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# MEDICAL BENEFITS SUMMARY

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|  | **Tier 1-Mercy** | **Tier 2-HealthLink** | **Out-of-Network** |
| 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 PersonPer Family Unit | $1,000$2,000 | $3,000$6,000 | $10,000$20,000 |
| The Calendar Year Deductible is waived for the following Covered Charges: -Preventive Care (as listed) |

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| **COPAYMENTS** |
| Physician visits:PrimarySpecialistUrgent Care | $20$30$50 | $30$60$100 | N/AN/AN/A |
| Note: The Copayment applies to the Out of Pocket maximum. |

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| **MAXIMUM OUT OF POCKET AMOUNT** (Deductible, Coinsurance, & Copayments) **PER CALENDAR YEAR** |
| Per covered PersonPer Family Unit | $3,000$6,000 | $5,000$10,000 | $20,000$40,000 |
| 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. Maximums accumulated in either Tier 1 or Tier 2 cross-apply. The Out-of-Network deductible and coinsurance are totally separate and do not contribute toward or offset Tiers 1 or 2. |
| **COVERED CHARGES** |
| **Ambulance Service** | 100% after deductible | 80% after deductible | 50% after deductible |
| **Contact Lenses or Glasses** |  |  |  |
| 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 | 80% after deductible | 50% after deductible |
| **Durable Medical Equipment** | 100% after deductible | 80% after deductible | 50% after deductible |
| **Emergency Room Visit** | $400 copayment then 100% | $400 copayment then 80% | 50% after deductible |
| **Home Health Care** | 100% after deductible | 80% after deductible | 50% after deductible |
| **Hospice Care** | 100% deductible waived | 80% after deductible | 50% after deductible |
| **Hospital Services** |
|  Room and Board |  100% after deductibleThe semiprivate room rate | 80% after deductibleThe semiprivate room rate | 50% after deductible The semiprivate room rate |
|  Intensive Care Unit | 100% after deductible Hospital's ICU Charge | 80% after deductible Hospital's ICU Charge | 50% after deductible Hospital's ICU Charge |
|  Newborn Nursery Care | 100% after deductiblethe semiprivate room rate | 80% after deductiblethe semiprivate room rate | 50% after deductiblethe semiprivate room rate |
| Other Outpatient Services not listed herein | 100% after deductible | 80% after deductible | 50% after deductible |
| **Jaw Joint/TMJ** | 100% after deductible | 80% after deductible | 50% after deductible |
| Note: Orthodontic treatment is not covered under this medical Plan. Only surgical treatment is covered. |
| **Mental Disorders** |
| Inpatient | 100% after deductible | 80% after deductible | 50% after deductible |
| Outpatient | 100% after deductible | 80% after deductible | 50% after deductible |
| Counseling & Office Visits | Copayment then 100% | Copayment then 100% | 50% after deductible |
| **Organ Transplants** | Designated Transplant Facility:100% after deductibleThese 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. | Non-Designated Transplant Facility:Not Covered | Non-Designated Transplant Facility:Not Covered |
| Mercy Transplant NetworkThe 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•Corneal transplants that are provided by a Physician at a Hospital. The Plan Administrator does not require that corneal 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 | 80% after deductible | 50% after deductible |
| **Outpatient Private Duty Nursing** | 100% after deductible | 80% after deductible | 50% after deductible |
| **Physician Services** |
| Inpatient Visits | 100% after deductible | 80% after deductible | 50% after deductible |
| Primary Care | $20 copayment then 100% | $30 copayment then 100% | 50% after deductible |
| Specialist  | $30 copayment then 100% | $60 copayment then 100% | 50% after deductible |
| Urgent Care | $50 copayment then 100% | $100 copayment then 100% | 50% after deductible |
| Surgery | 100% after deductible | 80% after deductible | 50% after deductible |
| All other Physician services | $20 copayment then 100% | $30 copayment then 100% | 50% after deductible |
| Allergy testing | $30 copayment then 100% | $60 copayment then 100% | 50% after deductible |
| Allergy Serum & Injections | $30 copayment then 100% | $60 copayment then 100% | 50% after deductible |
| **Pregnancy** | 100% after deductible | 80% after deductible | 50% after deductible |
| 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 | 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. |
| Routine Well Child Care | 100%, deductible waived | 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.) |
| **Prosthetics** | 100% after deductible | 80% after deductible | 50% after deductible |
| **Second Surgical Opinion, Voluntary** | 100% after deductible | 80% after deductible |  |
| **Skilled Nursing Facility** | 100% after deductibleThe facility's semiprivate room rate within 14 days of a 3 day stay  | 80% after deductibleThe facility's semiprivate room rate within 14 days of a 3 day stay | 50% after deductibleThe facility's semiprivate room rate within 14 days of a 3 day stay |
| **Spinal Manipulation/Chiropractic Services** | 100% after deductible | 80% after deductible | 50% after deductible |
| $1000 Calendar Year MaximumNote: All services rendered by a Chiropractor are subject to these maximums. |
| **Sterilization (Employees and Spouses Only)** | 100% after deductible | 80% after deductible | 50% after deductible |
| This applies to males only. Females are covered under Preventive Care services. |
| **Substance Abuse** |
| Inpatient | 100% after deductible | 80% after deductible | 50% after deductible |
| Outpatient | 100% after deductible | 80% after deductible | 50% after deductible |
| Counseling & Office Visits | Copayment then 100% | Copayment then 100% | 50% after deductible |
| **Therapies** |
| Cardiac Therapy36 visits in 12 consecutive weeks per event | 100% after deductible | 80% after deductible | 50% after deductible |
| Pulmonary Therapy36 visits in 12 consecutive weeks per event | 100% after deductible | 80% after deductible | 50% after deductible |
| Occupational Therapy | 100% after deductible | 80% after deductible | 50% after deductible |
| Physical Therapy | 100% after deductible | 80% after deductible | 50% after deductible |
| Speech Therapy | 100% after deductible | 80% after deductible | 50% after deductible |
| **Teeth**: Replacement of teeth removed for the medical management of a hazardous medical condition | 100% after deductible | 80% after deductible | 50% after deductible |
| **Weight Management** | 100% after deductible | 80% after deductible | 50% after deductible |
| **Wigs** | 100% after deductible | 80% after deductible | 50% after deductible |

# PRESCRIPTION DRUG BENEFIT SUMMARY

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|  | **PARTICIPATING PROVIDERS** | **NON-PARTICIPATING PROVIDERS** |
| **Retail Prescriptions- (Per 30-day supply)** |
| Generic Drugs | $15 copay after deductible | 50% after deductible |
| Single-Source Brand Name Drugs | $40 copay after deductible | 50% after deductible |
| Multi-Source Brand Name Drugs | $75 copay after deductible | 50% after deductible |
| Specialty Drugs | $250 copay after deductible | 50% after deductible |
| (Multi-source Brand Name drugs have a generic equivalent available.) |
| **Mail Order or Participating Pharmacies- (Per 90-day supply)** |
| Generic Drugs | $37.50 copay after deductible | 50% after deductible |
| Single-Source Brand Name Drugs | $100 copay after deductible | 50% after deductible |
| Multi-Source Brand Name Drugs | $187.50 copay after deductible | 50% after deductible |
| 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.** |