Medical Schedule of Benefits

Available to: Regular Full-Time Employees
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 Patient First Provider in Georgia or when you travel outside Georgia using 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: Out-of-Network:
$4,000 per Covered Participant Unlimited

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.

Claims Are Paid Based On
Medical Necessity of the services being provided and of Reasonable Charges

Claims are Processed & Paid By
Core Administrative Services, Inc. (CAS) (478) 741-3521 or 1-888-741-CORE

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.

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

Effective Date of Coverage
1st Day of Month Following Date of Hire or Eligibility

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.

Flu Vaccinations
Vaccines administered by Mercer Health Systems on the Macon campus and Campus Health Care on the Atlanta campus (during scheduled "Flu Clinics") are free to *all employees* and may be purchased at a reduced rate for family members. Annual flu vaccines administered at local pharmacies are covered at 100% to *insured members.*

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.
Refer to *Plan Payment Provisions* for detailed covered expenses.

Hospice Care
Refer to *Plan Payment Provisions* for detailed covered expenses.

Lifetime Maximum Benefit *There is no Lifetime Maximum.*

Unless otherwise noted under a specific area, all benefits are subject to the Lifetime Maximum Benefit.

Maternity Expenses

Maternity Benefits are available for all Covered Female Participants.

Network

The Networks for This Plan are: Patient First Network (Inside GA)
First Health Network (Outside GA)

Patient First Prescription Drug Benefit Co-Pays

All Prescription Co-Pays are 20% (Generic), 25% (Brand w/no generic available), or 30% (Brand name by preference) of the prescription costs OR the flat rate co-pay, whichever is greater. This includes a monthly max but no calendar year max: Prescriptions Purchased at Retail Pharmacies:

Day Supply	30 DAYS	60 DAYS	90 DAYS
Generic Drugs 20% or	$20 (Max $100)	$40	$60
Brand Name Drug is selected with NO Generic Available 25%	$50 (Max $200)	$100	$150
Brand Name Drug is selected with Generic Available 30% or	$75 (Max $300)	$150	$225
See Note			

****When a generic is available, but the pharmacy dispenses the brand name medication because the prescriber indicated "dispense only as written." The client will pay the cost of the brand name medication. When a generic is available, but the pharmacy dispenses the brand name medication because of the member's request, the plan member will pay the difference between the brand discount and the generic discount.****

Pre-Certification Authority

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

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* 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

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%. See also *Newborn Expenses*.