MERCER UNIVERSITY

Summary Health Insurance Program Description

STUDENT HEALTH INSURANCE PROGRAM

For coverage effective August 1, 2018

Health Insurance
Table of Contents

Mercer University Student Health Insurance Program (MUSHiP)

ARTICLE I

Adoption Agreement and Elections

Section 1.01 The undersigned University hereby makes the elections below and adopts this Student Health Insurance Program. This Program is intended to qualify as a Self-Funded Student Insurance Program.

Section 1.02 Effective Date: The terms and conditions of this Program shall be effective on and after August 1, 2018.

Section 1.03 Election Regarding Preferred Provider Agreement.

__x__ The University has entered into one or more Preferred Provider Agreements which are attached hereto to obtain discounts for medical supplies and services provided.

_____ The University has NOT entered into a Preferred Provider Agreement.

Participating Preferred Providers (hereinafter referred to as "Preferred Provider Organization" or "PPO") for this Program is:

1. Mercer Medicine
2. P1N

Signature _____

Title _____ Date _____

Health Insurance
Summary Program Description

Name of the Program:	Mercer University Student Benefit Health Program
Type of Program:	Self-Funded Student Insurance Program
Type of Administration:	Contract Administration with the Third-Party Administrator.
Address of the Program:	515 Mulberry Street, Suite 300 Macon, GA 31201
Group Number:	MSU, MSG, MSI, MSP
Program Sponsor:	Mercer University
Federal Tax ID#:	58-0566167
Program Effective Date:	August 1, 2014
Program Renewal Date:	August 1st
Program Fiscal Year Ends:	July 31st
Third Party Administrator:	Core Administrative Services PO Box 90 Macon, GA 31202-0090 (478) 741-3521 (888) 741-2673
Named Fiduciary:	Mercer University
Agent for Service of Legal Process:	Mercer University
Waiting Period:	None

PPACA NOTICE

Your student health insurance coverage meets the minimum standards required by the health care reform law. The annual dollar limits ensure that consumers have sufficient access to medical benefits throughout the annual term of the Program. If you have any question or concerns about this notice, contact Core Management Resources, at 888-741-2673. Be advised that you may be eligible for coverage under a group health Program of a parent's employer or a parent's individual health insurance Program if you are under the age of 26. Contact the Program administrator of the parents' employer Program or the parent's individual health insurance carrier for more information.

Introduction

Mercer University has retained the services of an independent Third-Party Administrator, Core Administrative Services (CAS), experienced in claims processing to handle claims.

This document fully describes and pertains to the Mercer University Student Health Insurance Program (MUSHIP). CORE Management Resources Group provides all of the claim adjudication and customer service activities for MUSHIP. A prescription drug card is also provided to member/students via an independent pharmacy vendor. The program includes both primary care and specialty physician networks under direct contract. The Program Sponsor has purchased excess risk insurance coverage which is intended to reimburse the Program Sponsor for certain losses incurred and paid under the Program. The excess risk insurance coverage is not a part of the Program.

This booklet, the Group Provisions Pages, and any amendments constitute the Program Document for the Student's benefit Program. This Program is maintained for the exclusive benefit of the Students and each Student's rights under this Program are legally enforceable. The Program Sponsor has the right to amend the Program at any time, and will make a "good faith" effort to communicate to you all such changes which affect benefit payment. Amendments or modifications which affect you will be communicated to you within sixty (60) days of the effective date of a modification or amendment.

The following pages of this booklet include: the requirements for being covered under This Program, the provisions concerning termination of coverage, a description of the Program benefits (including any limitations and exclusions), and the procedures to be followed in presenting claims for benefits and the appeal process for any claim that may have been denied.

The Program Administrator shall administer this Program in accordance with its terms and establish its policies, interpretations, practices, and procedures. It is the express intent of this Program that the Program Administrator shall have maximum legal discretionary authority to construe and interpret the terms and provisions of the Program, to make determinations regarding issues which are relative to a Program Participant’s rights, and to decide questions of Program interpretation and those of fact relating to the Program. The decisions of the Program Administrator will be final and binding on all interested parties.

The Program Administrator has the discretionary authority to decide whether a charge is Reasonable. Benefits under this Program shall be paid only if the Program Administrator decides in its discretion that a Covered Person is entitled to them.

Some of the terms used in the booklet begin with a capital letter. These terms have a special meaning under the Program and they are listed in the Program Payment Provision or Definitions section. When reading the provisions of the Program, it may be helpful to refer to these sections. Becoming familiar with the terms defined there will give you a better understanding of the procedures and benefits described. Payment of benefits are not guarantee and are subject to any subsequent reviews of medical information or records, the patient's eligibility on the date the service is rendered, and any other contractual provisions of the Program.

You are entitled to this coverage if you are eligible in accordance with the provisions in this booklet. This booklet is void if you have ceased to be entitled to coverage. No clerical error will invalidate your coverage if otherwise validly in force, nor continue coverage otherwise validly terminated.

If a clerical error occurs, Core reserves the right to make any corresponding contribution adjustment which will be computed on the basis of the contribution level then in effect. If any clerical error occurs in this document, the most current Student Health Insurance signed Program Document prevails. If you have any questions concerning your eligibility or benefits, please contact:

Core Administrative Services
PO Box 90
Macon, GA 31202

478-741-3521
888-741-CORE (2673)

Comprehensive Medical Expense Benefit

The Comprehensive Major Medical Expense Benefit provides coverage for a wide range of services called Covered Expenses. The services associated with this benefit are covered to the extent that they are:

1. Medically Necessary;
2. Prescribed by or given by a Physician;
3. Reasonable Charges (when no Network is in place or services are rendered Out-of-Network); and
4. Provided for care and treatment of a covered Illness or Injury.

Benefits are payable in accordance with any applicable deductible amounts and benefits percentages listed in the Program Payment Provisions.

Schedule of Benefits

No risk assessment or compliance required. Standard benefit levels applicable to eligible procedures, charges and prescriptions as set forth in Program Payment Provisions and Prescription Drug Card Benefits copayment sections. In-Network and Out-of-Network Out-of-Pocket amounts are not integrated.

Mercer University Program Schedule of Benefits

	Health Care In-Network Mercer Medicine First Health PPO Network	Health Care Out-of-Network
Maximum Benefit Per Program Year	Unlimited	
Program Year deductible per Covered Person *(Deductible applies to all charges, unless specified)*	$400	$500
Out-of-Pocket Limit per Covered Person per Program Year (includes deductible, Copays and Coinsurance)	$6,600	Unlimited
Out-of-Pocket Limit per Family per Program Year (includes deductible, Copays and Coinsurance)	$13,200	Unlimited

To receive benefits, Covered Students must visit the nearest campus Student Health Center first for treatment / referral. Exceptions are listed under "Referrals".

INPATIENT BENEFITS			
Student Health Center Referral Required Pre-Notification Recommended		**Health Care In-Network Mercer Medicine First Health PPO Network**	**Health Care Out-of-Network**
Room and Board	Limited to the daily average semi-private rate (except if intensive care unit)	80% of Allowable Charge	60% of Reasonable Charges
Hospital Miscellaneous	Includes expenses incurred for anesthesia and operating room; laboratory tests and x-rays, (including professional fees); oxygen tent; medicines (excluding take home drugs), dressings; and other Medically Necessary and prescribed Hospital expenses	80% of Allowable Charge	60% of Reasonable Charges
Physical/Occupational Therapy	During Hospital confinement	80% of Allowable Charge	60% of Reasonable Charges
Surgery Expense	Doctor's fees for a surgical procedure	80% of Allowable Charge	60% of Reasonable Charges
Assistant Surgeon		25% of Surgery Allowance	25% of Surgery Allowance
Anesthetist Services	In connection with surgery	80% of Allowable Charge	60% of Reasonable Charges
Registered Nurse or Licensed Practical Nurse (private duty nursing)		80% of Allowable Charge	60% of Reasonable Charges
Doctor's Visits	Services of a Doctor other than a Doctor who performed surgery or administered anesthesia (Limit to one visit per day)	80% of Allowable Charge	60% of Reasonable Charges
INPATIENT BENEFITS CONTINUED			
Student Health Center Referral Required		**Health Care In-Network**	**Health Care**

Pre-Notification Recommended		Mercer Medicine First Health PPO Network	Out-of-Network
Psychiatric Conditions Expense		80% of Allowable Charge	60% of Reasonable Charges
Alcoholism Expenses		80% of Allowable Charge	60% of Reasonable Charges
Substance Abuse Expenses		80% of Allowable Charge	60% of Reasonable Charges
Pre-Admission Testing		80% of Allowable Charge	60% of Reasonable Charges

OUTPATIENT BENEFITS

Student Health Center Referral required Pre-notification Recommended		Health Care In-Network Mercer Medicine First Health PPO Network	Health Care Out-of-Network
Surgery Expense	Doctor's fees for a surgical procedure	80% of Allowable Charge	60% of Reasonable Charges
Day Surgery Facility/ Anesthetist Services (In connection with surgery) / Miscellaneous	When scheduled surgery is performed in a Hospital or outpatient facility or ambulatory surgical center, including: use of the operating room; laboratory tests and x-ray examinations (including professional fees); anesthesia; infusion therapy; drugs or medicines and supplies; therapeutic services (excluding physiotherapy or take-home drugs and medicines)	80% of Allowable Charge	60% of Reasonable Charges
Assistant Surgeon		25% of Surgery Allowance	25% of Surgery Allowance
Outpatient Dialysis Treatment	(In-Network and Out of Network)- 100% of the lesser of (i) the Usual, Customary, and Reasonable Outpatient Dialysis Charge as defined in "Outpatient Dialysis Treatment" Section on page 31, (ii) the maximum allowable charge after all applicable deductibles and cost-sharing; and (iii) such charge as is negotiated between the Plan Administrator and the provider of Outpatient Dialysis Treatment.	80% of Usual, Customary and Reasonable Charge	60% of Usual, Customary and Reasonable Charge
Urgent Care		80% of Allowable Charge (after $25 per visit copay) (Deductible does not apply)	60% of Reasonable Charges (after $25 per visit copay) (Deductible does not apply)
Doctor's Visits (Including Chiropractic Care and Allergy Visits)	More than one visit per day may be allowed, provided the 2nd and subsequent visits are not with the	**90% of Allowable Charge at Mercer Medicine** (FHN) 80% of Allowable Charge	60% of Reasonable Charges (after $25 per visit copay)

	same doctor. (Chiropractic Care Benefits limited to twenty (20) visits)	(after $25 per visit copay) (Deductible does not apply)	(Deductible does not apply)
Consultant's Fees	When ordered by attending Doctor to confirm or determine diagnosis	80% of Allowable Charge (after $25 per visit copay) (Deductible does not apply)	60% of Reasonable Charges (after $25 per visit copay) (Deductible does not apply)

OUTPATIENT BENEFITS CONTINUED

Student Health Center Referral required Pre-notification Recommended		**Health Care In-Network Mercer Medicine First Health PPO Network**	**Health Care Out-of-Network**
Emergency Room	For Use of the Hospital emergency room, including operating room, laboratory and x-ray examinations and supplies. The copay is waived if the Covered Person is admitted to the Hospital as an inpatient. (student must return to the Student Health Center for necessary follow-up care)	$250 copay per visit (copay waived if admitted to Hospital)	
		80% of Allowable Charge	80% of Reasonable Charges
Physical/Occupational Therapy	Limited to Twenty-Five (25) visits	80% of Allowable Charge (after $25 per visit copay)	60% of Reasonable Charges (after $25 per visit copay)
Speech Therapy	Limited to Twenty-Five (25) visits	80% of Allowable Charge (after $25 per visit copay)	60% of Reasonable Charges (after $25 per visit copay)
Respiratory Therapy		80% of Allowable Charge (after $25 per visit copay)	60% of Reasonable Charges (after $25 per visit copay)
Chemotherapy/ Radiation Therapy		80% of Allowable Charge	60% of Reasonable Charges
X-rays, Laboratory and CAT/MRI/PET Scan		80% of Allowable Charge	60% of Reasonable Charges
Psychiatric Conditions Expense		80% of Allowable Charge (after $25 per visit copay) (Deductible does not apply)	60% of Reasonable Charges (after $25 per visit copay) (Deductible does not apply)
Alcoholism & Substance Expenses		80% of Allowable Charge (after $25 per visit copay) (Deductible does not apply)	60% of Reasonable Charges (after $25 per visit copay) (Deductible does not apply)

PRESCRIPTION BENEFITS

Prescribed Medicines Expense	Prescription benefits are based on a mandatory generic formulary. If the Covered Person or the Covered Person's Doctor chooses a brand-name drug, the Covered Person will pay the difference between the brand-name drug and the generic. (Present insurance card at participating pharmacies to obtain prescriptions.)	Caremark participating pharmacies: 80% subject to the following copays per prescription – limited to a 30-day supply.		
		Generic	**Formulary Brand**	**Specialty Brand**
		$10 copay	$30 copay	$50 copay
Prescribed Birth Control	(all FDA approved methods are covered)	**Generic**	**Formulary Brand**	**Specialty Brand**
		100% allowable	See Prescribed Medicines Expense for copay	

OTHER INSURANCE BENEFITS

Student Health Center Referral required Pre-notification Recommended		**Health Care In-Network Mercer Medicine First Health PPO Network**	**Health Care Out-of-Network**
Ambulance	For use of a professional ambulance in an emergency	80% of Allowable Charge	60% of Reasonable Charges
Durable Medical Equipment (Braces & Appliances)	Benefits are payable only upon Doctor's written prescription (replacement not covered)	80% of Allowable Charge	60% of Reasonable Charges
Dental Treatment (Injury only)	For treatment of injury to sound natural teeth (Not to exceed $100 per tooth)	80% of Allowable Charge	60% of Reasonable Charges
Maternity & Complications of Pregnancy		Paid as any other Sickness	Paid as any other Sickness
Preventive Services Benefit	Includes preventive services such as osteoporosis screening, counseling, other screenings, exams and immunizations as specified by the Patient Protection and Affordable Care Act. To view a list of covered preventive services: https://www.healthcare.gov/preventive-care-benefits/ or see pages 32-35 of this document.	100% of Allowable Charge Deductible waived	60% of Reasonable Charges

VISION CARE

Benefit	**Member**	**Program Will Pay**	
Pediatric Eye Exam: *For covered dependents under the age 19 only. The Plan doesn't restrict which provider is utilized for Vision Care.*	Examination subject to $50 copay. One (1) routine eye exam per Program year.	100% Allowable Charge after copay	
Lenses: *You may choose prescription glasses or contacts.*	$25 copay (one (1) pair of lenses per Program Year)	Single Vision (Lined) Bifocal (Lined) Trifocal Lenticular	Up to $40 Up to $60 Up to $80 Up to $80
Frame: *You may choose prescription glasses or contacts.*	$25 copay (One (1) pair of frames every 24 months)	Up to $70	
Contact Lenses:	$25 copay	Up to $100	

Covered once every calendar year in lieu of eyeglasses.	(one (1) pair of lenses per Program Year) Fit, follow-up Materials	
Other Vision Services:		
Non-Routine Benefit (Medically Necessary)	$25 copay	Up to $200
Ultra Violet Protective Coating	No copay	100%
Polycarbonate Lenses	$20 copay	Up to $20
Blended Segment Lenses	$20 copay	Up to $20
Intermediate Vision Lenses	$30 copay	Up to $20
Progressives	$50 copay	Up to $20
Photochromic Glass Lenses	$20 copay	Up to $20
Plastic Photosensitive Lenses (Transitions)	$65 copay	Up to $20
Polarized Lenses	$75 copay	Up to $20
Anti-Reflective (AR) Coating	$35 copay	Up to $20
Hi-Index Lenses	$55 copay	Up to $20
Low Vision – is a significant loss of vision but not a total blindness. One (1) comprehensive evaluation every 4 years.	$75 copay	Up to $250
Note: Lenses include choice of glass or plastic lenses, all lens powers (single vision, bifocal, trifocal, Lenticular), fashion and gradient tinting, oversized and glass-grey #3 prescription sunglass lenses. **All lenses include scratch resistant coasting with no additional copayment.** Note: Polycarbonate lenses and monocular patients with prescriptions ≥ +/- 6.00 diopters are covered.		

DENTAL CARE		
Benefit	**Member**	**Program Will Pay**
Preventive Services *For covered dependents under the age 19.*	20% Coinsurance One (1) dental exam every 6 months	80% Allowable Charge
Basic Services	30% Coinsurance	70% Allowable Charge
Major Services	50% Coinsurance	50% Allowable Charge
Orthodontic Services	50% Coinsurance Orthodontic coverage has a 24-month continuous waiting period before benefits are received. (Must be Medically Necessary)	50% Allowable Charge
Please see the Program Payment Provision section regarding payment details for Dental Care beginning on Page 49.		

Coverage for the following benefits to be paid as any other Sickness:

Maternity expense and routine newborn care, including 48 hours care in a Hospital or birthing facility following a normal vaginal delivery and a minimum 96 hours following a cesarean section. 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; Benefits for Mammography, Pap Smears, Chlamydia Screening; Benefits for Drug Treatment of Children's Cancer; Mastectomy Benefits; Dental Anesthesia Benefits; Benefits for Prostate-Specific Antigen (PSA) tests; Prescribed Contraceptives; Breast Cancer Treatment; Colorectal Cancer Screening; Diabetes; Surveillance Test for Ovarian Cancer; and Child Wellness Services. Please see the Program Payment Provisions section regarding payment details.

Intercollegiate Sports Injury

MUSHiP benefits are payable up to a $5,000 aggregate maximum per Injury per Program Year for treatment of injuries sustained during the practice or play of intercollegiate sports sponsored and supervised by Mercer University. When the

maximum has been reached, Core's Athletic Injury Policy will coordinate benefits by paying benefits for such injuries, with no dollar limits.

Program Payment Provisions

This Program will pay the percentages allowed, based on Reasonable and Customary charges when no network is in place or services are rendered Out-of-Network.

Abortion

Elective

This is NOT a Covered Expense under This Program.

Voluntary termination of pregnancy due to any reason other than endangering the life of the mother. However, if complications arise after the performance of an elective abortion, any eligible expenses incurred to treat those complications will be considered.

Medically Necessary

This is a covered expense under this Program.

Voluntary termination of pregnancy when carrying the fetus to full term would seriously endanger the life of the mother.

Accident Expense

This is a covered expense under this Program.

Acupuncture

This is NOT a Covered Expense under This Program.

Procedure involving the use of long, fine needles to puncture the surface of the body.

Alcoholism

See *Chemical Dependency / Alcoholism*.

Allergy Conditions

This is a covered expense under this Program.

Covered services include shots, serum and testing.

See *Exclusions* section for services not covered.

Ambulance, Air

This is a covered expense under this Program. The cap limits of allowable charge under this plan are set by a reasonable fee determined by Core Management Resources.

Transportation of the patient to a treatment facility by means of licensed air transportation when an alternative form of transportation would seriously threaten the condition or life of the patient. If the first facility cannot provide the necessary services, the hospital that the patient is being transferred to must be the nearest hospital that can provide services unless otherwise determined by Program Administrator.

Ambulance, Ground

This is a covered expense under this Program.

Emergency transportation by local, licensed professional, ground ambulance service to the nearest Hospital facility equipped to treat the emergency or to transport from one facility to another if necessary services are not available at the first facility.

Ambulatory Surgical Facility
This is a covered expense under this Program.
Services of an Ambulatory Surgical Facility only when an operative or cutting procedure is actually accomplished and cannot be performed in a Physician's office.

Anesthesia Services
This is a covered expense under this Program.
Anesthetics and their professional administration when ordered by the Attending Physician in connection with a Covered Procedure.

