | |
| **COPAYMENTS** | | | | |
| Physician visits:  Primary  Specialist  Urgent Care | | $10  $20  $50 | | N/A |
| Note: The Copayment applies to the Out of Pocket Maximum. | | | | |
| **MAXIMUM OUT OF POCKET AMOUNT** (Deductible, Coinsurance, & Copayments) **PER CALENDAR YEAR** | | | | |
| Per covered Person  Per Family Unit | | $2,500.00  $5,000.00 | | N/A  N/A |
| The Plan will pay the designated percentage of Covered Charges until out-of-pocket amounts are reached, at which time the Plan will pay 100% of the remainder of Covered Charges for the rest of the Calendar Year unless stated otherwise.  The following charges do not apply toward the Out-of-Pocket maximum and are never paid at 100%.  -Cost containment penalties  -Amounts over Usual and Customary Allowance  -Charges excluded by the Plan | | | | |
| Note: The maximum amounts an individual can contribute to the in-network deductible and coinsurance family maximums are amounts up to the in-network “Per Covered Person” maximums. | | | | |
| **COVERED CHARGES** | | | | |
| **Ambulance Service** | 100% after deductible | | Services not covered | |
| **Contact Lenses or Glasses** | 100% after deductible | | Services not covered | |
| Note: When required following cataract surgery. Refer to the Medical Benefit section for further details of this benefit. | | | | |
| **Diagnostic Testing (X-ray & Lab, including Pre-Admission**  **Testing)** | 100% after deductible | | Services not covered | |
| **Durable Medical Equipment** | 100% after deductible | | Services not covered | |
| **Emergency Room Visit** | $400 copayment then 100% | | $400 copayment then 100% | |
| **Home Health Care** | 100% after deductible | | Services not covered | |
| 100 visits Calendar Year Maximum | | | | |
| **Hospice Care** | 100% deductible waived | | Services not covered | |
| **Hospital Services** | | | | |
| Room and Board | 100% after deductible  the semiprivate room rate | | Services not covered | |
| Intensive Care Unit | 100% after deductible Hospital's ICU Charge | | Services not covered | |
| Newborn Nursery Care | 100% after deductible  the semiprivate room rate | | Services not covered | |
| Other Outpatient Services not listed herein | 100% after deductible | | Services not covered | |
| **Jaw Joint/TMJ** | 100% after deductible | | Services not covered | |
| Note: Orthodontic treatment is not covered under this medical Plan. Only surgical treatment is covered. | | | | |
| **Mental Disorders** | | | | |
| Inpatient | 100% after deductible | | Services not covered | |
| Outpatient | 100% after deductible | | Services not covered | |
| Counseling & Office Visits | Copayment, then 100% | | Services not covered | |
| **Organ Transplants** | Designated Transplant Facility:  80% after deductible  These services are only covered  under the Mercy Approved  Transplant Network including the Optum Transplant Network Facilities. All Transplant services require prior authorization and a Transplant Case Manager must be assigned to the case. | | Services not covered | |
| Mercy Transplant Network  The network designated by the Plan Administrator as the sole and exclusive network to provide transplant services under the Plan. The Mercy Transplant Network is composed of the Mercy-approved Transplant Center including the Optum Transplant Network. Covered Health Services for the following organ and tissue transplants when ordered by a Physician at a Plan Administrator designated Transplant facility. For Network Benefits, transplant services must be received at an approved facility in the designated transplant network.  Benefits are available for the transplants listed below when the transplant is Medically Necessary and is not an Experimental, Investigational or Unproven Service:  •Bone marrow transplants (either from You or from a compatible donor) and peripheral stem cell transplants, with or without high dose Chemotherapy. Not all bone marrow transplants meet the definition of a Covered Health Services.  •Heart transplants  •Heart/lung transplants  •Lung transplants  •Kidney transplants  •Kidney /pancreas transplants  •Kidney/liver  •Liver transplants  •Liver/small bowel transplants  •Pancreas transplants  •Small bowel transplants  •Cornea transplants that are provided by a Physician at a Hospital.  The Plan Administrator does not require that cornea transplants be performed at a Designated Mercy Approved Transplant Network Facility in order for You to receive Network Benefits. Corneal transplant does not require Prior Authorization. | | | | |
