MERCY HEALTH CORPORATION™ EMPLOYEE BENEFIT PLAN
EPO SCHEDULE OF BENEFITS – East Clinic Partners – Plan A 2023

IMPORTANT:

THIS SCHEDULE OF BENEFITS IS ONLY A SUMMARY OF COVERAGE. FOR A COMPLETE DESCRIPTION OF COVERAGE, AND THE RESTRICTIONS, EXCLUSIONS AND LIMITATIONS THAT APPLY TO THAT COVERAGE, READ THE SUMMARY PLAN DESCRIPTION (SPD). BENEFITS ARE PROVIDED AS STATED ON THIS SCHEDULE ONLY WHEN SERVICES ARE RECEIVED ACCORDING TO THE TERMS SET FORTH IN THE SPD.

COPAYS: THIS PLAN HAS SEPARATE LEVELS OF COPAYS FOR PRIMARY CARE PHYSICIANS (PCPs) AND SPECIALISTS. THIS IS REFLECTED, FOR THE MOST PART, IN THIS SCHEDULE OF BENEFITS. IF THERE IS A QUESTION AS TO WHETHER A PRACTITIONER IS A PCP OR A SPECIALIST, REFER TO THE DEFINITIONS IN THE GLOSSARY OF THE SPD.

MAXIMUM OUT-OF-POCKET:

COINSURANCE IS SUBJECT TO THE STATED SINGLE MAXIMUM FOR EACH MEMBER PER CONTRACT YEAR AND TO THE STATED FAMILY MAXIMUM IN THE AGGREGATE FOR THE EMPLOYEE AND HIS OR HER DEPENDENTS PER CONTRACT YEAR. ONCE THE MAXIMUM COINSURANCE HAS BEEN SATISFIED, THIS PLAN PAYS 100% OF COVERED SERVICES. IF PRIOR AUTHORIZATION IS NOT OBTAINED WHEN REQUIRED, THE BENEFIT MAY NOT BE PAID. ANY OUT-OF-POCKET EXPENSES INCURRED AS A RESULT OF NOT OBTAINING PRIOR AUTHORIZATION WILL NOT APPLY TO SATISFACTION OF OUT-OF-POCKET MAXIMUMS. SERVICES MARKED WITH A * DO NOT APPLY TO THE OUT-OF-POCKET MAXIMUMS AND WILL CONTINUE TO BE REQUIRED AFTER THE MAXIMUM OUT-OF-POCKET HAS BEEN REACHED. NOTE THAT THIS PLAN HAS SEPARATE MOOP FOR MEDICAL VS. PHARMACY BENEFITS.

TYPES OF COVERAGE	**Plan Benefits**
USUAL & CUSTOMARY	Not applicable
ANNUAL DEDUCTIBLE Coinsurance applies after any deductible.	No deductible
OUT-OF-POCKET MAXIMUM Applies to coinsurance, deductible and copay except those marked with an *.	MEDICAL: $3,000 Single/$6,000 Family PHARMACY: $3,600 Single/$7,200 Family

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* The copayment or coinsurance for these services do not apply to the out-of-pocket maximum.

** Prior authorization is required for these services.

MCEPOCO-90 2023

TYPES OF COVERAGE	Plan Benefits
Dependent Coverage	
	Dependent: Coverage terminates at end of month in which dependent reaches the limiting age of 26, subject to disability Military provision dependent: Coverage terminates at end of calendar year in which full-time status terminates, subject to disability or medically necessary leave of absence

MERCY HEALTH SYSTEM PARTNERS EPO SCHEDULE OF BENEFITS

TYPES OF COVERAGE	Plan Benefits
ACUPUNCTURE SERVICES Services are limited to 12 visits per year	First 2 visits per year covered, but only at Mercy Health System's Complementary Medicine Department, no copay, 100% Coverage. All other visits $40 copay, 100% coverage thereafter
AMBULANCE SERVICES **Air Ambulance**	100% Coverage
Ground Ambulance	100% Coverage
****AUTISM SERVICES**	
Intensive level services	
Limited to children aged 2-9	
Limited to 4 cumulative years of treatment, including that treatment provided before the child was covered under this plan.	
Office Services	$40 copay, 100% coverage thereafter
Therapy Services	90% Coverage
Nonintensive level services	
Office Services	$40 copay, 100% coverage thereafter
Therapy Services	90% Coverage
Diagnostic testing and evaluation	
Evaluation	$40 copay, 100% coverage thereafter
Testing	90% Coverage