Anorexia
This is NOT a Covered Expense under this Program.
An eating disorder manifested by an extreme fear of becoming obese and an aversion to food.

Artificial Insemination
This is NOT a Covered Expense under this Program.
Any means of Artificial Insemination, the treatment of sexual dysfunctions not related to organic disease, or treatment relating to the inability to conceive.

Assault or Illegal Occupation
This is NOT a Covered Expense under this Program.
Charges related to treatment received as a result of and while committing or attempting to commit an assault or felony, or injuries sustained while engaged in an illegal occupation.

Assistant Surgeon
This is a covered expense under this Program.
Not to exceed 25% of reasonable and customary charges for Surgeon's fees.

Behavioral Modification
See specific treatment, therapy or program.

Birth Control, Prescriptions
See *Prescription Drug Coverage*.

Birth Control, Procedure
This is a covered expense under this Program.
Any device or procedure that requires a prescription or fitting by a Physician.
See also *Prescription Drug Coverage* and *Sterilization*.

Blood and Blood Derivatives
This is a covered expense under this Program.

Blood transfusion services, including the cost of blood and blood plasma and other blood products not donated or replaced by a blood bank or otherwise, as well as the costs associated with autologous blood transfusions.

Bulimia
This is NOT a Covered expense under this Program.
An eating disorder involving repeated and secretive episodic bouts of binge eating followed by self-induced vomiting, use of laxatives or diuretics, or fasting.

Breast Pumps
This is a covered expense under this Program.
Breast pumps will be reimbursement with a doctor's written prescription and an itemized receipt of purchase. *(No replacement for loss or damage) (NOT subject to the deductible)*

Calendar Year Out of Pocket Maximum
A maximum amount established by This Plan that a Covered Person pays out of his or her personal funds for any Eligible Reasonable Charges during any Calendar Year. Once this maximum amount is reached, This Plan will pay 100% for any additional Eligible Charges during that Calendar Year.

Chemical Dependency / Alcoholism
This is a covered expense under this Program.
For the purposes of This Program, Chemical Dependency / Alcoholism treatment means the use of any or all of the following therapeutic techniques, as used in a treatment Program for individuals physiologically Dependent upon or abusing alcohol or drugs;

1. Medication;
2. Counseling;
3. Detoxification services; or
4. Other ancillary services; such as a medical testing, diagnostic evaluation, and referral to other services identified in a treatment Program.

Treatment of Chemical Dependency / Alcoholism on an inpatient or outpatient basis, provided such treatment is diagnosed and ordered by a licensed Physician and, only if such treatment is rendered by:

1. A licensed Hospital;
2. A state approved facility for the treatment of Mental / Nervous Conditions including Chemical Dependency / Alcoholism, operated by or under contract with the local health department;
3. A licensed consulting Psychologist;
4. A licensed professional counselor;
5. A licensed Psychiatrist; or
6. A licensed Physician.

Chemotherapy
This is a covered expense under this Program.
Treatment of disease by means of chemical substances or drugs.
See also *Prescription Drug Coverage*.

Chiropractic Care
This is a covered expense under this Program.
Covered services for Spinal Manipulation are available up to 20 visits per program year.

Circumcision, Penal

Adult
Routine procedures are NOT a Covered Expense under This Program.
Operation to remove part or all of the foreskin on the penis.
Procedures performed due to a medical condition require pre-treatment review to determine if coverage will be available.

Newborn
This is a covered expense under this Program with the initial hospitalization.
Operation to remove part or the entire foreskin of the penis.

Clinical Trials
The Patient Protection and Affordable Care Act (PPACA), and which applies for plan or policy years beginning on or after January 1, 2014, group health plans must provide coverage to a "qualified individual," then such plan:

- may not deny the individual participation in an approved clinical trial with respect to the treatment of cancer or another life-threatening disease or condition
- may not deny (or limit or impose additional conditions on) the coverage of routine patient costs for items and services furnished in connection with participation in the trial
- may not discriminate against the individual on the basis of the individual's participation in such trial

A "qualified individual" is a participant or beneficiary in a group health plan who is eligible to participate in an approved clinical trial according to the trial protocol with respect to the treatment of cancer or another life-threatening disease or condition, and either (i) the referring health care professional is a participating health care provider and has concluded that the individual's participation in such trial would be appropriate, or (ii) the participant or beneficiary provides medical and scientific information establishing that the individual's participation in such trial would be appropriate.

An "approved clinical trial" means a phase I, II, III or IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition, and is either (i) a federally funded or approved study or investigation, (ii) a study or investigation conducted under an investigational new drug application reviewed by the Food and Drug Administration, or (iii) a study or investigation that is a drug trial exempt from having such an investigational new drug application.

The Group Health plan requires a “qualified individual” to use an in-network provider for the approved clinical trial. The in-network provider must be an “approved trial participant” and will

accept the “qualified individual”. If the “qualified individual” uses an out-of-network provider, such benefits are covered if they are part of the patient’s coverage or plan.

Finally, "routine patient costs" include all items and services consistent with the coverage provided in the plan that are typically covered for a qualified individual who is not enrolled in a clinical trial. However, routine patient costs do not include (i) the investigational item, device or service itself, (ii) items and services that are provided solely to satisfy data collection and analysis needs, and that are not used in the direct clinical management of the patient, or (iii) a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis. Therefore, the PPACA does not require group health plans to cover the costs of the approved clinical trial itself, but rather just the routine patient costs (e.g., laboratory services) associated with the clinical trial.

Coinsurance
Coinsurance is the percent that the Program pays for a Covered Expense after any applicable Deductible has been satisfied.

Copayment
The specific amount that a Covered Person pays for certain services, procedures or prescriptions. See the specific treatment, therapy or program for applicable copayments.

Convalescent Care / Skilled Nursing Facility
This is a covered expense under this Program. (Limited to 30 days payable)

If there are no In-Network Convalescent Care Facilities within a thirty (30) mile radius of the participant’s residence, there is not a penalty for going Out-of-Network.

Confinement in a legally qualified Convalescent Care Facility provided such confinement:

1. Is prescribed by a Physician who remains in attendance at least once every seven (7) days;
2. Is for necessary recuperative care of the same condition requiring the prior hospitalization;
3. Provides Skilled Nursing care or Physical Restorative services or both from an Injury or disease, and it is expected that the care received will improve the patient's condition.

The total of all necessary services and supplies (including room and board) furnished by the facility cannot exceed the daily allowance and maximum number.

Cosmetic Expenses
In most cases, this is NOT a covered expense under this Program. If approved, claims will be reimbursed at the applicable coinsurance percentage.

This Program requires pre-approval on all Cosmetic Expenses. Procedures or services are only covered to the extent that they result in the improvement of a bodily function.

See also *Reconstructive Surgery & Limitations & Exclusions* sections.

Custodial Care

This is NOT a covered expense under this Program.
Services which are custodial in nature or primarily consist of bathing, dressing, toileting, feeding, home-making, moving the patient, giving medication or acting as a companion or sitter. Custodial care does not require the continued assessment, observation, evaluation, or management by licensed medical personnel.

Deductible
See Program Year Deductible.

Dental Care
Under this medical Program, Dental Care and treatment will be eligible only for:

1. Services necessitated as the direct result of an accidental Injury to sound natural teeth and jaw;
2. The removal of tumors;
3. The removal of unerupted, impacted teeth; or
4. The correction of congenital abnormalities.

Services that are preventive, basic restorative, major restorative, orthodontic, or for diagnostic care, including teeth broken while chewing, are not included under this medical plan except for Dental Care for dependent Children, see Dental Care Section.

See Oral Surgery and Dental Care section.

Diagnostic Services
This is a covered expense under this Program.
Diagnostic x-ray and laboratory examinations; services of a professional radiologist or pathologist.

Drugs – Prescription
See *Prescription Drug Coverage*.

Durable Medical Equipment
This is a covered expense under this Program.
Precertification REQUIRED if over $500.
Rental, not to exceed the purchase price (or if less costly, purchase) of Hospital bed, wheelchair and similar Medically Necessary Durable Medical Equipment when prescribed by a licensed Physician. These items may be bought rather than rented, with the cost not to exceed the fair market value of the equipment at the time of purchase but only if prior approval is obtained from the Program Administrator.

Eating Disorders
See *Anorexia, Bulimia, Obesity*.

Educational Services
Testing as described below is NOT covered under this Program.
Testing in connection with learning disorders or attention deficit disorders, etc.

Educational Services, Diabetes
This is a covered expense under this Program.
Up to three (3), one-hour sessions, will be covered at 100%. Any additional sessions will NOT be covered under this Program.

Nutritional counseling, self-care training, and/or certified diabetic education classes provided by a Registered Nurse, Registered Dietician, Physician or Pharmacist for any diagnosis of diabetes. All initial educational services must be provided by a Certified Diabetes Educator.

Emergency Room Services/Emergency Medical Services
This is a covered expense under this Program.
Coverage is provided for Hospital emergency room care for initial services rendered for the onset of symptoms for an emergency medical conditions or serious Accidental Injury which requires immediate medical care.

Emergency medical condition means a medical condition manifesting itself by acute symptoms of sufficient severity (including pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in one of the following conditions:

- Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- Serious impairment to bodily functions; or
- Serious dysfunction of any body organ or part

Non-Accident, Non-Emergency Services have a $250 Copayment. No additional Deductible if admitted to an In-Network facility (Out-of-Network facility – $500 Deductible). Additional charges are subject to the Deductible and applicable Coinsurance.

For Accident related services see *Accident Expense.*
See also *Urgent Care Facility*.

Employment Related Injury or Illness
This is NOT a covered expense under this Program.
Charges for or in connection with an Injury or Illness which arise out of or in the course of any employment for wage or profit, or for which the individual is entitled to benefits under Worker's Compensation Law, Occupational Disease Law or similar legislation.

Excess of Reasonable and Customary Charges
This Plan uses a variety of data sources to determine Reasonable Charges.
Charges in excess of the reasonable charges for Covered procedures rendered by any non-network providers are not covered.

Excess of the Benefits Specified in This Program
Charges not covered, or charges for Benefits not covered under This Program.

Experimental or Investigational Services or Supplies
This is NOT a covered expense under this Program.
Charges incurred for services, supplies, devices, treatments, procedures and drugs which are not reasonable and necessary or that are investigational or experimental for the diagnosis or treatment of any Illness, disease, or Injury for which any of such items are prescribed.

Experimental services are further defined as those services which:

1. Are not accepted as standard medical treatment for the Illness, disease or Injury being treated by a Physician's suitable medical specialty;
2. Are the subject of scientific or medical research of study to determine the item's effectiveness and safety;
3. Have not been granted, at the time services were rendered, and required approval by a federal or state governmental agency, including without limitation, the Federal Department of Health and Human Services, Food and Drug Administration, or any comparable state governmental agency, and The Centers for Medicare and Medicaid Services (formerly HCFA) as approved for reimbursement under Medicare Title XVIII; or;
4. Are performed subject to the Covered Person's informed consent under a treatment protocol that explains the treatment or procedure as being conducted under a human subject study or experiment.

Family Provided Services
This is NOT a Covered Expense under This Program.
Charges for services or supplies rendered by the Student, Student's Spouse, or the children, brothers, sisters, parents, or grandparents of either the Student or the Student's Spouse.

Flu Shots
This is a covered expense under this Program.
Influenza vaccine administered by the Public Health Department or any other licensed provider or facility. Immunizations/Flu (Influenza vaccine).

See also Preventive Services.

Foreign Assignments
Medically Necessary Charges and Services, rendered by a licensed Physician or facility, incurred in a foreign country will be covered the same as if they had been incurred within the United States subject to all other provisions of This Plan.

Foreign Travel
This is a covered expense under this Program.
When temporarily traveling outside the United States of America, Medically Necessary Charges and Services, rendered by a licensed Physician or facility, incurred in a foreign country will be covered the same as if they had been incurred within the United States subject to all other provisions of This Program. *Travel outside the United States of America must be sponsored event by Mercer University.*

When travel outside the United States is for the sole purpose of obtaining medical treatment, Charges and Services received are NOT Covered Expenses under This Program.

Genetic Counseling

A communication process between a specially trained health professional and a person concerned about the genetic risk of a disease. The person's family and personal history may be discussed and counseling may lead to genetic testing.

Genetic Testing

A genetic test examines the genetic information contained inside a person's cells, called DNA, to determine if that person has or will develop a certain disease or could pass a disease to their offspring.

1. Testing MUST be Pre-certified by Core Health Services (CHS). Pre-Certification requirements are:
    a. The beneficiary MUST have a history of the disease, breast cancer at the age of 45 or younger.
    b. There MUST be a high-risk family history.
    c. Pre-testing genetic counseling MUST be provided by a qualified genetic counselor. There MUST be an informed consent signed by the patient which includes a statement that he/she agrees to post-testing counseling. THIS IS REQUIRED.
2. The results of the testing MUST be used to manage the course of treatment of the patient's disease process.

Genetic Testing is not covered for routine diagnostic treatment, to rule-out pre-disposition, for prophylactic services (preventive screening).

See also Genetic Counseling.

Government Owned / Operated Facility

This is NOT a covered expense under this Program.

Charges by a facility owned or operated by the U.S. Federal, State or Local government, unless the individual is legally obligated to pay. This does not apply to Covered Expenses rendered by a hospital owned or operated by the U.S. Veteran's Administration when the services are provided for a non-service related Illness or Injury.

Hair Replacement and / or Wigs

This is NOT a Covered Expense under This Program.

Care, treatment, or replacement for hair loss whether prescribed by a Physician including Hair Pieces and Wigs, as well as Wig Maintenance.

Hearing Aids

This is NOT a covered expense under this Program.
An electronic amplifying device designed to bring sound more effectively in the ear.

Hearing Exams
This is NOT a covered expense under this Program.
Examinations to evaluate hearing quality or loss by a licensed Physician or Facility.

Home Health Care
This is a covered expense under this Program. Maximum One Hundred Twenty (120) days per Plan year.
Home Health Care provides a program for the Member's care and treatment in the home. A visit consists up to 4 hours of care. The program consists of required intermittent skilled care, which may include observation, evaluation, teaching and nursing services consistent with the diagnosis, established and approved in writing by the Member's attending Physician. Some special conditions apply:

- The Physician's statement and recommended program must be pre-certified.
- Claims will be reviewed to verify that services consist of skilled care that is medically consistent with diagnosis.
- A member must be essentially confined at home.

Covered Services:

- Visits by a RN or LPN-Benefits cannot be provided for services if the nurse is related to the Member.
- Visits by a qualified physiotherapist or speech therapist and by an inhalation therapist certified by the National Board of Respiratory Therapy.
- Visits to render services and/or supplies of a licensed Medical Social Services Worker when Medically Necessary to enable the Member to understand the emotional, social, and environmental factors resulting from or affecting the Member's illness.
- Visits by a Home Health Nursing Aide when rendered under the direct supervision of an RN.
- Nutritional guidance when Medically Necessary.
- Administration of prescribed drugs.
- Oxygen and its administration.

Covered Services for Home Health do <u>not include:</u>

- Food, housing, homemaker services, sitters, home-delivered meals.
- Home Health Care services which are not Medically Necessary or of a non-skilled level of care.
- Services and/or supplies which are not included in the Home Health Care plan as described.
- Services of a person who originally resides in the patient's home or is a member of the family of either the patient or patient's spouse.
- Any services for any period during which the Member is not under the continuing care of a Physician.
- Convalescent or Custodial Care where the Member is not under the continuing care of an illness or surgery and where skilled care is not required or the services being rendered are only for aid in daily living, i.e., for the convenience of the patient.

- Any services or supplies not specifically listed as Covered Services.
- Routine care and/or examination of a newborn child.
- Dietitian Services.
- Maintenance therapy.
- Dialysis treatment.
- Purchase or rental of dialysis equipment.

Hospice Care

This is a covered expense under this Program. If there are no In-Network Hospice Agencies, there is no penalty for going Out-of-Network.

Inpatient or outpatient hospice care is covered to the Program maximum provided that a written Program of treatment is furnished as part of the claim submission. The Hospice Program treatment must include:

1. Description of the services and supplies for the palliative care and medically necessary treatment to be provided to the covered patient;
2. Be reviewed and approved by the Physician every thirty (30) days;
3. A prognosis that the patient is terminally ill and has six (6) months or less to live; and
4. The concurrent opinion of the Physician and the Hospice care facility that such care will cost less total than any alternative treatment.

When furnished by a duly licensed agency, the following are covered expenses:

1. Facility charges including room and board for short term inpatient care;
2. Medical supplies, drugs and medications prescribed by a Physician which are normally covered under the Program;
3. Intermittent nursing care;
4. Physician charges;
5. Psychological counseling;
6. Physical or occupational therapy (for palliative reasons only);
7. Respite care that is continuous care in the most appropriate setting for a maximum of five days; and
8. Rental of durable medical equipment when prescribed by a Physician.

In addition to General Limitations in the Program, benefits will *NOT* be provided for any of the following:

1. Bereavement counseling;
2. Funeral arrangements;
3. Pastoral counseling;
4. Financial counseling which includes estate planning;
5. Legal counseling which includes the drafting of a will;
6. Homemaker or caretaker services which are not solely related to the care of the patient;
7. Transportation;
8. Supportive environmental materials such as handrails, ramps, air conditioners, telephones, whirlpool tubs, and similar appliances and devices;
9. Food service programs such as "Meals on Wheels";

10. Nutritional Guidance;
11. Services of a social worker;
12. Any services or supplies not included in the Program of treatment;
13. Services performed by a family member, household member, or volunteer worker;
14. Separate charges for records and reports; and
15. Expenses for the normal necessities of living, such as food, clothing, and household supplies.

Hospital Admissions
This is a covered expense under this Program.
All Hospital Admissions must be Medically necessary.

See also *Pre-Certification* and *Concurrent Review Requirements*.

Hospital Services
This is a covered expense under this Program.
Hospital room and board, general nursing care, and regular daily services to the room and board allowance, Intensive Care Unit or other special care unit such as Coronary Care (but not for the concurrent use of any other Hospital room), Ambulatory Surgical Center or a Birthing Center. Room charges made by a Hospital having only private rooms will be paid at the average private room rate.

Medically Necessary services and supplies furnished by a Hospital on an inpatient or outpatient basis, including but not limited to emergency and operating room charges, x-rays and other diagnostic procedures, laboratory tests, drugs, medicines, and dressings.

Personal comfort or incidental items such as telephones or televisions are excluded under This Program.

See also *Pre-Certification* and *Concurrent Review Requirements*.

Immunizations
This is a covered expense under this Program.
Immunization, injections/Flu (Influenza vaccine), see preventive services.
Immunizations required for foreign travel are not covered.

Infertility Treatment
This is NOT a covered expense under this Program; however, diagnostic testing to determine the cause of infertility is a covered expense, and will be covered at the applicable percentages after the deductible is met. Services, treatment and procedures rendered for the specific purpose of making conception possible.

Learning Disorders
This is NOT a covered expense under this Program.
Testing services in connection with Learning Disorders including such disorders as Attention Deficit Disorder and Dyslexia.

Lifetime Maximum Benefit
The maximum amount The Program will pay for non-essential Covered Expenses incurred during a covered participant's lifetime or by each of their Covered Dependents during the Dependent's lifetime.

Payments made for all essential benefits during the entire period of coverage for one Covered Person are not limited to the Lifetime Maximum Benefit, unless otherwise noted under a specific Covered Expense area.

See also *Chemical Dependency / Alcohol* and *Mental / Nervous Conditions*.

Mammogram
This is a covered expense under this Program.
When covered, age forty (40) years and older, one Mammogram procedure per year. For females under age forty (40), one Mammogram procedure per year only if determined to be Medically Necessary. Additional Mammogram procedures will be covered only if determined to be Medically Necessary.