| **Orthotics** | 100% after deductible | | Services not covered | |
| **Outpatient Private Duty Nursing** | 100% after deductible | | Services not covered | |
| **Physician Services** | | | | |
| Inpatient Visits | 100% after deductible | | Services not covered | |
| Primary Care | $10 copayment, then 100% | | Services not covered | |
| Specialist | $20 copayment, then 100% | | Services not covered | |
| Urgent Care | $50 copayment, then 100% | | Services not covered | |
| Surgery | 100% after deductible | | Services not covered | |
| All other Physician services | $10 copayment, then 100% | | Services not covered | |
| Allergy testing | $20 copayment, then 100% | | Services not covered | |
| Allergy Serum & Injections | $20 copayment, then 100% | | Services not covered | |
| **Pregnancy** | 100% after deductible | | Services not covered | |
| Note: Two ultrasounds will be considered eligible expenses for a routine Pregnancy for the following: to determine gestational age and for routine screening. The Physician’s global fee is billed by the Physician upon delivery even though the Physician may require monthly payments from the patient. Other services are billed separately upon the service being rendered. | | | | |
| **Preventive Care** | | | | |
| Routine Adult Well Care | 100%, deductible waived | | Services not covered | |
| Benefit restricted to those recommended preventive services under the Affordable Care Act (ACA). The ACA follows services recommended by the United States Preventive Services Task Force (categories A and B), as well as recommendations and guidelines of the Advisory Committee on Immunization Practices (ACIP), and the Health Resources and Services Administration (HRSA). A current listing of recommended preventive services under the Affordable Care Act can be accessed at [www.HealthCare.gov/center/regulations/prevention.html](http://www.HealthCare.gov/center/regulations/prevention.html).  Additional preventive care services for women are covered with no cost-sharing when rendered by Participating Providers/Pharmacies. View a current listing of required preventive services at <http://www.hrsa.gov/womensguidelines/>. Contact the Pharmacy Benefit Manager at the phone number on your health care plan ID card for specific information about medications which qualify for this benefit.  Any non-ACA services performed in conjunction with category “Routine” diagnosis codes in the current ICD book are not covered.  Note: Certain immunizations available from the Pharmacy will be covered. Contact the Pharmacy Benefit Manager or Claims Supervisor for further details. Contact the Health Department for availability of any immunizations free of charge. | | | | |
| Routine Well Child Care | 100%, deductible waived | | Services not covered | |
| Benefit restricted to those recommended by the United States Preventive Services Task Force categories A and B, such as certain laboratory tests and cancer screenings. A current listing of required preventive care can be accessed at www.HealthCare.gov/center/regulations/prevention.html. Revised recommendations by the Task Force will be made applicable to the Plan when required by law. (Through age 18.)  Any non-ACA services performed in conjunction with category “Routine” diagnosis codes in the current ICD book are not covered.  Certain immunizations available from the Pharmacy will be covered. Contact the Pharmacy Benefit Manager or Claims Supervisor for further details. Contact the Health Department for availability of any immunizations free of charge. | | | | |
| **Prosthetics** | 100% after deductible | | Services not covered | |
| **Second Surgical Opinion, Voluntary** | 100% after deductible | | Services not covered | |
| **Skilled Nursing Facility** | 100% after deductible  the facility's semiprivate room rate | | Services not covered | |
| 100 days Calendar Year Maximum | | | | |
| **Spinal Manipulation/Chiropractic Services** | 100% after deductible | | Services not covered | |
| $1000 Calendar Year Maximum  Note: All services rendered by a Chiropractor are subject to these maximums. | | | | |
