Mercer University 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:
$4,000 per Covered Participant/ $12,000 Family
Out-of-Network: Unlimited per person

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)

Pre-Certification Authority

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

Physician/ 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.

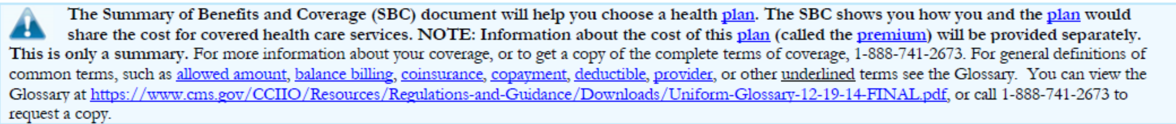
3. This benefit is available to all covered Participants under age one. For Children over one year of age, refer to *Routine Physical Exams*.

(Out-of-Network RWBC)
All Charges are subject to the Deductible, and then payable at 60%. See also *Newborn Expenses*.

CORE Management Resources: Mercer University — **Coverage Period: 07/01/2022– 06/30/2023**

Summary of Benefits and Coverage: What this Plan Covers & What it Costs — **Coverage for:** All Coverage Levels | **Plan Type:** PPO

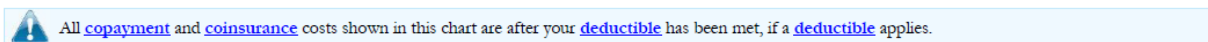
NETWORK- (Inside of GA): First Health Network/ (Outside of GA): First Health Network



The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows 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, 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 1-888-741-2673 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$700/person In-Network/ $1,400/person Out-of-Network** Doesn't apply to In-Network Routine Annual Exam.	Generally, you must pay all of 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. See your plan document for a list of covered **payment provisions**.
Are there other deductibles for specific services?	**No.**	You don't have to meet **deductibles** for specific services. 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?	For In-Network providers **$4,000**/person /**$12,000** family 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, and health care this plan doesn't cover.	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.	This **plan** uses a **provider network**. You will pay less if you use a **provider** in the plan's **network**. You will pay the most if you use an **out-of-network provider**, and you might receive a bill from a **provider** for the difference between the provider's charge and what your **plan** pays (**balance billing**). Be aware, your **network provider** might use an **out-of-network provider** for some services (such as lab work). Check with your **provider** before you get services.

Do you need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see a specialist you choose without a referral.


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 Network Provider (You will pay the least)	What You Will Pay Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% coinsurance	40% coinsurance	——————none——————
	Specialist visit	20% coinsurance	40% coinsurance	——————none——————
	Preventive care/screening/ immunization	No charge. See Limitations & Exceptions	40% coinsurance.	First $300 is paid at 100%, charges incurred for Routine Annual Exam in excess of $300 are payable at 80%, waiving the deductible.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	——————none——————
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	Preauthorization required, $200 penalty for noncompliance.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.corehealthbenefits.com	Generic drugs	(Retail)-$20 copay **OR** greater of 20% coinsurance (Max $100)/(Mail order)-$40 copay **OR** greater of 20% coinsurance (Max $200)	None	Co-payment is the greater of the flat-dollar co-payment or coinsurance. **Total costs not to exceed $300 for any 30-day supply/ $600 for any mail order 90-day supply.** Retail pharmacy – 30, 60, 90-day supply. Mail order – 90-day supply. ****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.****
	Brand Name Drugs (**No Generic Available**)	(Retail)-$50 copay **OR** greater of 25% coinsurance (Max $200)/(Mail order)-$100 copay **OR** greater of 25% coinsurance (Max $400)	None	
	Brand Name (**By Preference**)	(Retail)-$75 co-pay **OR** greater of 30% coinsurance (Max $300)/(Mail order)-$150 copay **OR** greater of 30% coinsurance(Max $600) ****See Note****	None	
	Specialty drugs	n/a	n/a	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	Preauthorization required within 2 business

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)	
	Physician/surgeon fees	20% coinsurance	40% coinsurance	days prior to admission, $200 penalty for noncompliance.
If you need immediate medical attention	Emergency room care	20% coinsurance	20% coinsurance	Preauthorization required within 2 days after admission, $200 penalty for noncompliance. Non-accident, non-emergency services $25 co-payment, waived if admitted.
	Emergency medical transportation	20% coinsurance	20% coinsurance	——————none——————
	Urgent care	20% coinsurance	40% coinsurance	Preauthorization required within 2 business days prior to admission, $200 penalty for noncompliance.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Preauthorization required within 2 business days prior to admission, $200 penalty for noncompliance.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	40% coinsurance	
	Inpatient services	20% coinsurance	40% coinsurance	
If you are pregnant	Office visits	20% coinsurance	40% coinsurance	Preauthorization required for any maternity hospital stay longer than 48 hours (vaginal delivery) or 96 hours (cesarean), $200 penalty for noncompliance.
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	Preauthorization required, $200 penalty for noncompliance. Must be reviewed and approved every 60 days. Maximum 120 days per calendar year.
	Rehabilitation services	20% coinsurance	40% coinsurance	Preauthorization required for pulmonary rehabilitation and speech therapy, $200 penalty for noncompliance. Limit 25 visits
	Habilitation services	20% coinsurance	40% coinsurance	Preauthorization required, $200 penalty for noncompliance.
	Skilled nursing care	20% coinsurance	40% coinsurance	Preauthorization required, $200 penalty for noncompliance. Must be reviewed and approved every 60 days. Maximum 120 days per

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)	
				calendar year.
	Durable medical equipment	20% coinsurance	40% coinsurance	Preauthorization required for all DME in excess of $500, penalty for noncompliance $200.
	Hospice services	20% coinsurance	40% coinsurance	Preauthorization required, penalty for noncompliance is $200. Must be reviewed and approved every 60 days. Maximum lifetime benefit is $35,000.
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	——————none——————
	Children's glasses	Not Covered	Not Covered	——————none——————
	Children's dental check-up	Not Covered	Not Covered	Not covered under Medical Plan; see Dental Plan.

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
- Hearing aids
- Infertility treatment
- Long-Term care
- Non-emergency care when traveling outside the U.S.
- Routine eye care
- 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
- Dental care - for accidental injury, removal of tumors, removal of unerupted/impacted teeth, or correction of congenital abnormalities
- 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: 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: 1-888-741-2673.

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.——

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 are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- **The plan's overall deductible** **$700**
- **Specialist *[cost sharing]*** **20%**
- **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	$700
Copayments	$0
Coinsurance	$2,440
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$3,140**

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

- **The plan's overall deductible** **$700**
- **Specialist *[cost sharing]*** **20%**
- **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	$700
Copayments	$0
Coinsurance	$1,360
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$2,060**

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

- **The plan's overall deductible** **$700**
- **Specialist *[cost sharing]*** **20%**
- **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	$700
Copayments	$0
Coinsurance	$380
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1080**