See also *Routine Physical Exams* for Coverage.

Mastectomy (Women's Health and Cancer Rights)
This is a covered expense under this Program.
For members receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending Physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same Deductible and Coinsurance applicable to other medical and surgical benefits provided under this Plan.

If you would like more information on WHCRA benefits, call your Plan Administrator.

See also *Reconstructive Surgery*.

Maternity Expenses
This is a covered expense under this Program.
Maternity Benefits are available for the Covered Student or Covered Spouse Only. Covered Dependent Children have no Maternity benefits. This Program, under federal law, generally may not

restrict benefits for any hospital length of stay in connection with childbirth for the mother or Newborn Child to less than forty-eight (48) hours following a vaginal delivery, or less than ninety-six (96) hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than forty-eight (48) hours (or ninety-six (96) hours as applicable).

In any case, This Program may not, under federal law, require that a provider attain authorization from The Program for prescribing a length of stay not in excess of forty-eight (48) hours (or ninety-six (96) hours as applicable). However, This Program recommends Pre-Notifying CHS during the first trimester of a Maternity Diagnosis and again within forty-eight (48) hours of delivery of the baby.

Any hospital stays longer than forty-eight (48) hours (or ninety-six (96) hours as applicable), must be Pre-Certified, and will be subject to the Pre-Certification penalties as defined in Pre-Notification Requirements.

Includes expenses incurred for Pregnancy and Complications of Pregnancy.

Coverage includes expenses for confinements in a Birthing Center and services rendered by a Certified Nurse Midwife.

Mental / Nervous Conditions

This is a covered expense under this Program.

Treatment of Mental / Nervous on an inpatient or outpatient basis, provided such treatment is diagnosed and ordered by a licensed Physician and, only if such treatment is rendered by:

1. A licensed Hospital;
2. A state approved facility for the treatment of Mental / Nervous Conditions including Chemical Dependency / Alcoholism, operated by or under contract with the local health department;
3. A licensed consulting Psychologist;
4. A licensed professional counselor;
5. A licensed Psychiatrist;
6. A licensed Physician;
7. A licensed Clinical Social Worker; or
8. A licensed Marriage & Family Therapist.

In addition to General Limitations of This Program, benefits will *NOT* be provided for any of the following:

1. Services rendered by any other providers, i.e., Psychiatric Nurse Practitioners, Counselors, or Therapists when such services are billed independently and not through a Covered Facility; and
2. Marriage and Family Counseling, unless all parties involved have a diagnosed Illness or injury. If one family member has a covered diagnosed condition, benefits will be prorated for the diagnosed Covered Person (individual) only.

See also *Chemical Dependency / Alcoholism*.

Network
Network refers to those hospitals and physicians which This Program has contracted with in order to obtain certain discounted fees. Each Covered Person under This Program is directed to use these Network providers by having different Reimbursement Rates for going In-Network versus Out-of-Network. See each Covered Service for the applicable Reimbursement Rates. A complete list of providers within the Network may be obtained from CAS at no charge.

All referrals for radiology, anesthesia, or pathology made by an In-Network Physician will be reimbursed at In-Network percentages. Specialists, other than those mentioned previously, must be a part of the Network in order to receive reimbursement In-Network.

Newborn Expenses
This is a covered expense under this Program.
Newborn Expenses (all Physician and facility fees), from birth until discharge, for routine care will be paid. These expenses will be paid under the Mother.

If the baby is ill, suffers an injury, or requires care other than routine care, from birth until discharge, benefits will be provided if coverage is requested within thirty-one (31) days of the child's birth (Enrollment must be submitted within thirty-one (31) days of the date of child's birth.) on the same basis, as for any other eligible expenses provided coverage is in effect. These expenses will be paid under the Newborn.

No Legal Obligation to Pay
This is NOT a covered expense under this Program.
Charges by a Physician, facility or other provider in which the individual is not legally obligated to pay.

Not Medically Necessary
This is NOT a covered expense under this Program.
Treatment of an Injury or Illness which is not Medically Necessary. This includes charges for care, supplies or equipment.

Obesity or Weight Control
This is NOT a covered expense under this Program.
Treatment, supplies, medication or surgery primarily intended for weight loss or any complications that occur as the result of any of the above services.

See *Preventive care.*

Oral Surgery
This is a covered expense under this Program.
Pre-certification is required. To obtain the highest level of benefits, the Member or Provider must obtain pre-certification.

Covered Services include only the following:

- Fracture or facial bones;
- Lesions of the mouth, lip, or tongue which require a pathological exam;
- Incision of accessory sinuses, mouth salivary glands or ducts;
- Dislocations of the jaw;
- Removal of impacted teeth and associated hospitalization;
- Treatment of Temporomandibular Joint Syndrome (TMJ) or myofascial pain including only removable appliances for TMJ repositioning and related surgery and diagnostic services. Covered services do not included fixed or removable appliances which involve movement or repositioning of the teeth, or operative restoration of teeth (fillings), or prosthetics (crowns, bridges, dentures);
- Plastic repair of the mouth or lip necessary to correct traumatic injuries or congenital defects that will lead to functional impairments; and
- Initial services, supplies or appliances for dental care or treatment required as a result of, and directly related to, accidental bodily injury to sound natural teeth or structure.

Organ/Tissue/Bone Marrow Transplant

Covered Services include certain services and supplies not otherwise excluded in this Plan and rendered in association with a covered transplant, including pre-transplant procedures such as organ harvesting (Donor Costs), post-operative care (including antirejection drug treatment, if Prescription Drugs are covered under the Plan) and transplant related chemotherapy for cancer limited as follows.

A transplant means procedure or series of procedures by which an organ or tissue is either:

- Removed from the body of one person (called a donor) and implanted in the body of another person (called a recipient); or
- Removed from and replaced in the same person's body (called a self-donor).

A covered transplant means a Medically Appropriate transplant

- Human organ or tissue transplants for cornea, lung, heart or heart/lung, liver, kidney, pancreas or kidney and pancreas when transplanted together in the same operative session.
- Autologous (self-donor) bone marrow transplants with high-dose chemotherapy is considered eligible for coverage on a prior approval basis, but **only** if required in the treatment of:
    - Non-Hodgkin's lymphoma, intermediate or high grade Stage III or IVB;
    - Hodgkin's disease (lymphoma), Stages IIIA, IIIB, IVA, or IVB;
    - Neuroblastoma, Stage III or Stage IV;
    - Acute lymphocytic or nonlymphocytic leukemia patients in first or subsequent remission, who are at high risk for relapse and who do not have HLA-compatible donor available for allogenic bone marrow support;
    - Germ cell tumors (e.g., testicular, m mediastinal, retroperitoneal, ovarian) that are refectory to standard dose chemotherapy, with FDA-approved platinum compounds;
    - Metastatic breast cancer that (a) has not been previously treated with systemic therapy, (b) is currently responsive to primary systemic therapy, or (c) has relapsed following response to first-line treatment;
    - Newly diagnosed or responsive multiple myeloma, previously untreated disease, those in a complete or partial remission, or those in a responsive relapse.

- Homogenic/allogenic (other donor) or syngeneic hematopoietic stem cells whether harvested from bone marrow peripheral blood or from any other source, but only if required in the treatment in the treatment of:
    - Aplastic anemia;
    - Acute leukemia;
    - Severe combined immunodeficiency **exclusive** of acquired immune deficiency syndrome (AIDS);
    - Infantile malignant osteoporosis;
    - Chronic myelogenous leukemia
    - Lymphoma (Wiscott-Aldrick syndrome);
    - Lysosomal storage disorder;
    - Myelodysplastic syndrome.

"Donor Costs" means all costs, direct and indirect (including program administration costs), incurred in connection with:

- Medical services required to remove the organ or tissue from either the donor's or the self-donor's body;
- Preserving it; and
- Transporting it to the site where the transplant is performed.

In treatment of cancer, the term "transplant" includes any chemotherapy and related courses of treatment which the transplant supports.

For purposes of this benefit, the term "transplant" does not include transplant of blood or blood derivatives (except hematopoietic stem cells) which will be considered as nontransplant related under the term of the Contract.

"Facility Transplant" means all Medically Necessary services and supplies provided by a health care facility in connection with a covered transplant except Donor Costs and antirejection drugs.

"Medically Appropriate" means the recipient or self-donor meets the criteria for a transplant established by CORE.

"Professional Provider Transplant Services" means All Medically Necessary services and supplies provided by a professional Provider in connection with a covered transplant except donor costs and antirejection drugs.

<u>Benefits for Antirejection Drugs</u>
For Antirejection drugs following the covered transplant, Covered Services will be limited to Prescription Drugs, if any, otherwise covered under the Plan.

<u>Pre-Certification Requirement</u>
All transplant procedures must be pre-certified for type of transplant and be Medically Necessary and not Experimental or Investigational according to criteria established by Core. To pre-certify, call Core at 888-741-2673.

To pre-certification requirements is a part of the benefit administration of the Plan and is not a treatment recommendation. The actual course of medical treatment the Member chooses remains strictly a matter between the Member and his or her Physician.

Your Physician must submit a complete medical history, including current diagnosis and name of the surgeon who will perform the transplant. The surgery must be performed at a recognized transplant center. The donor, donor recipient and the transplant surgery must meet required medical selection criteria as defined by Core.

If the transplant involves a living donor, benefits are as follows:

- If a Member receives a transplant and the donor is also covered under this Contract, payment for the Member and the donor will be made under each Member's Coverage.
- If the donor is not covered under this Plan, payment for the Member and the donor will be made under this Contract but will be limited by any payment which might be made under any other hospitalization coverage plan.
- If the Member is the donor and the recipient is not covered under this Plan, payment for the Member will be made under this Plan limited by any payment which might be made by the recipient's hospitalization coverage with another company. No payment will be made under this Plan for the recipient.

See also *Exclusions* section.

Osteoporosis

Benefits will be provided for qualified individuals for reimbursement for scientifically proven bone mass measurement (bone density testing) for the prevention, diagnosis and treatment of osteoporosis for Members meeting USPSTFB B criteria. For more information visit: http://www.uspreventiveservicestaskforce.org/

Out-of-Pocket Limit

See *Program Year Out-of-Pocket Maximum*.

Outpatient Dialysis

Outpatient Dialysis Treatment. When used in this document, the term "Outpatient Dialysis Treatment" shall mean any and all products, services, and/or supplies provided to Plan members/participants/beneficiaries for purposes of, or related to, outpatient dialysis.

A. The Plan has established a specialized procedure for determining the amount of Plan benefits to be provided for Outpatient Dialysis Treatment, regardless of the condition causing the need for such treatment; this procedure is called the "Dialysis Program". The Dialysis Program shall be the exclusive means for determining the amount of Plan benefits to be provided to Plan members and for managing cases and claims involving dialysis services and supplies, regardless of the condition causing the need for dialysis.

B. The Dialysis Program shall consist of the following components:

i. Application. All claims filed by, or on behalf of, Plan members/participants/beneficiaries for coverage of Outpatient Dialysis Treatment ("Dialysis Claims") shall be subject to the provisions of this section, regardless of the treating healthcare provider's participation in the Preferred Provider Organization (PPO).

ii. Mandated Cost Review. All claims for Outpatient Dialysis Treatment shall be subject to cost containment review, negotiation and settlement, application of the maximum benefit payable
analysis (as set forth below), and/or other related administrative services, which the Plan Administrator may elect to apply in the exercise of the Plan Administrator's discretion. The Plan Administrator reserves the right, in the exercise of its discretion, to engage relevant and qualified third-party entities such as Zelis Claims Integrity, LLC, for the purpose of determining the Usual, Customary, and Reasonable Outpatient Dialysis Charge.

iii. Maximum Benefit. The maximum benefit payable for any and all Dialysis Claims shall be 100% of the lesser of (x) the Usual, Customary, and Reasonable Outpatient Dialysis Charge (as defined below), (y) the maximum allowable charge after all applicable deductibles and cost-sharing, and (z) s u c h charge as is negotiated between the Plan Administrator and the provider of Outpatient Dialysis Treatment.

a. Usual, Customary, and Reasonable Outpatient Dialysis Charge. For the purposes of Outpatient Dialysis Treatment and the Dialysis Program, "Usual, Customary, and
Reasonable Outpatient Dialysis Charge" means that portion of a claim for Outpatient Dialysis Treatment that is, as determined by Zelis Claims Integrity, LLC, (i) consistent with the common level of charges made by other medical professionals with similar credentials, or other medical facilities, pharmacies, or equipment suppliers of similar standing, in the geographic region in which the charge was incurred; (ii) based upon the average payment actually made for reasonably comparable services and/or supplies to all providers of the same services and/or supplies by all types of plans in the applicable market during the preceding calendar year, based upon reasonably available data, adjusted for the national Consumer Price Index medical care rate of inflation; (iii) for reasonably comparable services performed or provided in accordance with generally accepted standards of medical practice applicable to a similarly-situated individual receiving similar services in the same geographic region; (iv) otherwise in compliance with generally accepted billing practices for unbundling and/or multiple procedures; and (v) necessary and appropriate for the care and treatment of illness or injury presented, taking into consideration relevant data, including, without limitation, industry practices and standards as they apply to similar scenarios, and various forms of normative data and price indexes. The Usual, Customary, and Reasonable

Outpatient Dialysis Charge does not necessarily mean the actual charge made, submitted, or accepted. The Plan Administrator reserves the right, in the exercise of its discretion, to engage relevant and qualified third-party entities, such as Zelis Claims Integrity, LLC, for the purpose of determining the Usual, Customary, and Reasonable Outpatient Dialysis Charge.

iv. Secondary Coverage. Plan members/participants/beneficiaries eligible for other health coverage under any other health plan are strongly encouraged to enroll in such coverage. Plan members w h o do not enroll in other coverage for which they are eligible may incur costs not covered by the Plan that would have been covered by the other coverage. The Plan will only pay for costs payable pursuant to the terms of the Plan, which may not include any costs that would have been payable by such other coverage.

The Plan Administrator shall perform its duties as the Plan Administrator and in its sole discretion shall determine appropriate courses of action in light of the reason and purpose for which this Plan is established and maintained. In particular, the Plan Administrator shall have full and sole discretionary authority to interpret all plan documents and to make all interpretive and factual determinations as to whether any individual is entitled to receive any benefit under the terms of this Plan. Any construction of the terms of any plan document and any determination of fact adopted by the Plan Administrator shall be final and legally binding on all parties. To the extent permitted by law, the Plan Administrator shall have the discretionary authority to rely conclusively upon all tables, valuations, certificates, opinions and reports which are furnished by accountants, counsel or other experts employed or engaged by the Plan Administrator.

Oxygen
This is a covered expense under this Program.
If there are no In-Network Providers, there is no penalty for going Out-of-Network.
Oxygen and its administration when prescribed by a licensed Physician.

Pap Smears
This is a covered expense under this Program.
See *Routine Physical Exams*.

Personal Hygiene
This is NOT a covered expense under this Program.
Items for personal hygiene and convenience which are Not Medically Necessary, such as, but not limited to, air conditioners, bathing / toilet accessories, and physical fitness equipment.

Physician / Specialist copayment
The Physician/Specialist copayment for this Program is $25 per In-Network office visit with 80% coinsurance. For Out-of-Network Physician/Specialist is $25 per office visit then payable at 60% coinsurance.

A copayment is a flat amount that a Covered Person pays at the time of the office visit. After the copayment, charges are covered at 80% with an In-Network provider. After the Program Year, Out-of-Pocket Maximum has been reached, the copayment amount will still apply.

Physician Charges, Certain
This is NOT a covered expense under this Program.
Failure to keep scheduled appointments, completion of claim forms or providing medical information necessary to determine coverage.

Physician Charges, Telehealth- The law defines Telemedicine services as, "The practice, by a duly licensed physician or other health care provider acting within the scope of such provider's practice, of health care delivery, diagnosis, consultation, treatment, or transfer of medical data by means of audio, video, or data communications which are used during a medical visit with a patient or which are used to transfer medical data obtained during a medical visit with a patient."

Program Year Deductible
The Program Year Deductible is satisfied using Covered Expenses incurred within the Program Year. The Program Year Deductible must be satisfied before the applicable Coinsurance will be applied.

Program Year Out-of-Pocket Maximum
A maximum amount established by This Program that a Covered Person pays out of his or her personal funds for any Eligible (Reasonable and Customary) Charges during any Program Year. Once this maximum amount is reached, This Program will pay 100% for any additional Eligible Charges during that Program Year.

Pre-Admission Testing
This is a covered expense under this Program.
Pre-Admission Testing performed within ten (10) days of admission.

Pre-Existing Conditions
This Program does not impose a pre-existing condition limitation. That means that if an individual or their Dependents have a pre-existing condition when enrolling in The Program, all eligible services related to the pre-existing condition will be covered without restriction, assuming the condition itself is covered.

Pre-Marital Exams
This is NOT a covered expense under this Program.
Blood testing for the purpose of obtaining a Marriage License.

Preventive Care
As required by the Patient Protection Affordable Care Act (PPACA), Covered Participants are not responsible for paying for eligible preventive care services received from an In-Network/participating provider. These eligible preventive care services will be paid by The Plan at 100%, no deductible. Such services include:

- Evidence-based recommended items or services of the United States Preventive Services Task Force (USPSTF) with a rating of "A" or "B";
- Immunizations recommended from the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control (CDC); and
- Evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA) for infants, children, adolescents and women.

Note: Recommended ages and populations vary for the services listed above. In addition, eligible preventive care services received from an Out-of-Network/non-participating provider will not be covered.

Providers are legally required to code and bill accurately for services they provide to patients. Covered services are paid based on the billing codes used by the Covered Participant's provider on the claim submitted to the medical Claims Administrator for payment. Therefore, the Covered Participants may be responsible for a portion of the preventive care visit when:

- the service is not billed as preventive care (including those that may have been received at the same time as the Covered Participant's preventive care visit);
- the Covered Participant does not meet the criteria (based on age or population) for the recommendation or guideline for the preventive care service; or
- the preventive care service was received from an Out-of-Network/non-participating provider.

