MERCER UNIVERSITY

Summary Health Insurance Program Description

STUDENT HEALTH INSURANCE PROGRAM

For coverage effective August 1, 2014

Health Insurance
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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, 2014.

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 may not meet the minimum standards required by the health care reform law for the restrictions on annual dollar limits. The annual dollar limits ensure that consumers have sufficient access to medical benefits throughout the annual term of the Program. Your student health insurance coverage has an annual limit of at least: $500,000 on essential benefits. 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 and Customary. 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 and Customary 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.

	Health Care at Student Health Center	Health Care In-Network Mercer Medicine First Health PPO Network	Health Care Out-of-Network
Maximum Benefit The first Eligible Expense must be incurred within 30 days after the date of the Accident causing the Injury.	$500,000 Maximum Benefit per Program Year		
Program Year deductible per Covered person *(Deductible applies to all charges, unless specified)*	Not Applicable	$400	$500
Out-of-Pocket Limit per Covered Person per Program Year	Not Applicable	$6,250	Unlimited

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

INPATIENT			
Student Health Center Referral Required, Pre-Notification Recommended	**Health Care at Student Health Center**	**Health Care In-Network Mercer Medicine First Health PPO Network**	**Health Care Out-of-Network**
Room and Board except if intensive care unit, up to average Semi-Private Room Rate	Not Applicable	80% of Allowable Charge	60% of Reasonable & Customary
Hospital Miscellaneous	Not Applicable	80% of Allowable Charge	60% of Reasonable & Customary
Physiotherapy	Not Applicable	80% of Allowable Charge	60% of Reasonable & Customary
Surgery	Not Applicable	80% of Allowable Charge	60% of Reasonable & Customary
Assistant Surgeon	Not Applicable	25% of Surgery Allowance	25% of Surgery Allowance
Anesthesia	Not Applicable	80% of Allowable Charge	60% of Reasonable & Customary
Registered Nurse or Licensed Practical Nurse (private duty nursing)	Not Applicable	80% of Allowable Charge	60% of Reasonable & Customary
Doctor's Visits (1 visit per day. Benefits do not apply when not related to physiotherapy)	Not Applicable	80% of Allowable Charge	60% of Reasonable & Customary
Psychiatric Conditions Expense	Not Applicable	Same as any other Sickness	Same as any other Sickness
Pre-Admission Testing	Not Applicable	80% of Allowable Charge	60% of Reasonable & Customary

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.

OUTPATIENT

Student Health Center Referral required, Pre-notification Recommended	Health Care at Student Health Center	Health Care In-Network Mercer Medicine First Health PPO Network	Health Care Out-of-Network
Surgery	Not Applicable	80% of Allowable Charge	60% of Reasonable & Customary
Day Surgery Miscellaneous (Reasonable and Customary Charges for Day Surgery Miscellaneous are based on the most recent edition of the Outpatient Surgical Facility Charge Index)	Not Applicable	80% of Allowable Charge	60% of Reasonable & Customary
Assistant Surgeon	Not Applicable	25% of Surgery Allowance	25% of Surgery Allowance
Anesthesia	Not Applicable	80% of Allowable Charge	60% of Reasonable & Customary
Urgent Care	Not Applicable	80% of Allowable Charge (after $25 per visit copay) (Deductible does not apply)	60% of Reasonable & Customary (after $25 per visit copay) (Deductible does not apply)
Emergency Room (Services must be rendered within 72 hours of the Accident or within 72 hours of the first onset of Sickness. The student must return to the Student Health Center for necessary follow-up care.)	Not Applicable	$250 copay per visit (copay waived if admitted to Hospital)	
		80% of Allowable Charge	80% of Reasonable & Customary
Doctor's Visits (1 visit per day when not related to surgery)	Covered under the Student Health Fee	**90% of allowable Charge at Mercer Medicine** 80% of Allowable Charge (after $25 per visit copay) (Deductible does not apply)	60% of Reasonable & Customary (after $25 per visit copay) (Deductible does not apply)
Outpatient Physiotherapy benefits (Limited to Eighteen (18) visits.)	Not Applicable	80% of Allowable Charge (after $25 per visit copay)	60% of Reasonable & Customary (after $25 per visit copay)
X-rays, Laboratory, Tests and Procedures	Not Applicable	80% of Allowable Charge	60% of Reasonable & Customary
Chemotherapy / Radiation Therapy	Not Applicable	80% of Allowable Charge	60% of Reasonable & Customary
Ambulance	Not Applicable	80% of Allowable Charge	60% of Reasonable & Customary
Prescribed Medicine Expense	Not Applicable	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	
		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.)	
Prescribed Birth Control (all FDA approved methods are covered, except IUDs and implants)	Not Applicable	**Generic** | **Formulary Brand** | **Specialty Brand**	
		100% allowable | See Prescribed Medicine Expense for copay	
Psychiatric Conditions Expense	Not Applicable	Same as any other Sickness	Same as any other Sickness

