

# CORE MANAGEMENT RESOURCES: MUSHIP

Coverage Period: Beginning on or after 8/01/2023

Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services

Coverage for: Individual | Plan Type: PPO

## NETWORK- First Health Network




The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. **NOTE: Information about the cost of this plan (called the premium) will be provided separately.**

**This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, contact CORE at 1-888-741-2673.

For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at <https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Uniform-Glossary-12-19-14-FINAL.pdf> or call CORE to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u> ?	<b>Student Health Clinic – N/A</b> \$400 person In-Network/ \$500 person Out-of-Network. Does not apply to urgent care, consultant’s fees, preventative services and office visits.	You must pay all the costs up to the <u>deductible</u> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <u>deductible</u> starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the <u>deductible</u> .
Are there services covered before you meet your <u>deductible</u> ?	<b>Yes.</b>	This <u>plan</u> covers some items and services even if you haven’t yet met the <u>deductible</u> amount. But a <u>Copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventative services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See the plan document for a list of covered <u>preventative services</u> .
Are there other <u>deductibles</u> for specific services?	<b>No.</b>	You don’t have to meet <u>deductibles</u> for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	<b>Student Health Clinic – N/A</b> For In-Network providers <b>\$6,600/person</b> . For Out-of-Network Providers <b>Unlimited/Person</b>	The <u>out-of-pocket limit</u> is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the <u>out-of-pocket limit</u> ?	Premiums, balance-billed charges, health care this plan doesn’t cover, and penalties for failure to obtain pre-authorization for services.	Even though you pay these expenses, they don’t count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u> ?	Yes. For a list of In-Network providers, see <a href="https://providerlocator.firsthealth.com/LocateProvider/LocateProviderSearch/">https://providerlocator.firsthealth.com/LocateProvider/LocateProviderSearch/</a> or call First Health at 1-800-226-5116.	If you use an in-network doctor or other health care <u>provider</u> , this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network <u>provider</u> for some services. Plans use the term in-network, <u>preferred</u> , or participating for <u>providers</u> in their <u>network</u> . See the chart starting on page 2 for how this plan pays different kinds of <u>providers</u> .
Do you need a <u>referral</u> to see a <u>specialist</u> ?	<b>Yes.</b> Covered Students must visit the nearest campus Student Health Center	This plan will pay some or all of the costs to see a <u>specialist</u> for covered services but only if you have the plan’s permission before you see the <u>specialist</u> .

first for treatment/referral.  
**Exceptions are listed in Plan document under “Referrals”.**

 All [copayment](#) and [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<b>If you visit a health care <a href="#">provider's office</a> or clinic</b>	Primary care visit to treat an injury or illness	\$25 copay plus 20% coinsurance	\$25 copay plus 40% coinsurance	Referral from Student Center required.
	<a href="#">Specialist</a> visit	\$25 copay plus 20% coinsurance	\$25 copay plus 40% coinsurance	Referral from Student Center required.
	<a href="#">Preventive care/screening/immunization</a>	No Charge	Subject to copay plus 40% coinsurance.	Referral from Student Center required.
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	20% coinsurance and deductible	40% coinsurance and deductible	Referral from Student Center required.
	Imaging (CT/PET scans, MRIs)	20% coinsurance and deductible	40% coinsurance and deductible	Referral from Student Center plus 20% penalty if services are not preauthorized.
<b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is available at <a href="http://studentplan.corehealthbenefits.com/mercer/PlanInformation.aspx">http://studentplan.corehealthbenefits.com/mercer/PlanInformation.aspx</a>	Generic drugs	\$10 copay plus 20% coinsurance (retail) Limited to a 30-day supply.	Not Covered	Prescription benefits are based on a mandatory generic formulary. Covered Person will pay the difference between the brand-name drug and the generic.
	Preferred brand drugs	\$30 copay plus 20% coinsurance (retail) Limited to a 30-day supply.	Not Covered	Prescription benefits are based on a mandatory generic formulary. Covered Person will pay the difference between the brand-name drug and the generic.
	Non-preferred brand drugs/	\$50 copay plus 20% coinsurance (retail) Limited to a 30-day supply.	Not Covered	Prescription benefits are based on a mandatory generic formulary. Covered Person will pay the difference between the brand-name drug and the generic.
	<a href="#">Specialty drugs</a>	*See Limitations, Exceptions, & Other Important Information		*In order to provide a comprehensive and cost-effective prescription drug program for you and your family, Mercer University Student Health Plan (MUSHIP), has contracted with

For more information about limitations and exceptions, see the plan or policy document at <http://studentplan.corehealthbenefits.com/mercer/PlanInformation.aspx>.

