

## Summary of Benefits and Coverage: What this Plan Covers & What it Costs



**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 <https://benefitpayroll.mercer.edu/benefits/health-plan.cfm> or by calling Gina Hall at Extension 2787

Important Questions	Answers	Why this Matters:
<b>What is the overall deductible?</b>	\$ 700 per insured person per plan year in network \$1400 out of network	The deductible is paid first before any co-insurance is applied.
<b>Are there other deductibles for specific services?</b>	Yes	Should you choose to go to an Urgent Care Center instead of a physician's office, you will be asked to pay a \$25 co-pay.
<b>Is there an out-of-pocket limit on my expenses?</b>	\$4000 annually ( up to a Max of 3 insured per family)	After the \$4000 is met, In-Network claims are paid at 100% There is no limit for claims outside the Network.
<b>What is not included in the out-of-pocket limit?</b>	Prescription drugs , Out-of-Network and non-eligible charges	The Pharmacy Benefit Plan is included with Medical but is a separate benefit. It has co-pays. ( See Tiers on page 2)
<b>Is there an overall annual limit on what the plan pays?</b>	No	The Mercer Health Plan has no annual or lifetime maximums
<b>Does this plan use a network of providers?</b>	Yes	Patient First & First Health
<b>Do I need a referral to see a specialist?</b>	No	Only if the specialists requires this. The Mercer Health Plan does not.
<b>Are there services this plan doesn't cover?</b>	Yes	See the full plan document for details.



- **Copayments** are fixed dollar amounts only applicable to Prescription Drugs. Doctor visits & Hospital care has no co-pay.
- **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 your pre-certified [In-Network] hospital stay was \$1,000, your **coinsurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.

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# Mercer Health Plan

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- The amount the plan pays for covered services is based on the **reasonable & customary amount (RCA)**. If an out-of-network **provider** charges more than the RCA, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the RCA is \$1,000, you may have to pay the \$500 difference. (This is called **Balanced Billing (BB)**)
- This plan encourages you to use Patient First Providers for the published deductibles and co-insurance payments.

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 <b>provider's</b> office or clinic	Primary care visit to treat an injury or illness	20%	40% plus any BB	After deductible is met
	Specialist visit	20%	40% plus any BB	After deductible is met
	Other practitioner office visit	20%	40% plus any BB	After deductible is met
	Preventive care/screening/immunization	20%	40% plus any BB	(Some are at no costs)
If you have a test	Diagnostic test (x-ray, blood work)	20%	40% plus any BB	After deductible is met
	Imaging (CT/PET scans, MRIs)	20%	40% plus any BB	After deductible is met
If you need drugs to treat your illness or condition	Generic drugs	<u>Pharmacy 30-day</u> Greater of 20% or \$20	<u>Mail Order 90-Day</u> Cost of a 30 - day x 2	
	Preferred brand drugs	Greater of 25% or \$50	Cost of a 30 - day x 2	
	Non-preferred brand drugs	Greater of 30% or \$75	Cost of a 30 - day x 2	
	Specialty drugs	Greater of 30% or 150		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20%	40% plus any BB	After deductible is met
	Physician/surgeon fees	20%	40% plus any BB	After deductible is met
If you need immediate medical attention	Emergency room services	100%		Within 1 <sup>st</sup> 14 days of injury
	Emergency medical transportation	100%		Within 1 <sup>st</sup> 14 days of injury
	Urgent care	20% after \$25 fee		After deductible is met
If you have a hospital stay	Facility fee (e.g., hospital room)	20%	40% + RC	After deductible is met
	Physician/surgeon fee	20%	40% plus BB	After deductible is met

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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 mental health, behavioral health, or substance abuse needs	Mental health outpatient services	20%	40% plus any BB	After deductible is met
	Mental/Behavioral health inpatient services	20%	40% plus any BB	After deductible is met
	Substance use disorder outpatient services	20%	40% plus any BB	After deductible is met
	Substance use disorder inpatient services	20%	40% plus any BB	After deductible is met
If you are pregnant	Prenatal and postnatal care	20%	40% plus any BB	After deductible is met
	Delivery and all inpatient services	20%	40% plus any BB	After deductible is met
If your child needs dental or eye care	Eye exam	Not covered		
	Glasses	Not covered		
	Dental check-up	Covered w/Dental Plan		Dental is not included in Health Plan

## Excluded Services & Other Covered Services:

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

- Injury/accident related to alcohol use.
- Injury/Accident related to illegal activities
- Injury/Accident related to cosmetic surgeries

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

- Annual Flu Shots @ local pharmacies 100%
- The 1<sup>st</sup> \$300 of In-Network Annual Exams
- Mammograms at age 50+ one free per year.

## Your Rights to Continue Coverage: Consolidated Omnibus Budget Reconciliation Act (COBRA)

A Covered Person whose coverage has been terminated for any qualifying event enumerated in the full plan document has the right to continue coverage for all benefits of this plan if covered for such benefits on the day immediately preceding the termination date.

## Your Grievance and Appeals Rights:

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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 may contact: Mercer University Benefits at 478.301.2787

### Does this Coverage Provide Minimum Essential Coverage?

Yes. The Affordable Care Act requires most people to have health care coverage that qualifies as “minimum essential coverage.” **This plan or policy provides minimum essential coverage.**

### Does this Coverage Meet the Minimum Value Standard?

Yes. 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 meets the minimum value standard for the benefits it provides.**

## Section 1557 of the Patient Protection and Affordable Care Act

The Mercer Health Plan does not discriminate on the basis of race, color, national origin, sex, age, or disability in certain health programs or activities.

Section 1557 is the nondiscrimination provision of the Affordable Care Act (ACA). Read the full text document at <https://www.federalregister.gov/>

This document has been provided in an attempt to make comparing and choosing a health plan for you (and your family) easier.

It is not intended to replace or add to any language in the full Plan Document for the Mercer Health and Dental Plan.

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

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# Mercer Health Plan

## Summary of Benefits and Coverage: Coverage Examples

### 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.

#### ESTIMATED ONLY

##### Having a baby

(normal delivery)

- Amount owed to providers: \$7,540
- Plan pays \$5,440
- Patient pays \$2,100

#### Sample care costs:

Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
<b>Total</b>	<b>\$7,540</b>

#### Patient pays:

Deductibles	\$700
Prescription Co-pays	\$40
Coinurance	\$1360
<b>Limits or exclusions (In Network)</b>	
<b>Total</b>	<b>2100</b>

#### ESTIMATED ONLY

##### Managing type 2 diabetes

(routine maintenance of A well-controlled condition)

- Amount owed to providers: \$5,400
- Plan pays \$3,280
- Patient pays \$ 2,120

#### Sample care costs:

Prescriptions (12 months)	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	-0-
Laboratory tests	\$100
Vaccines, other preventive	\$100
<b>Total</b>	<b>\$5,400</b>

#### Patient pays:

Deductibles	\$700
Prescription Co-pays	\$600
Coinurance	\$820
<b>Limits or exclusions (In-Network)</b>	
<b>Total</b>	<b>\$2120</b>

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### 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.