OUTPATIENT BENEFITS CONTINUED
Preventive Services • For eligible preventive services rendered at the Student Health Center, eligible expenses will be paid at 100% allowable charge, not subject to deductibles or copays. • Services rendered outside the Student Health Center with an In-Network provider, the first $300 of eligible expenses is covered at 100% *(Balances over $300 are subject to deductible and coinsurance). Out-of-Network providers will be subject* to the deductible, copay and coinsurance.
OTHER INSURANCE BENEFITS
Durable Medical Equipment (replacement not covered): In-Network: 80% of Allowable Charge; Out-Of-Network: 60% Reasonable & Customary
Braces and Appliances: In-Network: 80% of Allowable Charge; Out-Of-Network: 60% Reasonable & Customary.
Consultant (When ordered by attending Doctor to confirm or determine diagnosis): In-Network:80% of Allowable Charge (after $25 per visit copay); Out-Of-Network: 60% of Reasonable & Customary (after $25 per visit copay)
Alcoholism/Drug Abuse: In-Network: 80% of Allowable Charge, Out-Of-Network: 60% Reasonable & Customary
Dental (injuries to sound natural teeth only): 80% of Reasonable & Customary
Maternity and Complications of Pregnancy: Same as any other Sickness
Injections and/or Immunizations/Flu (Influenza vaccine**). See preventive services**

Intercollegiate Sports Injury

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.

Club Sports Injury

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 club sports sponsored and supervised by Mercer University.

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*.

Ambulance, Air

This is a covered expense under this Program. (Maximum payable is $10,000).

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 up to $250 with a doctor's written prescription and an itemized receipt of purchase. *(No replacement for loss or damage)(Subject to the deductible)*

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 NOT a covered expense under this Program.

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.

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 15 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. Begins within fourteen (14) days following an eligible Hospital confinement of at least three (3) days duration;
2. Is prescribed by a Physician who remains in attendance at least once every seven (7) days;
3. Is for necessary recuperative care of the same condition requiring the prior hospitalization;
4. 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*.

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 preventative, basic restorative, major restorative, orthodontic, or for diagnostic care, including teeth broken while chewing, are not included under this medical Program.

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

This is a covered expense under this Program.

Treatment for services rendered in a Hospital Emergency Room.

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

Charges in excess of the above percentile 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 preventive services.

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 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.

Genetic Testing is only covered under the Program if the following conditions are met:

1. Testing must be Pre-certified by Core Health Services (CHS).
2. The results of the testing will be used to determine the course of treatment for an existing condition.

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

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 or not 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 thirty (30) days per Plan year.

An agency or organization which provides a program of Home Health Care.

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. Maximum thirty (30) days per Plan year.

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

This is a covered expense under this Program.
Procedure to remove one or both breast(s), reconstruction of the breast on which the mastectomy was performed, surgery and reconstruction of the other breast to produce a

symmetrical appearance, and prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas.[2]

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.[3]

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, counseling, supplies, medication or surgery primarily intended for weight loss or any complications that occur as the result of any of the above services..

