MERCY One
Health Insurance for Individuals

HDHP (HSA Compatible): Summary of Benefits (80/60 plans)

Includes Plan: 1500B09

This Summary of Benefits is intended to give an overview of the Plan benefits.
In the event that this summary and the Policy differ, the Policy, or the associated benefit Riders will govern.
Authorization may be required on some services/procedures.
Limitations may exist for some benefits.

For a complete description of benefits, including exclusions and limitations, review the Policy.

NETWORK BENEFITS	
Annual Deductible *(Note: This is a Calendar Year Deductible)*	$1,500, per Covered Person, not to exceed $3,000 for all Covered Persons in a family
Out-of-Pocket Maximum *(Note: This does NOT include the Annual Deductible)*	$3,000 per Covered Person, not to exceed $6,000 for all Covered Persons in a family
Maximum Policy Benefit	No Maximum Policy Benefit
SERVICES (as outlined in Policy)	**YOUR COPAYMENT AMOUNT**
Physician's Office Services	20% after Deductible
Outpatient Surgery, Diagnostic and Therapeutic	20% after Deductible (*Certain Preventive Health Services are Covered in Full)
Outpatient Laboratory Services	20% after Deductible
Eye Examinations	20% after Deductible
Urgent Care Center Services	20% after Deductible
Emergency Health Services	20% after Deductible
Inpatient Hospital Stay	20% after Deductible
Outpatient Prescription Drug *(Note: Mandatory Generic Substitution)*	$10 Copayment for Generic Drugs - Copayments apply after deductible is met $40 Copayment for Preferred Brand Drugs - Copayments apply after deductible is met $65 Copayment for Non-Preferred Brand Drugs - Copayments apply after deductible is met $100 Copayment per 30 days for certain Specialty Pharmaceuticals - Copayments apply after deductible is met Mail Order 2.5x Copayment - Copayments apply after deductible is met
Ambulance	20% after Deductible
Maternity Services *(Must select maternity coverage)*	Maternity Benefits are Available for Applicant or Spouse after coverage has been in effect for 12 consecutive months Office Visit: 20% after Deductible No co-insurance applies to Physician office visits for prenatal care after the first visit Inpatient: 20% after Deductible Outpatient: 20% after Deductible
Mental Health Servics	Office Visit: 20% after Deductible Inpatient: 20% after Deductible Outpatient: 20% after Deductible
Chemical Dependency Services	Office Visit: 20% after Deductible Inpatient: 20% after Deductible Outpatient: 20% after Deductible
Durable Medical Equipment	20% after Deductible
Prosthetic Devices	20% after Deductible
Home Health Care	20% after Deductible
Hospice Care	20% after Deductible
Injections received in Physician's Office	20% after Deductible per injection
Professional Fees for Surgical and Medical Services	20% after Deductible
Rehabilitation Services – Outpatient Therapy	20% after Deductible
Skilled Nursing Facility / Inpatient Rehabilitation Facility Services	20% after Deductible
Transplantation Services	20% after Deductible * Preventive Health Services: Cholesterol Tests, Colon Screening, Colonoscopy, Double-contrast Barium Enema, Fecal Occult Blood Test, Flexible Sigmoidoscopy, Mammography, Pap Test, Pelvic Exam, Prostate Exam, PSA Test

NON-NETWORK BENEFITS	
Annual Deductible *(Note: This is a Calendar Year Deductible)*	$3,000, per Covered Person, not to exceed $6,000 for all Covered Persons in a family
Out-of-Pocket Maximum *(Note: This does NOT include the Annual Deductible)*	$6,000 per Covered Person, not to exceed $12,000 for all Covered Persons in a family
Maximum Policy Benefit	$5,000,000 per Covered Person per Lifetime
Covered Services *(Note: Please see the Policy for a description of benefits that are covered non-network)*	40% after non-network Deductible *(Note: Covered Benefits performed by non-network providers are subject to Usual and Customary Limits and the non-network providers may balance bill the member)*