

# Mercer Medical Plan

## 2012-2013 Schedule of Benefits

### **Calendar Year Deductible**

*In-Network - \$500 Per Covered Participant*

*Out-of-Network - \$1,000 Per Covered Participant*

### **Calendar Year Out of Pocket Maximum**

*In-Network:*

*\$3,000 per Covered Participant (includes deductible; maximum of 3 per family unit)*

*Out-of-Network:*

*Unlimited per Covered Participant*

### **Coinsurance (Co-pay)**

*After applicable deductibles are satisfied; the coinsurance (co-pay) for eligible charges is as follows:*

*In-network: 80%*

*Out-of-network: 60%*

### **Hospice**

*Maximum lifetime benefit of \$20,000, subject to the Hospice guidelines under the Plan Payment Provision.*

### **Network**

*The Networks for This Plan are:*

*Patient First (inside GA)*

*First Health (outside GA)*

### **Physician / Specialist Co-Pay**

*There is NOT a flat Physician/Specialist 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.*

### **Routine Physical Exams - In-Network \***

*The following benefits, which are available for all persons over age one 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 Routine Annual Exam Benefit includes the office visit along accompanied by any of the following tests administered at a Healthcare Facility In-Network. Tests included when prescribed in conjunction with the routine annual exam are, pap smears, prostate exams, and/or immunizations when administered at a registered healthcare facility)*

- 1. The First \$300 is paid at 100%, waiving the Deductible;*
- 2. Charges incurred for Routine Physical Exams in excess of \$300 are payable at 80%, waiving the Deductible.*

3. *This benefit is available to all covered Participants over age one.*

*Routine Mammograms are paid at 100%, waiving the Deductible.*

*Immunizations required solely for foreign travel are NOT COVERED. For Vision and Hearing services, refer to those sections. They are not considered a part of this benefit.*

### **Routine Physical Exams - Out-of-Network\***

*The following benefits that are available for all persons over age one covered under this Plan when services are performed by an out-of network provider (In-Network providers are paid as per the prior description). You must participate in Mercer's group health plan to receive this benefit.*

*Annual exams to include:*

- 1. Mammogram,*
- 2. Pap smear and the lab and office visit charges associated with it, and*
- 3. Prostate exam and the office visit charges associated with it, and*
- 4. Immunizations when recommended by a licensed Physician and administered at a registered Healthcare facility.*

*All Charges are subject to the Deductible, and then payable at 60%.*

*Immunizations required solely for foreign travel are NOT COVERED. For Vision and Hearing services, refer to those sections. They are not considered a part of this benefit.*

### **Well Baby Care**

*Calendar year maximum benefit per child of \$400, beginning after initial hospital discharge, up to age one. For Children over one year of age, refer to Routine Physical Exams.*

*Physician's fees for routine care, examination or immunizations. Eligible Charges are covered at 100%, waiving the Deductible.*