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		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
				PrudentRx to offer the PrudentRx Co-Pay Program for certain specialty medications. The PrudentRx Co-Pay Program assists members by helping them enroll in manufacturer co-pay assistance programs. If you enroll in the PrudentRx Co-Pay Program, your out-of-pocket cost for prescriptions covered under the PrudentRx Co-Pay Program will be \$0. Otherwise, medications in the specialty tier will remain subject to a 30% co-insurance.
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	20% coinsurance and deductible	40% coinsurance and deductible	Student Health Center Referral required. 20% penalty if services are not preauthorized.
	Physician/surgeon fees	20% coinsurance and deductible	40% coinsurance and deductible	20% penalty if services are not preauthorized.
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	\$250 copay per visit (waived if admitted) plus 20% coinsurance	\$250 copay per visit (waived if admitted) plus 20% coinsurance	Must be for a true emergency, Plan will not cover non-emergency use. The student must return to the Student Health Center for necessary follow-up care.
	<a href="#">Emergency medical transportation</a>	20% coinsurance and deductible	40% coinsurance and deductible	—————none—————
	<a href="#">Urgent care</a>	\$25 per visit copay plus 20% (Deductible does not apply)	\$25 per visit copay plus 40% (Deductible does not apply)	—————none—————
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	20% coinsurance and deductible	40% coinsurance and deductible	Pre-Notification and Referral required. Room and Board except if intensive care unit, up to average Semi-Private Room Rate. A 20% penalty if services are not preauthorized.
	Physician/surgeon fees	20% coinsurance and deductible	40% coinsurance and deductible	20% penalty if services are not preauthorized.
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	\$25 per visit copay plus 20% (Deductible does not apply)	\$25 per visit copay plus 40% (Deductible does not apply)	Certain services must be preauthorized; refer to benefits booklet for details. 20% penalty if services are not preauthorized.
	Inpatient services	20% coinsurance and deductible	40% coinsurance and deductible	Pre-Notification required. A 20% penalty if services are not preauthorized.
<b>If you are pregnant</b>	Office visits	\$25 copay plus 20%	40% coinsurance and	If a mother and newborn are discharged prior

For more information about limitations and exceptions, see the plan or policy document at <http://studentplan.corehealthbenefits.com/mercer/PlanInformation.aspx>.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
		coinsurance and deductible	deductible	to the postpartum inpatient length of stay, coverage includes up to 2 Post-Partum Visits, provided that the first such visit shall occur within 48 hours of discharge. 20% penalty if services are not preauthorized.
	Childbirth/delivery professional services	20% coinsurance and deductible	40% coinsurance and deductible	
	Childbirth/delivery facility services	20% coinsurance and deductible	40% coinsurance and deductible	
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	20% coinsurance and deductible	40% coinsurance and deductible	Pre-Notification required. Maximum thirty (120) days per Plan year. 20% penalty if services are not preauthorized.
	<a href="#">Rehabilitation services</a>	\$25 copay plus 20% coinsurance and deductible	\$25 copay plus 40% coinsurance and deductible	Limited to Twenty-Five (25) visits. Pre-Notification required for occupational therapy, pulmonary therapy, pulmonary rehabilitation and speech therapy. 20% penalty if services are not preauthorized.
	<a href="#">Habilitation services</a>	\$25 copay plus 20% coinsurance and deductible	\$25 copay plus 40% coinsurance and deductible	Pre-Notification required. 20% penalty if services are not preauthorized.
	<a href="#">Skilled nursing care</a>	20% coinsurance and deductible	40% coinsurance and deductible	Pre-Notification required. (Limited to 30 days payable). 20% penalty if services are not preauthorized.
	<a href="#">Durable medical equipment</a>	20% coinsurance and deductible	40% coinsurance and deductible	Pre-Notification required for all medical equipment in excess of \$500 in purchase price ( <b>Replacement not covered</b> ). 20% penalty if services are not preauthorized.
	<a href="#">Hospice services</a>	20% coinsurance and deductible	40% coinsurance and deductible	Pre-Notification required. 20% penalty if services are not preauthorized.
<b>If your child needs dental or eye care</b>	Children's eye exam	\$50 copay	\$50 copay	One (1) eye exam routine benefit per program year.
	Children's glasses	\$50 copay plus cost that exceed plan allowance	\$50 copay plus cost that exceed plan	One (1) pair of lenses per program year. One (1) pair of frames every 24 months.
	Children's dental check-up	20% coinsurance	20% coinsurance	One (1) dental exam every six (6) months

