CORE MANAGEMENT RESOURCES: MUSHIP

Coverage Period: Beginning on or after 8/01/2024

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 deductible?	**Student Health Clinic – N/A** **$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 **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** 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 **deductible**.
Are there services covered before you meet your deductible?	**Yes.**	This **plan** covers some items and services even if you haven't yet met the **deductible** amount. But a **Copayment** or **coinsurance** may apply. For example, this **plan** covers certain **preventative services** without **cost sharing** and before you meet your **deductible**. See the plan document for a list of covered **preventative services**.
Are there other deductibles for specific services?	**No.**	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
What is the out-of-pocket limit for this plan?	**Student Health Clinic – N/A** For In-Network providers **$6,600/ person.** For Out-of-Network Providers **Unlimited/Person**	The **out-of-pocket limit** 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 out-of-pocket limit?	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 **out-of-pocket limit.**
Will you pay less if you use a network provider?	Yes. For a list of In-Network providers, see https://providerlocator.firsthealth.com/LocateProvider/LocateProviderSearch/ **or call First Health at** 1-800-226-5116.	If you use an in-network doctor or other health care **provider**, 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 **provider** for some services. Plans use the term in-network, **preferred,** or participating for **providers** in their **network.** See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do you need a referral to see a specialist?	**No.**	You do not need a referral to see a specialist.

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)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 copay plus 20% coinsurance	$25 copay plus 40% coinsurance	No member cost share for services at Mercer University's Mercer Medicine clinic.
	Specialist visit	$25 copay plus 20% coinsurance	$25 copay plus 40% coinsurance	
	Preventive care/screening/ immunization	No Charge	Subject to copay plus 40% coinsurance.	
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance and deductible	40% coinsurance and deductible	
	Imaging (CT/PET scans, MRIs)	20% coinsurance and deductible	40% coinsurance and deductible	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at http://studentplan.corehealthbenefits.com/mercer/PlanInformation.aspx	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.
	Specialty drugs	*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 PrudentRx to offer the PrudentRx Co-Pay Program for certain specialty medications. The

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)	
				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.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance and deductible	40% coinsurance and deductible	
	Physician/surgeon fees	20% coinsurance and deductible	40% coinsurance and deductible	20% penalty if services are not preauthorized.
If you need immediate medical attention	Emergency room care	$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.
	Emergency medical transportation	20% coinsurance and deductible	40% coinsurance and deductible	——————none——————
	Urgent care	$25 per visit copay plus 20% (Deductible does not apply)	$25 per visit copay plus 40% (Deductible does not apply)	——————none——————
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance and deductible	40% coinsurance and deductible	Pre-Notification 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.
If you need mental health, behavioral health, or substance abuse services	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.
If you are pregnant	Office visits	$25 copay plus 20% coinsurance and deductible	40% coinsurance and deductible	If a mother and newborn are discharged prior to the postpartum inpatient length of stay, coverage includes up to 2 Post-Partum Visits,

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	Childbirth/delivery professional services	20% coinsurance and deductible	40% coinsurance and deductible	provided that the first such visit shall occur within 48 hours of discharge. 20% penalty if services are not preauthorized.
	Childbirth/delivery facility services	20% coinsurance and deductible	40% coinsurance and deductible	Pre-Notification required for any maternity hospital stay longer than 48 hours (vaginal delivery) or 96 hours (cesarean) section. See Plan document. 20% penalty if services are not preauthorized.
If you need help recovering or have other special health needs	Home health care	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.
	Rehabilitation services	$25 copay plus 20% coinsurance and deducible	$25 copay plus 40% coinsurance and deducible	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.
	Habilitation services	$25 copay plus 20% coinsurance and deducible	$25 copay plus 40% coinsurance and deducible	Pre-Notification required. 20% penalty if services are not preauthorized.
	Skilled nursing care	20% coinsurance and deducible	40% coinsurance and deducible	Pre-Notification required. (Limited to 30 days payable). 20% penalty if services are not preauthorized.
	Durable medical equipment	20% coinsurance and deducible	40% coinsurance and deducible	Pre-Notification required for all medical equipment in excess of $500 in purchase price **(Replacement not covered).** 20% penalty if services are not preauthorized.
	Hospice services	20% coinsurance and deducible	40% coinsurance and deducible	Pre-Notification required. 20% penalty if services are not preauthorized.
If your child needs dental or eye care	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

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, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or 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 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, kwiijigo holne' 1-888-741-2673.

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

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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 plan's overall deductible	$400
Specialist *[cost sharing]*	$25
Hospital (facility) *[cost sharing]*	20%
Other *[cost sharing]*	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)*

Total Example Cost	**$12,800**

In this example, Peg would pay:

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

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$400
Specialist *[cost sharing]*	$25
Hospital (facility) *[cost sharing]*	20%
Other *[cost sharing]*	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)*

Total Example Cost	**$7,400**

In this example, Joe would pay:

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

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$400
Specialist *[cost sharing]*	$25
Hospital (facility) *[cost sharing]*	20%
Other *[cost sharing]*	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)*

Total Example Cost	**$2,500**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$400
Copayments	$370
Coinsurance	$346
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,116**

The plan would be responsible for the other costs of these EXAMPLE covered services.

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