Oral Surgery

This is a covered expense under this Program.

Oral Surgery including routine x-rays, the treatment Program, local anesthetics and post-surgical care for:

1. Osseous surgery, including flap entry, closure per quadrant;
2. Osseous surgery, including flap entry, closure and donor sites;
3. Muco-gingival surgery; and
4. Surgical removal of impacted Wisdom teeth.

Out-of-Pocket Limit

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

Outpatient Dialysis

Benefits provided under this Program for treatment received in connection with Outpatient Dialysis are subject to the following provisions:

The Program provides an alternative basis for payment of claims associated with dialysis-related services and products on an outpatient basis ("Outpatient Dialysis"). This alternative basis may be applied to claims by any healthcare provider, regardless of the healthcare provider's participation in the Preferred Provider Organization (PPO).

All eligible students and their Dependents requiring Outpatient Dialysis are subject to cost containment review, negotiation and/or other related administrative services which the Program Administrator may elect to apply in the exercise of the Program Administrator's discretion.

The Program shall pay no more than the Usual and Reasonable Charges for covered services and/or supplies incurred in connection with Outpatient Dialysis, after deduction of all amounts payable by coinsurance or deductibles. The Program Administrator shall determine the benefits based on the Usual and Reasonable Charge. The Program Administrator may pay or reimburse charges greater than the Usual and Reasonable Charge based upon factors concerning the nature and severity of the condition being treated, geographic and market considerations and provider availability, in the exercise of the Program Administrator's discretion. All charges must be billed in accordance with generally accepted industry standards.

For the purpose of Outpatient Dialysis, the following definitions shall apply:

Usual and Reasonable Charge shall mean charges(s) based upon the average payment actually made for reasonable comparable services and/or supplies to all providers of the

same services and/or supplies by all types of Programs in the same market area during the preceding Plan year, adjusted for the National Consumer Price Index medical care rate of inflation.

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 flat amount that a Covered Person pays at the time of the office visit. After the copayment, charges are covered at 80%. The copayment amount does not go toward the Program Year Out-of-Pocket Maximum. Therefore, even 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.
Charges for telephone consultations, failure to keep scheduled appointments, completion of claim forms or providing medical information necessary to determine coverage.

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[4]

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.

Preventative Services Benefit

- For eligible preventive services rendered at the Student Health Center, eligible expenses will be paid at 100% allowable charge, not subject to deductibles or copays.
- Services rendered outside the Student Health Center with an In-Network provider, the first $300 of eligible expenses is covered at 100% (Balances over $300 are subject to deductible and coinsurance). Out-of-Network providers will be subject to the deductible, copay and coinsurance.

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 preventative treatment.

For the purposes of This Program, prophylactic or preventative 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 *Routine Preventative Services Benefit* 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.

Repair of a body part due to Injury or Illness.

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 Preventative 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 NOT 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 NOT a covered expense under this Program.*
Therapy – *This is NOT a covered expense under this Program.*
Counseling – *This is NOT 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*.

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.

Physical
This is a covered expense under this Program.
Limited to Eighteen (18) 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.

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.

Transplant

This is NOT a covered expense under this Program.

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).

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 Preventative Services Benefit and New Newborn 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 or not recommended by a Physician (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.

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.
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.
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 Program 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. "Cosmetic surgery" shall not include reconstructive surgery when such surgery is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part and reconstructive surgery because of a congenital disease or anomaly of a covered dependent newborn child which has resulted in a functional defect. It also shall not include breast reconstructive surgery after a mastectomy.
11. for preventive treatment, testing, immunizations, injections, medicines, serums, vaccines, vitamins, anti-toxins except as specifically provided in the Program.
12. as a result of committing or attempting to commit a felony or participation in a felony, riot, insurrection or civil commotion.
13. for Elective Treatment or elective surgery or complications arising therefrom.
14. after the date insurance terminates for a Covered Person except as may be specifically provided in the Extension of Benefits Provision.
15. for any services rendered by a Covered Person’s immediate family member.
16. for any treatment, service or supply which is not Medically Necessary.
17. for surgery and/or treatment of: acupuncture; gynecomastia; allergy injections, and anti-toxins; biofeedback-type services; breast implants; or breast reduction unless Medically Necessary following a mastectomy; circumcision; corns, calluses and bunions; deviated nasal septum,

including submucuous 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.