<u>Covered Preventive Services for Adults</u>

- Abdominal Aortic Aneurysm one-time screening for men of specified ages who have ever smoked
- Alcohol Misuse screening and counseling
- Aspirin use for men and women of certain ages
- Blood Pressure screening for all adults
- Cholesterol screening for adults of certain ages or at higher risk
- Colorectal Cancer screening for adults over fifty (50)
- Depression screening for adults
- Type 2 Diabetes screening for adults with high blood pressure
- Diet counseling for adults at higher risk for chronic disease
- Falls prevention in older adults: exercise or physical therapy
- Falls prevention in older adults: vitamin D
- Hepatitis B screening for nonpregnant adolescents and adults
- Hepatitis C virus infection screening: adults
- HIV screening for all adults at higher risk
- Immunization vaccines for adults--doses, recommended ages, and recommended populations vary:
    - Hepatitis A
    - Hepatitis B
    - Herpes Zoster
    - Human Papillomavirus
    - Influenza
    - Measles, Mumps, Rubella
    - Meningococcal

    - Pneumococcal
    - Tetanus, Diphtheria, Pertussis
    - Varicella
- Intimate partner violence screening; women of childbearing age
- Lung cancer screening for adults 55- 80 at high risk for lung cancer because they're heavy smokers or have quit in the past 15 years
- Obesity screening and counseling for all adults
- Physical activity counseling to prevent cardiovascular disease: adults with cardiovascular risk factors
- Preeclampsia prevention: aspirin
- Sexually Transmitted Infection (STI) prevention counseling for adults at higher risk
- Skin cancer behavioral counseling
- Syphilis screening for all adults at higher risk
- Tobacco Use screening for all adults and cessation interventions for tobacco users

<u>Covered Preventive Services for Women, Including Pregnant Women</u>

- Anemia screening on a routine basis for pregnant women
- Bacteriuria urinary tract or other infection screening for pregnant women
- BRCA counseling about genetic testing for women at higher risk
- Breast Cancer Mammography screenings every 1 to 2 years for women over forty (40)
- Breast Cancer Chemoprevention counseling for women at higher risk
- Breast Feeding interventions to support and promote breast feeding. This includes breast pumps.
- Cervical Cancer screening for sexually active women
- Chlamydia Infection screening for younger women and other women at higher risk
- Contraception: Food and Drug Administration-approved contraceptive methods, sterilization procedures, patient education and counseling, not including abortifacient drugs
- Domestic and interpersonal violence screening and counseling for all women
- Folic Acid supplements for women who may become pregnant
- Gestational diabetes screening for women 24 to 28 weeks pregnant and those at high risk of developing gestational diabetes
- Gonorrhea screening for all women at higher risk
- Hepatitis B screening for pregnant women at their first prenatal visit
- Human Immune Deficiency Virus (HIV) screening and counseling for sexually active women
- Human Papillomavirus (HPV) DNA Test: high risk HPV DNA testing every three years for women with cytology results who are 30 or older
- Osteoporosis screening for women over age sixty (60) depending on risk factors and in younger women whose fracture risk is equal to or greater than that of a sixty (60) year old women who has no additional risk factors
- Rh Incompatibility screening for all pregnant women and follow-up testing for women at higher risk
- Tobacco Use screening and interventions for all women, and expanded counseling for pregnant tobacco users
- Syphilis screening for all pregnant women or other women at increased risk
- Well-woman visits to obtain recommended preventive services

Covered Preventive Services for Children

- Alcohol and Drug Use assessments for adolescents
- Autism screening for children at eighteen (18) and twenty-four (24) months
- Behavioral assessments for children of all ages
- Blood Pressure screening for children
- Cervical Dysplasia screening for sexually active females
- Congenital Hypothyroidism screening for newborns
- Depression screening for adolescents
- Developmental screening for children under age three (3), and surveillance throughout childhood
- Dyslipidemia screening for children at higher risk of lipid disorders
- Fluoride Chemoprevention supplements for children without fluoride in their water source
- Gonorrhea preventive medication for the eyes of all newborns
- Hearing screening for all newborns
- Height, Weight and Body Mass Index measurements for children
- Hematocrit or Hemoglobin screening for children
- Hemoglobinopathies or sickle cell screening for newborns
- HIV screening for adolescents at higher risk
- Immunization vaccines for children from birth to age eighteen (18) — doses, recommended ages, and recommended populations vary:
    - Diphtheria, Tetanus, Pertussis
    - Haemophilus influenzae type b
    - Hepatitis A
    - Hepatitis B
    - Human Papillomavirus
    - Inactivated Poliovirus
    - Influenza
    - Measles, Mumps, Rubella
    - Meningococcal
    - Pneumococcal
    - Rotavirus
    - Varicella
- Iron supplements for children ages six (6) to twelve (12) months at risk for anemia
- Lead screening for children at risk of exposure
- Medical History for all children throughout development
- Obesity screening and counseling
- Oral Health risk assessment for young children
- Phenylketonuria (PKU) screening for this genetic disorder in newborns
- Sexually Transmitted Infection (STI) prevention counseling for adolescents at higher risk
- Tobacco use interventions: children and adolescents
- Tuberculin testing for children at higher risk of tuberculosis
- Vision screening for all children

For detailed information or for other covered preventive services, contact your Claims Administrator or go to. http://www.hhs.gov/healthcare/facts/factsheets/2010/07/preventive-services-list.html

Prophylactic Services
This is not a Covered Expense under This Program.
An institution of measures to protect the member from a disease to which he or she has been, or may be, exposed. Also, called preventive care treatment.
For the purposes of This Program, prophylactic or preventive care services includes (but is not limited to) surgery, facility charges, prescription drugs, and/or testing.
See also *Genetic Testing*.

Prostate Exam
This is a covered expense under this Program. See *Preventive Care* for Coverage.

Prosthetics / Orthotics
This is a covered expense under this Program.
Artificial limbs and eyes (standard prosthetic devices only), when necessitated as the result of a physical illness or injury, including prosthetic devices following a covered mastectomy. Penile Prosthesis must be Medically Necessary.
Charges for replacements will be covered only when required because of pathological change or the natural growth process. Charges for the repair and maintenance are not included; however, charges for a maintenance contract are included.

Radiation
This is a covered expense under this Program.
Medically Necessary treatment of disease by Radium and radioactive isotope therapy.

Reconstructive Surgery
This is a covered expense under this Program.
Pre-Certification is required. Reconstructive surgery does not include any service otherwise excluded in this Plan. (See Limitations & Exclusions)
Reconstructive Surgery is covered only to the extent Medically Necessary:

- To restore a function of any body area which has been altered by disease, trauma, Congenital/Development Anomalies or previous therapeutic processes;
- To correct congenital defects of a Dependent child that lead to functional impairment; and
- To correct medical complications or post-surgical deformity, unless the previous surgery was not a Covered Service.

See also *Mastectomy.*

Rehabilitation Care
Rehabilitation is a treatment or treatments designed to facilitate the process of recovery from injury, illness, or disease to as normal a condition as possible.

See also *Therapy.*

Robotic Assisted Surgery
For the purposes of This Program, robotic assistance is considered incidental to the primary surgical procedure. No additionally benefits are payable for the use of the robotic system. Surgical

procedures completed with robotic assistance should be billed under the CPT code for the primary surgical procedure. Robotic technique should be indicated on the bill with CPT S2900, but indicated with no separate charge for the technique.

Routine Physical Exams
This is a covered expense under this Program.

See Preventive Care Services Benefit

Second Surgical Opinion
This is a covered expense under this Program.
A Second Surgical Opinion is recommended, and may be required, when any surgical procedure is to be performed on an inpatient or outpatient basis.

See also *Pre-Certification* and *Concurrent Review*.

Self-Inflicted Injuries
This is a covered expense under this Program.
Charges for services or supplies furnished in connection with intentionally Self-Inflicted Injuries or suicide, whether committed while sane or insane.

Smoking Cessation
Programs – *This is a covered expense under this Program.*
Therapy – *This is a covered expense under this Program.*
Counseling – *This is a covered expense under this Program.*
Medication – See *Prescription Drug Coverage.*

Any Smoking Cessation program, therapy, counseling or medication for the purpose of quitting smoking.

Sterilization
This is a NOT covered expense under this Program.
Procedures such as Vasectomies and tubal ligations.

Supplies, Diabetic
This is a covered expense under this Program.
Needles, syringes, lancets, clinitest, glucose strips and chemstrips for diagnosed diabetes.

See *Prescription Drug Coverage*.

Supplies, Medical and Surgical
This is a covered expense under this Program.
Casts, splints, trusses, braces, crutches, surgical dressings and supplies, including ostomy supplies and similar Medically Necessary medical and surgical supplies as prescribed by a licensed Physician.

See also *Supplies, Diabetic*.

Temporomandibular Joint Syndrome (TMJ)
This is a covered expense under this Program.
Treatment of TMJ up to a Maximum indicated including only removable appliances for TMJ repositioning and related diagnostic services, excluding fixed or removable appliances which involve movement or reposition of the teeth, operative restoration of teeth (fillings) or prosthetics (crown, bridges and dentures).

See also *Oral Surgery.*

Therapy
This is a Covered Service under This Plan. Precertification required for Pulmonary Rehabilitation and Speech Therapy.

Biofeedback, Recreational or Educational
See specific treatment, therapy or program.

Occupational
This is a covered expense under this Program.
Medically prescribed Occupational Therapy rendered by a duly qualified Occupational Therapist to improve or restore a patient's ability to perform all activities of daily living.

Limited to Twenty-Five (25) visits.

Physical
This is a covered expense under this Program.
Limited to Twenty-Five (25) visits.

Medically prescribed Physical Therapy rendered by a duly qualified Physical Therapist to correct, alleviate or limit physical disability, bodily malfunction, or pain from Injury or disease.

Pulmonary Rehabilitation
This is a covered expense under the Program.
Medically prescribed Pulmonary Rehabilitation rendered by a duly qualified Therapist to structure a program of activity, progressive breathing and conditioning exercise, and patient education designed to return patients with pulmonary disease to maximum function.

See also *Rehabilitation Care*

Speech
This is a covered expense under this Program.
Congenital conditions or diseases causing delayed speech development in children are NOT a Covered Expense under This Program.

Medically prescribed services of a legally qualified Physician or qualified Speech Therapist for respiratory or rehabilitative Speech Therapy for speech loss or impairment due to an Illness or Injury, other than a functional nervous disorder, or due to surgery because of Illness.

Limited to Twenty-Five (25) visits.

Transplant
This is a covered expense under this Program.

See also *Organ/Tissue/Bone Marrow Transplant*

Transsexual Surgery
This is NOT a covered expense under this Program.
Charges for the treatment, surgery or services to modify sex/gender (transsexualism).

Urgent Care Facility
This is a covered expense under this Program.
Use of these types of facilities is *NOT* considered the same as using a Hospital Emergency Room.

- In-network benefits - $25 per visit copay, then 80% of Allowable Charge (Deductible does not apply)
- Out-of-Network benefits - $25 per visit copay, then 60% of Allowable Charge (Deductible does not apply)

For Accident Related Services see *Accident Expense*.

Services rendered at a facility described as an Urgent Care Facility, which is not a Physician's office, clinic, Hospital or ambulatory surgical facility.

Vision Expenses
This is NOT a covered expense under This Program.
Eye refractions, eyeglasses or contact lenses to correct refractive errors and related services, including surgery performed to eliminate the need for eyeglasses for refractive errors (such as radial keratotomy, Lasik or any surgery of the eye specifically designed for improving vision that can be corrected through the use of corrective eyewear). *This exclusion does not apply to Preventive Benefits mandated by the Patient Protection and Affordable Care Act.*

See also *Cataract Surgery, Eyewear Afterwards*.

War or Acts of War
This is NOT a covered expense under this Program.
Declared or undeclared, including an Injury sustained or Illness contracted while on duty with any Military Service for any country.

Well Baby Care

This is a covered expense under this Program. See Preventive Care and New Born Expenses

General Limitations and Exclusions – Medical

No payment will be made under any portion of This Program for expenses incurred by a Covered Person for:

Charges to the extent that the Covered Person is reimbursed, entitled to reimbursement, or in any way indemnified for those expenses by or through any public program;

Charges which would not customarily have been made if no coverage had existed, (except where prohibited by law);

Charges for services and supplies which are furnished without the recommendation of a Physician for the care and treatment of an Illness or Injury, including court ordered or directed care or evaluation;

Charges for any services rendered outside the scope of the license of the institution or practitioner providing the service;

Charges which are in excess of Reasonable and Customary Charges (when no Network is in place or services are rendered Out-of-Network);

Charges which are not Medically Necessary, or reasonably necessary to the care and treatment of an Illness or Injury;

Charges for benefits other than specifically provided or in excess of the benefits specified in This Program;

Charges which are Experimental, Investigational, or for research, or charges for services and supplies which are not in accordance with generally accepted professional medical standards or with the generally accepted methods of treatment;

Charges for Hospital confinement commencing or services and supplies provided before the Effective Date of Coverage under This Program, or provided after the Termination of Coverage under This Program (except as otherwise specified);

Charges for travel, whether recommended by a Physician or not (see the Ambulance Service benefit for additional details);

Charges as a result of Hospital inpatient admission primarily for diagnostic or medical examination for which necessary care or treatment could properly be performed on an outpatient basis without adversely affecting the health of the patient;

Based on date of service, charges outside of the twelve (12) month filing limit of the Program.

Expense incurred by a covered person, not a United States citizen, for services performed within the covered person's home country, if the covered person 's home country has a socialized medicine program.

PROGRAM EXCLUSIONS

The Program does not cover nor provide benefits for loss or expense incurred:

1. as a result of dental treatment, except for treatment resulting from injury to sound natural teeth. This exclusion does not apply to Preventive Services mandated by the Patient Protection and Affordable Care Act.
2. for services normally provided without charge by this Program Holder's Health Service, infirmary or Hospital, or by health care providers employed by this Program holder or services covered by the Student Health Center fee.
3. for eye examinations, eyeglasses, contact lenses, radial keratotomy or laser surgery; or treatment for visual defects and problems. "Visual defects" means any physical defect of the eye which does or can impair normal vision apart from the disease process. Eye refraction is not covered. This exclusion does not apply to Preventive Services mandated by the Patient Protection and Affordable Care Act.
4. for hearing examinations or hearing aids; or other treatment for hearing defects and problems. "Hearing defects" means any physical defect of the ear which does or can impair normal hearing apart from the disease process.
5. as a result of an Accident occurring in consequence of riding as a passenger or otherwise in any vehicle or device for aerial navigation, except as a fare-paying passenger in an aircraft operated by a scheduled airline maintaining regular published schedules on a regularly established route.
6. for Injury or Sickness resulting from war or act of war, declared or undeclared.
7. as a result of an Injury or Sickness for which benefits are paid under any Workers' Compensation or Occupational Disease Law.
8. as a result of Injury sustained or Sickness contracted while in the service of the Armed Forces of any country. Upon the Covered Person entering the Armed Forces of any country, the Company will refund any unearned pro-rata premium. This does not include Reserve or National Guard Duty for training unless it exceeds 31 days.
9. for treatment provided in a government Hospital unless there is a legal obligation to pay such charges in the absence of insurance.
10. for cosmetic surgery. Any non-medically necessary surgery or procedure, the primary purpose of which is to improve or change the appearance of any portion of the body, but which does not restore bodily function, correct a disease state, physical appearance or disfigurement caused by an accident, birth defect, or naturally improve a physiological function. Cosmetic Surgery includes but is not limited to rhinoplasty, lipectomy, surgery for sagging or extra skin, any augmentation or reduction procedures (e.g., mammoplasty, liposuction, keloids, rhinoplasty and associated surgery) or treatment to the consequences or as a result of Cosmetic Surgery.
11. as a result of committing or attempting to commit a felony or participation in a felony, riot, insurrection or civil commotion.
12. For Elective Treatment or elective surgery or complication arising therefrom.
13. for any services rendered by a Covered Person's immediate family member.
14. for any treatment, service or supply which is not Medically Necessary.
15. for surgery and/or treatment of: acupuncture; gynecomastia; biofeedback-type services; breast implants; circumcision; corns, calluses and bunions; deviated nasal septum, including submucosa resection and/or other surgical correction thereof; family planning except as specifically provided; infertility(male or female), including any services or supplies rendered for the purpose or with the intent of inducing conception; hair growth or removal; impotence, organic or otherwise; learning disabilities; nonmalignant warts, moles and lesions; premarital examinations; sexual reassignment surgery; sleep disorders, including testing thereof; vasectomy; and alopecia. This exclusion does not apply to Preventive Benefits mandated by the Patient Protection and Affordable Care Act.
16. for sterilization or sterilization reversal, including surgical procedures and devices except as specifically provided; or for birth control except as specifically provided.
17. for Injury resulting from bungee jumping.
18. for voluntary or elective abortions.
19. for Injury resulting from: professional and semi-professional sports activity, including travel to and from the activity and practice; hang gliding; parasailing; sky diving; glider flying; or parachuting.
20. for Injury resulting from fighting, except in self-defense.
21. for treatment of obesity, including, but not limited to the following: weight reduction or dietary control programs; prescription or nonprescription drugs or medications such as vitamins (whether taken orally or by

injection), minerals, appetite suppressants, or nutritional supplements; and any complication resulting from weight loss treatments or procedures.

22. for treatment, services, drugs, device, procedures or supplies that are experimental or investigational.
23. for treatment, service or supply for which a charge would not have been made in the absence of insurance.
24. for hormone treatment or hormone therapy not related to the treatment of a Sickness.
25. for Alcohol Services, supplies, care or treatment to a Covered Person for an Injury or Sickness which occurred as a result of that Covered Person's illegal use of alcohol. The arresting officer's determination of inebriation/incapacitation/DUI will be sufficient for this exclusion. Expenses will be covered for Substance Abuse treatment, as well as both physical and mental health conditions as specified in This Plan.
26. for Complications of non-covered treatments that required care, services or treatment are not covered under This Plan.
27. for Education or Vocational Testing or Training.
28. for exercise programs for treatment of any condition, except for Physician-supervised cardiac rehabilitation, occupational or physical therapy covered by This Plan.
29. for eye care, such as Radial keratotomy or other eye surgery to correct refractive disorders. Also, eye refractions or eye examinations for the correction of vision, lenses for the eyes and exams for their fitting. This exclusion does not apply to patients with aphakia and soft lenses or sclera shells intended for use as corneal bandages unless otherwise stated.
30. for Gastric Bypass Surgery/Bariatric Surgery, Services, supplies, care, treatment or complications following surgery.
31. for Charges for Illegal Acts, services received as a result of Injury or sickness caused by or contributed to by engaging in an illegal act or occupation; by committing or attempting to commit any crime, criminal act, assault or other felonious behavior; or by participating in a riot or public disturbance. This exclusion does not apply if the Injury resulted from an act of domestic violence or a medical (including both physical and mental health) condition.
32. for Illegal Drugs or Medications, services, supplies, care or treatment to a Covered Person for Injury or sickness resulting from that Covered Person's voluntary taking of or being under the influence of any controlled substance, drug, hallucinogen or narcotic not administered on the advice of a Physician. Expenses will be covered for Substance Abuse treatment, as well as both physical and mental health conditions as specified in This Plan.
33. for No Physician Recommendation. Services, supplies, care or treatment not recommended and approved by a Physician; or treatment, services or supplies when the Covered Person is not under the regular care of a Physician. Regular care means ongoing medical supervision or treatment which is appropriate care for the Injury or sickness.
34. for Not Medically Necessary. Services, supplies, care or treatment for an Injury or Illness which is not medically necessary;
35. for Not Specified as Covered. Non-traditional medical services, treatments and supplies which are not specified as covered under This Plan.
36. for Personal Comfort Items. Personal comfort items or other equipment, such as, but not limited to, air conditioners, air-purification units, humidifiers, electric heating units, orthopedic mattresses, blood pressure instruments, scales, elastic bandages or stockings, nonprescription drugs and medicines, and first-aid supplies and nonhospital adjustable beds.
37. for Physician Charges, Certain. Failure to keep scheduled appointments, completion of claim forms or providing medical information necessary to determine coverage.
38. for Services, supplies, care or treatment Before or After Coverage for which a charge was incurred before a person was Covered under This Program or after coverage ceased under This Plan.
39. for Spinal Decompression services, supplies, care or treatment related to spinal decompression as performed by facilities such as The Back Pain Institute.
40. for Allergy Services. Specific non-standard allergy services and supplies, including but not limited to, skin titration (Rinkel method), cytotoxicity testing (Bryan's Test), treatment of non-specific candida sensitivity, and urine auto injections.
41. Transplants – The following services and supplies rendered in connection with organ/tissue/bone marrow transplants:

1) Surgical or medical care related to animal organ transplants, animal tissue transplants, (except for porcine heart valves) artificial organ transplants or mechanical organ transplants;
2) Transportation, travel or lodging expenses for non-donor family members;
3) Donation related services or supplies associated with organ acquisition and procurement;
4) Chemotherapy with autologous, allogenic or syngeneic hematopoietic stem cells transplant for treatment of any type of cancer not specially named as covered;
5) Any transplant not specially listed as covered.

