**MERCYhealth™ PARTNERS**
**2023 SCHEDULE OF BENEFITS - PPO PLAN**

**IMPORTANT:**

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

**ANNUAL DEDUCTIBLE:**

THIS PLAN HAS AN ANNUAL DEDUCTIBLE WHICH MUST BE SATISFIED BEFORE WE WILL PAY MOST SERVICES. THE SINGLE AND FAMILY DEDUCTIBLE AMOUNTS THAT APPLY SEPARATELY TO PARTICIPATING AND NON-PARTICIPATING PROVIDER SERVICES ARE SPECIFIED ON THIS SCHEDULE OF BENEFITS. NO BENEFITS ARE PAYABLE FOR CHARGES USED TO SATISY YOUR DEDUCTIBLE.

**COPAYS:**

THIS PLAN HAS SEPARATE 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:**

DEDUCTIBLE AND COINSURANCE AND COPAYS ARE 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, MERCYCARE HEALTH PLAN PAYS 100% OF COVERED SERVICES. MEMBERS MAY BE REQUIRED TO MEET SEPARATE OUT-OF-POCKET LIMITS FOR ALL LEVELS OF BENEFITS. IF PRIOR AUTHORIZATION IS NOT OBTAINED WHEN REQUIRED, THE BENEFIT WILL 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 MAXIMUM. SERVICES MARKED WITH A * DO NOT APPLY TO THE OUT-OF-POCKET MAXIMUM 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 | LEVEL 1 BENEFITS | LEVEL 2 BENEFITS | LEVEL 3 BENEFITS |
|---|---|---|---|
| **USUAL & CUSTOMARY** | Not applicable | Not applicable | |
| **ANNUAL DEDUCTIBLE**<br>Coinsurance applies after any deductible. Two family members required to meet family deductible. | $750 Single / $1,500 Family<br>(Level 1 & 2 Deductible Accumulate To One Deductible Maximum ) | | $750 Single / $1,500 Family |
| **PER HOSPITAL ADMISSION CO-PAY**<br>Maximum co-pay of 2 family members per emergency hospital admission for each occurrence. Coinsurance and applies after co-pay. | $800 co-pay per hospital admission | $1600 co-pay per hospital admission | $3,500 co-pay per hospital admission<br>***Non-elective emergency hospital admissions pay at Level 2. |
| **OUT-OF-POCKET MAXIMUM - MEDICAL**<br>Applies to co-insurance and copays, except those marked with an * and includes deductible. | $4,250 Single / $8,500 Family<br>(Level 1 & 2 Cost Sharing Accumulate To One OOP Maximum ) | | $9,000 Single<br>$18,000 Family |
| **OUT-OF-POCKET MAXIMUM - PHARMACY** | $3,600 Single / $7,200 Family | | |
| **DEPENDENT COVERAGE**<br>Dependent: Coverage terminates at end of month in which dependent reaches the limiting age of 26, subject to disability.<br>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. | | | |

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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.

