This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.corehealthbenefits.com or by calling 1-888-741-2673.

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	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, August 1st). See your Plan document for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No.	Other than office visits at an in-network provider, you don't have to meet **deductibles** for specific services. See the chart in your Plan document for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	**Student Health Clinic – N/A** Yes. For In-Network providers **$6,250/ 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?	The copayment, premiums, balance-billed charges, etc., does not go toward the Program Year Out-of-Pocket Maximum.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit.**
Is there an overall annual limit on what the plan pays?	Yes, $500,000.	This plan will pay for covered services only up to this limit during each coverage period, even if your own need is greater. You're responsible for all expenses above this limit. See the chart in your Plan document for specific coverage limits.
Does this plan use a network of providers?	Yes. See **www.corehealthbenefits.com or call 1-888-741-2673** for a list of preferred providers.	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. See the chart in your plan document for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	**Yes.** Covered Students must visit the nearest campus Student Health Center first for treatment/referral**. Exceptions are listed in Plan document under "Referrals".**	This plan will pay some or all of the costs to see a specialist for covered services but only if you have the plan's permission before you see the specialist.
Are there services this plan doesn't cover?	Yes.	Some of the Program Exclusions are listed in your Plan document under **excluded services**.

Questions: Call 1-888-741-2673 or visit us at https://studentplan.corehealthbenefits.com/mercer/StudentHome.aspx.
If you aren't clear about any of the underlined terms used in this form call 1-888-741-2673 to request a copy of the Glossary.

- **Copayments** are fixed dollar amounts (for example, $25) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan encourages you to use in-network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
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	Referral from Student Center required.
	Specialist visit	$25 copay plus 20% coinsurance	$25 copay plus 40% coinsurance	Referral from Student Center required.
	Other practitioner office visit	$25 copay plus 20% coinsurance	$25 copay plus 40% coinsurance	Referral from Student Center required.
	Routine Annual Exam/Screening/Immunization	First $300 of eligible expenses is covered at 100%. Charges over $300 subject to deductible plus 20% coinsurance.	Subject to deductible, $25 copay plus 40% coinsurance.	Referral from Student Center required.
If you have a test	Diagnostic test (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 Preauthorization required.

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.corehealthbenefits.com.	Generic drugs	$10 co-pay plus 20% coinsurance (retail) Limited to a 30 day supply.	None	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 co-pay plus 20% coinsurance (retail) Limited to a 30 day supply.	None	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	$50 co-pay plus 20% coinsurance (retail) Limited to a 30 day supply.	None	Prescription benefits are based on a mandatory generic formulary. Covered Person will pay the difference between the brand-name drug and the generic.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance and deductible	40% coinsurance and deductible	Student Health Center Referral required, Pre-notification mandatory.
	Physician/surgeon fees	20% coinsurance and deductible	40% coinsurance and deductible	Pre-notification mandatory.
If you need immediate medical attention	Emergency room services	$250 co-pay per visit (waived if admitted) plus 20% coinsurance	$250 co-pay per visit (waived if admitted) plus 20% coinsurance	Emergency Room (Services must be rendered within 72 hours of the Accident or within 72 hours of the first onset of Sickness. 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——————

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you have a hospital stay	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.
	Physician/surgeon fee	20% coinsurance and deductible	40% coinsurance and deductible	Pre-Notification required.
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	20% coinsurance and deductible	40% coinsurance and deductible	Pre-Notification required.
	Mental/Behavioral health inpatient services	20% coinsurance and deductible	Same as any other sickness	Pre-Notification required.
	Substance use disorder outpatient services	20% coinsurance and deductible	40% coinsurance and deductible	Pre-Notification required.
	Substance use disorder inpatient services	20% coinsurance and deductible	40% coinsurance and deductible	Pre-Notification required.
If you are pregnant	Prenatal and postnatal care	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, provided that the first such visit shall occur within 48 hours of discharge.
	Delivery and all inpatient 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.

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
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 (30) days per Plan year.
	Rehabilitation services	$25 co-pay plus 20% coinsurance and deducible	$25 co-pay plus 40% coinsurance and deducible	Pre-Notification required. Medically prescribed Therapy rendered by a duly qualified Occupational , Speech & Physical Therapist. Physical Therapy - limited to Eighteen (18) visits.
	Habilitation services	$25 co-pay plus 20% coinsurance and deducible	$25 co-pay plus 40% coinsurance and deducible	Pre-Notification required. Medically prescribed Therapy rendered by a duly qualified Occupational , Speech & Physical Therapist. Physical Therapy- limited to Eighteen (18) visits.
	Skilled nursing care	20% coinsurance and deducible	40% coinsurance and deducible	Pre-Notification required. (Limited to 15 days payable) .
	Durable medical equipment	20% coinsurance and deducible	40% coinsurance and deducible	Pre-Notification required. In-Network: 80% of Allowable Charge; Out-Of-Network: 60% **(Replacement not covered).**
	Hospice service	20% coinsurance and deducible	40% coinsurance and deducible	Pre-Notification required. Inpatient or outpatient hospice care is covered to the. Maximum thirty (30) days per plan year.
If your child needs dental or eye care	Eye exam	Not Covered	Not Covered	————————none————————
	Glasses	Not Covered	Not Covered	————————none————————
	Dental check-up	Not Covered	Not Covered	————————none————————

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your plan document for other excluded services.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Hearing aids
- Infertility treatment
- Organ transplant
- Non-emergency care when traveling outside the U.S.
- Routine eye care
- Routine foot care
- Weight loss programs
- Chiropractic care

Other Covered Services (This isn't a complete list. Check your plan document for other covered services and your costs for these services.)

- Consultant – ordered by attending Doctor to confirm/determine diagnosis.
- Braces and Appliances
- Private-Duty nursing.

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply. For more information on your rights to continue coverage, contact the plan at 1-888-741-2673. You may also 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.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: 1-888-741-2673.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.
See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $9,480
- **Plan pays** $4,988.80
- **Patient pays** $1,647.20

Sample care costs:

Hospital charges (mother)	$3,300
Routine obstetric care	$2,700
Hospital charges (baby)	$430
Anesthesia	$2,100
Laboratory tests	$540
Prescriptions	$100
Radiology	$250
Vaccines, other preventive	$60
Total	**$9,480**

Patient pays:

Deductibles	$400
PPO Discount	$2,844
Coinsurance	$1,247.20
Limits or exclusions	$0
Total	**$2,360**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $11,950
- **Plan pays** $10,520
- **Patient pays** $1,430

Sample care costs:

Prescriptions	$8,500
Medical Equipment and Supplies	$1,800
Office Visits and Procedures	$1,200
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$50
Total	**$11,950**

Patient pays:

Deductibles	$500
Copays	$600
Coinsurance	$330
Limits or exclusions	$0
Total	**$1,430**

Note: These numbers assume the patient has given notice of her pregnancy to the plan. If you are pregnant and have not given notice of your pregnancy, your costs may be higher. For more information, please contact: 1-888-741-2673.

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.