T3ME

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MERCY HEALTH SYSTEM PARTNERS EPO SCHEDULE OF BENEFITS

TYPES OF COVERAGE	Plan Benefits
****BIOFEEDBACK**	90% Coverage
CARDIAC REHABILITATION **Phase I & II** Limit of 36 visits per Contract Year	90% Coverage
CHIROPRACTIC SERVICES	$40 Copay, 100% coverage thereafter.
COSMETIC & RECONSTRUCTIVE SURGERY	
Office Services ****Office Procedures**	90% Coverage
****Hospital Services** **(Inpatient/Outpatient)**	90% Coverage
****DENTAL SURGERY** **Resulting from Bodily Injury and** **Other Covered Services**	90% Coverage
DIABETES SERVICES	
Related Education	90% Coverage
Insulin Limited to a 30 day supply in the absence of a prescription drug rider.	$30 Copay
Equipment and Supplies Limited to a 30 day supply in the absence of a prescription drug rider.	90% Coverage
****DURABLE MEDICAL EQUIPMENT**	80% Coverage

T3ME

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MERCY HEALTH SYSTEM PARTNERS EPO SCHEDULE OF BENEFITS

TYPES OF COVERAGE	Plan Benefits
EMERGENCY CARE	$200 Emergency room copay, 100% coverage thereafter. Copayment waived upon admission.
HEARING EXAMS AND HEARING AIDS	
Exams	$40 Copay per exam, 100% coverage thereafter.
Hearing Aids One aid per ear every 36 months	100% Coverage $500 maximum per ear
Hearing Aids and Cochlear Implants – Children under age 18 One aid per ear every 36 months	90% Coverage
****HOME HEALTH CARE** Limited to a total of 40 visits per contract year.	90% Coverage
****HOSPICE CARE**	90% Coverage
****HOSPITAL SERVICES**	
Inpatient	90% Coverage
Outpatient	90% Coverage
KIDNEY DISEASE TREATMENT	90% Coverage
****MEDICAL SUPPLIES**	80% Coverage

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MERCY HEALTH SYSTEM PARTNERS EPO SCHEDULE OF BENEFITS

TYPES OF COVERAGE	Plan Benefits
NEWBORN BENEFITS	
Physician Charges	90% Coverage
****Hospital Charges**	90% Coverage
Wellness Child Care (to age 6)	100% Coverage
PHYSICAL THERAPY, SPEECH THERAPY AND/OR OCCUPATIONAL THERAPY Limited to a total of 30 visits per therapy per contract year.	90% Coverage
PHYSICIAN SERVICES	
PCP office visits	$30 Copay per visit, 100% coverage thereafter.
Specialist office visits	$40 Copay per visit, 100% coverage thereafter.
****Surgical Services – Inpatient, Office, Outpatient & Ambulatory**	90% Coverage
PODIATRY SERVICES	$40 Copay per visit, 100% coverage thereafter.
PREGNANCY BENEFITS	
Physician Charges	90% Coverage
****Hospital Charges**	90% Coverage