| **Sterilization (Employees and Spouses Only)** | 100% after deductible | | Services not covered | |
| This applies to males only. Females are covered under Preventive Care services. | | | | |
| **Substance Abuse** | | | | |
| Inpatient | 100% after deductible | | Services not covered | |
| Outpatient | 100% after deductible | | Services not covered | |
| Counseling & Office Visits | Copayment, then 100% | | Services not covered | |
| **Therapies** | | | | |
| Cardiac Therapy  36 visits in 12 consecutive weeks per event | 100% after deductible | | Services not covered | |
| Pulmonary Therapy  36 visits in 12 consecutive weeks per event | 100% after deductible | | Services not covered | |
| Occupational Therapy  20 visit limit per calendar year | 100% after deductible | | Services not covered | |
| Physical Therapy  20 visit limit per calendar year | 100% after deductible | | Services not covered | |
| Speech Therapy  20 visit limit per calendar year | 100% after deductible | | Services not covered | |
| **Teeth**: Replacement of teeth removed for the medical management of a hazardous medical condition | 100% after deductible | | Services not covered | |
| $1,500 Lifetime Maximum | | | | |
| **Weight Management** | 100% after deductible | | Services not covered | |
| **Wigs** | 100% after deductible | | Services not covered | |
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# PRESCRIPTION DRUG BENEFIT SUMMARY

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|  | **PARTICIPATING PROVIDERS** | **NON-PARTICIPATING PROVIDERS** |
| **Retail Prescriptions- (Per 30-day supply)** | | |
| Generic Drugs | $10 copay after deductible | Services not covered |
| Single-Source Brand Name Drugs | $35 copay after deductible | Services not covered |
| Multi-Source Brand Name Drugs | $60 copay after deductible | Services not covered |
| Specialty Drugs | $250 copay after deductible | Services not covered |
| (Multi-source Brand Name drugs have a generic equivalent available.) | | |
| **Mail Order or Participating Pharmacies- (Per 90-day supply)** | | |
| Generic Drugs | $25 copay after deductible | Services not covered |
| Single-Source Brand Name Drugs | $87.50 copay after deductible | Services not covered |
| Multi-Source Brand Name Drugs | $150 copay after deductible | Services not covered |
| Prior authorization is required for any prescription over $1,000 (30-day) or $2,000 (90-day). | | |
| **Generic Incentive:**  Covered Expenses will be limited to the cost of a Generic drug if an equivalent Generic drug is available when a Multi-source Brand Name drug is dispensed. In addition to the copayment, the Covered Person must pay the difference between the cost of the Generic drug and the Multi- source Brand Name drug. However, the Multi-source Brand Name drug will be considered a covered expense without the cost difference penalty if the Physician writes “DAW” (dispense as written) on the prescription. | | |
| **Filing receipts when PBM card is not used:**  *If this is your primary plan*, all prescriptions should be filed through the Pharmacy Benefit Manager (PBM). If the Pharmacy charges less than the Pharmacy’s discount price through the PBM, purchase the prescription without the card and submit the receipt with the claim form to the PBM and state the situation on the form.  The reimbursement (based upon the network allowance less a small processing fee) will be sent to the Covered Employee. Some exceptions to the network allowance may be made for extenuating circumstances. Typically, a pharmacy can refile a claim within 14 days if a problem existed in filing the claim electronically. The PBM help desk is available to assist the pharmacy with rejected claims. Refer to the phone number on your ID card.  *If this is your secondary plan,* submit your receipt and/or explanation of benefits from your primary plan to Mercy. The coordination of benefits provision applies and benefits are payable under the medical benefits of this Plan. The billed amount will be the amount listed on the receipt (total amount allowed or copayment, if total allowed is not listed).  A claim form may be obtained from [www.mercyoptions.net](http://www.mercyoptions.net). The PBM claim form may be obtained from their web site or by calling the number on the ID card. | | |
| **Refer to the Prescription Drug Section for details on the Prescription Drug benefit.** | | |