42. Core Administrative Services, the plan administrator, utilizes Medicare standards for acceptable Common Procedure Terminology (CPT) billing codes. CPT codes not recognized by Medicare (ie., S codes) will also not be recognized by Core Administrative Services

Prescription Drug Expense Benefit

Benefits are payable when a Covered Person incurs eligible drug expenses which are in excess of the copayment amount, per prescription or refill. No reimbursement will be made if a Covered Person chooses to have prescriptions filled at a pharmacy that does not participate in the Prescription Drug Program. The Covered Person must show their member identification card at the pharmacy in order to obtain the appropriate copayment. In the event the Covered Person must pay full retail price; the insured should file their claims through the Prescription Benefit Program. Forms may be obtained through the Benefits Office or CAS.

PARTICIPATING PHARMACIES:
Use the ID card at any participating pharmacy.

Each Covered Person will be responsible for the required copayment at the time of purchase. The remainder of the transaction will be handled between Patient First and the pharmacy. When a retail participating pharmacy is used, each prescription shall be limited to a 30-day supply per month.

The Covered Person is expected to show the ID card to the member pharmacy when paying for the prescription. However, if the Covered Person does not have the card with them at the time of purchase, the Covered Person must:

1. Pay the full charge for the prescription;
2. Obtain a paid receipt which includes prescription information, not a cash register receipt only; and
3. Complete a Direct Reimbursement Patient First Prescription Drug Claim Form (available from the Benefits Office or CAS) with the pharmacist's help, attach the receipt and send both directly to Patient First at the address indicated on the claim form.

NO reimbursement will be made if a prescription is filled at a pharmacy that does not participate in the Prescription Drug Program.

NO Coordination of Benefits will apply for Prescription Drug Coverage.

Prescription Drug Coverage

This Program may require a prescription to be approved prior to its being filled. If your prescription is rejected at the pharmacy, contact CAS at 478-741-3521 or 888-741-2673 to inquire about the Prior Authorization process.

The following list contains categories of Prescription Drugs which are covered or excluded from the Program:

C = Covered / N = Not Covered

A.D.D. / Narcolepsy
C Amphetamines / Dextroamphetamine (e.g. Adderall)
C Dextroamphetamine (e.g. Dexedrine) / through age eighteen (18)
C Methylphenidate (e.g. Ritalin) / through age eighteen (18)
C Pemoline (e.g. Cylert) / through age eighteen (18)

Anabolic Steroid
N Therapeutic classification (e.g. Winstrol, Durabolin)

Anorectics
N Therapeutic classification (e.g. Desoxyn, Fastin, Ionamin)

Appetite Suppressants
N Any drug used for the purpose of weight loss.

Birth Control (Contraceptives)
C Oral dosage forms (e.g. Ortho-Novum, Demulen)
C Non-oral dosage forms - IUD
C Non-oral dosage forms (Diaphragm)
C Injectable dosage forms (e.g. Depo Provera)
C Levonorgestrel/ all implants (e.g. Norplant)

Cosmetic Medication
C Accutane (for acne)
N Anti-wrinkle agents (e.g. Renova)
N Retin-A / through age twenty-five (25)
N Pigmenting/depigmenting Agents (e.g. Solaquin Forte)

DESI Drugs
C All legend drugs which would otherwise be covered.

Diabetic Supplies (requires prescription from physician)
C Insulin
C Disposable Insulin Needles/Syringes (for insulin only)

C Blood/Urine testing agents (strips)
C Alcohol swabs
C Blood Glucose testing monitors
C Glucose Tablets
C Glucagon
C Lancets
C Lancet Devices
C Non-Insulin Needles Syringes (for administering prescribed medications)
N Pre-Filled Insulin Pens

See also *Educational Services/Diabetes*.

Experimental or Investigational Drugs
This is NOT a covered expense under this Program.
Drugs labeled "Caution – limited by federal law to investigational use," or “Experimental drugs,” even though a charge is made to the Covered Person.

Facility Administered Medication
These medications are NOT covered under the Prescription Drug Coverage. However, they may be covered under Hospital Services.

Medication which is to be taken by or administered to a Covered Person, in whole or in part, while he or she is a patient in a licensed Hospital, rest home, sanitarium, extended care facility, convalescent hospital, nursing home or similar institution which operates on its premises, or allows to be operated on its premises, a facility for dispensing pharmaceuticals.

See also *Hospital Services*.

Fluoride Supplements
N Tablet forms except for (see preventive care for dependent children)
N Oral rinses except for (see preventive care for dependent children)
N Topical dental preparations except for (see preventive care for dependent children)

HIV / AIDS Medications
Pre-notification through CHS required.
C Therapeutic classifications

Imitrex (Motion Sickness)
C Oral dosage forms
N Injectable dosage forms

Infertility Medications
N Oral dosage forms (e.g. Clomid, Serophene)
N Injectable dosage forms (e.g. Metrodin, Pergonal)

Interferon
Pre-notification through CHS required.
C Therapeutic classification (e.g. Betaseron, Intron-A)

Miscellaneous Prescriptions
N Anti-Wrinkle Agents (e.g. Renova)
N Blood and Blood Plasma (see hospital services)
N Growth Hormones (e.g. Humatropin, Genotropin)
N Immunization Agents (e.g. Hepatitis, Chicken Pox) (See Preventive Services Benefit)
N Minoxidil (Rogaine-for the loss of hair)
N Impotency Drugs (e.g. Viagra, Cialis)

Non-Legend Drugs
N Over-the-counter medications

Nutritional Supplements
N Non-legend vitamins (over the counter)
N Legend vitamins (Rx required)
N Pediatric multi-vitamins with fluoride (Rx required)
C Prenatal vitamins
N Diet supplements (e.g. Calcium)
N Hernatinics (e.g. Folic Acid, Chromogen, Iron Supp.)
N Minerals (e.g. Phoslo, Potaba)

Prescriptions, Worker's Compensation Related
This is NOT a covered expense under this Program.
Prescriptions which a Covered Person is entitled to receive without charge from any Worker's Compensation Laws.

Smoking Cessation – only those drugs that require a doctor's prescription
N Gum (e.g. Nicorette)
N Patches (e.g. Habitrol, Nicoderm)

Therapeutic Devices
This is NOT a covered expense under this Program.
Therapeutic devices or appliances, including needles, syringes (except as specified), support garments and other non-medicinal substances, regardless of intended use.

Dental Care Schedule of Benefits

Dental Care Benefits Eligibility

Dental care Services are available for covered dependents under the age of 19

Covered Types of Dental Care:

Type A: Diagnostic and Preventive
Type B: Basic Procedures
Type C: Major Procedures
Type D: Orthodontia Procedures

Calendar Year Deductible

None

Coinsurance

The Calendar Year Coinsurance for This Plan is as follows:

Type A: 80% of Allowable Charge
Type B: 70% of Allowable Charge
Type C: 50% of Allowable Charge
Type D: 50% of Allowable Charge

Eligibility is based on the same eligibility requirements as for the Medical portion of the Plan.

Waiting Period for Late Enrollees

Type A, B, & C services are covered once coverage is in force. Type D services have a twenty-four (24) continuous month waiting period.

Benefits from Other Sources

For instance, your dependent may be covered by this plan and a similar plan through your Spouse's Employer. If your dependent is, we coordinate our benefits with the benefits from the other plans. We do this so no one gets more in benefits than the charges incurred. Read **"**Coordination of Benefits" for details.

Plan Payment Provisions – Dental Care

Preventive Services (Type A)

D0120 Periodic oral evaluation - Limited to 1 every 6 months;
D0140 Limited oral evaluation - problem focused - Limited to 1 every 6 months;
D0150 Comprehensive oral evaluation - Limited to 1 every 6 months;
D0180 Comprehensive periodontal evaluation - Limited to 1 every 6 months;
D0210 Intraoral – complete series (including bitewings) 1 every 60 (sixty) months;
D0220 Intraoral - periapical first film;
D0230 Intraoral - periapical - each additional film;
D0240 Intraoral - occlusal film;
D0270 Bitewing - single film 1 set every 6 months;
D0272 Bitewings - two films 1 set every 6 months;
D0274 Bitewings - four films 1 set every 6 months;
D0277 Vertical bitewings – 7 to 8 films 1 set every 6 months;
D0330 Panoramic film – 1 film every 60 (sixty) months;
D0340 Cephalometric x-ray;
D0350 Oral / Facial Photographic Images;
D0470 Diagnostic Models;
D1110 Prophylaxis – Adult - Limited to 1 every 6 months;
D1120 Prophylaxis – Child - Limited to 1 every 6 months;
D1203 Topical application of fluoride (excluding prophylaxis) – child - Limited to 2 every 12 months; (replaced by code D1206, topical application of fluoride for patients of any age.)
D1204 Topical application of fluoride (excluding prophylaxis) – Age 15 to 22 - 2 every 12 months; (replaced by code D1206, topical application of fluoride for patients of any age.)
D1206 Topical fluoride varnish - 2 in 12 months;
D1351 Sealant - per tooth - unrestored permanent molars - Less than age 19. 1 sealant per tooth every 36 months;
D1352 Preventive resin restorations in a moderate to high caries risk patient - permanent tooth - 1 sealant per tooth every 36 months;
D1510 Space maintainer – fixed – unilateral;
D1515 Space maintainer – fixed – bilateral;
D1520 Space maintainer - removable – unilateral;
D1525 Space maintainer - removable – bilateral;
D1550 Re-cementation of space maintainer;

Basic Procedures (Type B)

D9110 Palliative treatment of dental pain – minor procedure; Minor Restorative Services
D2140 Amalgam - one surface, primary or permanent;
D2150 Amalgam - two surfaces, primary or permanent;
D2160 Amalgam - three surfaces, primary or permanent;
D2161 Amalgam - four or more surfaces, primary or permanent;
D2330 Resin–based composite - one surface, anterior;
D2331 Resin-based composite - two surfaces, anterior;
D2332 Resin-based composite - three surfaces, anterior;

D2335 Resin-based composite - four or more surfaces or involving incisal angle (anterior);
D2910 Re-cement inlay;
D2920 Re-cement crown;
D2930 Prefabricated stainless steel crown - primary tooth – Under age 15 - Limited to 1 per tooth in 60 months;
D2931 Prefabricated stainless steel crown - permanent tooth - Under age 15 - Limited to 1 per tooth in 60 months;
D2940 Protective Restoration;
D2951 Pin retention - per tooth, in addition to restoration;

Endodontic Services (Type B)

D3220 Therapeutic pulpotomy (excluding final restoration) - If a root canal is within 45 days of the pulpotomy, the pulpotomy is not a covered service since it is considered a part of the root canal procedure and benefits are not payable separately;
D3222 Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development If a root canal is within 45 days of the pulpotomy, the pulpotomy is not a covered service since it is considered a part of the root canal procedure and benefits are not payable separately;
D3230 Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration) - Limited to primary incisor teeth for members up to age 6 and for primary molars and cuspids up to age 11 and is limited to once per tooth per lifetime;
D3240 Pulpal therapy (resorbable filling) - posterior, primary tooth excluding final restoration). Incomplete endodontic treatment when you discontinue treatment. - Limited to primary incisor teeth for members up to age 6 and for primary molars and cuspids up to age 11 and is limited to once per tooth per lifetime; Periodontal Services
D4341 Periodontal scaling and root planning-four or more teeth per quadrant – Limited to 1 every 24 months;
D4342 Periodontal scaling and root planning-one to three teeth, per quadrant – Limited to 1 every 24 months;
D4910 Periodontal maintenance – 4 in 12 months combined with adult prophylaxis after the completion of active periodontal therapy;

Prosthodontic Services (Type C)

D5410 Adjust complete denture – maxillary;
D5411 Adjust complete denture – mandibular;
D5421 Adjust partial denture – maxillary;
D5422 Adjust partial denture – mandibular;
D5510 Repair broken complete denture base;
D5520 Replace missing or broken teeth – complete denture (each tooth);
D5610 Repair resin denture base;
D5620 Repair cast framework;
D5630 Repair or replace broken clasp;
D5640 Replace broken teeth - per tooth;
D5650 Add tooth to existing partial denture;
D5660 Add clasp to existing partial denture;

D5710 Rebase complete maxillary denture - Limited to 1 in a 36-month period 6 months after the initial installation;
D5720 Rebase maxillary partial denture - Limited to 1 in a 36-month period 6 months after the initial installation;
D5721 Rebase mandibular partial denture - Limited to 1 in a 36-month period 6 months after the initial installation;
D5730 Reline complete maxillary denture - Limited to 1 in a 36-month period 6 months after the initial installation;
D5731 Reline complete mandibular denture - Limited to 1 in a 36-month period 6 months after the initial installation;
D5740 Reline maxillary partial denture - Limited to 1 in a 36-month period 6 months after the initial installation;
D5741 Reline mandibular partial denture - Limited to 1 in a 36-month period 6 months after the initial installation;
D5750 Reline complete maxillary denture (laboratory) - Limited to 1 in a 36-month period 6 months after the initial installation;
D5751 Reline complete mandibular denture (laboratory) - Limited to 1 in a 36-month period 6 months after the initial installation;
D5760 Reline maxillary partial denture (laboratory) - Limited to 1 in a 36-month period 6 months after the initial installation;
D5761 Reline mandibular partial denture (laboratory) Rebase/Reline - Limited to 1 in a 36-month period 6 months after the initial installation;
D5850 Tissue conditioning (maxillary);
D5851 Tissue conditioning (mandibular);
D6930 Recement fixed partial denture;
D6980 Fixed partial denture repair, by report;

Oral Surgery (Type B)

D7140 Extraction, erupted tooth or exposed root (elevation and/or forceps removal);
D7210 Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth;
D7220 Removal of impacted tooth - soft tissue;
D7230 Removal of impacted tooth – partially bony;
D7240 Removal of impacted tooth - completely bony;
D7241 Removal of impacted tooth - completely bony with unusual surgical complications;
D7250 Surgical removal of residual tooth roots (cutting procedure);
D7251 Coronectomy - intentional partial tooth removal;
D7270 Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth;
D7280 Surgical access of an unerupted tooth;
D7310 Alveoloplasty in conjunction with extractions - per quadrant;
D7311 Alveoloplasty in conjunction with extractions-one to three teeth or tooth spaces, per quadrant;
D7320 Alveoloplasty not in conjunction with extractions - per quadrant;
D7321 Alveoloplasty not in conjunction with extractions-one to three teeth or tooth spaces, per quadrant;

D7471 Removal of exostosis;
D7510 Incision and drainage of abscess - intraoral soft tissue;
D7910 Suture of recent small wounds up to 5 cm;
D7971 Excision of pericoronal gingiva;

Class C Major (Type C)

D0160 Detailed and extensive oral evaluation - problem focused, by report;
D2510 Inlay - metallic – one surface – An alternate benefit will be provided;
D2520 Inlay - metallic – two surfaces – An alternate benefit will be provided;
D2530 Inlay - metallic – three surfaces – An alternate benefit will be provided;
D2542 Onlay - metallic - two surfaces – Limited to 1 per tooth every 60 months;
D2543 Onlay - metallic - three surfaces – Limited to 1 per tooth every 60 months;
D2544 Onlay - metallic - four or more surfaces – Limited to 1 per tooth every 60 months;
D2740 Crown - porcelain/ceramic substrate - Limited to 1 per tooth every 60 months;
D2750 Crown - porcelain fused to high noble metal - Limited to 1 per tooth every 60 months;
D2751 Crown - porcelain fused to predominately base metal – Limited to 1 per tooth every 60 months;
D2752 Crown - porcelain fused to noble metal – Limited to 1 per tooth every 60 months;
D2780 Crown - 3/4 cast high noble metal – Limited to 1 per tooth every 60 months;
D2781 Crown - 3/4 cast predominately base metal – Limited to 1 per tooth every 60 months;
D2783 Crown - 3/4 porcelain/ceramic – Limited to 1 per tooth every 60 months;
D2790 Crown - full cast high noble metal– Limited to 1 per tooth every 60 months;
D2791 Crown - full cast predominately base metal – Limited to 1 per tooth every 60 months;
D2792 Crown - full cast noble metal– Limited to 1 per tooth every 60 months;
D2794 Crown – titanium– Limited to 1 per tooth every 60 months;
D2950 Core buildup, including any pins– Limited to 1 per tooth every 60 months;
D2954 Prefabricated post and core, in addition to crown– Limited to 1 per tooth every 60 months;
D2980 Crown repair, by report;

Endodontic Services (Type B)

D3310 Anterior root canal (excluding final restoration);
D3320 Bicuspid root canal (excluding final restoration);
D3330 Molar root canal (excluding final restoration);
D3346 Retreatment of previous root canal therapy-anterior;
D3347 Retreatment of previous root canal therapy-bicuspid;
D3348 Retreatment of previous root canal therapy-molar;
D3351 Apexification/recalcification – initial visit (apical closure/calcific repair of perforations, root resorption, etc.);
D3352 Apexification/recalcification – interim medication replacement (apical closure/calcific repair of perforations, root; resorption, etc.);
D3353 Apexification/recalcification - final visit (includes completed root canal therapy, apical closure/calcific repair of perforations, root resorption, etc.);
D3354 Pulpal regeneration (completion of regenerative treatment in an immature permanent tooth with a necrotic pulp) does not include final restoration;

D3410 Apicoectomy/periradicular surgery – anterior;
D3421 Apicoectomy/periradicular surgery - bicuspid (first root);
D3425 Apicoectomy/periradicular surgery - molar (first root);
D3426 Apicoectomy/periradicular surgery (each additional root);
D3450 Root amputation - per root;
D3920 Hemisection (including any root removal) - not including root canal therapy;

Periodontal Services (Type B)

D4210 Gingivectomy or gingivoplasty – four or more teeth - Limited to 1 every 36 months;
D4211 Gingivectomy or gingivoplasty – one to three teeth;
D4240 Gingival flap procedure, four or more teeth – Limited to 1 every 36 months; D4249 Clinical crown lengthening-hard tissue;
D4260 Osseous surgery (including flap entry and closure), four or more contiguous teeth or bounded teeth spaces per quadrant – Limited to 1 every 36 months;
D4270 Pedicle soft tissue graft procedure;
D4271 Free soft tissue graft procedure (including donor site surgery);
D4273 Subepithelial connective tissue graft procedures (including donor site surgery);
D4355 Full mouth debridement to enable comprehensive evaluation and diagnosis – Limited to 1 per lifetime;

Prosthodontic Services (Type B)

D5110 Complete denture - maxillary – Limited to 1 every 60 months;
D5120 Complete denture - mandibular – Limited to 1 every 60 months;
D5130 Immediate denture - maxillary – Limited to 1 every 60 months;
D5140 Immediate denture - mandibular – Limited to 1 every 60 months;
D5211 Maxillary partial denture - resin base (including any conventional clasps, rests and teeth) – Limited to 1 every 60 months;
D5212 Mandibular partial denture - resin base (including any conventional clasps, rests and teeth) – Limited to 1 every 60 months;
D5213 Maxillary partial denture - cast metal framework with resin denture base (including any conventional clasps, rests and teeth) – Limited to 1 every 60 months; D5214 Mandibular partial denture - cast metal framework with resin denture base (including any conventional clasps, rests and teeth) – Limited to 1 every 60 months; D5281 Removable unilateral partial denture-one piece cast metal (including clasps and teeth) – Limited to 1 every 60 months;
D6010 Endosteal Implant - 1 every 60 months;
D6012 Surgical Placement of Interim Implant Body - 1 every 60 months;
D6040 Eposteal Implant – 1 every 60 months;
D6050 Transosteal Implant, Including Hardware – 1 every 60 months;
D6053 Implant supported complete denture;
D6054 Implant supported partial denture;
D6055 Connecting Bar – implant or abutment supported - 1 every 60 months;
D6056 Prefabricated Abutment – 1 every 60 months;
D6058 Abutment supported porcelain ceramic crown -1 every 60 months;
D6059 Abutment supported porcelain fused to high noble metal - 1 every 60 months;

