Mercer University Medical Schedule of Benefits

The Mercer Health Plan is a self-insured plan that does not restrict participants to utilizing any specific physicians or hospitals; you may choose your own health providers. You receive the highest level of benefits when utilizing a First Health Network Provider in Georgia or when you travel outside Georgia using a First Health Provider. No risk assessment or compliance required. Standard benefit levels applicable to eligible procedures, charges and prescriptions as set forth in Plan Payment Provisions and Prescription Drug Card Benefits Co-Pay sections.

Accident Expense*

1. Treatment must be obtained within 14 (including the day of the accident) days of accident;
2. Outpatient treatment is paid at 100%, *waiving the deductible;
3. Charges incurred for Accident Expenses after the first 14 days are payable at 80% In Network and 60% Out-Of-Network, after the deductible has been met.

**Only injuries sustained as the direct result of non-occupational accident are covered under This Plan.*

Calendar Year Deductible In-Network:
$700 per Covered Participant
Out-of-Network:
$1,400 per Covered Participant

Calendar Year Maximum Benefit Unlimited per Covered Person

Calendar Year Out-of-Pocket Maximum – (includes deductible, maximum of 3 per family unit. Does NOT include pharmacy copays and expenses)
(includes deductible, maximum of 3 per family unit)
In-Network: $4,000 per Covered Participant/ $12,000 family
Out-of-Network: Unlimited per person

Chemical Dependency / Alcoholism / Mental / Nervous Conditions
Inpatient: Payable as any other benefit
Outpatient: Payable as any other benefit
Refer to *Plan Payment Provisions* for detailed covered expenses.

Chiropractic Care
The maximum annual benefit payable per Covered Person is $2,000.

Coinsurance
The Coinsurance for This Plan is as follows:
In-Network – 80% after applicable deductible is satisfied.

Out-of-Network – 60% after applicable deductible is satisfied.

Convalescent Care Facility
Maximum sixty (60) days per Calendar Year. *(Additional days must be approved by the Medical Director prior to the 60 days expires.)*
Refer to *Plan Payment Provisions* for detailed covered expenses.

Covered Medical Services
Services Medically Necessary for inpatient and outpatient care and treatment of a covered illness or injury, to include physician, hospital, lab, radiology, etc.

Dialysis Treatment – Outpatient (In-Network and Out-of-Network)
100% of the Reasonable Charge after all applicable deductibles and coinsurance
Refer to *Plan Payment Provisions* for detailed covered expenses.

Durable Medical Equipment
Payable as any other benefit. Preauthorization required for all DME in excess of $500, penalty for noncompliance $200.

Educational Services, Diabetes
Up to three (3), one-hour sessions will be covered at 100% per lifetime.

Emergency Room Services
Non-Accident, Non-Emergency Services have a $25 up-front fee, which will be waived if admitted. Additional charges are subject to the Deductible and applicable Coinsurance. Preauthorization required within 2 days after admission, $200 penalty for noncompliance.

Flu Vaccinations
Annual flu vaccines will be covered by the University at no cost to the Faculty and Staff members. Family members will be charged a reduced fee at their own expense. The vaccines are to be administered by Mercer Health Systems on the Macon campus and Campus Health Care on the Atlanta campus.

Home Health Care
Each visit by a nurse or therapist will be considered one visit and four hours of home health side services will be considered one visit. Your plan has a maximum limit of one-hundred twenty (120) visits per Calendar Year. If you live in a rural area which does not have a nearby home health care agency, private duty nursing services for up to 60 days per calendar Year may be covered; however, there is a maximum allowance of $75 per twenty-four (24) hour period (subject to all other conditions and limitations).
Please call one of the nurse case managers at CHS (478-741-3521 or 888-741-CORE) for assistance in making home health care arrangements. If there are no In-Network Home Care Agencies, there is no penalty for going Out-of-Network.
Refer to *Plan Payment Provisions in the SPD* for detailed covered expenses.

Hospice Care
Refer to *Plan Payment Provisions in SPD* for detailed covered expenses. Preauthorization required, penalty for noncompliance is $200. Must be reviewed and approved every 60 days. Maximum lifetime benefit is $35,000.

Maternity Expenses
Maternity Benefits are available for all Covered Female Participants.

Network
The Network for This Plan is First Health Network

Pre-Certification Authority
Core Health Services, Inc. (CHS)
(478) 741-3521 or 1-888-741-CORE

Physician/Specialist Co-Pay
There is NOT a flat Physician/Specialists Co-Pay for this Plan/ instead, the patient will be responsible for 20% of the bill when using an In-Network Physician and 40% when using an Out-of-Network Physician after the deductible has been met.
Refer to *Plan Payment Provisions in SPD* for detailed covered expenses.

Podiatry
Custom Shoes are limited to one pair (up to $200) per Calendar Year.

Psychiatric Benefits
Mental/Nervous Conditions
Inpatient: Payable as any other benefit
Outpatient: Payable as any other benefit
Chemical Dependency/Alcoholism
Inpatient: Payable as any other benefit
Outpatient: Payable as any other benefit

Recovery/Therapy
Rehabilitation Services- Payable as any other benefit. Preauthorization required for pulmonary rehabilitation and speech therapy, $200 penalty for noncompliance. Limit 25 visits.
Habilitation Services- Payable as any other benefit. Preauthorization required, $200 penalty for noncompliance.
Skilled Nursing Care- Payable as any other benefit. Preauthorization required, $200 penalty for noncompliance. Preauthorization required, $200 penalty for noncompliance. Must be reviewed and approved every 60 days. Maximum 120 days per calendar year.

Routine Physical Exams, In-Network*
Routine Annual Exams performed by network providers are paid at 100% for the first $300 in charges. The balance is paid at 80% since deductibles are waived. The tests included with this benefit are routine pap smears, prostate exams, and routine lipid profiles. Routine Mammograms are paid at 100%, deductible waived. All out-of-network services will be paid at 60% after calendar year deductibles have been met.

Routine Well Baby Care (RWBC)
(In-Network RWBC)
The following benefits, which are available for all persons under one year of age, are covered under the Plan when an in-network provider performs services. You must participate in Mercer's group health plan to receive this benefit.
The Well Baby Care Benefit includes routine office visits accompanied by standardized immunizations at a Healthcare Facility In-Network. (*Costs associated with treatment of sickness, injury, or diseases and immunizations required solely for foreign travel are excluded from this benefit.*)
1. The First $400 is paid at 100%, waiving the Deductible;
2. Charges incurred for Routine Well Baby Care in excess of $400 are payable at 80%, waiving the Deductible.
3. This benefit is available to all covered Participants under age one.

For Children over one year of age, refer to *Routine Physical Exams*.
(Out-of-Network RWBC)
All Charges are subject to the Deductible, and then payable at 60%.