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 Benefits	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 (Limit to one visit per day)	Services of a Doctor other than a Doctor who performed surgery or administered anesthesia	80% of Allowable Charge	60% of Reasonable Charges
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/ 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
Anesthetist Services	In connection with surgery	80% of Allowable Charge	60% of Reasonable Charges
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 same doctor. (Chiropractic Care Benefits limited to twenty (20) visits)	**90% of Allowable Charge at Mercer Medicine** (FHN) 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)
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)
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**	**Non-Formulary/ Specialty Brand**
		$10 copay + 20% Coinsurance	$30 copay + 20% Coinsurance	$50 copay + 20% Coinsurance
Prescribed Birth Control	(all FDA approved methods are covered)	**Generic**	**Formulary Brand**	**Non-Formulary/ 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		80% of Allowable Charge	60% of Reasonable Charges
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-	100% of Allowable Charge Deductible waived	60% of R&C

	benefits or see pages 32-35 of the Summary Plan Description (SPD).		

THE FOLLOWING VISION AND DENTAL BENEFITS ARE ONLY FOR DEPENDENTS ON YOUR PLAN WHO ARE UNDER THE AGE OF 19

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 contracts.*	$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 contracts.*	$25 copay (One (1) pair of frames every 24 months)	Up to $70	
Contact Lenses: *Covered once every calendar year in lieu of eyeglasses.*	$25 copay (one (1) pair of lenses per Program Year) Fit, follow-up Materials	Up to $100	
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 in the Summary Plan Description (SPD).		

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

Maternity expense and routine newborn care, including 48-hour 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.

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 complications 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; 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 aphakic patients and soft lenses or sclera shells intended for use as corneal bandages unless otherwise noted.
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 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. Charges for telephone consultations, 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 (Rinkle method), cytotoxicity testing (Bryan's Test), treatment of non-specific candida sensitivity, and urine auto injections.