| MERCYhealth PARTNERS PPO SCHEDULE OF BENEFITS | | | |
|---|---|---|---|
| **TYPES OF COVERAGE** | **LEVEL 1 BENEFITS** | **LEVEL 2 BENEFITS** | **LEVEL 3 BENEFITS** |
| **ACUPUNCTURE SERVICES**<br>Services are limited to 12 visits per year | 1st 2 visits per year covered, but only at Mercy's Complementary Medicine department, no copay, 100% coverage.<br>All other visits $50 copay, 100% Coverage thereafter | No Benefit<br>No Benefit | No Benefit<br>No Benefit |
| **AMBULANCE SERVICES** | | | |
| **Air Ambulance** | 100% Coverage | 100% Coverage | 100% Coverage |
| **Ground Ambulance** | 100% Coverage | 100% Coverage | 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** | $30 copay, then 100% | $50 copay, then 100% | $60 copay, then 100% |
| **Therapy Services** | 85% Coverage | 75% Coverage | 50% Coverage |
| Nonintensive level services | | | |
| **Office Services** | $30 copay, then 100% | $50 copay, then 100% | $60 copay, then 100% |
| **Therapy Services** | 85% Coverage | 75% Coverage | 50% Coverage |
| Diagnostic testing and evaluation | | | |
| **Evaluation** | $30 copay, then 100% | $50 copay, then 100% | $60 copay, then 100% |
| **Testing** | 85% Coverage | 75% Coverage | 50% Coverage |
| ****BIOFEEDBACK** | 85% Coverage | 75% Coverage | 50% Coverage |
| ****CARDIAC REHABILITATION** | | | |
| **Phase I & II**<br>Limit of 36 visits per Contract Year | 85% Coverage | 75% Coverage | 50% Coverage |
| **CHIROPRACTIC SERVICES** | $50 Copay per visit, 100% coverage thereafter | $70 Copay per visit, 100% coverage thereafter | $80 Copay per visit, 100% coverage thereafter |



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| MERCYhealth PARTNERS PPO SCHEDULE OF BENEFITS | | | |
|---|---|---|---|
| **TYPES OF COVERAGE** | **LEVEL 1 BENEFITS** | **LEVEL 2 BENEFITS** | **LEVEL 3 BENEFITS** |
| **COSMETIC & RECONSTRUCTIVE SURGERY** | | | |
| ****Inpatient** | 85% Coverage | 75% Coverage | 50% Coverage |
| ****Outpatient** | 85% Coverage | 75% Coverage | 50% Coverage |
| **Office** | $50 Copay per visit, 100% coverage thereafter | $70 Copay per visit, 100% coverage thereafter | $80 Copay per visit, 100% coverage thereafter |
| ****DENTAL SURGERY** | | | |
| **Resulting from Bodily Injury and other Covered Services** | 85% Coverage | 75% Coverage | 50% Coverage |
| **DIABETES SERVICES** | | | |
| **Related Education** | 85% Coverage | 75% Coverage | 50% Coverage |
| **Insulin** Limited to a 30 day supply in the absence of a prescription drug rider. | $25 Copay | 75% Coverage | 50% Coverage |
| **Equipment and Supplies** Limited to a 30 day supply in the absence of a prescription drug rider. | 85% Coverage | 75% Coverage | 50% Coverage |
| ****DURABLE MEDICAL EQUIPMENT** | | | |
| | 80% Coverage | 75% Coverage | 50% Coverage |
| **Wigs**: 100% to $300 max/year; $1000 lifetime max | | | |
| **EMERGENCY CARE** | | | |
| | $200 Copay per visit, 100% coverage thereafter Copayment waived upon admission. | $200 Copay per visit, 100% coverage thereafter Copayment waived upon admission. | $200 Copay per visit, 100% coverage thereafter Copayment waived upon admission. |
| **HEARING EXAMS AND HEARING AIDS** | | | |
| **Exams** | $50 Copay per visit, 100% coverage thereafter | $70 Copay per visit, | $80 Copay per visit, |
| **Hearing Aids** One aid per ear every 36 months | 85% coverage | 75% coverage | 50% coverage |
| **Hearing Aids and cochlear implants for children under age 18** One aid per ear every 36 months | 85% Coverage | 75% Coverage | 50% Coverage |