D6060 Abutment supported porcelain fused to predominately base metal crown - 1 every 60 months;
D6061 Abutment supported porcelain fused to noble metal crown - 1 every 60 months; D6062 Abutment supported cast high noble metal crown - 1 every 60 months;
D6063 Abutment supported cast predominately base metal crown - 1 every 60 months; D6064 Abutment supported cast noble metal crown - 1 every 60 months;
D6065 Implant supported porcelain/ceramic crown - 1 every 60 months;
D6066 Implant supported porcelain fused to high metal crown - 1 every 60 months;
D6067 Implant supported metal crown - 1 every 60 months;
D6068 Abutment supported retainer for porcelain/ceramic fixed partial denture - 1 every 60 months;
D6069 Abutment supported retainer for porcelain fused to high noble metal fixed partial denture - 1 every 60 months;
D6070 Abutment supported retainer for porcelain fused to predominately base metal fixed partial denture - 1 every 60 months;
D6071 Abutment supported retainer for porcelain fused to noble metal fixed partial denture - 1 every 60 months;
D6072 Abutment supported retainer for cast high noble metal fixed partial denture 1 every 60 months;
D6073 Abutment supported retainer for predominately base metal fixed partial denture - 1 every 60 months;
D6074 Abutment supported retainer for cast noble metal fixed partial denture - 1 every 60 months;
D6075 Implant supported retainer for ceramic fixed partial denture - 1 every 60 months; D6076 Implant supported retainer for porcelain fused to high noble metal fixed partial denture - 1 every 60 months;
D6077 Implant supported retainer for cast metal fixed partial denture - 1 every 60 months; D6078 Implant/abutment supported fixed partial denture for completely edentulous arch - 1 every 60 months;
D6079 Implant/abutment supported fixed partial denture for partially edentulous arch - 1 every 60 months;
D6080 Implant Maintenance Procedures -1 every 60 months;
D6090 Repair Implant Prosthesis -1 every 60 months;
D6091 Replacement of Semi-Precision or Precision Attachment -1 every 60 months;
D6095 Repair Implant Abutment -1 every 60 months;
D6100 Implant Removal -1 every 60 months;
D6190 Implant Index -1 every 60 months;
D6210 Pontic - cast high noble metal – Limited to 1 every 60 months;
D6211 Pontic - cast predominately base metal – Limited to 1 every 60 months;
D6212 Pontic - cast noble metal– Limited to 1 every 60 months;
D6214 Pontic – titanium – Limited to 1 every 60 months;
D6240 Pontic - porcelain fused to high noble metal – Limited to 1 every 60 months;
D6241 Pontic - porcelain fused to predominately base metal – Limited to 1 every 60 months;
D6242 Pontic - porcelain fused to noble metal – Limited to 1 every 60 months;
D6245 Pontic - porcelain/ceramic – Limited to 1 every 60 months;

D6519 Inlay/onlay – porcelain/ceramic – Limited to 1 every 60 months;
D6520 Inlay – metallic – two surfaces – Limited to 1 every 60 months;
D6530 Inlay – metallic – three or more surfaces - Limited to 1 every 60 months;
D6543 Onlay – metallic – three surfaces - 1 every 60 months;
D6544 Onlay – metallic – four or more surfaces -1 every 60 months;
D6545 Retainer - cast metal for resin bonded fixed prosthesis -1 every 60 months;
D6548 Retainer - porcelain/ceramic for resin bonded fixed prosthesis -1 every 60 months;
D6740 Crown - porcelain/ceramic -1 every 60 months;
D6750 Crown - porcelain fused to high noble metal - 1 every 60 months;
D6751 Crown - porcelain fused to predominately base metal - 1 every 60 months;
D6752 Crown - porcelain fused to noble metal - 1 every 60 months;
D6780 Crown - 3/4 cast high noble metal - 1 every 60 months;
D6781 Crown - 3/4 cast predominately base metal - 1 every 60 months;
D6782 Crown - 3/4 cast noble metal - 1 every 60 months;
D6783 Crown - 3/4 porcelain/ceramic - 1 every 60 months;
D6790 Crown - full cast high noble metal - 1 every 60 months;
D6791 Crown - full cast predominately base metal - 1 every 60 months;
D6792 Crown - full cast noble metal - 1 every 60 months;
D6973 Core buildup for retainer, including any pins - 1 every 60 months;
D9220 Deep sedation/general anesthesia - first 30 minutes;
D9221 Deep sedation/general anesthesia - each additional 15 minutes;
D9241 Intravenous conscious sedation/analgesia - first 30 minutes;
D9242 Intravenous conscious sedation/analgesia - each additional 15 minutes;
D9310 Consultation (diagnostic service provided by dentist or physician other than practitioner providing treatment);
D9610 Therapeutic drug injection, by report;
D9930 Treatment of complications (post-surgical) unusual circumstances, by report; and,
D9940 Occlusal guard, by report - 1 in 12 months for patients 13 and older.

Orthodontic Services (Type D)

D8010 Limited orthodontic treatment of the primary dentition
D8020 Limited orthodontic treatment of the transitional dentition
D8030 Limited orthodontic treatment of the adolescent dentition
D8050 Interceptive orthodontic treatment of the adolescent dentition
D8060 Interceptive orthodontic treatment of the transitional dentition
D8070 Comprehensive orthodontic treatment of the transitional dentition
D8080 Comprehensive orthodontic treatment of the adolescent dentition
D8210 Removable appliance therapy
D8220 Fixed appliance therapy
D8660 Pre-orthodontic treatment visit
D8670 Periodic orthodontic treatment visit
D8680 Orthodontic retention (removal of appliances, construction and placement of retainer(s))

Dental Services – Not Covered

D0320 TMJ arthrogram
D0321 Other TMJ films
D0322 Tomographic survey
D0360 Cone Beam CT
D0362 Cone Beam multiple images 2 dim.
D0363 Cone Beam multiple images 3 dim.
D0416 Viral culture
D0418 Analysis of saliva example chemical or biological analysis of saliva for diagnostic purposes.
D0425 Caries test
0431 Adjunctive pre-diagnostic test
D0475 Declassification procedure
D0476 Special stains for microorganisms
D0477 Special stains not for microorganisms
D0478 Immunohistochemical stains
D0479 Tissue in-situ-hybridization
D0481 Electron microscopy
D0482 Direct immunofluorescence
D0483 In-direct immunofluorescence
D0484 Consultation on slides prepared elsewhere
D0485 Consultation including preparation of slides
D0486 Accession Transepithelial
D1310 Nutritional counseling
D1320 Tobacco counseling
D1330 Oral Hygiene Instruction
D1555 Removal of fixed space maintainer
D7292 Surgical replacement screw retained
D7293 Surgical replacement without the surgical flap
D7880 TMJ Appliance
D7899 TMJ Therapy
D7951 Sinus Augmentation with bone or bone substitutes
D7997 Appliance removal
D7998 Intraoral placement of a fixation device
D2410 Gold Foil 1 surface
D2420 Gold Foil 2 surface
D2430 Gold Foil 3 surface
D2799 Provisional crown
D2955 Post removal
D2970 Temporary crown
D2975 Coping
D3460 Endodontic Implant
D3470 Intentional reimplantation
D3910 Surgical procedure for isolation of tooth

D3950 Canal preparation
D4230 Anatomical crown exposure 4 or more teeth
D4231 Anatomical crown exposure 1-3 teeth
D4320 Splinting intracoronal
D4321 Splinting extracoronal
D5810 Complete denture upper (interim)
D5811 Complete denture lower (interim)
D5820 Partial denture upper (interim)
D5821 Partial denture lower (interim)
D5862 Precision attachment
D5867 Replacement Precision attachment
D5986 Fluoride Gel Carrier
D6057 Custom abutment
D6253 Provisional Pontic
D6254 Interim pontic
D6795 Interim retainer crown
D6920 Connector bar
D6940 Stress breaker
D6950 Precision Attachment
D6975 Coping – mental

- Dental or Orthodontic care for dependent children age 19 and over
- Dental or Orthodontic care for members and spouses
- Repair to damaged orthodontic appliances
- Replacement of lost or missing orthodontic appliances
- Orthodontic services provided to a dependent of an enrolled member who has not met the 24-month continuous waiting period requirement

Pre-Notification Requirements

Pre-Certification

If a Covered Person fails to call Core Health Services (CHS) within the time limits specified below, the Covered Person will be subject to a 20% reduction penalty in benefits.

This Program only covers charges that are Medically Necessary for the care and treatment of disease or Injury. To determine Medical Necessity, CHS requires that you obtain advance approval (pre-certification) for all scheduled inpatient services. This includes all admissions to medical / surgical facilities, Hospital, Hospice, and convalescent facilities. Maternity and emergency admissions may also require notification.

The Student, patient, family member, attending Physician, or Hospital can contact CHS for pre-certification at 478-741-3521 or 888-741-CORE (2673). A nurse case manager is available to take calls Monday through Friday, 8am - 5pm EST, and the caller is able to leave a message after hours.

It is the patient's responsibility to notify CHS for pre-certification. **To avoid a penalty and obtain maximum benefits, pre-certification must be done within the following time limits:**

- **Scheduled Admissions** – must be pre-certified at least two business days prior to admission. You should notify CHS as soon as you know that a procedure has been scheduled and that you have to be admitted.

- **Maternity Admissions** – This Program, under federal law, generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or Newborn Child to less than forty-eight (48) hours following a vaginal delivery, or less than ninety-six (96) hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than forty-eight (48) hours (or ninety-six (96) hours as applicable). In any case, this Program may not, under federal law, require that a provider obtain authorization from the Program for prescribing a length of stay not in excess of forty-eight (48) hours (or ninety-six (96) hours as applicable).

  Any Maternity Hospital stays longer than forty-eight (48) hours (or ninety-six (96) hours as applicable), must be Pre-Certified, and will be subject to the Pre-Certification penalties as defined in Pre-Notification Requirements.[3]

- **Emergency or Urgent Inpatient Admission** – must be pre- certified within two (2) days after the admission or on the next business day if the admission occurs on a weekend or legal holiday. A Hospital confinement following an emergency or urgent admission undergoes concurrent review just like a scheduled admission.

  Durable Medical Equipment – all medical equipment in excess of $500 in purchase price requires pre-authorization by CHS.

When you call for pre-certification, a CHS nurse case manager will ask for the necessary information. Following is a list of the necessary information for pre-certification:

- Student's name and ID number;
- Patient's name, date of birth, sex, and contact telephone number;
- Facility or Hospital's name, address, and telephone number;
- Admitting Physician's name, address, and telephone number;
- Date of admission;
- Diagnosis and/or surgical procedure (if known); and
- Date of surgery.

Any additional information needed will be obtained from the attending Physician or Hospital by the CHS nurse case manager. All medical information is kept confidential. In some instances, CHS may suggest alternative modes of treatment or recommend a second surgical opinion. CHS can help reduce personal inconvenience and limit the increasing cost of medical care by eliminating unnecessary or questionable services. If it is determined that the Hospital confinement is Medically Necessary, your attending Physician, Hospital, and you will receive a notice of certification.

If there is a question about the scheduled procedure, treatment, or length of confinement, a CHS Physician will review your case. If the CHS Physician also has questions, he or she will contact your Physician for additional information. If you do not agree with the denial of your pre-certification request, discuss it with your Physician. Perhaps the recommended procedure can be done on an outpatient basis.

If you want to appeal a denial of pre-certification, you may call or write CHS to request that the denial of pre-certification be reconsidered.

Core Health Services
P O Box 90
Macon, GA 31202-0090
478-741-3521
888-741-CORE (2673)

Prior Determination

The following items require pre-certification:

- *Biopsy, radiation therapy, chemotherapy, transplant, and dialysis*
- *Bone Density Study – if part of complete physical exam*
- *Bronchoscopy*
- *Cat Scan (CT)*
- *Colonoscopy (Lower GI)*
- *Colposcopy*
- *DME over $500*
- *Echocardiogram*
- *Electroencephalogram (EEG)*
- *Electromyogram (EMG)*

- *Esophagogastroduodenoscopy (EGD) [Upper GI]*
- *Heart Catheterization – If elective or if admitted*
- *HIDA Scan*
- *Inpatient stay*
- *MRI*
- *Nerve Conduction Studies*
- *Nuclear Scan*
- *Observation Stay*
- *Orthognathic/TMJ*
- *Outpatient surgery (unless listed below)*
- *PET Scan*
- *Sleep Studies*
- *Therapies: pulmonary rehabilitation and speech therapy*

The following items do not require pre-certification:

- *Cardiac Stress Test*
- *Cataract Surgery*
- *Electrocardiogram (EKG)*
- *Mammogram*
- *Pap Smear*
- *Ultrasound*
- *X-rays*

You are required to obtain authorization for certain procedures that might be cosmetic or not medically necessary for the treatment of illness or injury. All requests for these procedures should be made in writing and should be submitted well in advance of the planned procedure date:

- *Blepharoplasty*
- *Breast reduction or mammoplasty*
- *Dermatolipectomy*
- *Diastasis recti repair (tummy tuck)*
- *Hernia repairs, all except inguinal*
- *Incision of the maxilla or mandible*
- *Keloid removal*
- *Mastectomy for gynecomastia*
- *Mentoplasty*
- *Otoplasty*
- *Panniculectomy*
- *Penile Implant*
- *Rhinoplasty*
- *Sclerotherapy*
- *Uvulopalatopharyngoplasty (UPPP)*
- *Varicose Vein ligation/stripping*

Concurrent Review

If the patient stays beyond the pre-certified time period, and the days are determined not to be Medically Necessary, room and board charges for these days will be denied.

If you need more time in the hospital, you may be certified for additional days while you are in the hospital. You, your hospital, or your attending Physician must call CHS no later than the last day certified.

Concurrent review is the process of evaluating the continued hospital confinement. This telephonic review is also conducted by CHS nurse case managers. If additional days are judged to be medically necessary, CHS will grant certification. If the CHS nurse case manager's opinion differs with the attending physician's opinion, the case will be reviewed by a CHS physician and final determination will be made.

If the continued confinement is determined not to be medically necessary, CHS will communicate the denial to all involved parties (the student, hospital and attending physician). If the patient chooses to remain in the hospital beyond the certified number of days, the patient will be fully responsible for any remaining expenses that are incurred. If the patient or student wishes to appeal the decision to deny benefits for a continued confinement, he or she can submit an appeal in writing to CHS.

Core Administrative Services, Inc.
PO Box 90
Macon, GA 31202-0090

Pre-certification approval does not guarantee benefits. Payment of benefits is subject to any subsequent reviews of medical information or records, the patient's eligibility on the date the service is rendered, and any other contractual provisions of the Program.

Eligibility and Effective Date of Coverage

The coverage of an eligible student who enrolls for coverage under the Program shall take effect on the latest of the following dates: (1) the Program Effective Date; (2) the day after the date for which the first premium for the Covered Student's coverage is received by the Program; (3) the date the member's term of coverage begins; or (4) the date the Student becomes a member of an eligible class of persons as described in the Description of Classes section of the Schedule of Benefits in the Program.

EXCEPTION: Medical students are able to be covered as early as July 1st since their classes began prior to the regular beginning coverage date of August 1st.

Insurance for a Covered Student will end at 11:59 p.m. on the first of these to occur:

(a) the date the Program terminates;
(b) the last day for which any required premium has been paid; or
(c) the date on which the Covered Student withdraws from the school because of entering the armed forces of any country (Premiums will be refunded on a pro-rata basis (less any claims paid) when written request is made.) If withdrawal from the University is for other than the Covered Student's entry into the armed services, no premium refund will be made. Students will be covered for the Program term for which they are enrolled and for which premium has been paid.

Eligibility

A person is eligible for coverage under the Mercer University Student Health Insurance Program (MUSHiP) if he or she is:

1. All students, Domestic or International Undergraduate who registers for three (3) or more credit hours are automatically assessed the "mandatory insurance requirement" single student health insurance coverage unless they previously have waived coverage during the appropriate semester/sessions.
2. ELI Student; or
3. Graduate or Professional student who enrolls in a graduate level course that is three (3) or more credit hours, in good academic standing, and making progress toward graduation.

EXCLUDED: Regional Academic Center Students and Distance Education Students are not eligible to participate.

EXCEPTIONS: Regional Academic Center non U.S. Citizen Students are automatically enrolled in the Student Health Insurance. Also Graduate Assistants in their Master's Higher Education program through the Regional Academic Center are eligible to purchase the Mercer Insurance.

Covered Person's Effective Date

Covered Student

The coverage of an eligible Student, including the student who initially waived coverage and subsequently enrolls within 31 days of ineligibility under another Creditable Coverage, shall take effect on the latest of the following dates: (1) this Program Effective Date; (2) the day after the date for which the first premium for the Covered Student's coverage is received by the Program; or (3) the date the

Program Holder's term of coverage begins; (4) the date the Student becomes a member of an eligible class of persons as described in the Description of Class section of the Schedule of Benefits.

The coverage of a student who enrolls for coverage under this Program during any subsequent Open Enrollment Period shall take effect on the later of the following dates: (1) the day after the date for which the premium for the Covered Student's coverage is received by the Program; or (2) the date this Program Holder's term of coverage begins.

However, a student who does not enroll himself or herself during an Open Enrollment Period may not apply for coverage until the next subsequent Open Enrollment Period unless application for coverage is made within 31 days of a Family Status Change. As a result of a Family Status Change, the Student may enroll for coverage for himself or herself. In that case, the insurance for the eligible student becomes effective on the latest of the following dates: (1) the day after the date on which the first premium for the Covered Student's coverage is received by the Program; or (2) the date the student becomes a member of an eligible class of persons as described in the Description of Class section of the Schedule of Benefits; or (3) the date the Program gives its written consent.

Covered Dependent
A covered Dependent's coverage shall take effect on the later the following dates: (1) the date the coverage for the Covered Student becomes effective; or (2) the date the Dependent is enrolled for coverage, provided premium is paid when due. If enrollment for coverage is made more than 31 days following the date the Dependent becomes eligible, then his or her insurance will become effective only if and when the Program gives its written consent.

A newborn child shall not be insured for Injury or Sickness, including the necessary care and treatment of premature birth unless enrolled within 31 days from date of birth. The Covered Student must notify the Program of the birth in writing and pay any additional premium required for the child's insurance within the 31 day period.

An adopted child shall not be insured for Injury or Sickness, including the necessary care and treatment of premature birth and medically diagnosed congenital defects and birth abnormalities furnished any infant from the earlier of placement for adoption or entry of the final decree of adoption unless enrolled within 31 days from date of birth. The Covered Student must notify the Program in writing of the filing of the petition for adoption and pay any required premium within the 31-day period after the placement or date of the filing of the decree for adoption in order to have insurance.

This Program Holder agrees to submit to the Program within 20 days after the effective date of each Covered Person's insurance: (1) the name of each person enrolled for coverage hereunder; (2) the effective date of insurance; and (3) the premium paid as to each such Covered Person. The insurance of those Covered Persons whose names and premiums were received more than 20 days after the date the insurance would have become effective will take effect on the date such name and premium is received by the Program or its authorized representative except as provided in the previous paragraph.