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MERCY HEALTH SYSTEM PARTNERS EPO SCHEDULE OF BENEFITS

TYPES OF COVERAGE	Plan Benefits
PRESCRIPTIONS DRUGS (copays based on a 30-day supply) Tier 1: Preferred Generic Drugs: $15 copay per prescription drug order Tier 2: Preferred Brand Name and Select Generic Drugs: $30 minimum copay or 20% of total cost (whichever is less) up to a maximum of $50 copay per prescription drug order. Tier 3: Non-Preferred Brand and Non-Preferred Generic Drugs: $100 minimum copay or 50% of total cost (whichever is less) up to a maximum $150 copay per prescription drug order. If the price of your prescription drug is less than your copay, you will pay the charged amount. Tier 4: Specialty Drugs: 25% of total cost.	
PREVENTIVE SERVICES	100% Coverage
As provided by the Affordable Care Act and found in the following federal resources: 1. American Academy of Pediatrics Bright Futures: http://brightfutures.aap.org/pdfs/AAP%20Bright%20Futures%20Periodicity%20Sched%20101107.pdf 2. Recommended immunization schedule for those aged 0-6 years: http://www.cdc.gov/vaccines/recs/schedules/downloads/child/2010/10_0-6yrs-schedule-pr.pdf 3. Recommended immunization schedule for those aged 7-18 years: http://www.cdc.gov/vaccines/recs/schedules/downloads/child/2010/10_7-18yrs-schedule-pr.pdf 4. Catch up immunization schedule for persons aged 4 months through 18 years who start late or who are more than 1 month behind: http://www.cdc.gov/vaccines/recs/schedules/downloads/child/2010/10_catchup-schedule-pr.pdf 5. Recommended adult immunization schedule: http://www.cdc.gov/vaccines/recs/schedules/downloads/adult/2010/adult-schedule.pdf Well child care to six years of age **Women's Preventive Services including:** Mammograms, well-woman visits, HPV testing, contraception, breastfeeding support and supplies. See Health Resources and Services Administration for more details. **Immunizations** As provided by the Affordable Care Act, and found in the following federal resources: • American Academy of Pediatrics Bright Futures: http://brightfutures.aap.org/pdfs/AAP%20Bright%20Futures%20Periodicity%20Sched%20101107.pdf • Recommended immunization schedule for those aged 0-6 years: http://www.cdc.gov/vaccines/recs/schedules/downloads/child/2010/10_0-6yrs-schedule-pr.pdf • Immunizations for children aged 7-18 as recommended immunization schedule for those aged 7-18 years: http://www.cdc.gov/vaccines/recs/schedules/downloads/child/2010/10_7-18yrs-schedule-pr.pdf	

T3ME

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TYPES OF COVERAGE	Plan Benefits

- Catch up immunization schedule for persons aged 4 months through 18 years who start late or who are more than 1 month behind: http://www.cdc.gov/vaccines/recs/schedules/downloads/child/2010/10_catchup-schedule-pr.pdf
- Recommended adult immunization schedule: http://www.cdc.gov/vaccines/recs/schedules/downloads/adult/2010/adult-schedule.pdf

OB/Gyn related services

- Screening for bacteriuria (limited to 1 screening per pregnancy)
- Chlamydial screening (limited to 1 screening per year for any woman)
- Screening for hepatitis B (limited to 1 screening per pregnancy)
- Screening for iron deficiency anemia (limited to 1 complete blood count (CBC) per pregnancy)
- Screening for Rh incompatibility
- Screening for syphilis and gonorrhea
- Screening for cervical cancer (limited to 1 screening per year for any woman)

Newborn related services

- Prophylactic ocular topical medication for newborns against gonococcal ophthalmia neonatorum (limited to one application)
- Screening for hearing loss (limited to one screening)
- Screening for sickle cell anemia (limited to one screening)
- Screening for congenital hypothyroidism (limited to one screening)
- Screening for phenylketonuria (PKU) (limited to one screening)

Pharmacy related services (services covered only with a prescription from a physician)

- Aspirin to prevent cardio vascular disease in men age 45 to 79
- Aspirin to prevent cardio vascular disease in women age 55 to 79
- Folic Acid supplement for women age 11 to 50
- Iron supplementation in children age 6 to 12 months

Breast cancer screening and counseling

- BRCA screening genetic testing, using prior authorization criteria established for coverage of any genetic counseling
- Screening for mammography covered yearly beginning at age 40
- Physician discussion of chemo-prevention of breast cancer covered for those with family or personal history of breast cancer