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| MERCYhealth PARTNERS PPO SCHEDULE OF BENEFITS | | | |
|---|---|---|---|
| **TYPES OF COVERAGE** | **LEVEL 1 BENEFITS** | **LEVEL 2 BENEFITS** | **LEVEL 3 BENEFITS** |
| ****HOME HEALTH CARE**<br>Limited to a total of 40 visits combined all levels of benefits per contract year. | 85% Coverage | 75% Coverage | 50% Coverage |
| ****HOSPICE CARE** | 85% Coverage | 75% Coverage | 50% Coverage |
| ****HOSPITAL SERVICES** | | | |
| **Inpatient**<br>Non-elective Level 3 emergency admissions pay at Level 2. Maximum of two co-pays collected per family for non-elective admissions for the same occurrence. | 85% Coverage<br>$800 Copay per hospital admission per stay per member. | 75% Coverage<br>$1,600 Copay per hospital admission per stay per member. | 50% Coverage<br>$3,500 Copay per hospital admission per stay per member. |
| **Outpatient** | 85% Coverage | 75% Coverage | 50% Coverage |
| ****KIDNEY DISEASE TREATMENT** | 85% Coverage | 75% Coverage | 50% Coverage |
| ****MEDICAL SUPPLIES** | 80% Coverage | 80% Coverage | 50% Coverage |
| **NEWBORN BENEFITS** | | | |
| **Physician Charges** | 85% Coverage | 75% Coverage | 50% Coverage |
| ****Hospital Charges** | 85% Coverage | 75% Coverage | 50% Coverage |
| **Well Child Care (to age 6)** | 100% Coverage | $70 Copay per visit, 100% coverage thereafter | $80 Copay per visit, 100% coverage thereafter |
| **PHYSICAL THERAPY, SPEECH THERAPY AND/OR OCCUPATIONAL THERAPY**<br>Limited to a total of 30 visits per therapy per contract year. | 85% Coverage | 75% Coverage | 50% Coverage |
| **PHYSICIAN SERVICES** | | | |
| **PCP Office Visits** | $30 Copay per visit, 100% coverage thereafter | $50 Copay per visit, 100% coverage thereafter | $60 Copay per visit, 100% coverage thereafter |
| **Specialist Office Visit** | $50 Copay per visit, 100% coverage thereafter | $70 Copay per visit, 100% coverage thereafter | $80 Copay per visit, 100% coverage thereafter |
| ****Surgical Services - Inpatient, Outpatient & Ambulatory** | 85% Coverage | 75% Coverage | 50% Coverage |

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| MERCYhealth PARTNERS PPO SCHEDULE OF BENEFITS | | | |
|---|---|---|---|
| **TYPES OF COVERAGE** | **LEVEL 1 BENEFITS** | **LEVEL 2 BENEFITS** | **LEVEL 3 BENEFITS** |
| **PODIATRY SERVICES** | $50 Copay per visit, 100% coverage thereafter | $70 Copay per visit, 100% coverage thereafter | $80 Copay per visit, 100% coverage thereafter |
| **PREGNANCY BENEFITS** | | | |
| **Physician Charges** | 85% Coverage | 75% Coverage | 50% Coverage |
| ****Hospital Charges** | 85% Coverage | 75% Coverage | 50% Coverage |
| **PRESCRIPTION DRUGS (copays based on a 30-day supply)**<br>Tier 1: Preferred Generic Drugs: $20 copay per prescription drug order<br>Tier 2: Preferred Brand Name and Select Generic Drugs: $60 per prescription drug order<br>Tier 3: Non-Preferred Brand and Non-Preferred Generic Drugs: $150 per prescription drug order<br>Note: if the price of your prescription is less than your copay, you will pay the charged amount.<br>Tier 4: Specialty Drugs: 30% of total cost. | | | |
| **PREVENTIVE SERVICES** | 100% Coverage | 100% Coverage | 50% Coverage |
| As provided by the Affordable Care Act and found in the following federal resources:<br>1. American Academy of Pediatrics Bright Futures: http://www.aap.org/en-us/professional-resources/practice-support/Periodicity/Periodicity%20Schedule_FINAL.pdf<br>2. Recommended immunization schedule age 0-18: http://www.cdc.gov/vaccines/schedules/hcp/child-adolescent.html#printable<br>3. Recommended adult immunization schedule: http://www.cdc.gov/vaccines/schedules/hcp/imz/adult-compliant.html<br>4. Services recommended by the US Preventive Task Force and ranked A or B: http://www.uspreventiveservicestaskforce.org/BrowseRec/Index | | | |
| ****PROSTHESIS** | 80% Coverage | 75% Coverage | 50% Coverage |