Premium Refunds

Student premium refunds are not allowed unless the covered student enters full-time active duty in any Armed Forces*. *(*Excludes Reserve or National Guard duty for training unless it exceeds 31 days. Submit proof of service to receive a pro-rata refund of premium for this period, less any claims paid.)*

Changing Coverage During the Plan Year - FAMILY STATUS CHANGES

The student is permitted to make changes in coverage during the Plan Year only in the event of certain specified "Changes in Status". "Changes in Status" which would permit the Student to make a change in coverage are as follows:

1. Marriage
2. Divorce
3. Birth or Adoption of a Child, or the assumption of legal responsibility for a Step Child or Foster Child
4. Death of an enrolled Dependent
5. Dependent Child reaches age 26
6. Dependent Child becomes employed full-time and if offered coverage with their employer
7. Dependent Child becomes totally or permanently disabled
8. Covered Dependent loses coverage under an outside Plan or suffers a substantial change in coverage under the outside Plan
9. Covered Dependent experiences a change in employment status

In the event of any of the above occurrences, the Student should notify Core at: studentplan@corehealthbenefits.com or call 1-888-741-2673 and ask for the appropriate forms necessitated by the Change of Status. The request to add or delete coverage must be made within 31 days of the Change in Status.

Referrals

A referral from the nearest Campus Student Health Center is required before benefits are payable.

This provision does not apply if:

(a) Emergency situations…Call 911 or go to nearest Urgent Care or Emergency Room. The student must return to the Student Health Center for any necessary follow-up care.
(b) Student lives more than 40 miles from the Macon or Atlanta Campus.
(c) Student is traveling more than 40 miles from Macon or Atlanta Campus (vacation, school assignment, semester break).
(d) for maternity(obstetrics) care;
(e) for mental health care; or

Benefits for Eligible Expenses incurred for medical care or treatment rendered for which no referral is obtained will be excluded from coverage. Benefits for Emergency Medical Condition will be payable at the PPO level whether treatment is received from a PPO provider or Non-PPO provider. The applicable deductibles and copay amounts shall apply to all of the exceptions to the referral requirement shown above.

This referral requirement does not apply to the Covered Student's dependent(s).

Instructions for Submission of Claims

Be sure the bills submitted include all of the following:

1. Student's name, student ID number and home address;
2. Patient's name, social security number and date of birth;
3. Program's Name
4. Name and address of the Physician or Hospital
5. Physician's diagnosis;
6. Itemization of charges;
7. Date the Injury occurred or Illness began; and
8. Receipt for payment if reimbursement is to be made to the insured.

These items are REQUIRED in order to accurately pay claims. Certain claims may require additional information before being processed. Benefits payable under This Program for any loss other than loss for which This Program provides any periodic payment, will be paid immediately upon receipt of due written proof of such loss.

All payments will be issued directly to the provider of the service unless receipted bills showing payment has been made are submitted.

Please direct all claims and questions regarding claims to:

Core Administrative Services
PO Box 90
Macon, GA 31202-0090
478-741-3521
888-741-CORE (2673)

Every attempt will be made to help Covered Persons understand their benefits; however, any statement made by an Employee of CAS or by Core will be deemed a representation and not a warranty.

Actual benefit payment can only be determined at the time the claim is submitted and all facts are presented in writing. All benefit payments are governed by the provisions of the Summary Program Description and Group Provisions pages.

Benefits may not be assigned to another party, including the right to bring legal action. A direction to pay a provider, directly or otherwise, is not an assignment of any right and that a direction to pay does not extend to a provider any legal right to initiate court proceedings.

If a definite answer to a specific question is required, please submit a written request, including all pertinent information and a statement from the attending Physician (if applicable), and a written reply will be sent, which will be kept on file.

General Provisions

ENTIRE CONTRACT; CHANGES This Program, the Application and any attached papers make up the entire contract between this Program Holder and the Program. In the absence of fraud or intentional misrepresentation of a material fact, all statements made by this Program Holder or any Covered Person will be deemed representations and not warranties.

No written statement made by this Program Holder or a Covered Person will be used in any contest unless a copy of the statement is furnished to this Program Holder or the Covered Person or his or her beneficiary or personal representative.

No change in this Program shall be valid unless approved by an officer of the Program. The approval must be noted on or attached to this Program. No agent has authority to change this Program or to waive any of its provisions.

INCONTESTABILITY The validity of this Program will not be contested after two year(s) from this Program Effective Date, except as to nonpayment of premiums.

PREMIUMS The Program sets the premiums that apply to the coverage provided under this Program. Those premiums are shown in a notice given to this Program Holder with or prior to delivery of this Program. The Program has the right to adjust the premium rate when the terms of this Program are changed. This Program Holder will be given notice of such premium adjustment at least 60 days before the date it is to take effect unless the change in Program terms is to take effect before the 60 days.

RENEWAL OF PROGRAM This Program is issued for this Program Term shown in the Schedule of Benefits. If this Program Holder wishes to continue coverage, the Program will issue a new Program for a new Program Term, subject to the then current underwriting requirements.

CLAIM FORMS Upon receipt of a written notice of claim, the Program will give the claimant such forms as are usually given by the Program for filing proofs of loss. If such forms are not given within 10 working days after the receipt of such notice, the claimant can fulfill the terms of this Program as to proof of loss by giving written proof of: (a) the occurrence of the loss; and (b) the nature of the loss; and (c) the extent of the loss.

PROOFS OF LOSS Written proof of loss must be given to the Program within 90 days after the date of such loss. Failure to give such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time. However, proof must be given as soon as reasonably possible.

TIME OF PAYMENT OF CLAIMS Benefits payable under this Program will be paid within 15 working days of receipt of an electronic claim, or 30 calendar days after receipt of a paper claim. If additional information is required, the Program will notify the claimant by letter or electronic notification within 15 working days of receipt of an electronic claim, or within 30 calendar days of receipt of a paper claim. Any undisputed portion of the claim will be paid in accordance with the days noted herein, based on

the format of the claim. Upon receipt of all outstanding information, the Program will pay or deny the claim within 15 working days for electronic claims and within 30 calendar days for paper claims.

ASSIGNMENT This Program is non-assignable.

PHYSICAL EXAMINATION AND AUTOPSY The Program at its own expense has the right to have a Doctor examine a Covered Person when and so often as it deems reasonably necessary while there is a claim pending under this Program and to make an autopsy in case of death where it is not forbidden by law.

LEGAL ACTIONS No action at law or in equity shall be brought to recover on this Program within sixty (60) days after written proof of loss has been furnished in accordance with the requirements of this Program. No such action shall be brought after the expiration of three (3) years from the time that proof of loss was required to be furnished.

RECORDS MAINTAINED This Program Holder shall maintain records of each person covered. The records shall show all data that is needed to administer this Program.

EXAMINATION AND AUDIT The Program shall be allowed to examine and audit this Program Holder's books and records which pertain to this Program at reasonable times. The Program must also be allowed to do this within three (3) years after the later of: (a) the date this Program terminates; or (b) until final settlement of all claims hereunder.

CONFORMITY WITH STATE STATUTES Any provision of this Program which, on its effective date, is in conflict with the statutes of the state in which this Program is delivered is hereby amended to conform to the minimum requirements of such statutes.

PROGRAM ERROR Clerical errors, whether by this Program Holder or the Program, will not void the insurance of any Covered Person if that insurance would otherwise have been in effect nor extend the insurance of any Covered Person if that insurance would otherwise have ended or been reduced as provided in this Program.

NOT IN LIEU OF WORKERS' COMPENSATION This Program is not a Workers' Compensation Program. It does not provide Workers' Compensation benefits.

RIGHT OF RECOVERY As a condition to receiving benefits under this Program, the Covered Person (or, if he or she is deceased, an authorized representative of the Covered Person) agrees, except as may be limited or prohibited by applicable law:

(a) to reimburse the Program for any such benefits paid to or on behalf of the Covered Person, if such benefits are recovered, as per the limitations stated below in paragraph (c), from any Third Party or Coverage;
(b) if the Covered Person is a minor or is not competent to make this agreement, the legal guardian of the Covered Person's property makes the agreement on the Covered Person's behalf as a condition to receiving benefits under this Program on behalf of the Covered Person. If the Covered Person has no guardian for his or her property, the person or persons who, in the

Administrator's opinion, have assumed the custody and support of the minor or responsibility for the incompetent person's affairs make the agreement on the Covered Person's behalf as a condition to receiving such benefits under this Administrator on behalf of the Covered Person; and

(c) if a Covered Person has a claim for damages from a third party or parties for any Sickness or Injury for which benefits are payable under this Administrator, the Administrator may have a right of recovery. The Administrator's right of recovery shall be limited to the recovery of any benefits paid for identical covered medical expenses under this Administrator, but shall not include non-medical items. Money received for future medical care or pain and suffering may not be recovered. The Administrator's right of recovery may include compromise settlements. The Covered Person or his attorney must inform the Administrator of any legal action or settlement agreement at least ten days prior to settlement or trial. The Administrator will then notify the Covered Person of the amount it seeks to recover for covered benefits paid. The Administrator's recovery may be reduced by the pro-rata share of the Covered Person's attorney's fees and expenses of litigation.

Coordination of Benefits

If a Covered Person is covered under more than one group plan, including This Plan and any other group medical benefits provided through or by the Employer, and one or more other plans, as defined below, the benefits will be coordinated. The benefits payable under This Plan for any Claim Determination Period, will be either its regular benefits or reduced benefits which when added to the benefits of the other plan, will equal no more than 100% of the Allowable Expenses, also defined below:

Coordination of Benefits Definitions

Allowable Expenses
Any Medically Necessary, Reasonable item of expense incurred by a Covered Person which is covered at least in part under This Plan.

Claim Determination Period
A Calendar or Plan Year or that portion of a Calendar or Plan Year during which the Covered Person for whom claim is made has been covered under This Plan.

Plan
Any Plan under which medical or dental benefits or services are provided by:

1. Group, blanket or franchise insurance coverage;
2. Preferred Provider Organization (PPO);
3. Wholly or partially self-insured or self-funded group plans;
4. Group coverage under labor-management trusted plans, union welfare plans, Employer organization plans or employee benefit organization plans;
5. Coverage, including Medicare, under governmental programs or coverage required or provided by a statute, or provided by or required by statute, including no-fault auto insurance. (Refer to the EFFECT OF MEDICARE provision for treatment of this coverage under This Plan).

Health Maintenance Organization Coverage
This Plan will not consider as an Allowable Expense any charge which would have been covered by a Health Maintenance Organization (HMO) had a Covered Person for whom the HMO would be primary payer, used the services of an HMO Participating Provider. Nor, will This Plan consider any charge in excess of what an HMO provider has agreed to accept as payment in full.

Order of Benefit Determination
When a claim is made, the primary plan pays its benefits without regard to any other plans. The secondary plan adjusts its benefits so that the total benefits available will not exceed the Allowable Expense. No plan pays more that it would without the Coordination of Benefits Provision.

A Plan without a Coordination of Benefits provision is always the Primary Plan. If all plans have such a provision:

1. The Plan covering the person directly, rather than as an Employee's Dependent, is primary and the others are secondary;
2. Dependent Children of parents not separated or divorced:
    a. The Plan covering the parent whose birthday falls earlier in the year pays first. The Plan covering the parent whose birthday falls later in the year pays second;
    b. If both parents have the same birthday, the Plan which covers the parent the longer period of time, pays first. However, if the other Plan does not have this rule but instead has a rule based upon the gender of the parent, and if, as a result, the Plans do not agree on the order of benefits, the rule in the other Plan will determine the order of benefits.
3. Dependent Children of separated or divorced parents: When parents are separated or divorced, their birthday rules do not apply. Instead:
    a. The Plan of the parent with custody pays first;
    b. The Plan of the spouse of the parent with custody (the step parent) pays next; and
    c. The Plan of the parent without custody pays last.
    d. Unless the divorce decree specifies order of benefit determination, in which case, the order will be determined by the divorce decree.
4. Active/Inactive Employee: The Plan covering a person as an employee who is neither laid off nor retired (or as that person's dependent) pays benefits first. The Plan covering that person as a laid off or retired employee (or as that person's dependent) pays benefits second. If both plans do not have this rule and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.
5. If none of the above rules determines the order of benefits, the Plan covering a person longer pays first. The Plan covering that person for the shorter time period pays second.

Recovery

If the amount of the payment made by This Plan is more than it should have paid, the Plan has the right to recover the excess from one or more of the following:

1. The person This Plan has paid or for which it has paid;
2. Insurance companies;
3. Other organizations.

Payment to Other Carriers

Whenever payments, which should have been made under This Plan in accordance with the above provisions, have been made under any other plan, This Plan will have the right exercisable alone and in its sole discretion to pay any organization making those payments any amounts it determines to be warranted in order to satisfy the intent of the above provisions. Amounts paid in this manner will be considered to be benefits paid under This Plan and, to the extent of these payments, This Plan will be fully discharged from liability.

Release of Information

For the purposes of determining the applicability of and implementing the terms of the above provisions of This Plan or any similar provision of another plan, the Third-Party Administrator may, without the consent of or notice to any Covered Person, release to or obtain from, any information concerning any Covered Person, which is necessary for those purposes.

Any person receiving benefits under This Plan must furnish to the Third-Party Administrator information about other coverage which may be involved in applying this Coordination of Benefits provision.

If This Plan contains a Patient First Prescription Benefit, NO Coordination of Benefits will apply for Prescription Drug Coverage.

APPEAL PROCEDURES

DEFINITIONS

Adverse Determination means a denial, reduction, termination or rescission of, or a failure to provide or make payment (in whole or in part) for, a benefit.

An Adverse Determination includes a denial, reduction, termination or rescission of, or a failure to provide or make payment (in whole or in part) for, a benefit that is based on:

- A Covered Person's eligibility for benefits under the Program;
- The results from the application of any utilization review;
- A determination that an item or service, for which benefits are otherwise provided, is experimental, investigational or not a Medical Necessity.

Appeal means a written request to the Administrator to reconsider an Adverse Determination.

Authorized Representative: An individual who the Covered Person willingly acknowledges to represent his or her interests during an appeal process. The Covered Person may be required to submit written verification of his or her consent to be represented. If the Covered Person has been determined by a Doctor to be incapable of assigning the right of representation, the appeal may be filed by a family member or a legal representative.

Covered Person means a person who claims to be entitled to receive benefits from the Administrator. References to Covered Person with respect to notifications also include the Covered Person's authorized representative.

Emergency Medical Condition means a medical or behavioral condition the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including, but not limited to, severe pain, that a prudent layperson, possessing an average knowledge of medicine and health, or as determined by the attending provider, could reasonably expect the absence of immediate medical attention to result in:

- Placing the health of the person afflicted with such condition in serious jeopardy, or in the case of a behavioral condition, placing the health of such person or others in serious jeopardy;
- Serious impairment to such person's bodily functions;
- Serious impairment or dysfunction of any bodily organ or part of such person; or
- Serious disfigurement of such person.

Internal Review Process means the procedure for an internal review of an Adverse Determination.

Medical Necessity means the providing of covered health care services or products that a prudent physician would provide to a patient for the purpose of diagnosing or treating an illness, injury, disease or its symptoms, in a manner that is:

- In accordance with generally accepted standards of medical practice;
- Consistent with the symptoms or treatment of the condition; and
- Not solely for anyone's convenience.

INTERNAL REVIEW PROCESS

The Administrator will provide written notice of the Internal Review Process to Covered Persons following any Adverse Determination. A Covered Person may submit an Appeal within 60 days of receiving written notice of an Adverse Determination or as soon as reasonably possible. If requested, the Administrator will provide written forms for submission of Appeals that will inform the Covered Person of the information necessary to pursue an appeal of an Adverse Determination.

If the Appeal is incomplete, the Administrator will immediately notify the Covered Person what information or materials is needed to make the Appeal complete. The Administrator may require that the Covered Person submit such written information or materials within 10 days of the Covered Person's receipt of the written form or as soon as reasonably possible. An Appeal shall be considered as received by the Administrator when the Administrator receives the written form, which the Covered Person purports to be complete. Under circumstances where an Appeal may not contain sufficient information and the Administrator requests additional information, such request will not be burdensome or require such information as the Administrator might reasonably be expected to obtain through the Administrator's normal claims process.

APPEAL PROCEDURE

When an Appeal is made, the Administrator will assign the Appeal to a staff member who has had no prior direct involvement with the Covered Person's case to conduct the review.

The Covered Person will have the opportunity to submit written comments, documents, records and other information relating to the claim for benefits, which the Administrator will review without regard to whether such information was submitted or considered in the initial benefit determination. The Administrator will provide the Covered Person, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the claim for benefits sufficiently in advance of the Appeal determination to give the Covered Person a reasonable opportunity to respond prior to such determination.

The review will be concluded as soon as possible in accordance with the medical exigencies of the case. Before the Administrator issues a determination that is based on new or additional rationale, the Covered Person will be provided, free of charge, with the rationale sufficiently in advance of the Appeal determination to give the Covered Person a reasonable opportunity to respond prior to such determination.

The Administrator will provide written notice of the Appeal determination to the Covered Person within ten (10) business days of receipt of the Appeal. In no event will an Appeal involving an Emergency Medical Condition exceed seventy-two (72) hours. In the event that the Adverse Determination is upheld, the written notice will include the reason for the determination, including the denial code and its corresponding meaning, and a review of the entire Internal Review Process. This information will include specific contact information (address and phone number).Information regarding external review will be provided to the Covered Person with the notice of the Adverse Determination.

COVERED PERSON'S RIGHTS

(a) The Administrator will not terminate or in any way penalize a Covered Person who exercises the right to appeal solely on the basis of filing the Appeal.
(b) Assistance
i. Upon the initiation of an Appeal, the Administrator will notify a Covered Person of the right to have
a staff member appointed to assist her/him with understanding the Internal Review Process.
ii. A Covered Person may request such assistance at any stage of the Internal Review Process.
iii. Upon such request, the Administrator will appoint a staff member who has had no prior direct involvement in the case to assist the Covered Person.
(c) After an Adverse Determination, a Covered Person will have the right to discuss a coverage determination with the staff member(s) who made the coverage determination.

If the Administrator does not adhere to all requirements of the Internal Review Process with respect to a claim, the Covered Person is deemed to have exhausted all internal appeals processes and may initiate an external review.

THE COVERED PERSON'S RIGHT TO AN EXTERNAL REVIEW

The Administrator will provide written notice of the right to an external review to Covered Persons following any Adverse Determination or final internal Adverse Determination. The Covered Person or authorized representative may file a written request for an external review with the external review examiner (hereafter referred to as the examiner) within four months after the date of receipt of a notice of an Adverse Determination or final internal Adverse Determination. If there is no corresponding date four months after the date of receipt of such a notice, then the request must be filed by the first day of the fifth month following the receipt of the notice. For example, if the date of receipt of the notice is October 30, because there is no February 30, the request must be filed by March 1. If the last filing date would fall on a Saturday, Sunday, or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or Federal holiday.

A Covered Person may make a written or oral request of an expedited external review with the examiner at the time the Covered Person receives:

(a) An Adverse Determination that involves an Emergency Medical Condition; and the Covered Person has filed a request for an expedited internal appeal; or
(b) An Adverse Determination that concerns an admission, availability of care, continued stay or health care item or service for which the Covered Person received services, but has not been discharged from a facility; and the Covered Person has filed a request for an expedited internal appeal; or
(c) A final internal Adverse Determination that involves an Emergency Medical Condition; or
(d) A final internal Adverse Determination that concerns an admission, availability of care, continued stay or health care item or service for which the Covered Person received services, but has not been discharged from a facility.

THE EXTERNAL REVIEW PROCESS

The examiner will review all of the information and documents timely received. In reaching a decision, the examiner will review the claim from the beginning and not be bound by any decisions or

conclusions reached during the Administrator's internal claims and appeals process applicable under paragraph (a) of the interim final regulations under section 2719 of the Public Health Service Act.

The examiner will forward all documents submitted directly to the examiner by the Covered Person to the Administrator. Upon receipt of any information submitted by the Covered Person, the examiner must within one business day forward the information to the Administrator. Upon receipt of any such information, the Administrator may reconsider its Adverse Determination or final internal Adverse Determination that is the subject of the external review. Reconsideration by the Administrator must not delay the external review. The external review may be terminated as a result of the reconsideration only if the Administrator decides, upon completion of its reconsideration, to reverse its Adverse Determination or final internal Adverse Determination and provide coverage or payment. Within one business day after making a decision to reverse, the Administrator must provide written notice of its decision to the Covered Person and the examiner. The examiner must terminate the external review upon receipt of the notice from the Administrator.