18. for routine medical care, physical examinations, health examinations or preschool physical examinations, including routine care of a newborn infant, well-baby care and related Doctor charges, except as specifically provided for in the Program.
19. for sterilization or sterilization reversal, including surgical procedures and devices except as specifically provided; or for birth control except as specifically provided.
20. for Injury resulting from bungee jumping.
21. for organ transplants.
22. for voluntary or elective abortions.
23. 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.
24. for Injury resulting from fighting, except in self-defense.
25. 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.
26. for treatment, services, drugs, device, procedures or supplies that are experimental or investigational.
27. for treatment, service or supply for which a charge would not have been made in the absence of insurance.
28. for hormone treatment or hormone therapy not related to the treatment of a Sickness.
29. for Intrauterine devices (IUD)s and birth control implants.
30. 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 will be sufficient for this exclusion. Expenses will be covered for injured Covered Persons other than the person illegally using alcohol and expenses will be covered for Substance Abuse treatment as specified in This Program. 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.
31. for Complications of non-covered treatments that required care, services or treatment are not covered under This Program. Complications from a non-covered abortion are covered.
32. for Education or Vocational Testing or Training.
33. for exercise programs for treatment of any condition, except for Physician-supervised cardiac rehabilitation, occupational or physical therapy covered by This Program.
34. 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.

35. for Gastric Bypass Surgery/Bariatric Surgery, Services, supplies, care or treatment or complications.
36. for Hearing Aids and Exams. Charges for services or supplies in connection with hearing aids or exams for the evaluation of hearing quality, loss or hearing aid fitting.
37. 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.
38. 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 injured Covered Persons other than the person using controlled substances and expenses will be covered for Substance Abuse treatment as specified in This Program. This exclusion does not apply if Injury resulted from an act of domestic violence or a medical (including both physical and mental health) condition;
39. for No Charge. Care and treatment for which there would not have been a charge if no coverage had been in force.
40. 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;
41. for Not Medically Necessary. Services, supplies, care or treatment for an Injury or Illness which is not medically necessary.
42. for Not Specified as Covered. Non-traditional medical services, treatments and supplies which are not specified as covered under This Program.
43. 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;
44. 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.
45. for Pregnancy of daughter. Services, supplies, care or treatment of pregnancy for a Dependent daughter only. Complications of pregnancy are covered.
46. 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 Program.
47. for Spinal Decompression services, supplies, care or treatment related to spinal decompression as performed by facilities such as The Back Pain Institute.

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 / Detroamphetamine (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 All Generic Prescriptions at 100%
C Oral dosage forms (e.g. Ortho Novum, Demulen)
N Non-oral dosage forms - IUD
C Non-oral dosage forms (Diaphragm)
C Injectable dosage forms (e.g. Depo Provera)
N 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
N Oral rinses
N Topical dental preparations

HIV / AIDS Medications
Pre-notification through CHS required.
C Therapeutic classifications (e.g. Hivid, Epivir, Videx, Zervit)

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. Renoval)
N Blood and Blood Plasma (see hospital services)
N Growth Hormones (e.g. Humatropin, Genotropin)
N Immunization Agents (e.g. Hepatitis, Chicken Pox) (See Preventative 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.

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 covers only 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 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 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).