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|---|---|---|---|
| **TYPES OF COVERAGE** | **LEVEL 1 BENEFITS** | **LEVEL 2 BENEFITS** | **LEVEL 3 BENEFITS** |
| ****PSYCHOLOGICAL DISORDER AND CHEMICAL DEPENDENCY** | | | |
| Level 3 Outpatient/Office Visits do not require prior authorization. | | | |
| **Inpatient** | 85% Coverage | 75% Coverage | 50% Coverage |
| **Transitional Treatment** | 85% Coverage | 75% Coverage | 50% Coverage |
| **> **Residential Treatment for Psycholgical Disorders Limited to 30 days per confinenent per contract year or the equivalent number of half days.** | | | |
| **> **Residential Treatment for Chemical Dependency Limted to 30 days per confinenent per contract year or the equivalent number of half days.** | | | |
| **Outpatient/Office Visit** | $30 Copay per visit, 100% coverage thereafter | $50 Copay per visit, 100% coverage thereafter | $60 Copay per visit, 100% coverage thereafter |
| **REPRODUCTIVE SERVICES** | | | |
| Infertility lifetime maximum of $10,000, combined all levels of benefits. | *50% Coverage | *50% Coverage | *50% Coverage |
| ****SKILLED NURSING FACILITY** | | | |
| Limited to 30 per confinement combined all levels of benefits per contract year. | 85% Coverage | 75% Coverage | 50% Coverage |
| **STAY HEALTHY PROGRAM** | | | |
| $200 Reimbursement per contract year per employee and/or dependents over age 18. $400 family max. | | | |
| **TEMPOROMANDIBULAR DISORDERS** | | | |
| **Office Visits** | $50 Copay per visit, 100% coverage thereafter | $70 Copay per visit, 100% coverage thereafter | $80 Copay per visit, 100% coverage thereafter |
| ****Surgical Procedures** | 85% Coverage | 75% Coverage | 50% Coverage |
| **Diagnosis Procedures** | 85% Coverage | 75% Coverage | 50% Coverage |
| ****Durable Medical Equipment** | 80% Coverage | 80% Coverage | 50% Coverage |
| ****TRANSPLANTS** | 85% Coverage | 75% Coverage | 50% Coverage |

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|---|---|---|---|
| **TYPES OF COVERAGE** | **LEVEL 1 BENEFITS** | **LEVEL 2 BENEFITS** | **LEVEL 3 BENEFITS** |
| **URGENT CARE** | $50 Copay per visit, 100% coverage thereafter | $75 Copay per visit, 100% coverage thereafter | $75 Copay per visit, 100% coverage thereafter |
| **VISION CARE** | | | |
| **Routine Exams** | $50 Copay per visit, 100% coverage thereafter | $70 Copay per visit, 100% coverage thereafter | $80 Copay per visit, 100% coverage thereafter |
| **Medical Exams** | $50 Copay per visit, 100% coverage thereafter | $70 Copay per visit, 100% coverage thereafter | $80 Copay per visit, 100% coverage thereafter |
| **X-RAY AND LABORATORY TESTS** | | | |
| **Physician's Office** | 85% Coverage | 75% Coverage | 50% Coverage |
| **Hospital** | 85% Coverage | 75% Coverage | 50% Coverage |
| **OTHER MEDICAL SERVICES** | | | |
| **Immunizations** | 100% Coverage | 75% Coverage | 50% Coverage |
| **Other** | 85% Coverage | 75% Coverage | 50% Coverage |
| **Two 30-minute massages per contract year performed at Mercy Complementary Medicine Department** | *15 Copay | No benefit | No benefit |



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