The examiner must provide written notice of the final external review decision as expeditiously as possible and within 45 days after the examiner receives the request for the external review. For expedited external reviews, the examiner must provide notice of the final external review decision within 72 hours after the examiner receives the request for the external review. For individuals with an Emergency Medical Condition who are also in an ongoing course of treatment for that condition, the external review decision must be provided within 24 hours. The examiner must deliver the notice of final external review decision to the Covered Person and the Administrator.

The examiner's final external review decision notice will contain:

(i) A general description of the reason for the request for external review, including information sufficient to identify the claim (including the date or dates of service, the health care provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, the treatment code and its corresponding meaning, and the reason for the previous denial, including denial codes);
(ii) The date the examiner received the assignment to conduct the external review and the date of the examiner's decision;
(iii) References to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;
(iv) A discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;
(v) A statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to either the Administrator or to the Covered Person;
(vi) A statement that judicial review may be available to the Covered Person; and
(vii) Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under Public Health Service Act section 2793.

After a final external review decision, the examiner must maintain records of all claims and notices associated with the external review process for six years. The examiner must make such records available for examination by the Covered Person or Administrator upon request.

For further information about external review or to request an external review:

Core Administrative Services, Inc.
515 Mulberry Street, Suite 300
Macon, GA 31202-1755
1-478-741-3521
Fax: 1-478-745-1843
www.corehealthbenefits.com

NOTICE OF PRIVACY PRACTICES

Privacy Officer: 478-741-3521

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Your Rights

You have the right to:

- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Answer coverage questions from your family and friends
- Provide disaster relief

Our Uses and Disclosures

We may use and share your information as we:

- Help manage the health care treatment you receive
- Run our organization
- Pay for your health services
- Administer your health Program
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say “no” to your request, but we’ll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests, and must say “yes” if you tell us you would be in danger if we do not.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request, and we may say “no” if it would affect your care.

Get a list of those with whom we’ve shared information

- You can ask for a list (accounting) of the times we’ve shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We’ll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 61.

- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Help manage the health care treatment you receive

We can use your health information and share it with professionals who are treating you.

Example: A doctor sends us information about your diagnosis and treatment Program so we can arrange additional services.

Run our organization

- We can use and disclose your information to run our organization and contact you when necessary.
- We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care Programs.

Example: We use health information about you to develop better services for you.

Pay for your health services

We can use and disclose your health information as we pay for your health services.

Example: We share information about you with your dental Program to coordinate payment for your dental work.

Administer your Program

We may disclose your health information to your health Program sponsor for Program administration.

Example: Your company contracts with us to provide a health Program, and we provide your company with certain statistics to explain the premiums we charge.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html**.**

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director

- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, and we will mail a copy to you.

THIRD PARTY ADMINISTRATORS

For access and control information, please direct your request to the following Third Party Administrators:

Core Administrative Services, Inc.
515 Mulberry Street, Suite 300
Macon, GA 31201
1-478-741-3521
Fax: 1-478-745-1843
www.corehealthbenefits.com

Termination of The Program

The Program Sponsor may terminate the Program by giving 60 days advance notice in writing to this Program Holder. This Program may, at any time, be terminated by mutual written consent of the Administrator and this Program Holder. This Program terminates automatically on the earlier of: (1) this Program Termination Date shown in the Schedule of Benefits; or (2) the premium due date if premiums are not paid when due. Termination takes effect at 11:59 p.m. Standard Time at this Program Holder's address on the date of termination. This Program is issued for this Program Term stated in the Eligibility and Effective Date of Coverage of this Program. If this Program Holder desires to continue coverage, a new Program will be issued for a new Program Term, subject to the then current underwriting requirements.

TERMINATION OF STUDENT COVERAGE

Insurance for a Covered Student will end at 11:59 p.m. on the first of these to occur:
(a) the date this Program terminates;
(b) the last day for which any required premium has been paid;
(c) the date on which the Covered Student withdraws from the school because of entering the armed forces of any country (Premiums will be refunded on a pro-rata basis (less any claims paid) when written request is made.) If withdrawal from the Program Holder's school is for other than the Covered Student's entry into the armed services no premium refund will be made. Students will be covered for this Program term for which they are enrolled and for which premium has been paid. Termination will not prejudice any claim for a charge that is incurred prior to the date coverage ends.

Note: Each Student must re-enroll each year even in the event this Program is renewed.

TERMINATION OF DEPENDENT COVERAGE

Insurance for a Covered Student's Dependent will end when insurance for the Covered Student ends. Insurance for Dependents will also terminate after any of the following events occur:
(a) the end of the month in which status as a Dependent ends;
(b) Dependent insurance is deleted from this Program (any unearned premium will be refunded); or
(c) at the end of the last period for which any required premium has been paid;
(d) in the event of a court or administrative order requiring coverage of a Dependent child, the date the court or administrative order is no longer in effect; or the date the Dependent child's comparable coverage provided through another carrier becomes effective. Satisfactory written evidence of this must be provided to the Program.

Definitions

The following are definitions of the terms which appear in the booklet:

Accident means an occurrence which (a) is unforeseen; (b) is not due to or contributed to by Sickness or disease of any kind; and (c) causes Injury.

Ambulatory Surgical Facility
A specialized facility:

1. Where licensing of such facility is mandated by law, has been licensed by the regulatory authority having responsibility for such licensing under the laws of the jurisdiction in which it is located; or
2. Where licensing of such facility is not mandated by law, meets all of the following requirements:
   a. It is established, equipped and operated primarily for the purpose of performing surgical procedures;
   b. It is operated under the supervision of a licensed Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.) who is devoting full-time to such supervision and permits a surgical procedure to be performed only by a duly qualified Physician who, at the time the procedure is performed, is privileged to perform such procedure in at least one Hospital in the area; and
   c. It is other than a private office or clinic of one or more Physicians.

Allowable Charges means the charges agreed to by the Preferred Provider Organization for specified covered medical treatment, services and supplies.

Chemical Dependency / Alcoholism Physically and/or emotionally dependent on drugs, narcotics, alcohol or other addictive substances to a debilitating degree.

Close Relative Any person that is immediately related to the insured (i.e. mother, father, brother, sister, spouse, or child) or directly related to the insured (i.e. aunt, uncle, grandparent, or cousin). Persons living in the insured's household such as domestic partners and/or significant others are also included.

Complications of Pregnancy means: (a) conditions which: require a Hospital stay when pregnancy is not terminated and whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy or are caused by pregnancy, such as: acute nephritis; nephrosis; cardiac decompensation; missed abortion; pre-eclampsia; intrauterine fetal growth retardation, and similar medical and surgical conditions of comparable severity; and (b) ectopic pregnancy which is terminated. The term does not include: false labor; occasional spotting; physician prescribed rest during the period of pregnancy; morning sickness; hyperemesis gravidarum; and similar conditions associated with the management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy.

Convalescent Care Facility May also be known as a Skilled Nursing Facility or Rehabilitative Center.

An institution, or a distinct part thereof, which is operated primarily for the purpose of providing inpatient Hospital, rehabilitative care, and treatment for individuals convalescing from an Injury or Illness, and:

1. is established and operated in accordance with applicable laws in the jurisdiction in accordance with applicable laws in the jurisdiction in which it is located or is licensed and/or approved by the regulatory authority having responsibility for licensing under the law;
2. provides appropriate methods of dispensing and administering drugs and medicines; and
3. has transfer arrangements with one or more Hospitals.

It does not include institutions which provide only minimal care, Custodial Care, ambulatory or part-time care services or an institution which primarily provides treatment of Mental / Nervous Conditions, Chemical Dependency / Alcoholism or tuberculosis.

Coinsurance means the percentage of the Eligible Expense payable by the Covered Person under this Program.

Co-pay means the initial dollar amount payable by the Covered Person for an Eligible Expense at the time service is rendered.

Covered Percentage means the percentage of the Eligible Expense that is payable as a benefit under this Program.

Covered Person means a Covered Student and his or her Dependent(s) insured under this Program.

Covered Student means a student of this Program Holder who is insured under this Program. This definition also includes scholars, as defined by the Program Holder.

Custodial Care Any room and board nursing services, and other institutional services that are primarily for daily living maintenance, even though the person is receiving medical services, when these services cannot reasonably be expected to substantially improve a medical condition.

Deductible/Deductible Amount means the dollar amount of Eligible Expenses a Covered Person must pay before benefits become payable.

Dependent means: (a) the Covered Student's Spouse residing with the Covered Student; and (b) the Covered Student's or Spouse's child until the date such child attains age 26.

Doctor as used herein means: (a) legally qualified physician licensed by the state in which he or she practices; and (b) a practitioner of the healing arts performing services within the scope of his or her license as specified by the laws of the state of such practitioner; and (c) certified nurse midwives and licensed midwives while acting within the scope of that certification. The term "Doctor" does not include a Covered Person's Immediate Family Member.

Durable Medical Equipment consists of, but is not restricted to, the initial fitting and purchase of braces, trusses and crutches, renal dialysis equipment, hospital-type beds, traction equipment, wheelchairs and walkers. Durable Medical Equipment must be prescribed by the attending Doctor and be required for

therapeutic use. The following items are not considered to be Durable Medical Equipment: adjustments to vehicles, air conditioners, dehumidifiers and humidifiers, elevators and stair glides, exercise equipment, handrails, improvements made to a home or place of business, ramps, telephones, whirlpool baths, and other equipment which has both a non-therapeutic and therapeutic use.

Elective Treatment means medical treatment, which is not necessitated by a pathological change in the function or structure in any part of the body, occurring after the Covered Person's effective date of coverage. Elective treatment includes, but is not limited to: vasectomy; breast reduction unless as a result of mastectomy; sexual reassignment surgery; submucous resection and/or other surgical correction for deviated nasal septum; treatment for weight reduction; learning disabilities; Botox injections; and treatment of infertility.

Eligible Expense as used herein means a charge for any treatment, service or supply which is performed or given under the direction of a Doctor for the Medically Necessary treatment of a Sickness or Injury: (a) not in excess of the Reasonable and Customary charges; or (b) not in excess of the charges that would have been made in the absence of this coverage; (c) with respect to the Preferred Provider, is the Allowable Charge; (d) is the negotiated rate, if any; and (f) incurred while this Program is in force as to the Covered Person except with respect to any expenses payable under the Extension of Benefits Provision.

Emergency Medical Condition means the occurrence of a condition of recent onset and sufficient severity, including, but not limited to, severe pain, that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that his or her condition, Sickness, or Injury is of such nature that failure to obtain immediate medical care could result in:

(a) placing the patient's health in serious jeopardy;
(b) serious impairment to bodily functions; or
(c) serious dysfunction of any bodily organ or part.

Emergency Services means, with respect to an Emergency Medical Condition:
(a)medical screening examination (as required under section 1867 of the Social Security Act, 42, U.S.C. 1395dd) that is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate such Emergency Medical Condition; and (b)such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the Hospital, as are required under section 1867 of the Social Security Act (42 U.S.C. 1395dd(e)(3)). Emergency does not include the recurring symptoms of a chronic illness or condition unless the onset of such symptoms could reasonably be expected to result in the complications listed above.

Essential Health Benefits has the meaning found in section 1302(b) of the Patient Protection and Affordable Care Act and as further defined by the Secretary of the United States Department of Health and Human Services and includes ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

Experimental/Investigational means a drug, device or medical care or treatment that meets the following: (a) the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished; (b) the informed consent document used with the drug, device, medical care or treatment states or indicates that the drug, device, medical care or treatment is part of a clinical trial, experimental phase or investigational phase, if such a consent document is required by law; (c) the drug, device, medical care or treatment or the patient's informed consent document used with the drug, device, medical care or treatment was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, if federal or state law requires such review and approval; (d) reliable evidence shows that the drug, device or medical care or treatment is the subject of ongoing Phase I or Phase II clinical trials, is the research, experimental study or investigational arm of ongoing Phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, it efficacy or its efficacy as compared with a standard means of treatment or diagnosis; or (e) reliable evidence shows that the prevailing opinion among experts regarding the drug, device, medical care or treatment is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with standard means of treatment of diagnosis. Reliable evidence means: published reports and articles in authoritative medical and scientific literature; written protocol or protocols by the treating facility studying substantially the same drug, device, medical care or treatment; or the written informed consent used by the treating facility or other facility studying substantially the same drug, device or medical care or treatment. Eligible Expenses will be considered in accordance with the drug, device, medical care or treatment at the time the Expense is incurred.

Family Status Change means the following:

(a) marriage; or

(b) birth or adoption of a child.

Fiduciary The person or organization that has the authority to control and manage the operation and administration of the Program. The Fiduciary has discretionary authority to determine eligibility for benefits or to construe the terms of This Program. The named Fiduciary for This Program is Mercer University.

Hospital means a facility which meets all of these tests:

(a) it provides in-patient services for the care and treatment of injured and sick people; and

(b) it provides room and board services and nursing services 24 hours a day; and

(c) it has established facilities for diagnosis and major surgery; and

(d) it is supervised by a Doctor; and

(e) it is run as a Hospital under the laws of the jurisdiction in which it is located; and

(f) it is accredited by the Joint Commission on Accreditation of Healthcare Organizations.

Hospital does not include a place run mainly: (a) as a convalescent home; or (b) as a nursing or rest home; (c) as a place for custodial or educational care; or as an institution mainly rendering treatment or services for: Mental or Nervous Disorders; or substance abuse. The term "Hospital" includes: (a) an ambulatory surgical center or ambulatory medical center; and (b) a birthing facility certified and licensed as such under the laws where located. It shall also include rehabilitative facilities if such is specifically for treatment of physical disability. Hospital also includes tax-supported institutions, which are not required to maintain surgical facilities.

Hospital Confinement/Hospital Confined means a stay of at least 18 consecutive hours or for which a room and board charge is made.

Immediate Family Member(s) means a person who is related to the Covered Person in any of the following ways: Spouse, brother-in-law, sister-in-law, son-in-law, daughter-in-law, mother-in-law, father-in-law, parent (includes stepparent), brother or sister (includes stepbrother or stepsister), or child (includes legally adopted or stepchild).

Injury means bodily injury due to an Accident which: (a) results solely, directly and independently of disease, bodily infirmity or any other causes; (b) occurs after the Covered Person's effective date of coverage; and (c) occurs while coverage is in force. All injuries sustained in any one Accident, including all related conditions and recurrent symptoms of these injuries, are considered one Injury.

Intensive Care Unit means a designated ward, unit or area within a Hospital for which a specified extra daily surcharge is made and which is staffed and equipped to provide, on a continuous basis, specialized or intensive care or services not regularly provided within such Hospital.

Medical Necessity/Medically Necessary means that a drug, device, procedure, service or supply is necessary and appropriate for the diagnosis or treatment of a Sickness or Injury based on generally accepted current medical practice in the United States at the time it is provided.
A service or supply will not be considered as Medically Necessary if:

(a) it is provided only as a convenience to the Covered Person or provider; or
(b) it is not the appropriate treatment for the Covered Person's diagnosis or symptoms; or
(c) it exceeds (in scope, duration or intensity) that level of care which is needed to provide safe, adequate and appropriate diagnosis or treatment; or
(d) it is Experimental/Investigational or for research purposes; or
(e) could have been omitted without adversely affecting the patient's condition or the quality of medical care; or
(f) involves treatment of or the use of a medical device, drug or substance not formally approved by the U.S. Food and Drug Administration (FDA); or
(g) involves a service, supply or drug not considered reasonable and necessary by the Center for Medicare and Medicaid Services Issues Manual; or
(h) it can be safely provided to the patient on a more cost-effective basis such as outpatient, by a different medical professional or pursuant to a more conservative form of treatment. The fact that any particular Doctor may prescribe, order, recommend, or approve a service or supply does not, of itself, make the service or supply Medically Necessary.

One Sickness means a Sickness and all recurrences and related conditions which are sustained by a Covered Person.

Orthopedic Brace and Appliance means a supportive device or appliance used to treat a Sickness or Injury.

Personal Item is one which is not needed for proper medical care and is used mainly for the purpose of meeting a personal need.

Physiotherapy means any form of the following administered by a Doctor for treatment of Sickness or Injury: physical or mechanical; diathermy; ultra-sonic therapy; heat treatment in any form; or manipulation or massage.

Physician A licensed Doctor of Medicine (M.D.), Osteopathy (D.O.), Dentistry, Podiatry and inalpractic providing a covered Service and acting within the scope of his/her license, who is not a member of the patient's immediate family.

Program Year means the period of time measured from the Effective date to the Termination Date as shown in the Schedule of Benefits.

Pre-Admission Testing means diagnostic tests and services ordered by the attending Doctor as appropriately related to the care and treatment of the Covered Person's condition in anticipation of a scheduled Hospital Confinement and required prior to surgery; a Hospital bed and operating room have been reserved before the tests are made; and the surgery is performed within 7 days after the tests; and the Covered Person is physically present for the tests. In the event pre-admission testing is ordered by the attending Doctor and the Hospital Confinement and/or surgery are subsequently canceled, benefits for pre-admission testing and services already performed will be covered and benefits will be payable under this Program based on the available coverage.

Pre-Notification means a method by which insurance companies monitor utilization through prior notification to the Program of services to be rendered.

Pre-Existing Condition means any physical or mental condition, Sickness, impairment, or ailment, regardless of cause, medical advice, diagnosis, care or treatment received within the 6 month period ending on the Covered Person's effective date of coverage under this Program.

Preventive Services mandated by the Patient Protection and Affordable Care Act and, In addition to any other preventive benefits described in the Program or Certificate, means the following services and without the imposition of any cost-sharing requirements, such as deductibles, copayment amounts or coinsurance amounts to any Covered Person receiving any of the following:

1. Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force, except that the current recommendations of the United States Preventive Service Task Force regarding breast cancer screening, mammography, and prevention of breast cancer shall be considered the most current other than those issued in or around November 2009;
2. Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the Covered Person involved;
3. With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health resources and Services Administration; and
4. With respect to women, such additional preventive care and screenings, not described in paragraph 1 above, as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

Reasonable and Customary means the charge, fee or expense which is the smallest of: (a) the actual charge; (b) the charge usually made for a covered service by the provider who furnishes it; (c) the negotiated rate, if any; and (d) the prevailing charge made for a covered service in the geographic area by those of similar professional standing. "Geographic area" means the three digit zip code in which the services, procedure, devices, drugs, treatment or supplies are provided or a greater area, if necessary, to obtain a representative cross-section of charge for a like treatment, service, procedure, device, drug or supply.

Sickness means disease or illness including related conditions and recurrent symptoms of the Sickness which begins after the effective date of a Covered Person's coverage. Sickness also includes pregnancy and Complications of Pregnancy.

Sound Natural Teeth means natural teeth, the major portion of the individual tooth which is present regardless of fillings and is not carious, abscessed, or defective. Sound Natural Teeth will not include capped teeth.

Spouse means the person to whom the Covered Student is married.

Student Health Center means any organization, facility or clinic operated, maintained or supported by this Program Holder.

Third Party Administrator The person/organization hired by the Program sponsor in connection with the operation of This Program and performing such functions, as processing and payment of claims, as may be delegated to it.

The Third Party Administrator is:
Core Administrative Services
PO Box 90
Macon, GA 31202-0090
478-741-3521 or 888-741-CORE

This Program / Program The Program of benefits as contained in the Summary Program Description and Group Provision Pages, and any agreements, schedules and amendments endorsed by the University or Program Sponsor.