For more information about limitations and exceptions, see the plan or policy document at <http://studentplan.corehealthbenefits.com/mercer/PlanInformation.aspx>.

## Excluded Services & Other Covered Services:

### Services Your [Plan](#) Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other [excluded services](#).)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

### Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

- Chiropractic care
- Private-duty nursing.

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. You may contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa](http://www.dol.gov/ebsa), or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov). Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance [Marketplace](#). For more information about the [Marketplace](#), visit [www.HealthCare.gov](http://www.HealthCare.gov) or call 1-800-318-2596.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact: [insert applicable contact information from instructions].

### Does this plan provide Minimum Essential Coverage? Yes

If you don't have [Minimum Essential Coverage](#) for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

### Does this plan meet the Minimum Value Standards? Yes]

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

## Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-888-741-2673.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-741-2673.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-888-741-2673.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-888-741-2673.

—————*To see examples of how this plan might cover costs for a sample medical situation, see the next section.*—————

OMB Control Numbers 1545-2229, 1210-0147, and 0938-1146 Released on April 6, 2016

## About these Coverage Examples:



**This is not a cost estimator.** Treatments shown are just examples of how this [plan](#) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your [providers](#) charge, and many other factors. Focus on the [cost sharing](#) amounts ([deductibles](#), [copayments](#) and [coinsurance](#)) and [excluded services](#) under the [plan](#). Use this information to compare the portion of costs you might pay under different health [plans](#). Please note these coverage examples

### Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$400
■ <a href="#">Specialist</a> [ <i>cost sharing</i> ]	\$25
■ Hospital (facility) [ <i>cost sharing</i> ]	20%
■ Other [ <i>cost sharing</i> ]	20%

This EXAMPLE event includes services like:

Specialist office visits (*prenatal care*)  
 Childbirth/Delivery Professional Services  
 Childbirth/Delivery Facility Services  
 Diagnostic tests (*ultrasounds and blood work*)  
 Specialist visit (*anesthesia*)

<b>Total Example Cost</b>	<b>\$12,800</b>
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$400
Copayments	\$150
Coinsurance	\$2,450
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Peg would pay is</b>	<b>\$3,000</b>

### Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$400
■ <a href="#">Specialist</a> [ <i>cost sharing</i> ]	\$25
■ Hospital (facility) [ <i>cost sharing</i> ]	20%
■ Other [ <i>cost sharing</i> ]	20%

This EXAMPLE event includes services like:

Primary care physician office visits (*including disease education*)  
 Diagnostic tests (*blood work*)  
 Prescription drugs  
 Durable medical equipment (*glucose meter*)

<b>Total Example Cost</b>	<b>\$7,400</b>
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$400
Copayments	\$660
Coinsurance	\$1,268
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Joe would pay is</b>	<b>\$2,388</b>

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$400
■ <a href="#">Specialist</a> [ <i>cost sharing</i> ]	\$25
■ Hospital (facility) [ <i>cost sharing</i> ]	20%
■ Other [ <i>cost sharing</i> ]	20%

This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)  
 Diagnostic test (*x-ray*)  
 Durable medical equipment (*crutches*)  
 Rehabilitation services (*physical therapy*)

<b>Total Example Cost</b>	<b>\$2,500</b>
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$400
Copayments	\$370
Coinsurance	\$346
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,116</b>

**The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.**