  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** – 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 require pre-authorization by CHS. *Breast pumps will be reimbursement up to $250 with a doctor's written prescription and a receipt of purchase (subject to the deductible).*

  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)*
- *Heart Catheterization – If elective or if admitted*
- *HIDA Scan*
- *Inpatient stay*
- *MRI*
- *Nerve Conduction Studies*
- *Nuclear Scan*
- *Observation Stay*
- *Outpatient surgery (unless listed below)*
- *PET Scan*
- *Sleep Studies*
- *Therapies – Physical therapy, occupational therapy, and speech therapy*

The following items do not require pre-certification:

- *Cardiac Stress Test*
- *Cataract Surgery*
- *Esophagogastroduodenoscopy (EGD) [Upper GI]*
- *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:

- *Blephareplasty*
- *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*

- *Sclerotherpy*
- *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 Program on file with the University becomes effective at 12:01 a.m. on August 1, 2014 and terminates at 11:59 p.m. on *August 19, 2015. 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.

*Specific Effective and Termination Dates:

- ELI Program Students: **August 20, 2014 – August 19, 2015
- All Other Covered Students: August 1, 2014 – July 31, 2015

**August 20, 2015 for those students enrolled in and maintaining continuous coverage from the 2014-2015 Mercer University Program.

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 then current academic year.
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 Engineering Distance Education Students are not eligible to participate

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.)*

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. No authorization or referral requirement shall apply to obstetrical care provided by in-network providers. The deductibles and copay amounts (other than Prescribed Medicines) will be waived when services are provided at the Student Health Center. 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.

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

This section will be used to determine a Covered Person's benefits under this Program if: 1. the person is insured for medical care benefits under this Program and is also covered for these benefits under other Programs; and 2. the benefits that would be paid by this Program, without this section plus the benefits that would be paid by the other Programs, without a section similar to this section would exceed Allowed Expenses as defined below.

Definitions

"Program" means a Program which provides benefits or services for, or by reason of Hospital, surgical medical, or dental care or treatment through:

1. any other group, blanket or franchise insurance coverage;
2. pre-paid Programs for:
   - group Hospital service
   - group medical service
   - group practice
   - individual practice and
   - any other such Programs for members of a group;
3. any Program provided by:
   - labor management trusts
   - unions
   - employer organizations
   - professional organization, or
   - employee benefit organizations;
4. a government program or statute, other than a state medical assistance Program that implements Title XIX of the Social Security Act of 1965; and
5. any part of a state auto reparation or indemnity act ("no fault insurance") with which the state permits coordination.

"This Program" means the medical care benefits provided by this Program.

"Allowed Expense " means an Expense which is:
- necessary, Reasonable and Customary;
- incurred while the person for whom the claim is made is insured, or is entitled to benefits after insurance ends, under this Program;
- at least partly covered under one of the Programs covering such person.

The difference between the cost of a private Hospital room and the cost of a semi-private Hospital room shall not be deemed to be an Allowed Expense unless the patient’s stay in a private room is Medically Necessary in terms of generally accepted medical practice.

When this Program does not pay its benefits first, "Allowed Expense" will not include an Expense which is not paid because of the claimant's failure to comply with the cost containment requirements of the Program which pays its benefits first.

When a Program provides a benefit as a service rather than a cash payment, the reasonable cash value of the service will be considered to be both an Allowed Expense and a benefit paid.

Effects On Benefits Under This Program
When this section is used, the rules listed below will determine the amount of benefit each Program will pay. All benefits will be determined on a Program Year basis.

These rules may require this Program to pay its benefits first. If so, this Program will pay its full benefits without taking into account other Program benefits. These rules may require one or more of the other Programs to pay their benefits before this Program. If so, this Program will reduce its benefits so that in any Program Year, the sum of all benefits to be paid to a person (by this and all other Programs) equals the Allowed Expenses for that year. Benefits to be paid under other Programs include benefits that would be paid if proper claim is made for such benefits.

Rules to Determine which Program Pays First
A Plan/Program or part of one, which does not have a section similar to this section, will pay its benefits before a Plan/Program that has such a section.