Interventions to support breast feeding (lactation counseling and breast pumps)

Cholesterol screening (limited to 1 screening per year)

Screening for colorectal cancer, by various methods, for members age 45 - 75 (limited to those services billed with screening diagnosis codes)

Screening for Type 2 diabetes (lab tests covered if billed with screening diagnosis code)

Screening for depression in adults and adolescents (covered as part of regular physical or routine patient care visit)

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MERCY HEALTH SYSTEM PARTNERS EPO SCHEDULE OF BENEFITS

TYPES OF COVERAGE	Plan Benefits
Counseling for a healthy diet for adults with known risk factors (covered for adult members in primary care setting, or by referral to nutritionist or dieticians)	
Screening for HIV	
Screening and counseling for obesity in adults and children	
Screening for osteoporosis for women age 60 and over (limited to 1 per year)	
Counseling for STIs for adults and adolescents (covered as part of regular physical or routine patient care visit)	
Counseling for tobacco use	
Screening for visual acuity in children under the age of 5 (limited to 1per year)	
Screening for abdominal aortic aneurysm for men aged 65-75	
Screening and counseling interventions in primary care settings to reduce alcohol misuse (if rendered by primary care provider)	
Screening for high blood pressure (covered as part of regular physical or routine patient care visit)	
****PROSTHESIS**	80% Coverage
****PSYCHOLOGICAL DISORDER AND CHEMICAL DEPENDENCY**	
Inpatient	90% Coverage
Transitional Treatment	
• ****Residential Treatment for Psychological Disorders Limited to 30 days per confinement or the equivalent number of half days.**	90% Coverage
• ****Residential Treatment for Chemical Dependency Limited to 30 days per confinement or the equivalent number of half days.**	90% Coverage
Outpatient	$40 Copay per visit, 100%

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MERCY HEALTH SYSTEM PARTNERS EPO SCHEDULE OF BENEFITS

TYPES OF COVERAGE	Plan Benefits
	coverage thereafter.
REPRODUCTIVE SERVICES Infertility lifetime maximum of $2,000.	
Office or Outpatient Hospital Services	*50% Coverage
Inpatient Hospital Services	*50% Coverage
****SKILLED NURSING FACILITY** Limited to 30 days per confinement per contract year.	90% Coverage
STAY HEALTHY PROGRAM	$200 Reimbursement per contract year per employee and/or dependents 18 and older. $400 family max.
TEMPOROMANDIBULAR DISORDERS	
Office Visits	$40 Copay per visit, 100% coverage thereafter.
****Surgical Procedures**	90% Coverage
Diagnosis Procedures	90% Coverage
****Durable Medical Equipment**	80% Coverage
****TRANSPLANTS**	90% Coverage

T3ME

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MERCY HEALTH SYSTEM PARTNERS EPO SCHEDULE OF BENEFITS

TYPES OF COVERAGE	Plan Benefits
URGENT CARE	
Mercy Health System	$50 Copay per visit, 100% coverage thereafter.
Non Mercy Health System	$60 Copay per visit, 100% coverage thereafter.
VISION CARE	
Routine Exams	
Optometrist	$30 Copay per visit, 100% thereafter
Ophthalmologist	$40 Copay per visit, 100% coverage thereafter.
Medical Exams	$40 Copay per visit, 100% coverage thereafter.
X-RAY, LABORATORY AND DIAGNOSTIC TESTING	
Physician's Office	90% Coverage
Hospital	90% Coverage
****Prior authorization is required for MRI and PET imaging.**	
Preventive tests required by the Affordable Care Act. Find list of required tests at www.healthcare.gov	100% Coverage

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MERCY HEALTH SYSTEM PARTNERS EPO SCHEDULE OF BENEFITS

TYPES OF COVERAGE	Plan Benefits
OTHER MEDICAL SERVICES	
Immunizations	100% Coverage
Other Services	90% Coverage
Two 30-minute massages per contract year performed at Mercy Health System Complementary Medicine Department	*$15 Copay

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