In all other cases, the Plan/Program that will pay its benefits first will be dependent upon the first applicable rule:

1. The Plan/Program that does not reserve the right to take this Program's benefits into account in figuring its own benefits will always be primary.
2. The Plan/Program which covers the Covered Person as an employee; rather than as a full or part-time student.
3. If 2 does not apply, the Plan/Program which covers the person as a dependent rather than as a full or part-time student.
4. If 1, 2, and 3 do not apply, the Plan/Program which covers the person as a Dependent of the parent whose month and day of birth occurs earlier in the year. If the other Plan/Program has a rule based on the gender of the parent, the gender rule will determine the order of benefits. However, a child's parents may be divorced or separated. If the parents are divorced or separated, the Plan/Program to pay its benefits first will be the Plan/Program which covers the child as a Dependent of the parent with custody rather than as a Dependent of the parent without custody.

If the parent with custody remarries:
- the Program which covers the child as a Dependent of a parent with custody will pay its benefits first,
- the Program which covers the child as a Dependent of a stepparent will pay its benefits next, and the Program which covers the child as a Dependent of a parent without custody will pay its benefits last.

For a Dependent child of separated or divorced parents, the following governs which Program pays first when the person is a Dependent of a student:

(a)when a court order makes one parent financially responsible for the health care expenses of the Dependent child, then that parent's Program pays first;
(b)if there is no such court order, then the Program of the natural parent with custody pays before the Program of the stepparent with custody; and
(c)the Program of the stepparent with custody pays before the Program of the natural parent without custody.

Item 1 will not apply unless a similar provision is contained in all Programs. In this case item 2, 3, or 4 will determine which Program pays first. If none of the above applies, then the Program which has covered the Covered Person for the longer time rather than the shorter time pays first. If the benefits of this Program are reduced due to these rules, such reduction will be done in proportion. Any benefits paid by this Program on a reduced basis will be charged against the benefit limits of this Program.

Right to Receive and Release Necessary Information
For this section to work, the Administrator must exchange information with other Programs. To do so, the Administrator may give to or get from any source all such information it thinks necessary. This will be done without the consent of or notice to any person except as required by the applicable state statute. Any person claiming benefits under this Program must give the Administrator the information it requires.

Facility of Payment
Another Program may pay a benefit that should be paid by the Administrator by the terms of the provision. If this happens, the Administrator may pay to such payer the amount required for it to satisfy the intent of this provision. This will be done at the Administrator's discretion. Any amount so paid will be considered a benefit under this Program. The Administrator will not be liable for such payment after it is made.

Right of Recovery
If the amount of the payments made by the Administrator is more than it should have paid under this Coordination of Benefits provision, it may recover the excess from one or more of:
(a) any person to or for or with respect to whom such payments were made; and
(b) any organization which should have made such payments.

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 on the first premium due date 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. Insurance may be continued for incapacitated dependent children who reach the age at which insurance would otherwise cease. The dependent child must be:

(a) chiefly dependent upon the Covered Student for support; and

(b) incapable of self-sustaining employment because of mental or physical handicap. Proof of the incapacity and dependency must be furnished to the Program by the Covered Student within 31days after insurance would terminate because of age and as often as the Program may subsequently request but not more often than once a year after the 2 year period following the child's attainment of the limiting age. Termination will not prejudice any claim for a charge that is incurred prior to the date coverage ends.

TERMINATION OF COVERAGE - EXTENSION OF BENEFITS

If the Covered Person is confined to a Hospital on the date his or her coverage terminates as a result of Sickness or Injury for which benefits were payable prior to the date his or her coverage terminated, benefits will be payable for the Eligible Expenses incurred until the earliest of: (1) the end of discharge; (2) the end of the 30 day period following the date his or her coverage terminated; or (3) the date the applicable Maximum Amount is reached.

The Extension of Benefits will apply only to the extent the Covered Person will not be covered under this Program or any other health insurance Program in the ensuing term of coverage.

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. All Sicknesses due to the same or a related cause are considered One Sickness.

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.